Name of Policy:	**Medical Record Documentation**		
Policy Number:	3364-103-PC-02		
Department:	Service Excellence- Pastoral Care		
Approving Officer:	Chief Experience Officer		
Responsible Agent:	Spiritual Support Manager	**Effective Date:**	10-4-2019
Scope:	UTMC Pastoral Care	Initial Effective Date:	1/1996

_____	New policy proposal	**X**	Minor/technical revision of existing policy
_____	Major revision of existing policy	_____	Reaffirmation of existing policy

(A) Policy Statement

Chaplains shall have access to the patient's medical record and shall make appropriate entries into the medical record.

(B) Purpose of Policy

To establish guidelines for clinically trained and supervised chaplains who document appropriate entries in the patient's medical records.

(C) Procedure

1. All visits made to patients by chaplains shall be documented in the "McKesson Care Organizer" of the patient's electronic chart.

2. Chaplains may make entries on the Pastoral Care Documentation Form and place in the Physician's Progress Notes section of the patient's medical record for notable events requiring expedited communications with medical team.

3. All documentation should be timely, accurate, and succinct.

4. Documentation should include a description of your intervention, pastoral assessment, and a pastoral/other plan with an expected outcome.
    a. Pastoral assessments may include:
        i. the patient's spiritual and/or emotional resources
        ii. the patient's religious affiliation (if any), beliefs, and practices
        iii. the patient's spiritual and/or emotional needs like: grief, fear, anger, anxiousness about their healing progress, health care decisions, meaning of their illness, the patient's religious background, resources, cultural needs or requests, if any.

5. Appropriate documentation shall also be made in the "Log Book" located in the Pastoral Care office. The purpose of internal documentation between department staff is to facilitate communication for follow-up visits.

6. With the exception of information that is deemed sacredly confidential (e.g., confessions, etc.), information shared with a chaplain during a pastoral visit or counseling session may be charted. Information provided by a patient that may be detrimental to their life or well-being (or that of others) shall be documented in the patient's chart and also brought to the attention of the medical team caring for that patient.

7. The format for chaplains' documentation in the patient's medical records is the SOAP format, and is as follows:

S ubjective observations
O bjective observations
A ssessment/Intervention
P lan

Example of SOAP:

4/1/04 Pastoral Care: 11:30 AM

S/O The chaplain responded to a nursing referral to intervene with the family of patient, John Doe, a 47 year old male, Roman Catholic, at the time of patient's death. The patient's spouse and 2 adult children were present at bedside and grieving openly.

A The chaplain provided pastoral support and prayer to the family and assisted them in contacting their parish priest. Note: the sacramental anointing of the sick took place on 3/30/04.

P Chaplain shall follow up with a phone call to the family.
Chaplain:_____

Example of SOAP:

4/1/04 Pastoral Care: 14:30

S/O The chaplain provided baptism for preemie infant patient girl Doe in the ED at the request of the patient's mother. The patient's mother and father, both Lutheran (Grace Lutheran Church), were present at the baptism and both expressed fear and hope for the child's survival.

A They were relieved to have the spiritual support that was provided for the child, whom they named Jane Ann, through the Rite of Baptism.

P Chaplain shall obtain a Baptismal Certificate from the Patient and Family Support and Pastoral Care office on its next business day. He/she shall also do a follow-up to provide on-going pastoral support.
Chaplain:_____

8. The following elements should always be included in each Pastoral Care documentation:
   a. Date and time
   b. Title of service
   c. Referral source
   d. Religious affiliation, if any (with consent of patient)
   e. Name of chaplain

Approved by: /s/ Mario Toussaint Chief Experience Officer Date *Review/Revision Completed By:* *Dan Deeter*	**Review/Revision Date:** 3/1998 10/23/2015 4/2001 08/17/2018 9/2002 10/4/2019 3/2004 2/2005 102006 8/15/2008 10/29/2012 **Next Review Date:** 10/4/2022
Policies Superseded by This Policy: PC-12	