Spiritual Care In Medical Records

A Guide to Reporting and Documenting Spiritual Care in Health Services

Produced by Spiritual Health Association

Spiritual Health Association (SHA) is the peak body enabling the provision of quality spiritual care in all health services.

Spiritual Health Association

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About Spiritual Health Association (SHA)

Spiritual Health Association (SHA) is the peak body enabling the provision of quality spiritual care in all health services. We believe that when spiritual needs are recognised and responded to as an integral part of person-centred care, an essential contribution is made to people's health and wellbeing. SHA works in collaboration with spiritual care practitioners, faith communities and health services to develop spiritual care services responsive to people's needs. SHA is supported by the State Government of Victoria through Safer Care Victoria.

This version of the "SPIRITUAL CARE IN MEDICAL RECORDS: A Guide to Reporting and Documenting Spiritual Care in Health Services" incorporates:

- References to the National Safety and Quality Health Service Standards 2nd Edition which were published in 2017
- 2017 updates of the ICD10-AM/ACHI/ACS Spiritual Intervention Codes
- Information on the Victorian Integrated Non-Admitted Health (VINAH) minimum dataset which was not included in the original 2015 version.

Spiritual Health Association acknowledges the traditional Custodians of the land where we work, the Wurundjeri people, and pay our respects to their Elders, past and present, and to Elders from all other Country.

Your comments are important to us

Feedback on how you are using this Spiritual Health Association publication in your organisation helps us to improve the quality of our resources.

We welcome your comments and invite you to email them to: development@spiritualhealth.org.au

Section 1

1. Target audience

This section is applicable to Directors of Allied Health, executives and health services' managers who have oversight of spiritual care departments. It provides background information about the development of a minimum dataset for spiritual care.

> *Developing a consensus approach promoted reliable and accurate data collection within the spiritual care sector in Victoria.*

2. Background to the development of a minimum dataset for spiritual care

In 2008, Spiritual Health Victoria (formerly the Healthcare Chaplaincy Council of Victoria Inc.) commissioned a report on benchmarking in Victorian health services (Boddé, 2008). The report's recommendations included the continued development of metrics for a minimum dataset for pastoral care. This was followed by the development of reporting standards in 2012 (Healthcare Chaplaincy Council of Victoria Inc., 2012).

Spiritual Health Victoria (SHV) developed the Spiritual Care Minimum Data Set (SCMDS) Framework in consultation with spiritual care coordinators and managers in health services to improve reporting to the Department of Health and Human Services (DHHS). The framework evolved from the Spiritual Care Minimum Data Set Pilot Project which was undertaken by SHV in 2013–2014 (Spiritual Health Victoria, 2014). Twenty-two health services participated in the first phase of the project.

A Spiritual Care Minimum Data Set (SCMDS) Working Group was established for Phase 2 of the project and the Working Group reached consensus on a new framework for data collection. This met the DHHS' requirements for the 2014-2015 financial year (Spiritual Health Victoria, 2014).

Developing a consensus approach promoted reliable and accurate data collection within the spiritual care sector in Victoria. It provided an effective platform for the spiritual care sector to engage in quality assurance and research projects. (Australian Commission on Safety and Quality in Health Care, 2012). Work toward a consistent approach to data collection continues with stakeholders in other Australian states providing input to inform the developments nationally. This is evidenced by the "Principles for Design and Delivery of Spiritual Care Services" and the "Policy Statements" from the 2017 National Consensus Conference: Enhancing Quality and Safety. (Spiritual Care Australia and Spiritual Health Victoria, 2017).

Section 2

1. Target audience

This section is applicable to spiritual care managers, professional spiritual care practitioners and students providing spiritual care in health services. Volunteer spiritual carers can be informed about the Guidelines and instructed on how to document spiritual care by their spiritual care manager.

2. Purpose of guidelines

The Guidelines provide a consistent interpretation and approach to data collection and documentation for spiritual care practitioners for admitted and non-admitted patients across health services.

It establishes a basis for reporting spiritual care activity in health services. The document provides a minimum requirement for data collection with definitions reached by consensus in the spiritual care sector in Victoria in 2015 (Spiritual Health Victoria, 2015). It also meets current Australian standards on documentation in health services (Australian Commission on Safety and Quality in Healthcare, 2017). Health services may use additional descriptors and categories for the recording of spiritual care activity as part of their reporting requirements.

3. Context

In Victoria, data for admitted patients is collected by health services and reported to the Department of Health and Human Services as part of the Victorian Admitted Episodes Dataset (VAED) (Victoria State Government, 2018). Non-Admitted patients are documented under the Victorian Integrated Non-Admitted Health (VINAH) which is a separate dataset (Victoria State Government, 2018). Other datasets are also used to report activity to the Department of Health and Human Services as part of HOSData – Victorian Hospitals Data Report (Victorian Agency for Health Information, 2018).

Spiritual care managers and practitioners should be clear about how to document spiritual care activity and referrals according to the requirements of their state/territory health departments and individual health services. Individual health services have a Medical Record Documentation policy and guidelines. Where a health service uses volunteers to provide spiritual care, the level of documentation required needs to be established according to a volunteer's scope of practice (Spiritual Health Victoria, 2016), p.15.

4. Reporting and documenting spiritual care

a. Reporting to the Department of Health and Human Services

In Victoria, health services report data to the Department of Health and Human Services according to its business rules and using the relevant datasets. Spiritual care managers and practitioners should be familiar with the interventions identified for documenting spiritual care accurately (Victoria State Government, 2018).

Professional spiritual care practitioners would most likely use the VAED or VINAH datasets as mentioned on page 6 of these Guidelines. Health services can provide support and education to ensure that the correct interventions are used to record data in data collection systems which are integrated in the health service. Spiritual care managers and practitioners need to request clarification regarding which datasets are relevant from their line manager and health information management.

In some health services, spiritual care activity is documented in organisational activity data to ensure the accurate costing of an episode of care.

Victorian Admitted Episodes Dataset (VAED)

Clinical coders primarily use the Spiritual Intervention Codes from the ICD-10-AM/ACHI/ACS, Tenth Edition (Spiritual Health Victoria, 2017) or the Australian Classification of Health Interventions (ACHI Code 95550-12 Allied health intervention, spiritual care), to document spiritual interventions as part of Episodes of Care for inpatients in the Victorian Hospitals Data Reports (Victorian Agency for Health Information, 2018).

These codes are listed in Appendix 2.

Victorian Integrated Non-Admitted Health Dataset (VINAH)

It may be appropriate for spiritual care practitioners working with outpatients or family/carers in Palliative Care (including Community Palliative Care) or in Hospital in the Home (HITH) to use VINAH codes to document their visits. If unsure, please check with your line manager whether documentation under VINAH is appropriate when you receive a referral from these programs.

b. Reporting spiritual care within the health service

In addition to health services reporting and transmitting aggregate data to government departments, documenting spiritual care contributes to comprehensive information about person-centred care. National Safety and Quality Health Service Standards lists "Communication for Safety" as a standard which "recognises the importance of effective communication and its role in supporting continuous, coordinated and safe patient care" (Australian Commission on Safety and Quality in Healthcare, 2017) p.49.

Spiritual Care Australia Standards of Practice, specifically Standards 4 and 9 stipulate the need to record and document spiritual care contacts as part of best practice (Spiritual Care Australia, 2013).

SHV's Capability Framework for Spiritual Care Practitioners in Health Services under Domain 1 Provision of care, "1.2.3 Information management" includes:

"Maintain accurate, up to date, and legible records according to established data collection and local guidelines"
(Spiritual Health Victoria, 2016) p.15.

These standards identify the requirements and the necessary capabilities for practitioners to document spiritual care as part of provision of care.

Accurate documentation in medical records is integral to the care provided by spiritual care practitioners in health services. Documentation may be used for communication between health professionals, assessment, auditing, legal or research purposes. Patients or clients may also request information from their health records. To meet best practice, spiritual care practitioners must ensure that they are aware and adhere to their existing health service's policies, standards or guidelines as well as current legislation for documenting in patients' health records.

Internal reporting usually consists of reporting the total number of spiritual care contacts with a patient and/or with their families. It can also include the patient's attendance in groups. The best practice approach is to document this data electronically on the health service's integrated information system and in patient medical records.

Relevant definitions for data collection are included in Appendix 1.

"The document provides a minimum requirement for data collection...

5. General principles for documentation

Principles for documentation are aligned with The National Safety and Quality Health Service Standards (Second Edition) in particular Standard 5: Comprehensive Care Standard, Standard 6: Communicating for Safety Standard and Standard 8: Recognising and Responding to Acute Deterioration Standard (Australian Commission on Safety and Quality in Healthcare, 2017) and with relevant legislation, acts and other standards. (See Appendix 4).

Health services will specify in detail the requirements for documentation in their Medical Record policies and guidelines. Please ensure that you are familiar with these documents.

Spiritual care departments often provide organisational and staff support which are not patient related. This work is important and needs to be documented and reported as part of service provision. Please discuss how to best do this with your line manager or Director of Allied Health.

In addition, general principles for documenting spiritual care include the following:

1. The intervention used and a future care plan if appropriate, is recorded in the entry. The Australian ICD-10-AM/ACHI/ACS Spiritual Intervention Codes are used to identify the intervention for admitted patients (See Appendix 2).
2. For non-admitted patients, VINAH Contact Purpose codes include "Spiritual Care" and "Bereavement Support".
3. Your health service will advise how to document Memorial Services as they usually occur many months after patients' deaths.
4. Entries identify the discipline which has provided the intervention: use a Pastoral/Spiritual Care sticker or print PASTORAL/SPIRITUAL CARE clearly with a box around it or enter under Pastoral or Spiritual Care in the Electronic Medical Record.
5. The entry reflects the patient's perspective, their goals of care and the developed shared goals.
6. Entries include any risks identified.
7. The following procedure is suggested to record spiritual care contacts when using the ICD- 10-AM/ ACHI/ACS codes or follow your health service's documentation guideline:
    - If more than one spiritual care practitioner is involved, each practitioner will note a contact with a patient/client using the relevant ICD-10-AM/ACHI/ACS Spiritual Intervention Codes or the Australian Classification of Health Interventions Codes Tenth Edition (ACHI) as per Appendix 2
    - The time to record and document details of the spiritual care contact is counted as part of that contact
    - The **primary** expression of a Spiritual Intervention is recorded for reporting spiritual care to admitted patients, as per the ICD-10-AM/ACHI/ACS Spiritual Intervention Codes. Therefore, one contact with a patient = **one Spiritual Intervention**

- Spiritual Ritual: practitioners should record **one intervention per ritual** undertaken regardless of the number of people present. Practitioners can include the number of people attending and the time taken according to the individual health services' internal documentation requirements
- If the intervention is as a response to a referral, this is clearly documented and the source is identified whether internal (within the health service) or external (from external organisations, faith communities or their representatives, family, support persons)
- The number of referrals to the Spiritual Care Department is also recorded.

8. The entry uses objective language using generic descriptors of the issues discussed. This provides additional information to staff and enables optimum patient care (Ziegler, Harriet and Moore, Danni, 2016), (Breguet, 2017). The patient's own words are inserted in quotation marks when recording subjective data.
9. The entry is structured according to an approved method of documentation such as **SOAP** or **ISBAR/ ISOBAR** (Victoria State Government, 2018) (See Appendix 3).
10. Individual health service's standard abbreviations are used so that these can be interpreted correctly by all professionals involved in patient care.

6. Recommended methodologies for documenting spiritual care

There are many professional methodologies for structuring medical record documentation. A health service may already use an approved, preferred structured narrative style or an acronym as a structure for documentation.

Spiritual care practitioners need to be oriented and educated to do this in a consistent way, as is the case with other health service disciplines. An agreed methodology or "documentation protocol" which is used by everyone "provides a framework for [the] daily work" in their own discipline (Glenister, 2011) whilst aligning with the health service's procedures and policies.

Examples of some of the recognised methodologies are in Appendix 3.

7. Conclusion

Spiritual Care in Medical Records: A Guide to Reporting and Documenting Spiritual Care in Health Services directs practitioners in the use of a minimum dataset to describe and document the provision of spiritual care to patients/clients and their families. It also acknowledges the importance of documenting patient care as well as recording staff and organisational support. It is based on current standards and will continue to evolve to align with the requirements for documentation.

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Appendices

Appendix 1

Definitions

Episode of Admitted Patient Care: VAED Dataset

An Episode of Care is defined as:

> "The period of admitted patient care between a formal or statistical admission and a formal or statistical separation, characterised by only one care type. Patient activity must be reported under the campus code at which it occurred."
> (Victoria State Government, 2018) p.7

Patient Identifier:

A Patient Identifier is defined as:

> "An identifier unique to a patient with this hospital or campus (patient's record number/unit record number)."
> (Victoria State Government, 2018) p.109

Non-Admitted – Care:

Non-admitted patient care may be recorded under the Victorian Integrated Non-Admitted Health (VINAH) minimum dataset.

> "All public hospitals providing non-admitted services in scope for VINAH must report a minimum data set of patient-level data related to their activities."
> (Victoria State Government, 2018 - 2019).

The referral usually determines under which dataset the intervention should be recorded.

The Independent Pricing Authority describes it as follows:

> "Non-admitted care encompasses services provided to patients who do not undergo a formal admission process and do not occupy a hospital bed. For example, services provided by hospitals:
> - In hospital outpatients clinics
> - In community based clinics
> - In patients' home." (Independent Hospital Pricing Authority, n.d.)

Spiritual Care Contact:

A conversation or interaction between a spiritual care practitioner and a patient/client and/or their family/support person(s)/carer(s).

A **spiritual care contact** may include:

face to face contact, contact by telephone, video link or correspondence which relates directly to the patient/client, documentation in the medical record (paper or electronic), referrals to other disciplines or to an external organisation, finding resources as part of the patient's spiritual care. Generally, contacts of less than five minutes duration are not considered to be clinically significant.

For **spiritual care contact** for VINAH: please check with your line manager or health information management which interventions you may use.

Interventions by a spiritual care practitioner under VINAH may include:

- Spiritual care
- Bereavement support.

Section 2 of the VINAH manual has definitions and criteria for programs for non-admitted patients (Victoria State Government, 2018 - 2019). It also defines the term "Contact" on page three.

Spiritual care contacts may be recorded as:

- A contact with a **single** patient/client and/or with the patient's family or significant others.

  Example: A spiritual care practitioner supports a patient and a group of his/her family members and a carer. This would be recorded as a **single contact**.

- A contact in a group session where multiple patients/clients are present and/or when the patients' families or significant others are present. VINAH states that:

  > "Each patient/client who attends a group session should be reported as having received a contact independent of the number of patients/clients who participated in the group activity."
  > (Victoria State Government, 2018) p.4

  Example: A spiritual care practitioner facilitates a Support Group where six patients/clients are present, this would be recorded as **six separate contacts**.

A contact by a **spiritual care practitioner** would meet all the following criteria:

- More than 5 minutes duration
- Provided by a spiritual care practitioner employed by a health service or employed by an external faith organisation and accredited by the health service
- Provided for a patient, client or family, carer or significant other
- Requires a dated entry in the medical record of the patient/client using the relevant intervention with a patient unit record number.

Medical record and electronic medical record:

In Victoria, the Health Records Act 2001 regulates the collection and handling of health information:

> "The Act applies to the health, disability and aged care information handled by a wide range of public and private sector organisations. This includes health service providers, and also other organisations that handle such information."
> (Victoria State Government, 2001)

A medical record is

> "a collection of information about a patient's healthcare that are essential for his or her present and future care."
> (Victoria State Government, 2012) p.1

An Electronic Medical Record (EMR)

> "refers to a patient-centred system that staff can use to fulfil their patient-care duties without using paper medical records."
> (Victoria State Government, 2012) p.1.

Appendix 2

Spiritual care intervention codes ICD-10-AM/ACHI/ACS Tenth edition

(Spiritual Health Victoria, 2017)

It is important to only use the title of the Code (not the block numbers) and to document one code per intervention.

Block [1824] other assessment, consultation, interview, examination or evaluation

96186-00 Spiritual assessment

Initial and subsequent assessment of wellbeing issues, needs and resources of a client. This intervention can often lead to other interventions.

Includes:

- informal explanatory dialogue to screen for immediate spiritual needs including religious and pastoral issues;
- the use of a formal instrument or assessment tool

Block [1869] other counselling or education

96087-00 Spiritual counselling, guidance or education

An expression of spiritual care that includes a facilitative in-depth review of a person's life journey, personal or familial counsel, ethical consultation, mental health support, end of life care and guidance in matters of beliefs, traditions, values and practices.

Block [1915] other client support interventions

96187-00 Spiritual support

Spiritual support is the provision of a ministry of presence and emotional support to individuals or groups.

Includes:

- companioning of person(s) confronted with profound human issues of death, dying, loss, meaning and aloneness
- emotional support and advocacy
- enabling conversation to nurture spiritual wellbeing and healing
- establishing relationship
- hearing the person(s) narrative

96240-00 Spiritual ritual

All ritual activities, both formal and informal.

Includes:

- anointing
- blessing and naming
- dedications
- funerals
- meditation
- memorial services
- private prayer and devotion
- public and private worship
- rites
- sacraments
- seasonal and occasional services
- weddings and relationship ceremonies

Block [1916] Generalised allied health interventions

95550-12 Allied health intervention, spiritual care

Appendix 3

Recommended methodologies for documenting spiritual care

1. SOAP

SOAP is a method of documentation that is commonly used by healthcare professionals from many disciplines. As this is recognised across professional healthcare disciplines, this method is highly recommended.

Subjective observation describes how the patient feels about or perceives their situation. It comes from the patient's self-report. It is information that does not have independent or external validation. When possible it is best to use the patient's own words in quotations. It can also be information about the patient given by someone else that cannot be verified.

Objective observation is information gained by direct observation by professionals, clinical examination, data collection etc. This information can be independently verified.

Assessment refers to the professional conclusions from reviewing the subjective and objective observations.

Plan describes how the practitioner intends to address the specific problems identified. (Kagle, 2005)

2. ISBAR/ISOBAR

(Note: in some health services this methodology is only used for verbal communication and handover, however in others it can also be used in written documentation. Before using ISBAR or ISOBAR, confirm the practice in your health service).

Identify
Who you are, your role, where you are and why you are communicating.

Situation
What is happening at the moment?

Background
What are the issues that led up to this situation?

Assessments
What do you believe the problem is?

Recommendations/risk
What should be done to correct this situation?
(Clinical Governance, Hunter New England, NSW Health, May 2009)

Appendix 4

Key related documents

Key legislation, acts and standards:

Charter of Human Rights and Responsibilities Act 2006 (Victoria)

Public Record Office Victoria – Retention & Disposal Authority for Patient Information Records 2011 (PROS 11/06)

Australian Standard AS 2828.1-2012 - Paper-Based Health Records

Australian Standard AS 2828.2 (Int)-2012 – Digitized (scanned) health record system requirements

Aged Care Act 1997 (Commonwealth)

Mental Health Act 2014 (Victoria)

Health Services Act 1988 (Victoria)

Health Records Act 2001 (Victoria)

My Health Records Act 2012 and My Health Record (Strengthening Privacy) Act 2018 (Commonwealth).

Further Information

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