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Writing The Chaplain Progress Note

Greystone Park Psychiatric Hospital
Department of Pastoral Services
Training Module
In support of Performance Improvement Project

Progress Notes, General

Given: Clergy did not learn to write progress notes in medical records from their seminary training. Clinically trained chaplains probably had exposure from their CPE training, but institutions differ; like psychotherapy training, it may have been process oriented; and, at any rate, the experience could have been a long time ago.

Therefore, this module may be new information for some; it may be remedial; it may be a refresher; it may be old news. The examples are not exclusive. They are guidelines. There is certainly more than one way to write a progress note.

Chaplains will inevitably develop their own charting style. **Chaplains have varying degrees of comfort, clinical skill, and experience—as well as their own orientations to faith practice—which will influence their charting.**

Pastoral care is such a "soft" narrative based, discipline, that sometimes our observations and interventions are difficult to chart. However, progress note should usually contain certain structural elements. Progress notes should always be as brief as possible, as clear as possible, and as relevant as possible. Progress notes written by chaplains should have pastoral or spiritual content.

Not only do progress notes interpret pastoral needs and concern to the line staff and treatment team, they also help the chaplain think clearly about what we are doing and help us stay on task.

The ability to enter appropriate progress notes on the patient record is an element on the Chaplain PAR, and will be evaluated twice annually.

In general, progress notes document:

- Discipline specific services
- Reasons services were rendered
- Objectives of services rendered
- Patient's response
- Relationship to the treatment plan
- Recommendations

Progress notes are not the place for:

- Comments about other clinicians
- Comments about the writer
- Comments about administrative issues
- Disagreements among the staff about treatment
- Pontificating or editorializing

Additionally:

- Chaplain should keep in mind the difference between a *progress* note and a *process* note.[1]

[1] A *progress* note documents information about the patient for the clinical record and other clinicians. A *process* note speaks of the alliance with the patient, the clinician's thoughts and feelings, or information that would only be on interest within the discipline. *e.g. "The patient goes out of his way to undermine my*

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- Progress notes should be brief. Few clinicians have time to read more than a few lines. No one is going to read a progress note that runs more than a page. The longer the note, the less chance anyone will read it.[2]
- Progress notes should be legible. They should contain as few errors as possible and be written in standard English grammar. The harder the note is to read, the less chance anyone will read it.
- Progress notes are legal documents. Do not record anything you would not be able to testify to in a court of law. This includes factual data, such as date, time, and observed behavior. This also includes staying within your area of expertise. The chaplain's area of expertise is religion and pastoral care.[3]

Progress note entries by GPPH chaplains in the patient's medical record follow standard form used throughout the hospital for other clinical disciplines: Data | Assessment | Plan (DAP).

Progress Notes, Chaplain

Chaplains will enter progress notes unique to their discipline. Appropriate charting for chaplains might include:

- Significant contact with the patient
- Patient's request and receipt of rites, rituals and sacraments
- Significant attendance or behavior at worship services
- Referrals by clinical staff/treatment team
- Contacts with the patient's family/partner, pastor, or faith community
- Some assessment of religious ideation as might be helpful to the treatment team. Such might include:

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authority as a woman minister" is not an appropriate progress note entry. The note should articulate the patient's relationship with God and how that might be therapeutically significant. The note is not about the patient's relationship with the chaplain and how thoughtful/clever/faithful the chaplain might be.

[2] There might be exceptions, *e.g.,* an interim note when a patient is using religious behavior to act out and disrupt the milieu, summary notes at the end of a month of intense contact, an esoteric spiritual practice that may need to be documented and explained to staff. The exceptions will be few. If you are writing a long involved note, there better be something important to say.

Rookie pastoral notes usually contain a lot of redundant information. Consider it within the realm of possibility that the treatment team already knows that the patient has a psychiatric disorder, has financial and family problems, is unhappy with their treatment, is deceitful and manipulative, would like more attention, and would just as soon go home. Like Job, many patients think this is just a big misunderstanding. This will not be news to the staff and treatment team. Likewise, if the patient is sweet and needy—or belligerent and difficult—the staff likely already knows that as well. Be a pastor and write something helpful from your own field of expertise.

[3]*e.g. "The patient expressed her feelings of being ignored and discounted,"* might be a valid spiritual issue for a chaplain's note. However, "*The patient is being ignored by the evening nursing staff*" is not an appropriate chaplain entry; the chaplain's job does not include management and supervision of nursing. Nor is *"the patient reports better results on Klonopin rather than Depakote"* an appropriate chaplain's note, as the chaplain does not practice medicine. Again, don't waste everyone's time, interdisciplinary goodwill, or put yourself in legal jeopardy practicing outside your scope and trying to write a nursing, medical, psychology, or social work note.

- Whether a patient's religious beliefs and production is consistent with their religious tradition, or whether it is more a function of their psychiatric disorder.[4] [5]
- Some idea of the quality or depth of the patient's religious concern.[6]
- Specific religious or spiritual issues with which a patient is concerned.[7]

If trained and credentialed to provide structured, ongoing pastoral counseling—and if it is incorporated into the treatment plan by the treatment team—the chaplain may provide regular progress notes on objective, assessment, and plan of such counseling. Pastoral counseling is not a typical need in an acute, state, psychiatric setting.

Formal Pastoral Assessments are completed through a separate process, on a dedicated four page instrument, and filed in another section of the chart by Board Certified Chaplains with the appropriate clinical background. The progress note might reference the Formal Assessment, but would normally not contain the same material.

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[4] While not absolutely required, familiarity with DSM-IV and multi-axial diagnosis will be extremely helpful to chaplains in psychiatric setting. Think of it as the common language of your mission field.

[5] Summary statements are good here. A psychotic patient who speaks to you for 30 minutes explaining that he is the anointed and long awaited savior sent from God the Father… may simply be described as *"patient's religious ideation is consistent with his psychiatric diagnosis."*

On the other hand, an evangelical Christian's belief that *"I am possessed by the demon of depression"* or a sacramental Christian's instance that *"Jesus lives inside of me"* may be a normative understanding of their religious tradition. In such case, a chaplain might write something like, *"While the patient's language is highly stylized, it is consistent with their religious tradition and may need to be seen as a separate phenomena from their psychiatric diagnosis."*

Hardest are those traditions which have historically been highly represented in psychiatric populations, and whose beliefs might themselves border on the delusional or pathological. *"The patient's language is consistent with an extreme interpretation of his faith tradition—one that looks for the eminent destruction of the world; values fear and condemnation of 'non-believers', and ambivalence to civil authority. He uses the intensity of his religious ideation to try to make meaning of his situation, defend against perceived threat, and mediate his anxiety. Chaplain will 1) reassure patient of his safety and God's care and concern, 2) reassess at regular intervals to interpret patient's religious ideation in relation to his treatment plan.*

[6] Some patients will present with a very thin and immature "religion"; some will articulate a very conventional and programmed belief; some will portray a life of deep and profound faith. Spiritual development frequently mirrors psychological, social, and emotional development. See: this department's "Corrective Action Plan for Age Specific Competency," (Fowler/Whitaker 2003) which all chaplains have completed. Competence in developmental assessment is an element within the Chaplain PAR.

Some patients will suddenly generate a religious concern in order to receive the continual interest and attention of the chaplain. While it is easy to dismiss these patients as "needy" or "attention seeking," the need for acknowledgment and affirmation is indeed a spiritual one. The chaplain can acknowledge the personality pathology, while treating the spiritual need with disciplined, time sensitive respect. The progress note will witness that the chaplain understands both, as well as help the chaplain stay on task. Again, familiarity with DSM-IV and multi-axial diagnosis will prove helpful here, as well as pastoral implications as typified in the disciplinary literature of Paul Pruyser and Wayne Oates, among others.

[7] Chaplains can use any schema for pastoral assessment they find helpful, *e.g.,* Oates, Hopewell, Prusyer, Fowler, etc. The specific technique is not important, but the essential result must be the identification of *religious or spiritual* issues, rather than being snookered into medical, nursing, and social work issues, or just visiting. Chaplains who wish to be doctors, nurses, or social workers should return to school and retrain for those fields. If you just want to visit friends, please refer to the GPPH Policy on Patient/Staff Interactions AD-HR-0906.

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Chaplain notes are typically not time critical. Sometimes thinking about your interactions for a day or two—or considering a series of interactions over a period of days or weeks for a summary— will give you a more concise, focused progress note. This will be a more helpful entry than several rambling, chaotic entries which do not show a consistent assessment or plan.

Writing the Note

After identifying the date, time and discipline, Chaplain Notes sometimes need to briefly state how the chaplain happens come into contact with the patient. Because access to pastoral services is voluntary on the behalf of the patient, and because the chaplain may not have regular contact with the treatment team, this helps other clinicians establish the basis for the chaplain's presence with the patient. The unit staff has a legitimate interest in knowing why someone is coming onto "their" unit and spending lengthy or frequent periods with "their" patient—particularly if behind a closed door. A few words can contain a lot of information that will reduce anxiety in the nurse's station.

Date	Time	Objective	Progress Note
12/3/2001	***1400***		***Chaplain Note***
			Patient referred by social worker X.X.

Date	Time	Objective	Progress Note
12/3/2001	***1400***		***Chaplain Note***
			Patient well known by all chaplains…

Date	Time	Objective	Progress Note
12/3/2001	***1400***		***Chaplain Note***
			Patient remembered chaplain from a prior hospitalization and asked if we could speak.

DAP Format

GPPH currently uses a D-A-P structure. DAP sorts the contents of the note to differentiate observable **d**ata from inferences (**a**ssessment), decisions (**p**lan), or speculation (not to be included) based on the data.

All notes begin with *data*: a statement of observable, uninterpreted fact. Data would be something you as the writer saw or heard the patient do or say. The subject of the data is always the patient. The verb should be active and frequently formulated in the past tense.

Date	Time	Objective	Progress Note
12/3/2001	*1400*		*Chaplain Note*
			Patient referred by social worker XX. **D-** ***Patient stated that he believes God is punishing him for committing adultery and sends a 'demonic angel' to torture him with a flaming sword every night.***

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Date	Time	Objective	Progress Note
12/3/2001	*1400*		*<u>Chaplain Note</u>*
			Patient is well known by all chaplains and frequently asks for special prayers and blessings. **D- *Chaplain received v/m from patient today stating she needed chaplain to come pray for her.***

Date	Time	Objective	Progress Note
12/3/2001	*1400*		*<u>Chaplain Note</u>*
			Patient remembered chaplain from a prior hospitalization and asked if we could speak. **D- *Patient said she feels like she has failed her family by going back into the hospital and they will never forgive her: "I am just a piece of shit… God hates me."***

The **<u>a</u>**ssessment section contains any inference based on the **<u>d</u>**ata. In general, if you are aware of using your clinical, pastoral, or theological knowledge; if you are aware of giving an opinion; if you are aware of having a reaction to the data; then you are probably making an assessment.[8]

Date	Time	Objective	Progress Note
12/3/2001	*1400*		*<u>Chaplain Note</u>*
			Patient referred by social worker XX. D- *Patient stated that he believes God is punishing him for committing adultery and sends a 'demonic angel' to torture him with a flaming sword every night.* A- ***Patient's religious ideation is consistent with his psychiatric diagnosis (Schizophrenia).***

Date	Time	Objective	Progress Note
12/3/2001	*1400*		*<u>Chaplain Note</u>*
			D- *Patient remembered chaplain from a prior hospitalization and asked if we could speak. Patient said she feels like she has failed her family by going back into the hospital and they will never forgive her: "I am just a piece of shit… God hates me."* A- **Spiritual issues = guilt, failure, shame, worthlessness.**

Date	Time	Objective	Progress Note

[8] Chaplains frequently worry that the assessment makes them sound judgmental. However, we work in a medical setting. The first principle of medicine is diagnosis. If chaplains wish to be effective and understood in this setting, we first have to answer the question: What is it? What I am seeing? See, *The Minister as Diagnostician,* Paul Pruyser, Westminister, 1976.

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12/3/2001	*1400*		<u>*Chaplain Note*</u>
			Patient referred by social worker XX. D- On Friday 12/2/01, treatment team told patient that her mother had died in the nursing home. Pt did not seem to understand or react to the information. During conversation with chaplain this afternoon, pt spoke in long, frequently lucid narrative about her mother and their relationship. At the end of the conversation, when she was asked if she understood her mother had died, pt responded, "I don't want to talk about it anymore." A- **Pt seems to have some understanding that her mother has died and is managing her grief process in her own way and at her own pace.** P- Chaplain will continue to monitor pt closely through the weekend. Mother's viewing is Monday evening 12/5 and funeral Tuesday morning. Chaplain will follow up with social worker to help access pt's readiness or desire to attend either event.

The **<u>a</u>**ssessment section is also the place to document patient outcomes. Patient outcomes are the result of an intervention.

Date	Time	Objective	Progress Note
12/3/2001	*1400*		<u>*Chaplain Note*</u>
			D- *Patient is well known by all chaplains and frequently asks for special prayers and blessings. Received v/m from patient today stating she needed chaplain to come pray for her.* A- ***Patient is calmed by traditional religious practices, and responds well to pastoral acknowledgment, ritual, and affirmation.***

Sometimes further assessment can be inferred from the outcome.

Date	Time	Objective	Progress Note
12/3/2001	*1400*		<u>*Chaplain Note*</u>
	Outcome		D- *Patient was seen by chaplain in admission on referral from social worker XX for the patient's religious preoccupation. Patient stated that he had committed "the unpardonable sin" and was going to hell. Patient was raised in a juridical, conservative Christian faith tradition. The chaplain offered prayer and gave him a short series of affirmative bible verses to assure him of his safety and salvation.* A- ***Patient reports, "That prayer and the bible verses really worked for a while… do you have anything else?" but that he began obsessing about the "unpardonable sin" again after he was transferred to***

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	Further assessment		***Abell. Patient's religious obsession seems related to his stress level. Patient's spiritual perception is consistent with a very early developmental level which includes magical thinking and dependence on outside authority for protection.***

The **p**lan section of the progress note contains a statement about how the chaplain is going to respond as a result of the assessment.[9] The plan section might also contain any recommendation to the treatment team resulting from the chaplain's assessment.

Date	Time	Objective	Progress Note
12/3/2001	*1400*		*Chaplain Note*
			D- *Patient is well known by all chaplains and frequently asks for special prayers and blessings. Received v/m from patient today stating she needed chaplain to come pray for her.* A- *Patient is calmed by traditional religious practices, and responds well to pastoral acknowledgment and affirmation.* P- ***Pastoral services remains available and attentive.***

Date	Time	Objective	Progress Note
12/3/2001	*1400*		*Chaplain Note*
			D- *Patient remembered chaplain from a prior hospitalization and asked if we could speak. Patient said she feels like she has failed her family by going back into the hospital and they will never forgive her: "I am just a piece of shit… God hates me."* A- *Spiritual issues = guilt, failure, shame, worthlessness.* P- ***Pt has responded well in the past to pastoral acceptance and prayer, remembering biblical stories involving forgiveness and hope out of failure, as well as encouragement to maintain contact with her family. Chaplain will follow with these interventions.***

Date	Time	Objective	Progress Note
12/3/2001	*1400*		*Chaplain Note*
			D- Patient is known by all chaplains, using pastoral

[9] The rookie mistake is for chaplains to create too ambitious and detailed a plan. Many of our patients function at a compromised intellectual and developmental level. Many of our patients have poor reading and language skills. Unlike pastoral counseling, or pastoral care in a congregation, or even medical hospital patients facing crisis, most of our patients are not really motivated to insight and growth. Most do not need more insight into themselves, they need enough self and hope to get out of bed in the mornings. If they are "assigned" something that they cannot do, cannot understand, or are not interested in, it only compounds their feelings of shame and failure. Many times the best "plan" is simply to acknowledge them, sit with them, and assure them they are known and loved by God.

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			contact to repeatedly voice complaints about her situation in life. A- Spiritual issue = Lamentation, Hope. Patient can frequently be directed to interrupt her thought process by recitation of Psalm 126, a short psalm of hope. P- **Pt encouraged to raise the issue of "Hope" (future) in a positive manner with members of her tx tm. Pastoral Services will continue to follow.**

Date	Time	Objective	Progress Note
12/3/2001	*1400*		*Chaplain Note*
			Patient referred to chaplain by social worker. D- *Patient asked about availability of Shabbot Services and was given the necessary information.* A- *Patient was raised by Jewish relatives, well articulates Jewish religious tradition and wishes the comfort and support of the ritual and community.* P- ***Chaplain recommends to treatment team that patient be allowed to attend Shabbot Services on Fridays at 11am in CAC. Referral is made to Rabbi Savitz who will follow up for Pastoral Services.***

Date	Time	Objective	Progress Note
12/3/2001	*1400*		*Chaplain Note*
			Patient self referred to chaplain after the Sunday evening worship service. D- *Pt gave a long narrative about church and childhood, ultimately involving sexual abuse by clergy to whom her family took her to be counseled. Pt states that "an older male HSA who only works every now and then on the weekend has been trying to witness [i.e., evangelize] to me and it kindda reminds me of that and really makes me uncomfortable."* A- *Inappropriate religious communication from a hospital staff member is reactivating abusive dynamics from the patient's history. Pt does occasionally attend religious services, but would be better and positively empowered if she is able to access faith practice on her own terms.* P- ***Chaplain recommends that treatment team review this issue internally to correct in compliance with division and hospital policy.***

Many disciplines state a patient objective or target behavior in the **p**lan section. While it is possible for a pastoral note to do this, it is not easy, and frequently undesirable—even

prohibited—in this state setting. We can help a patient with *their own religious practice*, but we cannot promote a religious practice.[10]

Some Shortcuts

Sometimes quoting a few words of a staff's or patient's production is more helpful than too many of your own.

Date	Time	Objective	Progress Note
12/3/2001	*1400*		*Chaplain Note*
			Patient referred by the ADN over the weekend for ***"disrupting the unit with religious preoccupation."*** D- *LPN reported,* ***"She is driving everybody crazy."*** *Pt observed addressing several other patients and their visitors in the dayroom:* ***"I feel there is an angel inside me whom I am constantly shocking."*** *Further conversation reveals that pt understands herself as a poet and is fond of quoting Jean Cocteau, Sylvia Plath, and Anne Sexton—* ***"God went out of me as if the sea dried up like sandpaper."*** A- *Pt's verbal religious production is consistent with her Axis I diagnosis (Bi-Polar Disorder, manic phase); her presentation is consistent with Axis II cluster B. Her spiritual practice seems self-styled and centered in interpretation of dead poets and her own creativity and imagination. The religious content is designed to draw attention and heighten the intensity of interaction.* ***"O, Priest, My Priest! Will you really come back, or will it be as when I give my heart to Jesus, and he never calls?"*** *Pt is not in eminent spiritual or religious crisis.* P- *Chaplain will follow-up with pt and treatment team as needed.*

Sometimes you can more succinctly place the note in context by labeling it with a designation like "occasional," "intermittent," "monthly," or "summary" note. This is particularly valuable with patients you see briefly on a non-crisis basis over a long period of time. It is also handy when it is impossible or unnecessary to chart after each contact, but you still have information to document.

Date	Time	Objective	Progress Note
12/3/2001			*Chaplain Note -Summary*
			D- Patient regularly attends weekly worship service with appropriate behavior and active participation. He often speaks articulately during the lesson response or prayers. Other patients consider him an elder in faith and practice and look to him for leadership.

[10] See proselytizing under Administrative order AO4:08, D-6, GPPH Policy AD-HR 0906; CL-PC-0258.

			A- Pt finds the routine of religious practice helpful and enjoys the support of community. P- Pastoral Services remains available and attentive.

Usually the DAP format will usually make a note sharper and shorter. But sometimes the DAP format actually makes things *more* complicated than they need to be. Let common sense prevail. You could also chart something like this:

Date	Time	Objective	Progress Note
12/3/2001	*1400*		*Chaplain Note - Occasional*
			Patient regularly attends Sunday afternoon worship service and participates actively and appropriately.

Date	Time	Objective	Progress Note
12/3/2001	*1400*		*Chaplain Note - Situational*
		Safety	As chaplain was approaching the loading dock door, patient was observed ingesting what appeared to be a AAA battery. When questioned, pt denied and there was nothing in his mouth. Head nurse XX advised.

Signing the Progress Note

All progress notes must be signed with the name and title of the writer. Chaplains may use a combination of honorific, academic degree, or certification according to their tradition. If you are a CPE student or Intern, the director or other supervisor will countersign your notes behind you.

Rev. Josiah P. Smith
Chaplain

Chaplain James Brown
Pastoral Intern

Rabbi Deborah Stern, BCC
Chaplain

Deacon Julia T. Barnes, D.Min.
Chaplain x-1234

H. Wilson Deford, M.Div
ACPE Supervisor

Sr. Margaret Thompson, BCC
Chaplain

Performance Improvement

The improvement of charting by chaplains will be organized as a Performance Improvement (PI) Project within the Department of Pastoral Services.

The Director has been auditing progress notes over the last year as part of the evaluation of individual chaplains. The content of this education module was formulated out of that initial data.

A more formal evaluation of Chaplain Progress Notes will begin with the September – February PAR cycle using the criteria below. Feedback will be continuous, *i.e.,* during this period, chaplains may receive copies of their notes with comments or corrective suggestions. Chaplain will also receive positive feedback for the documentation that they

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have done, and continue to do everyday. Other discipline heads, quality assurance staff, or educators may be asked to help review chaplain notes.

Goal	Measurement
Increase the:	
A- incidence	A- In a random check of any unit or cluster, a chaplain note can be found on at least two patients within the last 30 days.
B- discipline specificity	B- The question: "Why did a *chaplain* need to write this note?" can be answered.
C- clarity	C- The note a. implicitly or explicitly contains data, assessment, and a plan from a pastoral perspective. b. is written legibly, with few errors, and in standard English grammar.
D- brevity	D- The note only contains necessary information about the patient's religious or spiritual issues and the provision of pastoral services.
E- relevance	E- The note contains information that is helpful to the treatment team, applicable to the treatment plan, or helpful to the staff in understanding or managing the patient. (The *"so what?"* test.)
of chaplain notes in patient records.	

In March 2005, after the completion of the six month cycle, a sample will be gathered to evaluate the results and formulate an ongoing standard for Chaplain Progress Notes.