White Paper ERICH: charting by chaplains in health care

1 Why a white paper?

A white paper aims to present information in order to understand a complex issue, invite opinions, inspire reflection and also to propose ways of acting. As documenting is a complex issue in contemporary healthcare chaplaincy, this paper aims to bring some structure and cohesion to the many aspects that are connected with documenting and also to include principles of record keeping. The initiative to write this white paper is taken by ERICH, the European Research Institute for Health Care Chaplaincy, founded by the European Network for Health Care Chaplains (ENHCC). We chose to write a European white paper as it is already complex to take into account the variations in ethical, legal, spiritual care, health care and cultural aspects that determine documenting within Europe. Within the European context, charting is increasingly a topic of research as the Swiss project has shown in 2018-2021 (Peng-Keller & Neuhold, 2020).

Chaplaincy and health care are two evolving realities. To secure and broaden their impact, chaplains need to be integral members of interdisciplinary health care teams. One of the reasons they are often not is terminology. For example, Massey et al., (2015) suggest that if chaplains could talk a 'common language' then the evidence base would be further enhanced because chaplains would all be naming the same concepts in the same way, and so evidence acquired on one side of the world would be mutually understood and where appropriate transferred to the other because everyone would be using the same language. Another key and related issue is documentation. Similar words are 'record keeping' or 'charting', as it is often currently referred to (Peng-Keller & Neuhold, 2020).

Chaplains have been documenting for a long time, for example from the earliest days of Clinical Pastoral Education, and more recently charting has progressed to an electronic medium in electronic patient files and healthcare records. Contemporary health care is making documenting more important and more challenging. Electronic patient files, the recent data protection law of the EU, the need for interdisciplinary care, the increasing autonomy of patients in health care and the need for chaplains to be accountable are but a few of the aspects this white paper shall touch upon which make charting in spiritual care enriching and challenging at the same time. Charting can take on different forms: by checking boxes or by narrative charting or both, by documenting for yourself as a chaplain or for your colleagues or for the interdisciplinary team, in a file that can be partially or fully read by the patient. Some forms of charting are built on theoretical foundations, others have organically grown out of the practice. All these different forms present their own possibilities and challenges.

This paper will use the word "charting" for taking notes that describe the spiritual care between a chaplain and a patient or family member and more specifically notes that reflect the language patients use as well as their stories. We will use the term "chaplains" to refer to those persons who are hired by health facilities or faith groups to provide spiritual care to patients, family members and staff. They are trained and educated to be specialists of spiritual care in the context of health care. We also use the term "patient" to refer to those who are cared for in nursing homes, hospitals, hospices, mental health centers or centers for people with disabilities and are in need of physical, emotional, social and spiritual care.

2 Why is charting important?

Charting is important to improve spiritual care in several ways. It contributes to better care for patients, to the professionalism of the chaplain, to interdisciplinary cooperation and to policy on spiritual care.

a. Better care for patients

The first purpose of charting is to improve spiritual care for patients. The contribution to the mental and spiritual well-being of patients depends basically on the quality of the interaction between the chaplain and the patient, individually or in groups, virtually or face-to-face. But the written account of what has taken place is also important. Firstly, through charting, the chaplain can give a voice to the patient's story in the electronic file, and the language the patient uses, so that every professional can take this into account and provide patient centered care. It doesn't matter whether these notes are either of a more narrative nature or divided in sections. Secondly, charting helps chaplains to reflect on their own actions; thus, the patient meets a chaplain who acts deliberately and consciously. Thirdly, charting promotes continuity of care. The patient is assured of a good follow-up in the future by the same or another chaplain or another professional to whom the care is transferred (for example home care).

b. Professionalism of chaplains

What chaplains report provides insight into their interaction with patients and also into the reflection on their job. Charting stimulates chaplains to reflect on all aspects of their professional actions: the goals, the counselling method, other interventions and the effects of their actions. Accountability is most basically translated into the simple question: 'what have you discussed with the patient (or his/her loved ones) and what have you done so that I can continue with it when I meet the patient?' From this perspective also arose the need for spiritual screening and diagnosis, in order to discuss the 'spiritual impressions' that have been gained (Smeets & de Vries, 2016). Charting helps to orient joint reflection with fellow chaplains. The international Clinical Pastoral Education (CPE) movement has been an important incentive for analyzing and reflecting on charting by chaplains. It contributes to improvement of counseling skills and professional identity of the spiritual caregiver. Research also highlights that charting provides greater insight into the nature and effect of the work of chaplains. But before such research is properly shaped, the reporting must be more extensive – and therefore more time-consuming – and according to a mutually agreed format and (sufficient) content (Smeets & de Vries, 2020).

c. Interprofessionalism

Sharing of information within chaplaincy and between professions would seem important for a number of reasons. First, it enables the provision of person-centered care, which is joined up and holistic, not fragmented or conflicting. Second, the whole team has sight of what's most important to the person and each discipline can channel its specialist expertise into working towards the same shared goal. Blending of the 'science' and the 'art' of the different professions is an added benefit, bringing a balanced holistic approach to care provision (Ross & McSherry 2010). Thirdly silo working is minimized.

This integrated, or ‘team’ approach to care has many benefits:

i. More effective care: conflicting interventions will be minimised with everyone working towards the same outcome.
ii. More efficient and prudent care: only what is most important to the patient is addressed- for example by using a tool such as the 2Q-SAM (The Ross & McSherry 2 Question Spiritual/Holistic Assessment Model, Ross & McSherry 2018).
iii. Greater patient satisfaction (Balboni et al., 2017; Ross and Miles, 2020; Steinhauser et al., 2017) and staff resilience (Snowden et al 2018)

This way of working assumes that all disciplines are prepared to share with each other. However in some countries, such as the UK, chaplains are not always considered part of the interdisciplinary team. The reasons are complex, but include concerns and complexities around boundaries, disclosure, confidentiality, data protection, data privacy and fear of litigation (Ross and McSherry, 2020; Ross et al in press).

d. Spiritual care policy

Charting is a good basis for chaplains to take leadership by control of one’s own work. Charting also offers a team of chaplains insight into their own activities and helps them to make choices in that way. Finally, charting offers concrete data with a view to accountability of their work as contribution to the quality assurance and policy of spiritual care departments and of the organisation (Smeets, Gribnau & van der Ven, 2011). At the end, charting helps the professional association to integrate the contribution of the discipline into national care policies.

3 Considerations for reflection on chaplains charting

a. Foundations

It is important to note that the movement of “Clinical Pastoral Education” (CPE) was from the very beginning supportive to charting: clinically trained chaplains should be part of the health care team and document their experiences in medical records. CPE encompassed, therefore, forms of record keeping for at least three different purposes: for personal reflection, supervision, and interprofessional communication. Russell L. Dicks, a pioneer in modern pastoral care, stated in 1940: “This is a brief note, similar to that which the consultant writes, which is simply a record of the chaplain’s impression of the patient. The chaplain often discovers significant things about a patient which the physician needs to know; these discoveries as well as impressions should be available in the record.”

The “significant things” must be recorded in the medical documentation so that they are not lost. “If it wasn't charted it didn't happen.” This expression, often used in health care, expresses that documentation serves to select from the wealth of daily observations, analyses, findings, actions, and effects those that are considered essential in the community of professionals to best support patients. The dimensions of care that are not documented risk evading clinically shared attention.

Chaplains’ documentation thus helps to ensure that essential dimensions of the patient's data are perceived and remembered.

If chaplaincy is to communicate its content interprofessionally through an existing electronic documentation system as part of quality control systems, it faces two challenges:

- When charting in electronic patient files, chaplains enter a system based on underlying (medical) paradigms. Their first challenge is to adapt while retaining the distinctiveness of spiritual care.
- A second challenge regarding charting in the health care system is to present the specialist spiritual perspective of chaplaincy in such a manner that it is comprehensive and helpful to other professions.

When analyzing existing chaplains’ documentation systems, it does not always seem clear which theoretical – if any – understanding is guiding.

b. Whole person care and interprofessional charting

Chaplaincy brings its own perspectives and its own methods, communication style, hermeneutics and understanding into the interprofessional collaboration and documentation. For example, it distinguishes between curing and healing; it is particularly interested in patients' narratives, and it examines the spiritual dimensions of phenomena such as fear and despair. In this way, it expands the bio-psycho-social conception of health to include the spiritual dimension. The question here is whether the terminology is clarified within chaplaincy and also between chaplains and the other healthcare professionals.

Even within healthcare chaplaincy, there is currently neither standardized language for spiritual concerns, interventions, and outcomes, as recent research in the field testifies. Nor exists a common understanding for achieving inter-professional consensus on terms such as "hope", "anxiety" or "distress". Chaplaincy specific usage of terms like “hope” and “anxiety” raises the question of whether shared terminology and shared conceptional application can in fact improve inter-professional communication. Furthermore, will interprofessional consensus on terms not only facilitate communication between different members of the care team, but potentially help measure the impact of care itself? Finally, in all these questions concerning language, the language of the patients themselves must be taken into account. It is one of the concerns of chaplaincy to express the language and understanding of the patients themselves.

c. Prerequisites for interprofessional cooperation

Spiritual care documentation should present the chaplain’s contribution to patient care in such a way that other professions can quickly recognize and utilize it to improve their care. In order to achieve the summary of a chaplain’s intervention and assessment, it is necessary to link to communicative structural elements that are common in health care.

Chaplain documentation should include the following structural elements which are mostly mentioned in current literature: *first*, the data describing the patient's situation as well as the referral reason; *second*, the assessment mentioning the spiritual concerns and resources in the current treatment situation; *third*, the interventions describing the actions of the chaplain; *fourth*, the effect or outcomes of the interventions; and *fifth*, the intended continuation of the care (plan of care).

The description of the outcomes is particularly important and difficult: On the one hand, describing the effect of spiritual care interventions communicates to the treatment team how they may affect the patient's wellbeing. But they are also a way for the spiritual care team to critically review the impact of their own activities. Montonoye and Calderone (2010) found that chaplains' recording of hospitalized patients' feedback was more descriptive of the chaplains themselves than informative from the patient's perspective. Chaplains' self-reported data may be subject to self-report bias, and chaplains may tend to over-report positively perceived experiences. Careful review and description of the impact of chaplaincy interventions helps to provide a realistic assessment of their actions that is open to discussion.

In order for spiritual care documentation to actually promote an interprofessional perspective and collaboration, education and binding forms of collaboration are needed. That means that educational efforts within chaplaincy, as well as educational opportunities for other health professionals can improve and evaluate their understanding of the content of documentation. Charting spiritual care both requires and inspires cultures of collaboration.

d. Multi- or interdisciplinary integration and confidentiality

In order for chaplains to be able to work together with other health professionals, spiritual care must be implemented, and chaplains must be integrated into the team to promote interprofessional exchange of information and consideration. Only in this way is it possible for observations of chaplains to flow into the joint care and for it, in turn, to receive impulses to provide spiritual care in the best possible way. The integration of spiritual care into interprofessional treatment teams, however, may be in some tension with maintaining chaplain's confidentiality vis-à-vis the patient. It should be emphasized that this tension is present for all professionals who share information. It is therefore essential that not as much content as possible is communicated, but only that which is relevant to the patient's treatment process. Checkboxes are usually less problematic because they only contain standardized information. In the case of free text fields, it is helpful to imagine the patient looking over the documenter's shoulder. Documentation should be done in an attitude of appreciation and transparency towards the patient and in regard to the patient's right to information including his own documentation. The patient should be aware of the interprofessional communication community in which chaplaincy is integrated, and he/she should have the possibility to control the flow of information, i.e. also to ensure that certain information is not passed on to other professional groups.

e. Caring relationship and open notes

The patient-chaplain relationship is fundamentally based on trust; this needs to be the underlying principle of charting spiritual care. A new form of documentation, which builds on the basis of trust and even aims to deepen it, is the so-called *open notes*. Open notes is an international movement promoting and studying transparent communication in healthcare. Its intention is to help patients and health care professionals share meaningful notes in medical records. Patient access to notes may offer a way to improve both patient engagement and quality of care. The concept of open notes, an initiative to allow patients to view the notes written by physicians, nurses, chaplains and other care providers, adds a new, more immediate demand for patient-centeredness in clinical documentation. Although it is still too early to state with certainty how the increased transparency of open notes will change existing clinical documentation, the following changes—all of which are believed to be

positive by provider and patient participants in pilots of the open notes initiative—are likely: avoidance of pejorative language in descriptions of patients, patient behaviors, and findings; increased documentation and clarity in documentation of care plans; and increased efforts at timely completion of notes.

4 Aspects of charting

Chaplains chart to communicate about their care for patients so that it can be integrated in the team's care (interdisciplinary charting) and so that, if needed, this care can be continued by their colleagues (disciplinary charting). It can also be argued that chaplains chart for their patients, by hearing, interpreting and recording what is important to the patient as he/she navigates through ill health. Chaplains by charting capture the 'story' of the patient in their healthcare record. This is a valuable dimension that captures and records the experience and unique story of the patient rather than an 'illness-focused' approach.

a. What are determining factors in how chaplains chart?

1. The patient

The philosophy of health care is moving more and more towards ownership by patients. This means that a patient's file is seen as the property of the patient, at least from an ethical perspective if not from a legal. When charting, chaplains need to start from the perspective that the patient is reading over their shoulders. This should inspire reflection on confidentiality and transparency (asking permission of patients to chart aspects of the visit). In some countries patients already have full access to their files, in others the access is limited. Patients' rights are a determining factor in how to deal with patients' files. However, in all cases chaplains should operate from the stance that a patient (or his/her family) will read the notes.

2. The software

Although there is some discussion about a national file per patient that is accessible for everyone who is involved in the treatment, in most countries a patient's electronic file is kept within an individual health care facility. Hospitals and other health care facilities buy software, offered by different companies, or develop their own. As a consequence there is a lot of difference in the form and space provided for chaplains to chart. Sometimes the bought software comes with an integrated part for chaplaincy, sometimes it is lacking, sometimes the software is a rather basic frame where chaplains can add a module. When a health care facility is developing its own software, chaplains should be involved with regard to the integration of spiritual care. When no software is involved and charting happens in paper files, the other mentioned factors still determine charting.

3. The healthcare facility

Although chaplains are best seen as part of an interdisciplinary team, some managers start from the perception that chaplains are mere representatives from particular religions or beliefs. Some facilities therefore are not giving permission to chaplains to consult patients' files or to chart. Others demand that chaplains chart as they aim to make the care they provide transparent in order to achieve

quality standards. External quality control organizations will look at transparency and coordination of care to evaluate health care systems. In this context chaplains are perceived as accountable members of the health care team. Not charting parts of spiritual care is discouraged by management in the context of interdisciplinarity, accountability, quality control and efficiency. All healthcare facilities should recognize the importance of integrating their chaplains as full members of the interdisciplinary healthcare teams, and with that comes responsibilities on both the chaplain and the institution.

4. Data protection laws like GDPR (General Data Protection Regulation)

GDPR is the EU data protection law which was put into effect in 2018. The data protection law applies to everyone who participates in processing the personal data of EU citizens or residents. Every member state of the EU needs to integrate the law in its systems and organizations. The law emphasizes the privacy rights of people and will continue to have an impact on the way we chart in health care.

5. Confidentiality

Chaplains contribute significantly to health care. As such they are bound by confidentiality, protecting the patient's right to privacy. Patients entrust their stories to chaplains. Often religious traditions and laws influence the chaplain's and the patient's perception on confidentiality. Chaplains who belong to religious communities are part of religious traditions that hold confidentiality high, which in some religious traditions takes on the form of absolute confidentiality in the sacrament of confession. In return, despite the widespread secularization in Europe, many patients still link chaplains with confidentiality. This may be a determining factor for many chaplains in how and what to chart. Software that is used for electronic patient files can include a charting space for chaplains that is not accessible for others. If available, chaplains use it to make notes on what patients confided to them but do not want to be shared. Within an electronic environment the question can be raised if anything can really remain unshared. Most professional associations for chaplains have a code of conduct which always integrates rules and professional limits about confidentiality. In all cases chaplains should be transparent about the boundaries of confidentiality so that the patient can retain autonomy in what they may choose to share.

6. Models

There is no one model that European chaplains use for charting. Some chaplains tick boxes, some use preexisting codes, others use free text boxes or a combination of the previous possibilities. Some models that are used are built on theoretical and/or theological underpinnings, others grew out of the practices of chaplains. The leading motive for any choice of model should be how it serves the communication about the patient's care best.

The way chaplains in Europe are charting differs because of the legal context, the different types of software, the space offered by health care facilities, the many different models that are used and because of different perspectives on confidentiality (from strict to shared).

7. How to communicate and chart in the tension between sharing information and confidentiality?

The following principles are important:

i. The patient's autonomy: What does the patient want and allow?

ii. Beneficence: Integral care integrates spiritual care in order to offer patients the best coordinated care.
iii. Non- maleficence: Being professional means being able to communicate about the given care and being accountable and to chart in a way that does not lead to mis-interpretation which may cause harm.
iv. Transparency: Chaplaincy needs to be visible, transparent and integrated.
v. Justice: Functional charting where it is deemed necessary allows the chaplain to balance confidentiality and integrated care.

5 What kind of models are out there and what determines the differences?

A. Different objectives lead to different models

There are very different documentation models around the world. What they all have in common is that they take place in the interest of the best possible spiritual care for the patient. The direct recipients and the objectives associated are different. Four groups of recipients for documentation can be distinguished, which often overlap.

1. Patients and their relatives

The knowledge that the patient has the right to read the notes initially triggers a quality requirement: notes should be written as if the patient is looking over the writer's shoulder. It goes without saying that judgments about the patient are to be refrained from, as is the disclosure of knowledge or conjectures that have not been discussed with the patient. When the patient reads the notes, he/she should not be surprised, but should recognize himself/herself in everything, because he/she is aware of it, because he/she supports the documented decisions, and because he/she considers the information contained in the entries to be relevant to his/her situation in the hospital. The latest development even leads to *documentation becoming part of the communication between patient and chaplain* and thus part of chaplaincy care. For the patient and family members (who activate their right to see medical records), these records summarize how the patient is being treated as a respected human being regardless of any difficulties s/he may be seen as causing.

2. The chaplaincy profession

Documentation can serve to improve the quality of chaplaincy. For example, developing practice theory by analyzing both effective and ineffective practice patterns has the potential to improve patient care and help identify potential strategies to prevent 'never events'. The results can also be used for continuing education.

Documentation, however, can also be used to support spiritual care research. For example, charting can form a basis for a policy making and for researchers in spiritual care to carry out statistical operations and to come to an analysis of data. Policies such as care pathways or protocols can be changed in order to integrate spiritual care based on charting by spiritual care givers. Charting can

show that chaplains are regularly involved in certain patient groups or in certain circumstances. Research based on charting can be executed in order to answer questions such as: who is involved in the care of the patient, which spiritual interventions take place in visits with patients with certain diagnoses and is spiritual care a factor that determines the length of stay? Chaplains' charting can also be used to collect statistical material to strengthen their integration and position in hospitals. Charting can show the value of spiritual care through the interventions or outcomes that are used.

3. The disciplinary and interdisciplinary team

The main motivation to chart in an electronic patient file is the contribution that disciplinary and interdisciplinary charting can offer to the best possible spiritual care. Furthermore documentation will help create more visibility for the chaplain as a professional. Charting allows chaplains to demonstrate their reliability in responding to referrals and to educate their interdisciplinary colleagues regarding their role.

Contents and goals

Different contents and goals can be distinguished. In many existing documentation models, combinations of the following topics can be found:

i. «The chaplain was there»

A basic task of documentation is to let the interdisciplinary team know that spiritual care took place and who the chaplain is to contact. This person can be contacted and referred to again. In the simplest form of documentation, the only thing noted is that the chaplain visited the patient. Sometimes it is mentioned what the topic of the accompaniment was and whether a follow up is planned.

ii. Spiritual needs and resources of the patient.

Documenting selected content of the spiritual care assessment serves to integrate the spiritual dimension of the individual into health care. By noting spiritual needs and resources, the interdisciplinary team is informed of what might contribute to disrupting or enhancing the therapeutic process. This simultaneously helps to promote a whole perception of the patient.

iii. Spiritual status

In some models, spiritual distress and resources are not only recorded, but a diagnostic weighting or status description is also provided. The care team is told whether, from the spiritual care perspective, the current situation results in spiritual stress for the patient (and how high the stress level is to be assessed) that requires accompaniment.

iv. Spiritual care activities

Chaplains documenting assessment, interventions, outcomes and plan is part of the essential communication between care providers so as not to confront the patient with fragmentation and contradictions in diagnosis and treatment. The process of recording enables care providers to focus on what the patient needs right now and the documentation allows for planning of the therapeutic process, as it not only records diagnosis and treatment so far, but has medical appointment scheduling functionality as well.

v. Recommendations

Finally, there are various forms of recommendation that can be found in documentation models. They range from general recommendations that concern the patient's perception to very specific recommendations that seek to influence the actions of other health professionals as well. Charting allows the chaplain to influence the therapeutic process in such a way as to better serve the interests of the patient – even if advocating them is contrary to the impressions of the therapeutic team – for instance by drawing attention to aspects of the patient's well-being that have been neglected so far.

4. Stakeholders

The stakeholders of documentation by chaplains can be the management of the institutions, health insurers, the health authority or state authorities. The documentation must prove to these stakeholders which services spiritual care provided in order to prove they happened, to measure their quality or to justify their financing. The content of the documentation refers to the requirements laid down in laws, ordinances and agreements. The level of detail required varies considerably.

In Quebec, Canada, spiritual care services receive their funding following the compilation of 'units of measurement'. The types of spiritual care intervention that qualify as units are listed in a document produced by the *Ministère de la Santé et des Services sociaux* (MSSS) in 2002. For each unit of measurement reported, there must be a note in the medical file. In Victoria, Australia, the College of Chaplains requested the inclusion of pastoral care intervention codes for the Third Edition of ICD10-AM (National Centre for Classification in Health 2002). In the USA, documentation of spiritual interventions is proof of compliance with regulatory requirements by the Joint Commission to provide for the spiritual needs of all patients. In the Kanton Bern in Switzerland the ordinance to Article 53 of the Hospital Care Act specifies the services provided by chaplaincy, which it must report in a performance report at the end of the year.

B. Good practices

i. Checkboxes are the appropriate tool for the performance record as well as for many research projects. The required information is already given in the tool and can be quickly recorded. The information can be summarized and presented at any time.

ii. For interprofessional communication, a mixture of checkboxes, in which summary, statistical information is recorded, and free text fields, in which the current situation is recorded, proves to be suitable.

iii. The five-part model has become widely established for narrative charting in the free text fields: 1. reason for referral (by whom was spiritual care called in and for what reason?), 2. comprehensive spiritual assessment (spiritual needs and resources, concerns of the patient), 3. care provided (interventions of chaplain), 4. outcome (from the perspective of the chaplain and the patient) and 5. plan of care (continuation of chaplain support, recommendations to the team). The narrative should be clear, concise, and respectful (no intimate details and respecting the difference between need to know and nice to know).

iv. All information should be passed on in such a way that it is understandable and helpful for other professionals in order to provide whole person care. This requires a language, form and structure known in the health care system. A language should be used, that is "accessible" to

those outside of chaplaincy, which is consistent with the understanding of the same terminology of other professions and contains no “code-language”. At the same time, it should be a language that properly allows and expresses the spiritual dimension.

v. With regard to the patient, the following is essential: the documentation should not contain interpretations about the patient and his or her process, unless they themselves were part of the process, which was designed together with the patient and confirmed by him/her; the documentation must be characterized by appreciation for the patient and her process; the documentation preserves the patient's confidentiality. Would the patient/family see themselves in your note, agree with your assessment, and feel as if you upheld their humanity, personhood, and values?

6 Final recommendations

In many European countries the current aim is to organize the spontaneous reporting practice by chaplains. We list the following recommendations for this process.

a. 5 steppingstones for charting

Whatever the system or form of charting, it is important that chaplains address the following aspects of the visit to the patient: 1. What was the reason for your visit? 2. What is your assessment of the patient? 3. What difference did your visit make? 4. What did you do in order to make a difference (interventions)? 5. How will you ensure possible further care (accountability/spiritual care plan)?

b. Charting and working with patients’ stories.

The patient's narrative is an important tool in the chaplain's work. In order to retain this narrative during the treatment of patients and to be able to refer to it, it is essential to keep notes and to voice as much as possible the storytelling by the patient. This contributes to patient centered care.
In most cases the shared part of the patient file is the most suitable place to chart, in view of the interdisciplinary team. When confidentiality should be addressed in a special way, chaplains can make use of a closed off part of the patient file or of another digital or paper form. These should be properly secured and must be kept in accordance with the legal archiving periods.

c. Need to know does not equal nice to know

Taking into account general norms and values, what is legally permitted and professionally allowed, the question remains what information can be shared. Chaplains who chart in patient files take into consideration the following ground rules: 1. The shared information is always in the best interest of the patient. Confidential information should be documented only with the consent of the patient. 2. Chaplains only share information if it contributes to the best overall, coordinated care and the

wellbeing of the patient. This also applies to confidential information coming from family/loved ones. Depending on local regulations, the patient may be entitled to see the chaplain's notes.

d. Conditions for research

To be able to do quantitative and qualitative research on the charted data (check boxes and free text fields) it is important that there is uniformity in categories of charting, also among different care sectors, within a country and within Europe. Collecting patient files for research should meet the ethical research rules of the care facility, the country and the European regulations. Training of chaplains to chart in the same way is important – so that notes will be rich and comparable.

e. Language, quality improvement, education and training

Charting contributes to the visibility of chaplaincy in health care. Essential is that charting is short, concise, clear and easy to access. To achieve this, chaplains need to learn, develop and use a language that clearly communicates what chaplaincy contributes to overall care. Charting is a way to improve quality of spiritual care as chaplains needs to reflect on their practice. Based on the charted interventions and outcomes, training and education of chaplains and health care staff can be informed.

7 What research has been done and needs to be done?

Healthcare chaplains carry out their work in a complex clinical environment defined by a professional ethics which valorises evidence-based decision-making, accountability and transparency in order to provide the best possible care. Through their participation in institutional record keeping, chaplains can participate in this professional context, making their work more visible, understood, and accessible. Research can help improve this integration and has been growing in recent years. The following is a brief summary of research findings thus far:

a. **Conceptual differentiation between forms of confidentiality**

As Ruff (1996) argued in his work 'Leaving Footprints', chaplains leave traces of their work through their notes. Ruff also spoke of the professional need for the 'visibility of chaplains'. It was in 2007, that this 'visibility of chaplains' led to a heated debate revolving around the professional identity of healthcare chaplains (Springer Loewy & Loewy 2007 and McCurdy 2012). Wintz and Handzo (2013, 2015), drew attention to the differences between parish clergy and healthcare chaplains. They defined 'clergy confidentiality' as referring to the 'information that someone seeking forgiveness shares with a clergyperson within the context of ritual confession'. As ritual confession only plays a marginal role in the work of healthcare chaplains, the reference to 'clergy confidentiality' is misleading. They point to the standards of the Association of Professional Chaplains (USA), which state that the passing on of information is allowed if it is 'relevant to the patient's medical, psycho-social, and spiritual/religious goals of care'. In the same vein, Alex Liégeois speaks of the 'application

of the relevance filter' (Liégeois 2010, 93). Only information relevant for interprofessional care should be recorded (Vandenhoeck 2020).

Main research insights:

i. *By charting their interactions with patients, healthcare chaplains leave important footprints, enhancing their visibility and accountability, while improving communication in the interprofessional team and encouraging ongoing professional self-reflection and -improvement.*
ii. *Healthcare chaplains have to define their own understanding of confidentiality and distinguish it from «clergy confidentiality».*
iii. *Being solely a means, documentation must serve the best care of the patient.*

b. Check-boxes or narratives?

In developing models and tools for record keeping, printed and electronic forms typically provide chaplains with two options: narratives or checkboxes (Mösli, Wey-Meier & Neuhold 2020). The above question touches on an important aspect of spiritual care. In his paper «Pastoral Products or Pastoral Care?», Tarris D. Rosell (2006) referred specifically to the terminology used in charting and the power of language to both describe and create realities. Burkhart (2011) discussed the advantages and disadvantages of a Likert scaled flowsheet with fixed categories compared to progress notes. While the checkbox-approach saves time and is more discreet, they are unsuitable for conveying clinically relevant information in a reader-friendly way. Rebecca Johnson and colleagues (2016) advocate the development of new language skills and the cultivation of clarity so that the work of chaplains can be properly understood and accessible for later reference. Lee and colleagues (2017) questioned the usefulness of chaplaincy electronic medical record notes for interprofessional communication. For, 'documentation should provide clinically relevant communication', and has to be interprofessionally oriented and relevant (Katie Rimer 2020). What healthcare providers would like to read and what can, should or may be written is an important question when working in an interprofessional context. As Galchutt and Connolly (2020) show, it is important to address underlying assumptions and perceptions of those who read healthcare chaplains notes, in particular medical professionals without specific spiritual competencies.

Main research insights:

i. *Chaplain's documentation should include only clinically relevant information, avoiding the danger of overloading EMR with extraneous and repetitive data.*
ii. *Using a balanced combination of checkbox-data and short, structured narratives is most useful for effective patient care.*
iii. *Interprofessionally-oriented documentation affords specific language skills, the cultivation of clarity and addressing assumptions and perceptions within the whole care team.*

c. What do patients think about charting?

In Switzerland Tschannen and colleagues (2014) surveyed 50 patients about their general attitudes towards charting by healthcare chaplains. At the end of the visit, chaplains summarized what they would chart and asked for patient's permission. About 70% of the respondents considered it desirable. Patients who were more pessimistic about their health status were more inclined to find the disclosure problematic. Remarkably, this study also found that patients' answers were connected with the person of the chaplain-interviewer. In order to measure the impact of chaplains' interventions and consequently the clinical and strategic worth of chaplaincy, Snowden and Telfer (2017) introduced PROMs (patient reported outcome measures) in the Scottish health care context. Feed-back from patients is important. Even more patient participation and involvement is gained where shared or open notes have been used (Richards et al. 2021), i.e. that patients get insight in what has been written. In a process of so-called 'co-writing', the patients' notes could even become more important in the future of whole person care (Steve O'Neill 2021).

Main research insights:

i. *It seems necessary and important that patients are informed with regards to documentation.*
ii. *In an evidence-based environment, patients' feedback is important to attest to a certain difference chaplains make.*
iii. *More patient participation in charting could empower patients own perspectives in diagnosis and care planning.*

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9 Appendix of items to use in charting

(in different languages) (After the ENHCC consultation)

Taxonomy

a. Categories and items for spiritual assessment

b. Categories and item for interventions

c. Categories and items for outcomes