February 1, 2020

To whom It may concern:

I have been asked to write a letter to provide a rationale for the need for professional chaplains to document in the patient health record. The Association of Professional Chaplains supports a professional model of spiritual care in which chaplains demonstrate 31 clinical competencies and work within a defined scope of practice to provide holistic care by a multi-disciplinary team. This letter provides guidance and support regarding professional chaplains’ access to and documentation in the patient’s health record.

Who are Professional Chaplains?

Professional chaplains have a Master’s Degree in Theology or its equivalent, have competed 1600 hours of Clinical Pastoral Education (allied health training recognized by US Department of Education), have completed 2000 hours work in the field and have demonstrated 31 clinical competencies before a committee of their peers and have earned the credential Board Certified Chaplain (BCC).

Professional chaplains have job descriptions that require board certification and are considered a part of the hospital’s work force. Chaplains are interdisciplinary team members with the goal of providing holistic care. The department in which they work has a description of the chaplain’s scope of service. Just like all other clinicians, their access to the patient health record is based on need to know and they comply with all HIPAA regulations.

Who is allowed access?

Some health systems also utilize volunteer chaplains, community clergy, or friendly visitors. These individuals are not professional chaplains and should not have access to document in the medical record. The difference between clinically trained, certified chaplains who are a part of the work force and volunteer community clergy is a crucial distinction in identifying who should have access to the health record.

Competencies and Standards

Several of the competencies and standards of practice for board certified chaplains address documentation in the patient’s health record.

- **PPS10** Formulate and utilize spiritual assessments, interventions, outcomes, and care plans in order to contribute effectively to the well-being of the person receiving care.
- **PPS11** Document one’s spiritual care effectively in the appropriate records
- **PIC7** Function within the Common Code of Ethics for Chaplains, Pastoral Counselors, Clinical Pastoral Educators, and Students
- **Standard 3, Documentation of Care:** The chaplain documents in the appropriate recording structure information relevant to the care recipient’s well-being.

Why is it important for Professional Chaplains to document their work?

Professional Chaplains serve the wider mission and vision of the health system.

- **Patient-centered care** is built upon an individualized plan of care. Professional chaplains are specialists who are trained to address spiritual needs in a respectful, non-proselytizing manner. By means of documentation in the health record the professional chaplain is able to make other
staff aware of unique spiritual or cultural needs that impact the plan of care. Here is one example – A family has requested anointing of the sick for their loved one. There is no indication in the medical record that the priest has visited. So you have to call again when the sacrament may have already been given. How do we convey to families that their spiritual needs are important and are taken seriously?

- **The Joint Commission** requires respecting patients’ beliefs and accommodating religious practices. Professional chaplains assist the hospital in understanding and making an appropriate plan for accommodation. The Joint Commission has referred to professional chaplains as “cultural brokers” because of their skill in navigating these conversations and helping the hospitals in using best practices.

- **Advanced Directives** are often discussed with a professional chaplain. As people explore their beliefs and values in conversation with the chaplain, they may express wishes regarding care or end of life. Some health systems have established protocols about how these conversations can be added to the medical record in a way that can inform the plan of care and capture these stated wishes.

- **Palliative Care Certification** by The Joint Commission requires a dedicated professional chaplain as a member of the interdisciplinary team. During certification surveys the chaplain’s documentation in the medical record is seen as evidence that the plan of care addresses the spiritual needs of dying patients and their families. A system that did not allow documentation by this team member would have difficulty showing compliance with the standards for palliative care.

**Defined Scope of Practice**

The Department of Spiritual Care should have a written policy regarding documentation by professional chaplains.

- Board Certified Chaplains would have broadest access; as they would have demonstrated competencies to document and would write a plan based on an assessment and identifying interventions and desired outcomes.

- Departments with learners enrolled in Clinical Pastoral Education may limit these students to checkboxes or pull down menus. After they have received training and demonstrate competence, greater access can be given to allow free text notes.

- Chaplains in the department with limited religious functions (e.g., priest for sacraments) may have a limited access that allows documenting the completed religious service.

**References**

Common Qualifications and Competencies for Professional Chaplains, Accessed 12/30/2016


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Standards of Practice for Professional Chaplains, Accessed 12/30/2019  
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If I can provide further information, do not hesitate to contact me at the address below.

Sincerely,

Rev. Jon A. Overvold, M.Div., BCC  
President-elect, Association of Professional Chaplains  
2800 W. Higgins, Suite 295 | Hoffman Estates, IL 60169 | Phone: 847.240.1014  
516-770-7663 mobile  
jovervold@gmail.com