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Behavioral Health Audit Tool Implementation and Health Care Documentation

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This is to certify that the doctoral study by

Stephanie Weatherly

has been found to be complete and satisfactory in all respects,
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Abstract

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MS, Western Governors University, 2014

BS, University of South Carolina, 2003

Project Submitted in Partial Fulfillment

of the Requirements for the Degree of

Doctor of Nursing Practice

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Abstract

Quality documentation is a foundational element in healthcare. This QI project was conducted to examine the extent to which the implementation of a standardized behavioral health audit tool influenced compliance with required documentation elements. The context, input, process, product evaluation model was used to support the need for documentation compliance in behavioral health. A new audit tool was developed and implemented. Retrospective audit data were gathered from 86 locations over a period of 3 years, reflecting quarterly corporate audits and monthly program self-audit results. The first five quarters exhibited the widest variation in scoring; 28 locations required action plans for compliance scores lower than 90%. To further examine the variability of the first five quarters of data a series of nonparametric tests were performed on the audit results. The Friedman test comparing the first five quarters showed a statistically significant increase in scores ($X^2 = 12.982$; $p = .011$). A Wilcoxon signed ranks test showed the significance of the gap in scoring between the corporate and self-audit scores for 2018 ($Z = –3.381$; $p = .001$), 2019 ($Z = –3.578$; $p = .001$), and 2020 ($Z = –5.809$; $p = .001$). The audit subsections that exhibited the most improvement over the five quarters were individualized treatment planning and treatment team. In response to a staff perception survey, staff indicated highly valuing the corporate audits and that host hospital leadership feels the programs are regulatorily compliant. This project offers other disciplines of nursing practice the opportunity to use this same audit process approach with tools appropriate to their care environment, which could bring about positive social change by improving patient care and regulatory compliance.

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Dedication

I would like to dedicate this project to the people cared for in mental health care environments. They are the true heroes battling an invisible monster in a world that stigmatizes mental health concerns and treatment. I hope this project helps improve these patients' care in some small way.

Acknowledgments

I want to start by acknowledging Dr. Niedz help and support. Our weekly calls were invaluable in streamlining this process and, ultimately, for my success in completing this project. I believe that completion of this project would have taken much longer without Niedz's mentorship and for that I am forever grateful. I would also like to thank Jay, my husband, for calming me down when writing seemed impossible and the challenges of life wanted to pull me in other directions. He always pointed me toward the path of completion, and he is my north star always. Lastly, my adult children had childhoods filled with discussions of healthcare and leadership woes. They have moved on to their own lives during this chapter of mine, but I appreciate the support they continue to show me for accomplishing my dreams.

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Section 1: Nature of the Project

Introduction

Nurses learn the importance of documentation beginning with their first nursing course. Following graduation, nurses enter a work force with increasing demands for quality care and expectations for documentation to be reflective of the care provided. The Centers for Medicare and Medicaid Services (CMS) created a core quality measures program that requires evidence-based practices for certain disease states. Medical records are audited to ensure the core quality measures have been met. This model allows for reimbursement to be tied to evidence-based care and drives quality outcomes nationally through a value-based purchasing program (CMS, 2020).

In addition to nationally driven quality improvement, hospitals must meet regulatory standards to operate and receive Medicare and Medicaid reimbursement. Failure to meet conditions of participation (CoP) standards could lead to hospital closure. According to Barrins & Associates (2019), citations are based in documentation failure, not failure to provide quality care. The Joint Commission's (TJC) top 10 survey findings in behavioral health for 2018 were all rooted in documentation failures (Barrins & Associates, 2019). Surprisingly, even with these consequences, many behavioral health hospitals operate under the assumption that nursing staff are documenting accurately and thoroughly.

Beyond adverse outcomes for the care organization if documentation is lacking, clinical documentation is the core of legal defense when an adverse outcome occurs. Lack of thorough documentation can have financial consequences. Nursing

documentation is a communication tool that often springboards other disciplines' care of the patient (Hanson et al., 2012). TJC has placed increasing focus on patient safety. In their revamped patient safety chapter, TJC Resources (2018) focused on leadership's responsibility to create constant performance improvement through standardization of systems, identification of risk, and continuing education.

The creation and implementation of a standardized audit tool in behavioral health could improve clinical documentation and compliance. Implications for positive social change could be achieved through the identification of processes that need improvement and the implementation of changes. Such changes impact both the direct care giver and the patient. The ability to have clinical documentation accurately reflect the care provided not only helps with risk management, but also helps the entire team caring for the patient have access to the details needed to provide safe and effective care across disciplines and locations. Thus, this doctor of nursing practice (DNP) project was a quality improvement (QI) endeavor and a retrospective evaluation of an audit tool used to assess intensive outpatient behavioral health documentation in 86 critical access hospitals (CAHs).

Problem Statement

In the outpatient environment, communication among disciplines is essential. Intensive outpatient psychotherapy (IOP) behavioral health environments provide 3 hours of group therapy 3 days a week. The patients also receive additional individual psychotherapy sessions and monthly visits by the attending psychiatrist. The treatment team is comprised of a registered nurse, a licensed therapist, an office and patient coordinator, and a psychiatrist. Each discipline is responsible for portions of the medical

record documentation. The gap in practice that I attempted to fill with this project is the lack of standardized tools in outpatient behavioral health settings used to ensure the team is meeting compliance and clinical standards. The components required to have quality documentation may vary, but without it, patient care suffers (Hanson et al., 2012).

In this doctoral project, I focused on the retrospective results of the implementation of a standardized audit tool in IOP environments. Documentation deficits have been identified relating to lack of detail and consistency between the treatment plan and the extent to which the treatment was consistently carried out. The previous audit practice led to several deficient findings during TJC surveys. Poor documentation outcomes led to the creation of a tool that would allow individual programs to self-assess and become compliant in their medical record documentation.

IOP's documentation primarily consists of group and individual therapy session notes, treatment plans, treatment team updates, psychiatric progress notes, discipline-specific assessments, and patient testing. To ensure compliance with regulatory and national standards, both the completeness of the documents and the accuracy of the information within the document must be evaluated. In behavioral health documentation, the treatment plan is the central document that guides a patient's journey of healing and how the entire team supports the patient. Treatment planning is an area of high survey oversight and has a high risk of receiving regulatory citations regarding incomplete treatment planning (Barrins & Associates, 2019).

A self-audit tool was created in response to the lack of standardized quality clinical documentation seen across the company in multiple locations following CMS

surveys. Prior to the drafting of this tool, no audit form existed for the IOP environment. The audit tool created addresses regulatory requirements, including CMS conditions of participation, local state mandates, and TJC standards as well as the mental health care organization's standards for documentation within the program. The tool, which is an audit checklist, assigns point values for every time the documentation is complete and additional points for information accuracy. Missing data elements are scored at zero points. The audit tool is also used to evaluate documentation about the physical environment and safety factors. The audit provides a final point score, and any program scoring less than 90% overall is placed on an action plan for compliance improvement. The audit tool has been in place for approximately 3 years. In this project, I evaluated the programs over time following implementation of the tool.

Nursing leadership is imperative to ensuring thorough and accurate documentation. In a recent study of perioperative nurses' documentation, Søndergaard et al. (2017) discovered that nurses often refer to guidance about documentation provided by their nurse leader. Nursing leaders need tools to assist their staff in creating documentation that meets national standards. This project assists the nursing field by providing a standardized tool that could assist staff in behavioral health settings of all types to meet these standards.

Purpose Statement

The lack of national standards for the content of quality documentation creates gray areas for clinicians, including how much or how little to document. Teams may be uncertain whether their documentation is complete and accurate. If teams have a tool to

ensure documentation is complete and meets regulatory standards, documentation compliance is likely to improve, which is needed. Hanson et al.'s (2012) study of an audit tool reviewing advance practice behavioral health nurses' documentation showed only 14% of the notes met the minimum requirements. Without oversight, documentation failure may not be identified until an adverse event occurs. Thus, the practice-focused question that framed this retrospective QI program evaluation project was: To what extent did the implementation of a standardized behavioral health audit tool influence the compliance of required documentation elements?

Nursing documentation should reflect the care provided and leave little room for ambiguity as to what occurred. Cutugno et al. (2015) studied nursing documentation of geriatric patients receiving evidence-based care protocols but were unable to determine if the care had been provided and not documented or if gaps in documentation were gaps in practice as well. Failures such as these can lead to reimbursement penalties and possible poor outcomes to patients. Cutugno et al.'s project demonstrated a need for shortening the gap between clinical care provided and quality documentation.

Nature of the Doctoral Project

In this retrospective project, I reviewed data gathered from 86 IOP programs in 19 states serving CAHs. These programs treat senior patients suffering from depression and anxiety. These programs are in multiple locations and are all managed by a company that will be referenced under the pseudonym Mental Health Company (MHC). These programs all use the same forms and processes. The singular management philosophy of MHC allows for a systematic roll out of new tools to all locations. At the initiation of this

project there were no standardized tools used at MHC to ensure documentation compliance and accuracy. For the clinical leader of MHC, implementation of a standardized tool was a top priority. The audit tool was created to encompass the CMS conditions of payment, the CMS conditions of participation, and MHC standards of excellence. The programs perform a self-audit monthly. The MHC corporate clinical team performs oversight audits for each program quarterly. These quarterly oversight audits from January 2018 through December 2020 were used for this project.

This project was a retrospective QI program evaluation of an audit process that had been established across the sites and in place for 3 years. MHC has 3 years of audit data from 86 IOP programs in 19 states. The quarterly audit data are stored for each program and are available to show the program's evolution through time with use of the audit and subsequent clinical documentation improvement or decline. The audit tool is comprised of over 100 required elements and is broken up into 15 subsections: (a) intake process, (b) program admission process, (c) suicide prevention measures, (d) outcome measures, (e) group attendance, (f) therapist documentation, (g) daily nursing checklist, (h) MD follow up, (i) individualized treatment plan, (j) treatment team meetings, (k) discharge paperwork, (l) patient compliance, (m) safety measures, (n) physical environment, and (o) staff training. The audit tool is evaluated annually, and based on trends, slight changes are made to the tool every December to create process improvement. The program receives a total score that determines the need for placement on an action plan.

The context, input, process, and product (CIPP) evaluation model was ideal for this project. The CIPP model is appropriate for use in clinical settings and has been recognized as a valid performance improvement model (Stufflebeam & Zhang, 2017). Using the CIPP evaluation model with this project, I was able to first evaluate the context of the original problem (Stufflebeam & Zhang, 2017): understanding the environment the programs operate within, the regulations they must meet, and the problems caused by the lack of compliance. Moving into the input stage, I examined the staffing makeup of the units, the strategic thought behind why an audit tool could provide improvement, and the plan used to implement the audit tool. In the process evaluation stage, I outlined the monitoring of the audit tool, the status of its use, and reported on the implementation process. Lastly, with the product evaluation phase, I evaluated both the short- and long-term impacts the audit tool has on the programs and their compliance scores.

In this project, I compared initial audit scores with continuing audit scores in 86 IOP programs in 19 states to derive an improvement or decline in clinical documentation following the implementation of the standardized audit tool. Initial data from 2018 and quarterly data were available for each program to date. Programs closed or added since 2018 were excluded from the data. The quarterly oversight audits by the MHC corporate team were used as the data points. In this project, I examined changes in documentation compliance following implementation of a standardized audit tool. The audit tool could be used throughout behavioral health care environments and may reduce the gap between clinical practice and quality, compliant documentation.

Significance

Rural hospitals have been shown to have fewer 4-year degree nurses, lower quality and safety engagement, and a lacking a shared vision of patient care (Newhouse et al., 2011). The IOP programs in question were all based in CAHs in rural communities. The stakeholders for this project included the CAHs senior leadership responsible for the clinical and financial performance of their programs. The leaders of MHC are responsible for managing quality programs for the host hospital and have stake in the quality of their programs. The clinical behavioral health team comprised of a registered nurse, licensed therapist, office and patient coordinator, and psychiatrist are also stakeholders. This team is the most impacted by the implementation of an audit tool. The team had to learn the audit tool and potentially change current documentation habits. The teams were also visited by corporate clinical team members for oversight audits, which can create stress. Lastly, the patient who remains at the center of the care provided was also a stakeholder and deserves documentation that reflects the care received.

Gaps in documentation can lead to reimbursement penalties and open a clinician to liability. Nursing leadership is often unaware of whether their staff members are meeting documentation standards (Cutugno et al., 2015). A standardized behavioral health tool allows clinicians to be confident in their documentation meeting standards. Such a tool allows nursing leadership to provide oversight and ensure that documentation meets standards. This process would positively impact nursing practice. Additionally, this project impacted the behavioral health teams directly affected and has the potential to be more widespread. Clinical leaders in other disciplines of nursing could use the tool as a

springboard for creation of an audit tool that meets their standards of care and documentation.

The lack of standardized outpatient behavioral health audit tools to evaluate quality clinical documentation is a gap in practice that needs to be addressed. An audit tool a method for oversight and an educational tool and change agent. The use of the audit tool teaches and reinforces the mandatory requirements in documentation (Corben, 1997). This project has the opportunity to bring about social change by addressing quality improvement that could affect the lives of staff members and patients served in rural communities nationwide.

Summary

Nursing students presumably set out with an intention to be a competent clinician and documentarian. Once in the field, the demands placed on front-line clinicians can lead to documentation failures that impact reimbursement and patient care. Nurses look to their leaders to provide guidance and oversight of their care delivery (Søndergaard et al., 2017). However, nurse leaders are often ill equipped to provide the needed guidance in a manner that allows for objective review and feedback.

In this section, I discussed the history and context for the creation and implementation of a standardized audit tool in behavioral health care to create an objective way to measure and compare compliant documentation improvement or decline over time. I reviewed the content of the audit tool and how it is used. Lastly, I addressed the significance of how this tool could bring about social change. In Section 2, I cover the concepts, models, and theories this project was based in. Additionally, I discuss the

project's relevance to nursing practice, the local context of the project, and the role of the DNP student.

Section 2: Background and Context

Introduction

Insufficient documentation creates gaps in medical records that can lead to negative outcomes for the hospital and create risk for the patient and care provider. Detailed and thorough nursing documentation provides needed information to other members of the team providing care to the patient (Wong, 2009). There is potential for patient harm when the medical record lacks accurate documentation. According to Wong (2009), implementation of an audit tool followed with feedback to the clinician has shown a significant improvement in compliant documentation. There was no standardized audit tool for the intensive outpatient behavioral health environment prior to the creation of this audit tool. Therefore, the practice-focused question that framed this project was: To what extent did the implementation of a standardized behavioral health audit tool influence the compliance of required documentation elements? In this project, I examined the effects of the implementation of a standardized tool and its impact on the compliance of clinical documentation.

In the following subsections, I discuss the supporting models by Donabedian (2003) on the creation of quality improvement and the CIPP evaluation model (Stufflebeam & Zhang, 2017). I then move into the relevance of this project in nursing practice. Current literature will be reviewed to identify documentation compliance in behavioral health, obstacles to documentation compliance, and solutions to achieving compliance in documentation. Next, I describe the context of the problem including the

local setting and the challenges that arise in the CAH setting (Newhouse et al., 2011). This section is concluded with the role of the DNP student.

Concepts, Models, and Theories

In 1966, Avedis Donabedian, a physician, published the first model of quality improvement in healthcare: the Donabedian model. The Donabedian model subsequently went on to be the most cited model for healthcare quality improvement to date (Sunol, 2000). The CIPP evaluation model was best suited to this project because the model provides not only improvement evaluation and opportunities, but also accountability for sustained change (Stufflebeam & Zhang, 2017). The CIPP evaluation model, however, is rooted in the Donabedian Model.

Donabedian (2003) published work directed at all levels of quality improvement in healthcare. Three primary steps for quality improvement were outlined: (a) structure, (b) process, and (c) outcome. Structure is the measurable portion of the physical environment, including staff, that impact the area being considered for improvement. Process is the components that make up the healthcare environment, which includes the processes and practices of the clinicians and any actions taken by patients. The outcome is the culmination of the healthcare processes on the patient and can be seen in the patients' health and well-being (Donabedian, 2003). The Donabedian model has been challenged as one directional and lacking in ability to move back and forth between stages to continue improvement (Mitchell et al., 1998).

The CIPP evaluation model was the model used for this project. The CIPP model is appropriate for use in clinical settings and has been shown to be a valid performance

improvement model (Stufflebeam & Zhang, 2017). The CIPP evaluation model is first used to evaluate the context of the original problem. The input stage is used to determine which changes should be implemented. In the process evaluation stage, implemented changes are reviewed to see if they were completed. Lastly, the product evaluation phase is used to evaluate whether the changes in process were successful and whether revision is necessary (Stufflebeam & Zhang, 2017).

Documentation Compliance in Behavioral Health

Documentation compliance in behavioral health care environments is rooted in regulatory and national standards for clinical documentation. In this subsection, I examine the makeup of quality documentation (De Groot et al., 2019), the influence of accreditation on documentation quality (Nomura et al., 2016), and the improvement in care and documentation following the implementation of national standards for inpatient psychiatric units (Rasinski et al., 2018). There are limitations noted to the comparison of these studies to this project, but the overarching themes are relevant.

De Groot et al. (2019) performed a systematic review of 11 mixed methodology studies to review standards for nursing documentation and determine if trends or tools to support nursing documentation compliance arose (De Groot et al., 2019). The authors first assessed the quality of each systematic review, then compared the findings in three categories: (a) quality of documentation, (b) quality as related to the nursing process, and (c) quality related to the use of clear and consistent nursing terminology (De Groot et al., 2019). Common themes related to quality nursing documentation emerged, which included that documentation should be patient centered, complete, accurate, documented

congruently with care, and have both objective and subjective components (De Groot et al., 2019). Every systematic review provided standards for compliant nursing documentation; however, only four of the 11 reviews offered tools to determine compliance (De Groot et al., 2019).

Nomura et al. (2016) conducted an observational study of 112 hospital records prior to initial TJC accreditation. The researchers examined the quality of nursing documentation, and another 112 records were studied following accreditation to determine if changes in documentation quality occurred (Nomura et al., 2016). Nomura et al. used the Quality of Nursing Diagnoses, Interventions and Outcomes, Brazilian version, to examine the rate the quality of nursing documentation in 29 areas. Those 29 areas were in four domains: (a) process of nursing diagnosis, (b) product of nursing diagnosis, (c) nursing interventions, and (d) nursing outcomes (Nomura et al., 2016). A marked improvement was noted following the accreditation survey, with 82.8% of the documentation areas in compliance. The authors attributed this to the culture change that occurred among nursing staff during the regulatory preparation process (Nomura et al., 2016). This study is limited in its relevance based on its location in Brazil; however, TJC operates in the United States, and its mission to promote patient safety and quality outcomes is prevalent in both accreditation lines (Joint Commission International, 2021). The initial improved results could reflect the hospitals survey preparation and not sustained change over time, but the initial improvement is encouraging as a starting place to identify if meeting regulatory standards improves documentation.

In 2007, there were regulatory changes in behavioral health that included the first ever reporting of outcome data sets to CMS known as the hospital-based inpatient psychiatric measures (HBIPS), and all CMS provider inpatient hospital-based psychiatric units had to comply (Rasinski et al., 2018). In a longitudinal analysis, Rasinski et al. (2018) examined the time of the adoption and reporting of the six HBIPS measures compared with success with achieving the measures in 368 hospitals. The authors' assumption that hospitals that chose early adoption of the measures were higher performing was false, however, the data supported that regardless of where the psychiatric unit started in its quality measures, it improved significantly over time with reporting of the measure (Rasinski et al., 2018). A bias of this study was that the authors were employed by TJC. The findings highlight the importance of regulatory oversight and how it changes patient care and staff performance.

Measuring quality documentation cannot occur without first defining it. Quality nursing documentation should be patient centered, complete, accurate, documented congruently with care, and have both objective and subjective components (De Groot et al., 2019). Quality nursing care and documentation are overseen by regulatory bodies. Regulatory oversight through the forms of accreditation (Nomura et al., 2016) and creation of HBIPS core measures (Rasinski et al., 2018) improve quality clinical documentation. Each study has limitations but provides a foundation for better understanding quality documentation in behavioral health.

Obstacles to Compliance

Compliance with documentation standards is a common expectation of healthcare leaders; however, obstacles arise that can create challenges to achieving compliance in nursing documentation. In this subsection, I examine how documentation lacking context (Martin & Ricciardelli, 2021), amount of time required to complete compliant documentation (Petkovšek-Gregorin & Skela-Savič, 2015), and lack of discipline specific understanding of quality documentation (Hanson et al., 2012) are barriers to compliant documentation in clinical documentation. The findings of these studies further expound on the need for improvement in quality nursing documentation.

Martin and Ricciardelli (2021) used a constructed semigrounded data analysis to determine themes in psychiatric nursing documentation by retrospective chart review of 1,650 individual notes and interviews of 55 nursing staff. The setting of the study was a 346-bed psychiatric hospital in Ontario, Canada. When the authors compared the themes that emerged in the nursing documentation, they discovered they did not align with the Canadian nursing organizations' recommendations for quality nursing documentation in the assessment of the situation or patient, the documented plan, the documented implementation of the plan, and the documentation of the evaluation of the plan (Martin & Ricciardelli, 2021). In addition to not meeting regional quality standards, the nursing documentation did not provide context for the documentation present. The authors provided several examples of documentation failure for lack of appropriate context being documented (Martin & Ricciardelli, 2021). Some suggestions made by Martin and Ricciardelli (2021) for improvement included providing education of the entire

documentation process and the uses of documentation; educating nurses on the importance of context in their documentation; and encouraging hospitals to support their nurses in contextual documentation practices.

Petkovšek-Gregorin and Skela-Savič (2015) used a quantitative nonexperimental model to examine their hypothesis of the perception of 592 nursing staff in 10 Slovenian hospitals. The study examined the participants' education level in comparison to their beliefs about the importance of documentation and the amount of time it takes to document versus the nurses' attitude about documentation importance (Petkovšek-Gregorin & Skela-Savič, 2015). The authors were unable to show a correlation between level of education of nurses and nurses' attitudes about documentation compliance; however, the results did show a decline in nurses' attitudes about documentation compliance when documentation time increases (Petkovšek-Gregorin & Skela-Savič, 2015). The location of this study is limiting in that it cannot be assumed these nurse perceptions would hold true in the United States, but the study is relevant in helping nurse leaders understand the importance of nurses' perceptions to better achieve compliance in nursing documentation.

Hanson et al. (2012) performed a qualitative study using 163 participants, including patients, providers, nurses, and administrative staff, to determine how best to define quality documentation in an outpatient environment. Hanson et al. noted there were no tools available to ensure quality documentation. The authors organized the findings into three themes: (a) attributes of quality documentation, (b) components within a clinical entry, and (c) improvement elements needed to ensure quality documentation in

an outpatient environment (Hanson et al., 2012). From the themes, 42 separate characteristics of quality documentation emerged and were shared based on the applicable discipline they would be valuable to (Hanson et al., 2012). Hanson et al. attempted to address an obstacle to quality documentation in the outpatient setting by starting with identifying what quality documentation entails.

Identification of problems is needed before solutions can be examined. In the three studies discussed, researchers examined barriers to quality nursing documentation: (a) lack of context in nursing documentation (Martin & Ricciardelli, 2021), (b) nurses' perceptions' impact on compliant documentation (Petkovšek-Gregorin & Skela-Savič, 2015), and lack of quality documentation standards in outpatient environments (Hanson et al., 2012). Barriers can be specific to care environment, location, and disciplines. Nonetheless, barriers gain more meaning in the context of solutions to achieve quality documentation.

Solutions to Achieving Compliance

In the previous two subsections, I highlighted documentation compliance and obstacles to achieving it. In this subsection, I provide insight into achieving compliant nursing documentation. Solutions discussed include peer audits, retrospective audits (Hayter & Schaper, 2015), staff education, cue cards (Moldskred et al., 2021), and audit tool implementation (Instefjord et al., 2014). Limitations also exist in these studies, but the central themes are relevant.

Hayter and Schaper (2015) performed retrospective audits following the implementation of unit-level interventions and a peer review chart audit over a 9-month

period to improve pain documentation compliance scores on a cardiopulmonary unit in a 325-bed hospital. The unit's initial compliance with documenting patient pain scores was 17%, which improved to 72% over the course of the study (Hayter & Schaper, 2015). The authors implemented multiple interventions: a concurrent peer performed audit to allow for immediate feedback on missing documentation, a retrospective audit tool for quality staff, medical record flow sheet changes, staff education on pain documentation, visual cues on computers, and staff training (Hayter & Schaper, 2015). Hayter and Schaper noted the importance of including the concurrent peer review audit and retrospective quality department audit to having high levels of compliance with pain documentation (Hayter & Schaper, 2015)

A quantitative study of 38 medical records of patients in long-term care environments in Norway was performed using a standardized auditing tool that encompassed the Norwegian regulations for medical record documentation (Moldskred et al., 2021). The initial audit showed all charts to be substandard. and Moldskred et al. (2021) implemented interventions to improve documentation. Interventions included staff education on documentation standards, staff education on electronic medical records, identification of nursing staff influencers, and providing notecards at each documentation station with documentation tips and reminders (Moldskred et al., 2021). Six months after the initial audit, the authors again performed audits on 38 records, finding significant improvement in documentation completion and compliance (Moldskred et al., 2021). The limitations of location and care setting are significant for the purpose of this project;

however, the interventions used to improve documentation, such as education of staff, are applicable.

A cross-sectional, retrospective review of 21 hospital based psychiatric care records was examined to determine if documentation failures that were observed in other nursing specialties also applied to psychiatric nursing documentation (Instefjord et al., 2014). The authors used a scoring system that rated each record for the presence of certain elements such as nursing admission assessment, care plan, and nursing progress notes. Certain elements were scored based on the content of the documentation such as nursing admission assessment, nursing diagnosis, nursing outcomes, nursing interventions, nursing progress notes, and nursing discharge notes (Instefjord et al., 2014). A limiting factor in this study is the small sample size and the study location in Norway. However, the authors conclusion that the psychiatric nurse documentation did not meet regulatory standards and could be improved with the use of an audit tool is translatable to this paper (Instefjord et al., 2014).

Solutions to improving clinical documentation can vary based on variables in practice environment, treatment team, and documentation system. The solutions examined in this section include peer audits, retrospective audits (Hayter & Schaper, 2015), staff education, cue cards (Moldskred et al., 2021), and audit tool implementation (Instefjord et al., 2014). A theme through all three sections are audit tools used to measure clinical documentation.

It is important to define terminology that was used in this doctoral project. For the purposes of this paper the term audit will refer to the audit tool created for use in the

outpatient behavioral health environment. The term clinician is referring to licensed nurses and licensed therapists. The term program director is referring to the registered nurse leader for the outpatient behavioral health program.

Relevance to Nursing Practice

Nursing documentation is the foundation for communication between nurses and other disciplines. In an analysis of 41 previously conducted studies on nursing documentation, it was determined that there is a lack of a global approach to ensuring accuracy in nursing documentation even though nursing documentation is often subpar (Saranto & Kinnunen, 2009). Another study linked poor documentation with poor patient outcomes. The authors were unable to determine if the poor outcomes were related to lack of evidence-based interventions as there was repeated failure to document the interventions used by the nursing staff (Cutugno et al., 2015).

Brooks (2021) asserted that as a professional, nurses are obligated to complete accurate and through documentation. She provided a road map to support the nurse in creating documentation that meets regulatory and clinical standards. Brooks (2021) focused on the following techniques for improvement: follow regulatory guidelines, use professional judgement in determining what should be included in your documentation, write succinctly and clearly, be objective in your language choice, record the interventions completed, document timely, and document any areas of risk and what was done to mitigate the risk. Petkovšek-Gregorin and Skela-Savič (2015) studied 592 nurses and determined that nurses understand and agree with the importance of nursing documentation including how the accuracy of that documentation impacts patient safety.

Auditing is a tool that is used to review records and nursing documentation. Wong (2009) studied the process of audit tool implementation and found that the process allowed for identification of faulty documentation, which was expected, but also allowed the reviewers to identify trends and root causes so that change could occur. Another successful intervention for nursing documentation is peer review. In a study using a peer review audit tool Hayter and Schaper (2015) found an increase in documentation compliance from 56% to 72% in 4 weeks.

This doctoral project addressed the gap in practice regarding a standardized audit tool for outpatient behavioral health. Even though the need for quality nursing documentation is widely known, little research has been conducted to determine the differences in how quality documentation across the disciplines within nursing is achieved. (Martin & Ricciardelli, 2021). Quality documentation can become even more difficult to ascertain in environments with multiple disciplines such as outpatient behavioral health. This project examined the creation of a standardized way to measure clinical documentation in an outpatient behavioral health environment and using the audit tool to teach clinicians about required documentation elements and their deficits therein.

Local Background and Context

The public often sees the nurse's role as providing medication and physical care, and while employers assume that care provision will occur, they also hold nurses to high standards of documentation. Nurses are responsible for their own documentation and often end up ensuring that other disciplines are completing their documentation timely as well. Nurses are taught the standards of documentation beginning with their first nursing

course, but systems are often not in place to ensure they have habits of documentation that will last them their career. A study identified that an audit tool reviewing nursing student's documentation could potentially prevent negative effects of poor documentation during the nurse's career (Moore et al., 2017).

Even though reimbursement and quality outcomes are tied to complete and accurate documentation, there are no standardized tools in outpatient behavioral health care to ensure that standards are met (Hanson et al., 2012). In addition to audit tools improving documentation, a study of the implementation of a daily audit tool on an acute care unit highlighted that patient's clinical outcomes improved along with the documentation (Denton et al., 2016). Another issue in mental health treatment is finding available treatment in an inpatient environment for patients. A study highlighted that utilizing an audit tool to look at patient utilization of beds in a behavioral health inpatient hospital improved patient throughput to open more beds for patients in need (Zeitz & Hester, 2016).

This retrospective project reviewed data gathered from 86 IOP programs in 19 states. These programs are in critical access hospitals in rural communities. Critical access hospitals must meet several standards including being in a rural area: have 25 licensed beds or less, have an average length of stay that does not exceed 96 hours, and have a functioning emergency department (CMS, 2013). Critical access hospitals face different challenges that their metropolitan counterparts do not. Critical hospitals are less likely to offer clinical ladders for nurse staff, have less bachelor's degree prepared nurses, and lower levels of quality engagement from staff (Newhouse et al., 2011). The MHC

managed programs operate within the footprint of the critical access hospital and must develop quality programs to overcome the obstacles presented in rural communities.

The audit tool was created to encompass the CMS conditions of payment, the CMS conditions of participation, and MHC standards of excellence. The programs perform a self-audit monthly. The audit tool is comprised of the following parts: intake and admission process, suicide prevention measures, outcome testing, therapist documentation, nursing documentation, treatment plan, treatment team documentation, provider documentation, patient compliance, discharge paperwork, program observations. The MHC corporate clinical team, comprised of two master's level prepared board-certified psychiatric nurses and three masters prepared licensed therapists, perform oversight audits for each program quarterly. These quarterly oversight audits from January 2018 through December 2020 were used for this project.

It is important to further define terminology that was used in this doctoral project. Documentation compliance is achieved when a program scores 90% or higher on their quarterly audit. Timely documentation refers to progress note completed by 3pm the following business day, treatment plans completed by the end of the third treatment day, and concurrent documentation of mental and physical health concerns. The federal context of the critical access hospital as described above should be the lens through which these definitions are viewed.

Role of the DNP Student

I joined MHC as its chief clinical officer (CCO) over 6 years ago. In the role of CCO, I am responsible for the clinical systems, quality improvement, and outcomes

across all service lines. Beginning the DNP program was important to me in my professional growth when I joined MHC. MHC was a small company and operated in 16 hospitals when I first began my role. MHC now operates in over 165 hospitals and has added three additional service lines. The DNP student experience pushed me to become a better leader.

The exponential growth of MHC highlighted the need for standardized tools to allow for program compliance. The creation of the audit tool came out of necessity. Corporate clinical team members would go to programs and be overwhelmed with what to review next. Program teams were frustrated with what felt like a shifting landscape as the subject of the moment changed audit to audit.

Creating internal separation that allows for the student role to be independent from the leadership role was difficult in the beginning. Traditionally, a student might not have vested interest in the success of the outcomes of their role. My investment in the success of our clinical outcomes is a bias I closely examined during this project.

Summary

Accurate and detailed documentation is essential to quality nursing care and patient outcomes (Brooks, 2021). The CIPP model outlined in this section highlights the process to bring about quality improvement. The section goes on to explain the setting and reasoning behind the importance of the needed documentation changes. The section finishes with the DNP student experience and examination of bias. The next section will discuss current research and begin to examine the data collection process.

Section 3: Collection and Analysis of Evidence

Introduction

Quality and complete documentation in medical records is important for a regulatory compliant outpatient behavioral health program. However, there is a lack of guidance on what constitutes quality nursing documentation in behavioral health (Instefjord et al., 2014). This gap creates ambiguity for clinicians and creates difficulty in managing the quality process for clinical leaders. MHC created a standardized outpatient behavioral health audit tool to address this gap. In the literature review for this project, I identified three categories of relevant studies: documentation compliance in behavioral health, obstacles to compliance in behavioral health documentation, and solutions to overcoming these obstacles in behavioral health documentation. In this section, I identify the data sources available, the ethical considerations taken with the data, the process for how the data were collected and used, and how the data were analyzed and shared.

Practice-Focused Question

Regulatory standards remain relatively constant, but oversight of documentation is often haphazard by quality departments, and department managers seldom make the time to ensure accurate documentation of staff members. A recent study regarding inaccurate nursing documentation placed the primary reason as lack of leadership oversight for documentation (Kamil et al., 2018). Additionally, there is little agreement on how to measure performance, both clinically and compliantly, in behavioral health. A recent literature review of 222 sources revealed no consensus on how to determine if care provision was of high or low performance (Urbanoski & Inglis, 2019). Lack of

standardized tools to measure quality clinical documentation in behavioral health has contributed to MHC's potential for poor regulatory performance and potential reimbursement issues. The practice-focused question that framed this project was: To what extent did the implementation of a standardized behavioral health audit tool influence the compliance of required documentation elements?

MHC implemented the audit tool and oversight process in 2018 to attempt to improve the completeness and accuracy of clinical documentation. The purpose of this quality improvement project was to examine the previously implemented standardized outpatient behavioral health audit tool in MHC's intensive outpatient psychiatric units. Examining the corporate oversight audit scores, the self-audit scores, and the staff's attitudes about the audits provides context to the practice-focused question and assists in determining if process changes need to be examined for MHC moving forward.

Operational definitions for this project include documentation compliance, timeliness, corporate oversight audit, and self-audit. Documentation compliance is achieved when a program scores 90% or higher on its quarterly audit. Timely documentation refers to a progress note completed by 3 p.m. the following business day, treatment plans completed by the end of the third treatment day, and concurrent documentation of mental and physical health concerns. A corporate oversight audit occurs once a quarter and is completed by a master's-prepared licensed clinician who has at least 5 years' experience in the behavioral health field. Self-audit refers to audits completed monthly by program staff. These can be completed by one team member or by

a combination of team members. Both the corporate clinical team member and the program staff self-audit use the same audit tool for evaluation.

Sources of Evidence

This project was comprised of multiple sources of evidence. Currently published literature has been heavily relied on to shape and guide the project. The project includes quantitative data from corporate oversight audits and program self-audits. The project also includes information collected about staff perceptions of the audit tool, the ease of its use, and the value or lack of value they perceive in the audit tool and process.

These sources of evidence provide the scholarly foundation for the project as well as the impact at a local level these data points represent. Collecting and analyzing the audit scores showed whether a statistically significant improvement was achieved by implementing the standardized outpatient behavioral health audit tool. The monthly self-audit data points were examined to see if they align with the quarterly oversight audit. These data points spoke directly to whether the standardized outpatient behavioral health tool influenced quality documentation as queried in this project's practice-focused question.

Published Outcomes and Research

The Walden University library website was used for all literature searches in this project. The databases used include Cumulative Index to Nursing & Allied Health Literature, Medline, ProQuest Nursing and Allied Health, and PubMed. Multiple searches were completed. The following search term combinations were used: *nursing, audit tool; audit tool, behavior* or mental or psych, EMR or electronic medical records or EHR or*

electronic health records or chart; quality, nursing documentation, audit tool; nursing documentation, audit; nursing documentation, behavioral health; compliance, nursing documentation, behavioral health; behavioral health, audit tool; and *clinic, audit.*

This search was then narrowed to include only full-text articles that had been published in a peer-reviewed journal from 2016 to 2021 and that were available in English. The broadest searches, *clinic* and *audit tool*, returned 1,355 findings before being narrowed to 324 with the date and publication qualifiers added. The most narrowed search was *using compliance, nursing documentation, behavioral health* which originally provided 13 studies, but with the limiters, returned only two studies. Once the limiters were placed, the article summaries were reviewed to determine relevance to this project. To ensure this search was exhaustive, a Walden University librarian assisted in search terminology choices and education on how to best use the databases available.

Archival and Operations Data

The data gathered for this project were separated into the subsets of the CIPP evaluation model. During Stufflebeam and Zhang's (2017) context phase, data were gathered from leadership meeting minutes outlining concerns with compliance prior to audit tool implementation and barriers to change. These meetings include feedback from the chief executive officer, CCO, chief financial officer, and vice president of operations for MHC. These minutes provide a reliable snapshot of the history that led to the creation of the standardized behavioral health audit tool and the oversight process. The minutes were taken by the MHC administrative assistant and verified by committee members for accuracy. A limitation of this data is the succinct nature of the meeting minutes; the

minutes offer a broad view of the conversation without the nuances of what potentially was occurring at the organization.

During Stufflebeam and Zhang's (2017) input stage, the standardized behavioral health audit tool was used as the data collection tool (See Appendix A). The audit tool was created by the CCO using regulatory and national behavioral health standards. The audit tool is comprised of over 100 required elements and is broken up into 15 subsections: (a) intake process, (b) program admission process, (c) suicide prevention measures, (d) outcome measures, (e) group attendance, (f) therapist documentation, (g) daily nursing checklist, (h) MD follow up, (i) individualized treatment plan, (j) treatment team meetings, (k) discharge paperwork, (l) patient compliance, (m) safety measures, (n) physical environment, and (o) staff training. The audit tool was implemented in January 2018 following an all-staff training on completion of self-audits in December 2017. Beginning in January, each program was expected to complete the audit tool and submit it to MHC by the fifth day of the following month. The self-audit could be completed by the registered nurse program director or other members of the team. A corporate clinical team member performs an oversight audit using the same tool once a quarter. These oversight audits began in January 2018. A limitation of this data is the annual change in the audit tool through MHCs quality improvement process. Minor changes were made in the audit tool annually; however, the scoring method that resulted in a final score from 0 to 100 remained intact.

Additionally, in the input stage, a staff survey on perception of the audit tool and its value was used (See Appendix B). These data were collected from current staff using

the standardized behavioral health audit tool at MHC programs. The survey was created by the CCO to obtain anonymous feedback from the staff to add to the results' validity. A limitation of the staff survey is that responders were voluntary which was self-limiting.

In Stufflebeam and Zhang's (2017) process evaluation stage, the quarterly corporate oversight audit scores were gathered for 12 quarters. Additionally, a sampling of monthly self-audit scores completed by the program staff in 86 units in 19 states was used. The data used were from January 2018 to December 2020. The audit scores were originally collected by MHC on Excel spreadsheets each quarter. These historic data were validated as accurate by MHC leadership. Limitations exist with the changes in the annual audit tool having the potential to cause changes in individual item scoring; however, the overall scoring method remained consistent.

In Stufflebeam and Zhang's (2017) product evaluation stage, the data collected in the process evaluation stage were examined to determine if the standardized behavioral health audit tool, self-audit, and quarterly corporate oversight audit process made statistical impact on quality documentation. The information learned was shared in an executive summary presented to MHC's chief executive officer, chief financial officer, and vice president of operations. The executive summary could be limited by the leaderships team's bias toward the presenter who was the CCO. To gain access to the needed information for this project, the chief executive officer gave permission as did MHC's board of directors. The information was gathered from the MHC databases. Legal documents were not used for this project. Historical operational data were used. These

data were validated at MHC by the program staff of each program, clinical leadership, and board of director oversight.

Evidence Generated for the Doctoral Project

Participants

MHC's chief executive officer, chief financial officer, and vice president of operations participated in the executive summary. The chief executive officer was also on the board of directors for MHC. The chief financial officer is second in command of MHC. The audit process impacts the locations the vice president of operations is responsible for, and the results of this project could be valuable to the role moving forward.

Procedures

The audit results were gathered in an Excel spreadsheet that separates the data into calendar quarters. The data were also listed in the individual subsections that made up the total score: intake process, program admission process, suicide prevention measures, outcome measures, group attendance, therapist documentation, daily nursing checklist, MD follow up, individualized treatment plan, treatment team meetings, discharge paperwork, patient compliance, safety measures, physical environment, and staff training. Additionally, 1 month of self-audit per quarter was available in the spreadsheet for comparison. The project process and conclusion were presented in an executive briefing to the chief executive officer, chief financial officer, and vice president of operations.

Protections

Participants were offered protection during this project process. MHC was protected by deidentifying the company name and by withholding certain identifying details, such as headquarters and individual locations. The MHC senior leadership team members who participated in the executive briefing are not identified beyond job title.

In addition to the protections listed above this project complied with all of Walden University's Institutional Review Board requirements and all requirements for protection from the Walden University Quality Improvement Manual. MHC does not have an institutional review board; therefore, this project relied on Walden University's Institutional Review Board (IRB) as the IRB of record (approval number: 07-29-21-0627974).

Analysis and Synthesis

MHC uses Microsoft SharePoint to house its data. This is a HIPAA (Health Insurance Portability and Accountability Act) compliant platform that allows data to be shared by corporate leaders with appropriate access (Microsoft Office 365, 2019). The audit scores used for this project were gathered from excel spreadsheets housed on the MHC SharePoint site.

Two primary data points were collected from this historical data: quarterly corporate oversight audit scores and a sampling of monthly self-audit scores by program staff. Both the quarterly oversight audits and the monthly self-audits were broken down into the following subcategories: intake process; program admission process; suicide prevention measures; outcome measures; group attendance; therapist documentation;

daily nursing checklist; MD follow up; individualized treatment plan; treatment team meetings; discharge paperwork; patient compliance; safety measures; physical environment; and staff training. Each subcategory was assigned a point value. The point values added together and divided by the total potential points that could be scored provide the overall audit score. Potential scores per audit range from 0 to 100. Quarterly corporate audit data was present for the time frame of this project. Monthly self-audit data is present, but with some months unaccounted for. For every quarter oversight audit, one month in the quarter self-audit is examined. If a monthly audit is missing, another month within the quarter was used.

Once the historical data had been validated, secondary statistical analysis occurred. This analysis highlighted improvement over time with quality documentation. Nonparametric statistics were employed beginning with a Friedman test and then moving into a Wilcoxon signed ranks test comparing quarters of data. Locations with action plans were compared quarter to quarter, to demonstrate improvement. Additionally, the analysis compared scores on the self-audit to the corporate oversight audit.

MHC leadership is interested in not only the quality outcomes from the audit process, but also the staff's feelings about the process. They surveyed their staff using 10 questions that allowed staff to rate their perceptions of the value of the survey process related to its purpose, timeliness, and quality. The staff perception survey underwent secondary analysis. A comparison was performed to examine difference of perception of survey value based on employee tenure.

Once analysis was completed both the audit results and employee perception survey results were shared during the executive session with MHC senior leadership. These results have relevance to the leadership of MHC and provide a framework for the company for future decision-making. In addition to the immediate value to MHC, these analyses provided insight into the practice-focused question: To what extent did the implementation of a standardized behavioral health audit tool influence the compliance of required documentation elements?

Summary

Lack of a standardized way of ensuring quality documentation across multiple locations led to the creation of a standardized outpatient behavioral health audit tool by MHC. Literature supports the difficulties in measuring quality documentation and the use of an audit tool to measure documentation quality objectively. This project has been clearly outlined and then moved into the final sections of data collection, analysis, and dissemination of findings.

Section 4: Findings and Recommendations

Introduction

MHC provides intensive outpatient psychiatry services to seniors in rural communities nationwide. From 2014-2017 MHC encountered retrospective payment audit concerns and regulatory survey findings, which led to a lack of leadership confidence in program documentation compliance. In late 2017, staff were educated on the use of a standardized outpatient behavioral health audit tool created by the MHC CCO. This tool was implemented in January 2018 with monthly self-audits and quarterly corporate oversight audits. In this project, I examined 3 years of data from these audits and used these to answer the practice-focused question that frames this retrospective QI program evaluation project: To what extent did the implementation of a standardized behavioral health audit tool influence the compliance of required documentation elements?

In this project, I gathered information from two data sources for analysis. The first source was the quarterly, and some monthly, audit compliance scores over a 3-year period, which were used to evaluate the corporate processes and, ultimately, the product. The second data set was employees' perceptions of the audit tool value via a survey that completed by 185 staff members; this provided the input aspect of the CIPP model. Descriptive statistics were used to analyze the survey results. The Friedman test and Wilcoxon signed-ranks test were used to analyze the audit scores and to make comparisons on the mean scores at several different time periods. In this section, I provide further detail on the analyses performed.

Findings and Implications

In this retrospective QI project, I examined quarterly corporate oversight audit scores and monthly self-audit scores from 86 IOP programs. Additionally, I examined 185 responses to a staff survey on the value of the audit tool. The CIPP evaluation model provided the framework to examine the findings of the data analysis (Stufflebeam & Zhang, 2017).

Context

To better understand the context in which the audit tool was created, I conducted a review of leadership meeting minutes. This review included quarterly corporate meeting minutes and weekly operations leadership call minutes. Several themes emerged from the review. The first was a lack of consistent messaging to staff during corporate clinical team visits to programs. Corporate leadership noted that staff provided feedback they were fearful of the corporate clinical team visits and the staff never felt prepared for the visits. Another theme was corporate and hospital leadership uncertainty in the consistency of compliance standards being upheld. I noted that hospital contacts struggled to find ways to measure the program's clinical success. The last theme was uncertainty with reimbursement. Corporate leadership wanted tools to ensure accurate documentation to support billing. These identified concerns were the driving force behind the creation of the standardized outpatient behavioral health audit tool.

Input

During the input stage, the program staff were educated on the audit tool in December 2017. Following the education, the program staff completed the audit monthly

and submitted the completed audit tool to the CCO by the fifth of the subsequent month. Beginning in January 2018, corporate clinical team members began using the same audit tool to perform quarterly oversight audits of each program. Programs that scored less than 90% on a clinical team oversight audit were placed on a corrective action plan.

Another component of the input stage was a staff survey created by the CCO to better understand staff perceptions of the value of the audit tool and audit process. This 10-question survey was sent to all program staff; 185 staff members responded to the survey and provided feedback. There were three reverse-scored questions to ensure readers were being deliberate in their responses (Polit, 2009), resulting in scores that ranged from 1 (very negative) to 10 (very positive), and a total score per participant that could range from as low as 10 to as high as 100. Table 1 includes the survey questions and the responses provided after the data were entered in SPSS and tabulated.

Table 1

Staff Perception Survey

	Number of responses	Minimum score	Maximum score	Mean	Standard deviation
Q1 How valuable do you feel the monthly chart self-audit process is to your program?	185	1	10	7.19	2.52
Q2 How valuable do you feel the quarterly corporate clinical team audit process is to your program?	185	1	10	8.50	1.9
Q3 Does completing the monthly chart audit tool makes me feel prepared for any regulatory audit?	185	1	10	7.14	2.53
Q4 Does completion of the monthly chart audit tool make me feel prepared for my quarterly corporate clinical team audit?	185	1	10	7.15	2.32
Q5 The amount of time it takes to complete the monthly chart self-audit can be accomplished in a reasonable amount of time.	185	1	10	7.09	2.48
Q6 My host hospital leadership team feels that the program's compliance with regulatory standards is exceptional.	185	1	10	8.57	1.78
Q7 The audit tool includes items or sections that I feel are unnecessary.	185	1	10	5.71	2.75
Q8 The corporate clinical team oversight audits are opportunities to learn more about compliance. (Reverse scored)	185	1	10	6.72	3.38
Q9 Completion of the monthly chart audit tool has improved our team's documentation. (Reverse scored)	185	1	10	5.98	2.98
Q10 If given the choice I would continue using the audit tool even if it were not mandatory. (Reverse scored)	185	1	10	5.96	3.02

The highest scoring question with a mean score of 8.57 was Question 6: *My host hospital leadership team feels that the program's compliance with regulatory standards is exceptional*. As a management company, MHC promises to deliver compliant and

quality programs to its host hospitals. This score reflects the confidence the host hospitals have in the program's regulatory compliance. The second highest score was Question 2: *How valuable do you feel the quarterly corporate clinical team audit process is to your program?* This reflects the value the IOP program staff feel in the corporate clinical staff auditing their program once a quarter.

The lowest scored item with a mean score of 5.71 was Question 7: *The audit tool includes items or sections that I feel are unnecessary.* This score indicates opportunities for revision in the audit tool when staff perceptions are considered. Another question with low scoring was Question 10: *If given the choice, I would continue using the audit tool even if it were not mandatory*. This question referred to the self-audit completed using the same tool by each program monthly. This question highlights that lack of alignment with the use of the tool on a program level versus when completed by a corporate team member. Feelings around willingness to continue to use the audit tool were relatively low; however, in Question one, the staff rated the value of the self-audit process at a mean of 7.19, which would indicate they place value in the self-audit process. The feedback from staff highlighted the value the staff have in the corporate team and the oversight process. The findings bring into question whether all the elements in the audit are necessary and whether the team feels the self-audit is valuable.

Process

During the process stage, audit scores from monthly self-audit and quarterly corporate clinical team oversight audits from January 2018 through December 2020 was entered into SPSS and tabulated. One monthly self-audit score for the second quarter of

each year was compared to the quarterly audit score completed by a corporate clinical team member. The data is represented in Table 2.

Table 2

Comparison of Self-Audit (M) to Corporate Audit (Q)

	Number of programs	Minimum score	Maximum score	Mean	Standard deviation
Q22018M	42	90	100	98.05	2.17
Q22018Q	38	69	100	92.13	8.55
Q22019M	54	90	100	98.68	1.75
Q22019Q	72	90	100	97.53	1.95
Q22020M	73	90	100	98.89	1.94
Q22020Q	72	90	100	97.53	1.91

Table 2 includes the 2nd quarter audit for each year and a corresponding self-audit score by the program for the same quarter. The first quarter exhibits the greatest difference in scoring with the self-audit mean score being 98.05 while the corporate oversight audit had a mean score of 92.13. Inferential analysis was performed by way of Wilcoxon signed ranks testing which showed that the gaps in scoring between the corporate oversight audit and the self-audit by program staff are statistically significant for 2018 (Z = -3.381; p =.001), 2019 (Z = -3.578; p =.001), and 2020 (Z = -5.809; p =.001). While the gap in self-audit and corporate clinical team audits lessened over the 3-year period, the program staff consistently score themselves higher than the corporate clinical team members do using the same tool. This indicates a bias that is inherent in self-assessment and highlights the need for oversight audits to continue (Saranto & Kinnunen, 2009). Table 3 below compares corporate clinical team audits quarter to quarter over the 3-year period.

Table 3

Corporate Oversight Audits

	Number of programs	Minimum score	Maximum score	Mean	Standard deviation
Q12018Q	50	71	100	93.78	6.69
Q22018Q	38	69	100	92.13	8.55
Q32018Q	43	56	100	92.79	8.63
Q42018Q	44	81	100	95.14	4.33
Q12019Q	70	59	100	96.58	5.61
Q22019Q	72	90	100	97.53	1.91
Q32019Q	76	92	100	97.70	1.91
Q42019Q	80	90	100	97.31	2.22
Q12020Q	72	91	100	98.15	1.81
Q22020Q	72	90	100	97.53	1.91
Q32020Q	76	92	100	97.70	1.91
Q42020Q	80	90	100	97.31	2.22

The first five quarters exhibit the widest variation in scoring. The mean score of 50 programs in 1st quarter 2018was 93.78. The mean score of 1st quarter 2019 with 70 programs was 96.58. The mean score of 80 programs in quarter 4 of 2020, the final quarter examined, was 97.31. This improvement in scores shows the impact of the standardized audit tool process in documentation compliance.

To further examine the variability of the first five quarters of data a series of nonparametric tests were performed. The Friedman test comparing the first five quarters showed a statistically significant increase in scores ($X2 = 12.982$; $p = .011$). This showed that the results were significant but did not isolate the quarter in which significance occurred. To do that a Wilcoxon signed ranks test comparing pairs of quarters was performed. This test showed the comparison of 1st quarter 2018 to 1st quarter 2019 to be

statistically significant (Z = -3.106; p =.002). The comparison of 4th quarter 2018 to 1st quarter 2019 also showed statistical significance (Z = -2.567; p =.01).

Table 4 shows the mean subsection scores for the corporate oversight audits during the 3-year period. The greatest improvement was seen between the 2018 to 2019 in the audit scores. Documentation that was the most improved by staff during this 5-quarter period were the two sections that audited documentation regarding: individualized treatment plan (ITP) and treatment team meetings. The mean score for each of these sections in 2018 was 88.78 for ITP and 84.8 for treatment team meetings. In 2019 the mean score improved to 95.95 for ITP and 92.17 for treatment team meetings. These sections further improved in 2020 to 98.63 for ITP and 97.3 for treatment team meetings. Several sections received high scores with the initial audits in 2018 and remained consistently high throughout the measuring period such as: outcomes measures, group attendance, patient compliance, and environment. The consistently high scores in these subsections indicate that these would be potential areas to remove from the audit moving forward. The environment subsection has consistently had a mean score of 100 for all three years. This would indicate that it could be removed from the audit tool moving forward. Another area that has scored consistently high is the suicide prevention subsection, however the regulatory and patient risk that would occur if these items were not present are reason to leave this subsection of the audit unchanged.

Table 4

Audit Subsections

Audit subsections	2018 mean score	2019 mean score	2020 mean score
Intake process	97.49	97.19	97.55
Admission process	94.99	97.08	97.84
Suicide prevention	98.21	95.94	96.89
Outcome measures	100	99.05	99.72
Group attendance	99.96	98.81	100
Therapist doc	93.44	95.25	98.12
Daily nursing check	95.21	97.23	98.47
Physician follow-up	92.94	96.65	96.32
I. treatment plan	88.78	95.95	98.63
Treatment meetings	84.80	92.17	97.27
Discharge paperwork	96.99	95.95	96.29
Patient compliance	99.26	99.1	99.49
Safety measures	98.79	98.86	99.65
Environment	100	100	100
Staff training	94	95.71	98.61

Table 5 shows the improvement in compliance by comparing number of programs on an action plan over time. Programs that scored less than 90% on the corporate clinical oversight audit were placed on action plans until their documentation was brought back into compliance. As noted below, the last program to be placed on an action plan occurred in 1st quarter 2019. There have been seven subsequent quarters without any program falling out of compliance and requiring an action plan. These results would seem to indicate that the process of the self-audit with corporate oversight audits, and the action plan process were successful in creating and maintaining compliant documentation.

Table 5

Programs on Action Plans

	Number of programs	Programs on action plan
Q12018Q	50	7
Q22018Q	38	8
Q32018Q	43	7
Q42018Q	44	3
Q12019Q	70	3
Q22019Q	72	0
Q32019Q	76	0
Q42019Q	80	0
Q12020Q	72	0
Q22020Q	72	0
Q32020Q	76	0
Q42020Q	80	0

Product

The final phase of the CIPP process is the product evaluation phase (Stufflebeam & Zhang, 2017). During this phase, the information learned completing this project were shared in an executive session with the chief executive officer, chief financial officer, and vice president of operations for MHC. During this session, the process of audit creation and implementation was reviewed, the statistical significance of program improvement was highlighted, and recommendations for the future based upon these learnings were covered. MHC leadership was able to ask questions and suggest further insight into the findings based on their experiences.

There are several limitations to the data presented in this section. There were some monthly and quarterly data that were not collected due to temporary program closures during the COVID-19 pandemic. There were other months where self-reported

audits were not submitted by program staff for a variety of reasons. In these instances, other months within the same quarter were used in the comparison data listed above in Table 2. Lastly, the audits contain both objective and subjective data measurement points. Thus, subjective judgment can vary by examiner and can account for some degree of variability amongst the scores between staff and corporate clinical team members.

The implication of the findings of this project for the individuals who work in the IOP programs should be reinforcement to the actions that they have already taken to bring their programs into compliance. The outpatient behavioral health community can look to the tool used in this project to standardize a tool that is appropriate for their setting. This project implies that the process of self-auditing and oversight audits by trained clinicians results in improved documentation compliance which could benefit the mental health care environments and the larger healthcare community in many settings. Nursing documentation is central to practice of nursing. Improving ways to ensure compliant documentation offers positive social change to the nurse who is providing care and completing the documentation, the nurse leader responsible for the quality nursing being delivered, and ultimately the patient receiving the care. The opportunity for positive social change in nursing is to be more objectively data driven in quality documentation improvement.

Recommendations

Martin and Ricciardelli (2021) brought focus to the lack of research that has been conducted to determine the differences in how quality documentation across the disciplines within nursing is achieved. This project examined the creation of a

standardized way to measure clinical documentation in an outpatient behavioral health environment. The findings of statistically significant improvement in audit scores along with elimination of programs on action plans after five quarters emphasize the success of the audit process in improving documentation compliance. The use of the audit tool and the corporate clinical team oversight audits teach clinicians about required documentation elements and the deficits in their medical record documentation. This was further emphasized in the employee perception of audit tool value that was administered. Staff reported high value placed on the audit process as performed by the corporate clinical team.

The findings of the gap between self-audit and corporate oversight audit scores lead to the recommendation of continuing the corporate clinical team oversight audits. The staff feedback regarding the value of all items on the survey leads to a second recommendation. Further evaluation on the breakdown of the individual sections of the audit should be done to determine if questions or entire sections of the audit should be eliminated. A focus group of front-line staff that can provide more details into the reasoning for the answers given would be a helpful next step. The current process of monthly self-audits, and quarterly corporate clinical team oversight audits (see Appendix A) has assisted MHC with achieving documentation compliance. This doctoral project addressed the gap in nursing practice regarding a standardized audit tool for the outpatient behavioral health environment.

Strengths and Limitations of the Project

This project had both strengths and limitations. A strength of the project was available access to deidentified historical data. The high response rate to the employee survey was an additional strength. The support offered by MHC senior leadership during the project and while receiving the executive briefing are further strengths. Lastly, the possibility of further exposure on the importance of better understanding how to support staff in achieving quality, compliant clinical documentation is a strength.

Limitations of this project include the exclusion of comments from the employee survey on audit value is a limitation in better understanding some of the more moderately scored responses. Lastly, the project does not address the other elements that could have influenced improvement of compliance that occurred over the 3 years that were examined, such as staff training and education sessions.

Work has been done to address improvement in nursing documentation. Some solutions that have been suggested have included peer audits, retrospective audits (Hayter & Schaper, 2015), staff education, cue cards (Moldskred et al., 2021), and audit tool implementation (Instefjord et al., 2014). This project focused on audit tool implementation in the field of outpatient behavioral health where there had not previously been a standardized tool. As further work is done to examine how to improve clinical documentation it would be helpful to determine if you can reduce the amount of oversight and still achieve results. In this project, oversight audits are completed quarterly. Future work could be done to determine if the compliance results would be sustained if this gap in oversight increased to semiannually or annually.

Section 5: Dissemination Plan

The findings of this project were communicated to the chief executive officer, chief financial officer, and the vice president of operations in an executive briefing. The board of directors has asked to see the project at the next board meeting. Leadership is currently determining next steps for communicating the results of the staff perception survey and project findings with the staff. The American Psychiatric Nurses Association hosts an annual conference, and in their next call for proposals, I will submit this project for presentation. Following graduation, I plan to prepare this project for publication.

Analysis of Self

Balancing the role of clinical leader, student, and project manager proved to be difficult at times during this process. As a leader, there is an expectation that you always have the answers or know where to find them; as a student, I was constantly reminded of gaps in my knowledge. The student role allowed me to tap into the passion that drove my desire to further my education and become the best nurse leader possible. The project manager role led to frustrations at times when it was not moving at the speed I would have liked as a leader but was being developed carefully by the student. When I first became a nurse leader, I was passionate about providing staff tools to provide quality care. That passion grew over the years, and I felt dedicated to not only instilling processes for improvement but creating consistent changes that sustain over time. The journey of the doctoral student was a joy because it allowed me to clearly outline and show the long-term improvement that ultimately led to improvement in care for patients. I hope to one day be able to have a platform to effect change for patients experiencing

mental health challenges. Accomplishing this degree is my first step toward achieving that goal.

This project process presented several challenges. I had taken 3 years off between completion of my classes and starting my project. The biggest challenge was to carve time out of my life to write. I was not used to writing daily as when originally enrolled, so I took time to reacquaint myself with the Walden University library, resources, and writing center. Another challenge was finding literature on documentation in behavioral health settings. Behavioral health has long been a neglected area of focus, and I hope this project signifies the importance of quality documentation regardless of the care setting.

Summary

Lack of quality documentation can lead to financial and regulatory consequences and can cause potential harm to patients (Hanson et al., 2012). In this project, I examined the implementation of a standardized outpatient behavioral health audit tool. The tool was used monthly in a self-audit by staff; a corporate clinical team member used the same oversight audit tool quarterly. Improvement in compliant documentation was statistically significant, and all programs have achieved compliant documentation for the seven quarters studied. This audit process has the potential to be replicated in other care environments nationally.

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Appendix A: Audit Tool

REFERRAL INTAKE
Do NOT do a “Referral Intake” until you have verified insurance. Review 3 records for compliance.
During an Initial Referral Intake (#3) patient must sign the release at the top of page 1.
Referral intake completed prior to Psychiatric Evaluation & Admission
Intake justifies admission - For intake to justify admission it must be detailed and specific to the symptomology the patient is experiencing. Using words like ‘depressed’, ‘anxious’, ‘isolative’, etc. must only be done when specific details are provided to discuss how these symptoms are manifested for this specific patient.
PROGRAM ADMISSION PROCESS
The psychiatric evaluation is completed (signature is dated & timed) prior to the admission order.
No patients are enrolled into the program until ordered by the Physician. Face sheet admission time must be after the Physician Admission Order.
The Physician must complete the following documents for a patient to be admitted:
Psychiatric Evaluation #15 justifies admission.
Medical Necessity Checklist #16
Physician Admission Order #17 - includes all required information including ordered frequency of treatment, admitting diagnosis, signed, dated, & timed.
After admission to the program the following paperwork must be completed before the patient can begin participating in group, individual or family therapy.
Face Sheet stamped voluntary
Face Sheet has admitting diagnosis (signed and dated if handwritten)
Consent for Treatment #5
Consent for Telehealth #5A (Signed prior to admission if admitted via telehealth)
Consent for Release of Information #7 present and completed correctly. (May use the Hospital Form if preferred by Hospital.)
Hospital Registration Form
Advance Healthcare Directive #8. May use the Hospital Form if available. If patient has AD, it should be present in chart. Document efforts to obtain.
Patient Rights. This is a Hospital Form. *(If Hospital does not have form refer to Form #9)*

Notification to staff of presence at IOP. #9A
Patient Responsibilities/Confidentiality Agreement #10
Patient Handbook Acknowledgement #11
Consent for Follow Up #12
Transportation Agreement #13 *Always have this agreement signed even if the patient is not anticipating need for transportation. (Should be signed prior to admission if SLS provides transportation to program for admission.)
Self-Administration of Medication Release Form. #18.4
Patient Orientation Checklist. #11.1
H&P present in record, received within 30 days of admission, date of service within 6 months of admission, and updated annually as needed
Nursing assessment completed before patient attends groups
Medication Log reconciled, has necessary signatures, & is updated with changes as appropriate
Suicide Prevention Measures
SBQ-R completed at intake and quarterly
CSSR-S completed at intake if warranted; completed correctly
Safety Plan completed if warranted and treatment plan updates note the review of safety plan with patient
Suicide Prevention Treatment Plan initiated if warranted
Outcome Measures
Geriatric Depression Scale completed at the initial intake and quarterly.
Zung Anxiety Scale completed at the initial intake and quarterly.
Life Satisfaction Survey completed at the initial intake and quarterly.
MMSE completed at the initial intake and at discharge.
Patients cannot have significant dementia (MMSE-2 score of 15 or lower) and participate in the program.
GROUP ATTENDANCE & SIZE
Patient did not begin attending group/individual/family sessions until all required paperwork had been completed.
The minimum number of patients in a group is 2 and the maximum is 10.
THERAPIST DOCUMENTATION

Psychosocial should be completed by the third treatment day.
Individual therapy sessions are occurring as ordered
Group note specifies content and use of intervention
All areas of note are complete; if dictated, note is completed according to Therapist Progress Note Template.
Patient's response & progress toward treatment plan goal is noted in Narrative
Plan indicates how patient will utilize information and skills learned in group to reach their treatment plan goal.
Progress note dated & signed
Group therapy sessions should be between 45-60 minutes; an individual must be in the group session at a minimum of 45 minutes to bill for the group.
A 5-15-minute break between group sessions is provided.
If it is a Doctor Day and the doctor pulls the patient out of the group, you cannot bill for both services unless the patient still receives at least 45 minutes of group. Recorded Doctor time can never overlap with group time
You may not bill for sessions until notes have been completed. Verifiable triple check occurring.
All treatment notes must be completed in a timely fashion *(best practices are notes completed day of care but must be completed by 3pm the next business day).*
DAILY NURSING CHECKLIST
#25 is completed each group day by the Nurse
Patient Initial must be placed on the document each group day
If health issues are a concern (including BP outside of established parameters), documentation is present of action taken (PCP contacted and/or pt. encouraged to go to the Emergency Room).
Vitals should be taken prior to group starting. Vital Signs may be completed by the OPC upon patient arrival; however, a licensed nurse must review and sign off on these vitals upon completion.
New medication instructions signed by patient if applicable
Psychotropic drug consent signed if applicable

Falls Assessment (form 20C) completed monthly
Actual Abuse Tool (form 20E) completed monthly
MD FOLLOW UP
While the patient is in the program, he/she must be seen by the doctor monthly. The patient must be seen within each calendar month with visits not to exceed more than 40 days apart. Patients may need to be seen more often depending on mental health needs.
Progress note justifies patient's severity, current symptomology, and need for continued treatment. Medical Necessity is met by MD documentation.
Orders should be dated, timed, and signed.
INDIVIDUALIZED TREATMENT
Discharge planning starts on admission with the Continuing Care/Discharge Instructions Form #21
Treatment Plan #24 should be started on the first treatment day, with at least one goal established and dated prior to first treatment, and all portions completed by the third treatment day
Problems written in specific behavioral terms according to format guidelines, consistent with diagnosis & assessments; reflect DSM-V symptomology criteria.
Problems and goals indicate date initiated
SMART GOALS: Specific: Focused on reduction of a **symptom** specific to the patient. Is it a goal that you could give to any patient with this dx? If so- it is not specific to the patient at hand.
SMART GOALS: Measurable: Is this goal measurable, with a current baseline? How much? How many? How will I, and the patient, know when it is accomplished?
SMART GOALS: Attainable: Can this short-term goal should be accomplished by the patient in four (4) weeks?
SMART GOALS: Relevant: Does this goal seem meaningful to this patient by *improving their symptoms*? For example- learning symptoms of depression are not relevant to the patient but improving their ability to sleep is.
SMART GOALS: Time Bound: When will this goal be achieved by? ("Target Date")
Treatment Plan Interventions: Indicate evidence-based therapeutic modalities utilized to assist patient in reaching short term goal.
All areas of initial assessment page complete & reflect **symptoms** specific to the patient, summarized from each assessment.
All areas of the Treatment Plan diagnosis & signature page are completed correctly and entirely.
TREATMENT TEAM MEETINGS

Goal Updates #24 and the Treatment Team Meetings #28 should occur every 2 weeks. The treatment updates must document specific, measurable progress towards each of the patient's short-term goals to be given credit.
Specific symptomology the patient is currently experiencing is referenced.
Reasons for continued treatment documented
Discharge Plan is summarized
Continued Stay Checklist is completed fully and accurately on each patient if pt. has been attending more than 60 treatment days
DISCHARGE PAPERWORK
Physician Discharge Orders #30 completed
Physician Discharge Summary #31 completed
Therapy Discharge Summary #32 completed
Continuing Care/Discharge Instructions #21 completed at discharge, including pt. signing & receiving a copy
Treatment Plan goals closed out
Necessary referral/follow up for patient made upon discharge
PATIENT COMPLIANCE
Patients must attend sessions as ordered by Doctor. Document any discrepancies and your efforts to improve compliance on a Patient Absence note, Form #29A
Any patient absent between 14-30 days will have a Patient Update Form completed and will show continued medical necessity.
If the patient does not improve compliance, discharge will occur.
Even with abrupt discharges, aftercare is still coordinated by Senior Life Solutions staff.
SAFETY MEASURES
Any potential patient who we are not able to help must have appropriate referrals. Review referrals that were not admitted ensuring this measure is met.
Environment of Care Rounds completed by staff at appropriate intervals and maintained in binder.
Bathrooms must have call lights and be handicapped accessible.

Staff able to verbalize safety plan utilized for any time staff will be alone with patients.
Each program should have a recorded message directing individuals to contact 911 or go to the nearest emergency room for after-hours emergencies. This recorded message/answering machine must be in a confidential area so that only Senior Life Solutions staff have access.
Van Safety/Maintenance is extremely important and must be strictly followed. Follow hospital protocol. **Do not transport patients in your own vehicle. Our transportation is for patient pickup/drop off only. No additional stops are allowed.**
Fire, Tornado and Emergency Drills: Programs should follow hospital protocol for fire drills, tornado, and emergency drills and these should be conducted and documented per hospital protocol.
Refrigerator Logs: Temperature levels will be recorded daily, and expiration dates checked. Fridge is free of expired products. All multiple use items are labeled with an open date.
The following must be posted in the program: Choking Poster, Patient Rights, Emergency Numbers, Evacuation Route, and Numbers for Patient to Make Complaint. Give 1 point for each item posted as described.
We do not dispense or store any medication in our programs. If a patient needs to take medications during group hours, they must bring their own medication from home. This includes medicines such as aspirin. Verify no medications present.
Contacting Adult Protective Services: If you suspect Elder neglect or abuse you are required by law to contact Adult Protective Services. If your Treatment Team determines a report should be filed contact the Medical Director, the Hospital Risk Management Department, and your PMC supervisor for guidance on how to make the call.
COMPLIANCE
Anyone entering the Senior Life Solutions space and who is not a staff member or a hospital employee (who has signed a hospital confidentiality agreement) must sign the SLS confidentiality form. Review previous SLS confidentiality forms for compliance.
Only active patients can participate in a group session. Potential patients cannot attend a group session to see if they like it. Family members can attend a family session, but not a group session. Validate no visitors attending group.
If more than 30 days occur due to a medical issue, which can involve hospitalization, the patient must be discharged and can be readmitted when the health issues are resolved.
Patients who have changes in level of care will have the Level of Change form completed and sent to the billing department.

Patients receiving Skilled Nursing Home Care or Hospice Care are not eligible for admission to the program. Patients receiving Home Health, PT/OT, and other home care services might be eligible for our program. Contact regional director before admitting the patient for assistance in determining if patient will be allowed to participate in the program. Verify no SNF or Hospice patients in program.
PHYSICAL LOCATION
Physical location presents professionally
Patients greeted promptly and brought into treatment areas
Therapy spaces are clean and ordered
Therapy spaces are age appropriate and representative of the senior population we serve, i.e., appropriate music and art
Patient Care and Treatment Must Occur at the Program Facility
Usual group psychotherapy days are Monday, Wednesday, and Friday. (3 days a week)
Usual daily operational hours are 8:30 am to 4:30 pm. Monday through Friday
MONTHLY IN-SERVICES
Required to be conducted for staff on topics which are relevant to geriatric patients; Staff sign-in sheets up to date and maintained in binder.

Appendix B: Staff Survey

On a scale of 1 to 10 using anchor words at each pole, describe your beliefs, thoughts, and feelings about the monthly and quarterly self-audit process.

1. How many months have you worked for MHC? _____Years _____Months

2. How valuable do you feel the monthly chart self-audit process is to your program?

not valuable 1 2 3 4 5 6 7 8 9 10 exceptionally valuable

3. How valuable do you feel the quarterly corporate clinical team audit process is to your program?

not valuable 1 2 3 4 5 6 7 8 9 10 exceptionally valuable

4. Does completing the monthly chart audit tool make me feel prepared for any regulatory audit?

no impact on preparedness 1 2 3 4 5 6 7 8 9 10 maximum preparedness

5. To what extent does completion of the monthly chart audit tool make me feel prepared for my quarterly corporate clinical team audit?

no impact on preparedness 1 2 3 4 5 6 7 8 9 10 maximum preparedness

6. The amount of time it takes to complete the monthly chart self-audit:

takes much too long 1 2 3 4 5 6 7 8 9 10 can be accomplished in a reasonable amount of time

7. My host hospital leadership team feels that the program's compliance with regulatory standards is:

very poor 1 2 3 4 5 6 7 8 9 10 exceptional

8. The audit tool includes items or sections that I feel are unnecessary.

strongly agree 1 2 3 4 5 6 7 8 9 10 strongly disagree

9. The corporate clinical team oversight audits are opportunities to learn more about compliance.

strongly agree 1 2 3 4 5 6 7 8 9 10 strongly disagree

10. Completion of the monthly chart audit tool has improved our team's documentation.

strongly agree 1 2 3 4 5 6 7 8 9 10 strongly disagree

11. If given the choice I would continue using the audit tool even if it were not mandatory.

strongly agree 1 2 3 4 5 6 7 8 9 10 strongly disagree