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Nursing Documentation in an Inpatient Behavioral Health Unit: A Best Practice Quality Improvement Project

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Nursing Documentation in an Inpatient Behavioral Health Unit: A Best Practice Quality Improvement Project

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By

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Abstract

Nursing documentation is a fundamental clinical routine that improves safety of care. It is utilized for communication within healthcare team members and other disciplines, credentialing, legal matters, and to measure performance outcomes. In the healthcare profession, it is crucial to provide quality nursing documentation. There is an increase in non-adherence and documentation errors amongst nurses. A quality improvement project was developed with the goal to improve nurse's knowledge on quality nursing documentation and improve nurses' attitude and adherence to documentation. The project was obtained in an inpatient behavioral unit located in an urban South Florida hospital. Participants included nurses who work on the inpatient behavioral units.

A comprehensive literature review was conducted using research data bases such as CINAHL and MEDLINE to identify studies relevant to quality nursing documentation. The quality improvement project utilized a pretest entailing the general self -efficacy scale and posttest. A total of thirty nurses contributed to the quality improvement project. Results of the pre-test indicated nurses in the inpatient behavioral unit have a perceived positive self-efficacy, thus likely to adhere to improving documentation requirements. Overall, fifty- nine percent agreed that their attitude changed about documentation. In addition, results displayed a 17% increase to nurses' knowledge about quality documentation after engaging in the educational in-service.

Keywords: *Nursing documentation, Adherence, Attitude towards documentation, Nurses' knowledge.*

I. Introduction

Background

Documentation is a written or electronically generated record that describes the health history, health status, and delivery of care to patients (McCarty et. al, 2018). It is an impetrative function within the healthcare profession and is critical to ensure high quality, effective, and most of all, safe nursing care (Mykkanen et al., 2016). Documentation also serves as a communication exchange tool for stored information between nurses and other healthcare disciplines. As one of the largest groups of healthcare personnel, nurses have the responsibility to provide professional, legal, and ethical care to patients, and therefore are required to record quality documentation (Rooddehghan et.al., 2018).

Quality nursing documentation is based on the nursing process model which includes assessing, planning, implementing, and evaluation. Quality nursing documentation consists of accessibility, accuracy, auditability, clarity, and being organized and concise (Selvi, 2017). High quality nursing documentation is essential in every area of care and in every healthcare setting (Wilson et al, 2012). However, the quality of nursing documentation is known for failing to meet recommended standards (Okasiu et al, 2015).

Scope of the Problem

There has been an increase in lack of documentation and errors amongst nurses. Twenty-three percent of documenting errors were reported with inaccurate description of an individual medical history (Bell et. al, 2020). In fact, out of every 8000 patients discharged from an inpatient psychiatric unit, one out of five patients encountered a medical error such as a documentation error (Vermeulen, 2018). In addition, Matholoadakis et al. (2016), discovered

that sub-standard documentation can be linked to prolonged hospital stays and increase in patient morality (Matholoadakis, 2016).

In the case of Memorial Regional Hospital inpatient behavioral health unit, audits of patient records display that nurses are missing pertinent documentation, especially in the area of substance abuse and tobacco screening, tobacco treatment plan upon discharge, and verifying patients who are being discharged with multiple antipsychotics medication. Under the Hospital – Based Inpatient Psychiatric Services (HBIPS), there are five core measures that are critical and affect the course of an individual's hospitalization from admission through discharge (Joint Commission National Quality Measures, 2021). Substance abuse and tobacco screening along with multiple antipsychotic medication justification are within the five core measures.

Substance abuse can be described as excessive use of psychoactive, painkillers and illegal drugs that results in social, emotional, or physical harm (Davis, 2021). Tobacco is one the most widely abused substance. Tobacco dependence occurs when an individual relies on tobacco and cannot stop using it. Knowing about a patient's substance or tobacco abuse is vital to understanding and providing quality care for their overall health. Efforts to integrate and document substance abuse and tobacco screening is still a major concern within this unit, thus, indicating an intervention for change.

Significance to Nursing

Documentation is an integral part of nurse's daily work (Selvi, 2017). Nursing documentation is important for communication with healthcare teams and other disciplines, credentialing, and legal matters. With communication of healthcare professionals, documentation can facilitate continuity of care by displaying a clearer view of current plans and treatments (Brooks, 2021). In regard to legal affairs, one out of every four negligence cases in patient care

are attributed to nursing documentation mistakes (Mountain et. al., 2015). Documentation that is incomplete, inaccessible, false or misleading can lead to serious consequences such as jeopardizing legal rights and putting healthcare organization at risk for liability (Perry & Potter, 2014). Subsequently, documentation can be utilized for research aspects. It can be used to screen subjects for research studies and collect documented data for analyzation and evaluation for evidence-based practice (Selvi, 2017).

Documentation is especially important to measure performance outcomes from standards, healthcare team members, and from individual nurses (American Nurses Association, 2021). Performance outcomes are evaluated from using quality improvement tools called audits. Audits focus on keeping accurate, complete and up-to-date documentation. There is quote notable in the nursing profession that states "If it is not documented, then it is presumably not done". This rationalizes the importance of documentation and displays that without documentation, there is no proof of an assessment, intervention or evaluation.

II. Summary of Literature

Search Strategy

In order to find the effectiveness of nurses' adherence to documentation, evidence-based research is imperative. Through FIU library access the data bases of Cumulative Index to Nursing and Allied Health Literature (CINAHL), MEDLINE, PubMed and Science Direct were obtained. Key words included quality nursing documentation, evidence-based practice and nurse's attitudes towards documentation. The PICO question of "Will administering an educational in-service for nursing staff within a psychiatric health unit, improve adherence and nurses perceived attitudes towards documentation?" was the foundation of the search. Inclusion criteria were particular to studies on nursing documentation. The search was limited to research

studies pertaining to quality nursing documentation, published articles in the English language, and publication dates from 2014-2021.

Originally, 384 articles were retrieved from CINAHL. With the full inclusion applied, only three articles were left. While using MEDLINE, forty studies were available and filtered down to two articles that met the full criteria. Within the PubMed database over 943 studies were founded, however after full inclusion criteria, only were three utilized. The studies included randomized trials, qualitative, descriptive and systematic reviews. Each study was ranked based on the evidence-based hierarchy system. Studies were analyzed by methodology, study design, and results.

Barriers to documentation

Nursing care documentation is one of the major nursing requirements that is commonly left undone (Kebede et. al., 2016). Research displays that there are various barriers such as shortage of time, heavy patient loads, and lack of proper training that prevent quality documentation (Kebede et. al., 2016). In regard to shortage of time, a study discovered that nursing staff in a psychiatric setting spend more time managing the ward environment and staff matters leaving documentation to be incomplete (Joubert & Bhagwan, 2018). On the other hand, patient ratio is significantly associated with nursing care documentation. One descriptive review study discovered that nurses with fewer patients were 95% more likely to have good documentation compared to those with a heavy patient load (Jones et.al, 2015). Another descriptive study indicates nurses with lower patient demands are less stressful and have less chaotic situations that will make them less likely to be interrupted from patients, hence leading to adequate documentation (Ofi & Sowunmi, 2012).

Moreover, lack of training is a major barrier to documentation. Low rates of screening for substance abuse are linked to inadequate healthcare personnel education (Brereton, 2017). According to Ofi & Sowumini (2012), inadequate knowledge of nursing process can progress to issues with nursing documentation. Whereas nurses who obtain good knowledge of nursing care documentation are twice as more as likely to practice good nursing documentation (Kebede et.al., 2016). Henceforth, indicating that an educational session will be helpful in improving documentation.

Additionally, a healthy work environment is vital to documentation. The definition of a healthy workplace entails safety, empowerment, and satisfaction (Wei et al., 2018). Nurses are more favorable to work in an environment that upholds staff morale and improves their mood. A healthy work environment can promote effective communication, enhance nursing staff perceived self- efficacy and confidence, which ultimately improves adherence.

Nurses attitude towards documentation

Attitude, which is an evaluation of a concept or idea, has the power to influence a behavior and can help individuals to attract information. Dissatisfaction attitude among nurses may result in lower documentation quality (Winatal & Hariyati, 2021). Nonetheless, failure to properly document nursing care can majorly affect the treatment of severe clinical conditions in mental health (Stewart et. al., 2017). One cross- sectional study displayed that nurses often do not perceive the importance and powerfulness of documentation (Kebede et. al., 2016). Furthermore, nurses perceived that spending time on documentation is an irrelevant requirement and is an addition to the already demanding workload. On the other hand, having a positive attitude promotes good nursing documentation.

Education needed

Education plays a vital role in adherence to documentation. According to Ausserhofer et al (2014), the cross-sectional study showed that nurses who takes part in an in-service training were 2.59 times more likely to have good nursing care documentation compared to those who did not take part in the training (Ausserhofer et al, 2014). Furthermore, it is imperative to promote nurse's knowledge and skills through effective teaching methods (Ebrahimpor & Pelarak, 2016).

According to Ghazanfri et al study, out of 226 nurses working in a hospital setting, only 46.5% have a medium knowledge about documentation principles (Ebrahimpor & Pelarak, 2016). The study also displayed a positive relationship with participating in educational course and higher reported knowledge (Ebrahimpor & Pelarak, 2016). Hence, having an educational in service can improve documentation adherence.

Furthermore, finding the right teaching method is essential. In today society, the nursing education is constantly changing to accommodate the ever-changing needs of the nursing profession (Wege et al., 2020). In order for teaching to be effective, participants must be engaged, motivated, and interested. Participants are usually engaged and motived to learn when education is consistent with their learning style (Hallin, 2014).

Recommendation for future studies

Although various studies have been obtained emphasizing documentation, further research are needed. According to Tajabadi, et al. (2019) future research is needed to understand perceptive of nursing documentation from other healthcare personnel and solutions to improvement. Additionally, it is recommended that authentic management and leadership is essential for training quality nursing documentation (Albsoul et al. 2019). Currently there are only few studies focusing on documentation in behavioral healthcare setting, therefore research of improving documentation in an inpatient behavioral health hospital is critical.

III. AIM/ Purpose/ PICO Question

The aim of this project is to successfully implement an educational in-service to nurses on an inpatient behavioral health unit, in order to increase positive attitudes and adherence to documentation. This will also improve hospital-based audits and inpatient behavioral health safety measures. The purpose of the project is as follows, assess nurse's knowledge of quality nursing documentation, evaluating nurses' adherence to substance abuse and tobacco screening documentation after an educational in-service, improving nurse's attitudes towards documentation after a pre/posttest and to improve nurses' adherence to documentation after a pre/posttest.

PICO Clinical Question

The clinical question was "Will administering an educational in-service session for nursing staff in a behavioral health unit, improve adherence and nurses' attitudes towards documentation? The breakdown of the PICO includes **P**opulation= Nursing staff at Memorial Hospital Behavior Health Unit, **I**ntervention= educational in-service session, **C**ompare= normal teaching methods and **O**utcome= improve attitude and adherence towards documentation.

IV. Definition of Terms

Advance Practice Registered Nurses: registered nurses with specialized, advanced education and clinical practice competency to provide quality healthcare for diverse populations in acute, primary and long-term care settings (American Association of Nurse Practitioner, 2021).

*Nursing Documentation***:** is the record of nursing care that is designed and delivered to individual patients by qualified nurses (Tasew et al, 2019).

*Nursing Audit***:** A review of the patient record designed to identify, examine, or verify the performance of a specific aspect of nursing care (Ramukumba & Amouri, 2019).

*Substance Abuse***:** A pattern of overindulgence in or dependent of an additive substance such as drugs and alcohol (Johns Hopkins, 2021).

V. Theoretical Framework

This quality improvement project is based on self – efficacy. Self-efficacy can be described as the level of an individual confidence in their ability to effectively perform a behavior. (LaMorte,2019). It is part of a self- system encompassed of an individual's attitude, cognitive skills, and abilities (Cherry, 2020). Individuals with a strong positive self-efficacy view challenging problems as a job to be mastered, recover quickly from disappointments or setbacks, and can result to less perceived barriers to a specific behavior (Cherry, 2020). A person with a weak self- efficacy believe that difficult tasks and situations are beyond their capabilities, lose confidence in personal abilities and avoid hardship.

The self-efficacy scale can be used in the healthcare setting. Utilizing the self- efficacy to healthcare workers can enhance patient outcomes and provide great satisfaction (Petripin, 2020). For instance, nurses who has positive perceived self-efficacy in the nursing process can display proper documentation. Hence, this framework model can be applied to educate and counsel nursing staff on adherence to documentation.

VI. Methodology

The methodology used as a guide to implement this project will be the Plan, Do, Study, and Act (PDSA) cycle. The PDSA cycle is considered the building block of healthcare improvement (Leis & Shojania, 2017). The goal of the plan stage is to identify a problem, brainstorm ideas, and discover an aim statement. The "Do" phase, involves implementing the project and gathering

data to analyze. The "study" phase of the cycle encompasses a complete observation of data analysis, flow charts or graphs to help visualize changes and determines if the project was effective. The last phase of the PSDA cycle, the "act" stage evaluates the project. This stage focuses on reflection of what modification can be made to the project.

Plan phase

The plan phase described the problem of documentation and the importance of why it should be evaluated. This phase involved a detailed review of literature of documentation, its barriers and knowledge gaps. Through research, it was discovered that documentation amongst nurses were not meeting standards of the hospital's policy. The literature review was helpful in displaying external data that supported the need for evaluating ways to improve adherence and nurses' attitudes towards documentation.

Planning for the project involved discussing with colleagues and mentors within the workforce place. Discussion amongst the colleagues was vital in order to discover an additional gap in the unit. In order to successful implement a quality improvement project, a thorough investigation of the current state of the unit was imperative.

Study Design

The design will include a pre-test questionnaire consisting of twenty items, focusing nurse's perceived self-efficacy scale in regard to documentation. The intervention consists of an educational in-service session of evidence-based power-point presentation and interactive discussion encompassing quality nursing documentation. The posttest questionnaire will consist of eleven questions, including a rating scale, where nurses can express their viewpoint of how confident and how likely they will adhere to documentation standards after engaging in the educational session.

Setting and Participants

The study setting was Memorial Regional Hospital, a stand-alone public hospital located in Hollywood, FL. The focus was the behavioral health unit, which emphases on providing a safe and therapeutic environment and offers services to help improve and assist with mental health disorders. This setting has currently fifty -one beds, divided into four inpatient units, including adolescents ages sixteen and older. Participants of the study included nursing staff, both female and male, who works in the inpatient behavioral unit. Total sample size was thirty nurses.

Recruitment

A flyer was created and posted on the door of the nursing staff break room and in the clinical educator office, two weeks prior to bring awareness to the DNP Project. The flyer entails dates, times, and summary of the project. The start date was September 20th and extended through September 23rd. The recruitment of participants was on a voluntary basis and participants were made aware that they could withdraw from the intervention at any time.

Project Approach

After obtaining Intuitional Review Board (IRB) approval, recruitment of the nursing staff was obtained. Informed consent forms were administered and accepted by participants. The pre-test survey includes participants demographics questionnaire, nurses perceived self- efficacy scale and nurses' attitudes towards documentation. The survey was anonymous, which allows participant to express their feelings freely. Total time allotted to accomplish the pre-test was fifteen minutes. The educational in-service will be power point based, including photos and interactive discussions on quality nursing documentation. The educational service lasted no longer than thirty minutes. Participants will be educated on the evidence-based practice of quality nursing documentation. After the educational presentation, participants will be able to ask

any questions or address any concerns. In addition, participants will take a posttest survey lasting no more than fifteen minutes. The goal of the DNP project to increase participants adherence and attitude towards nursing documentation.

Protection of Human Subjects

This project qualified as a Quality Improvement (QI) project. IRB approval was obtained from Memorial Regional Hospital and from Florida International University (FIU). (See Appendix) Data was collected anonymously using the Qualtrics programming system. The Qualtrics system uses an untraceable link to collect and analyze responses. Results of the study was stored on a password protection computer equipped with anti-virus software to ensure safety of data.

Data Management and Analysis

Responses to the pre- and -posttest survey was the main source of the data processing. Participants information was de-identified. The pre-test, educational in-service and posttest was accessible via electronic devices such as an apple I-pad, laptop, cell phones, computers and tablets by accessing a link created by Qualtrics. The analysis of the data was displayed in the form of ranges, percentages and graphs. Within the Qualtrics software system, reported data can be analyzed for inferential analysis.

Instruments

The General Self- Efficacy Scale (GSE) was used to conduct a pre intervention survey to measure participants perceived self- efficacy. This tool can be used to access one's belief in their ability to respond to a specific behavior or demand. This scale is self- administered and can be accomplished in less than ten minutes. The reliability of GSE, is between 0.76 and 0.90. (Schwarzer, 2012). The validity of the GSE scale is correlated to optimism, emotion, work and

satisfaction. Negative correlation of the scale is linked with anxiety, stress and burn-out. The GSE scoring includes one point for “not at all true”, two points for “hardly true”, three points for “moderately true” and lastly four points for exactly true. The total score is calculated from adding the total sum of all the items. Score ranges is between ten and forty, with the higher score indicating more self-efficacy.

VII. Results

Intervention Sample

In total, there was thirty nurses who participated in the pre-test questionnaire. Demographics were majority female (n= 23, 76.7 %), identified as white race (n= 13/30, 43.3%), and between the ages of 51-60 years old (12/30, 40%). In addition, majority of the nurses have been nurses for over fifteen years (n= 21/30, 70%) and worked in the behavior health unit for over fifteen years (n=20/30, 66.7 %). Thirty participants completed the post-test, making the posttest demographics the same. Figure one through three will describe nursing demographics.

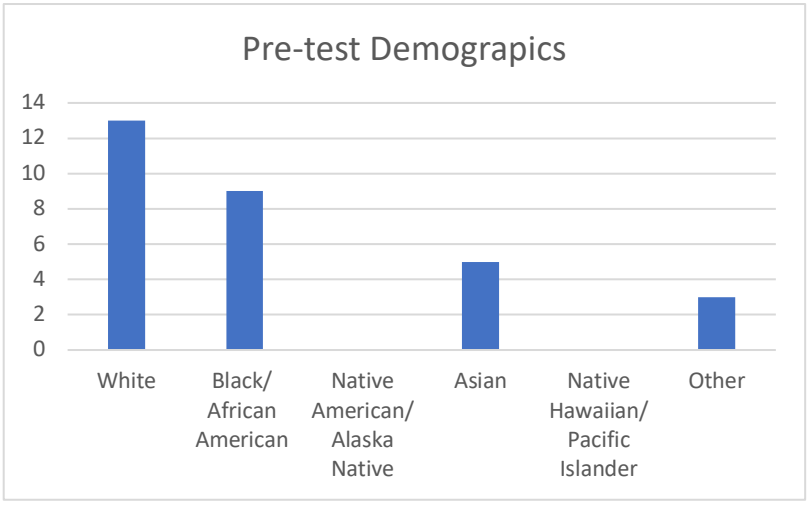


Figure 2:

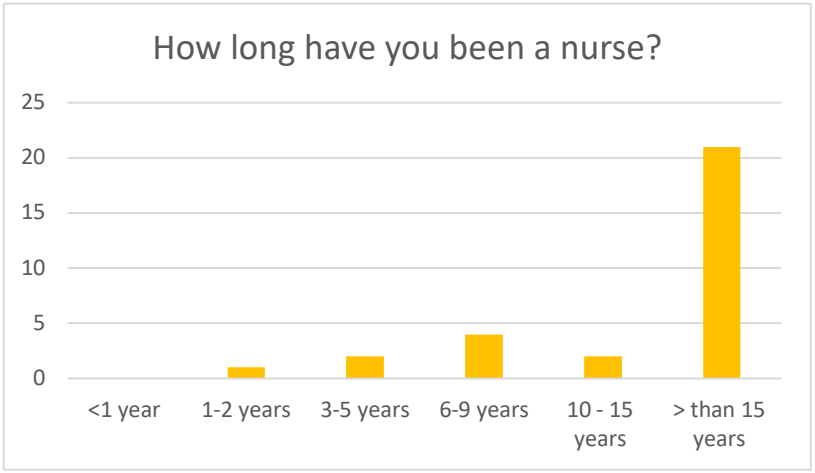
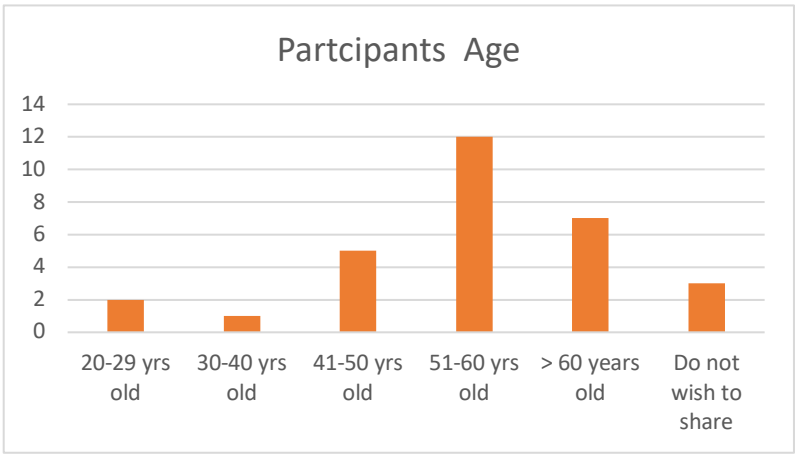
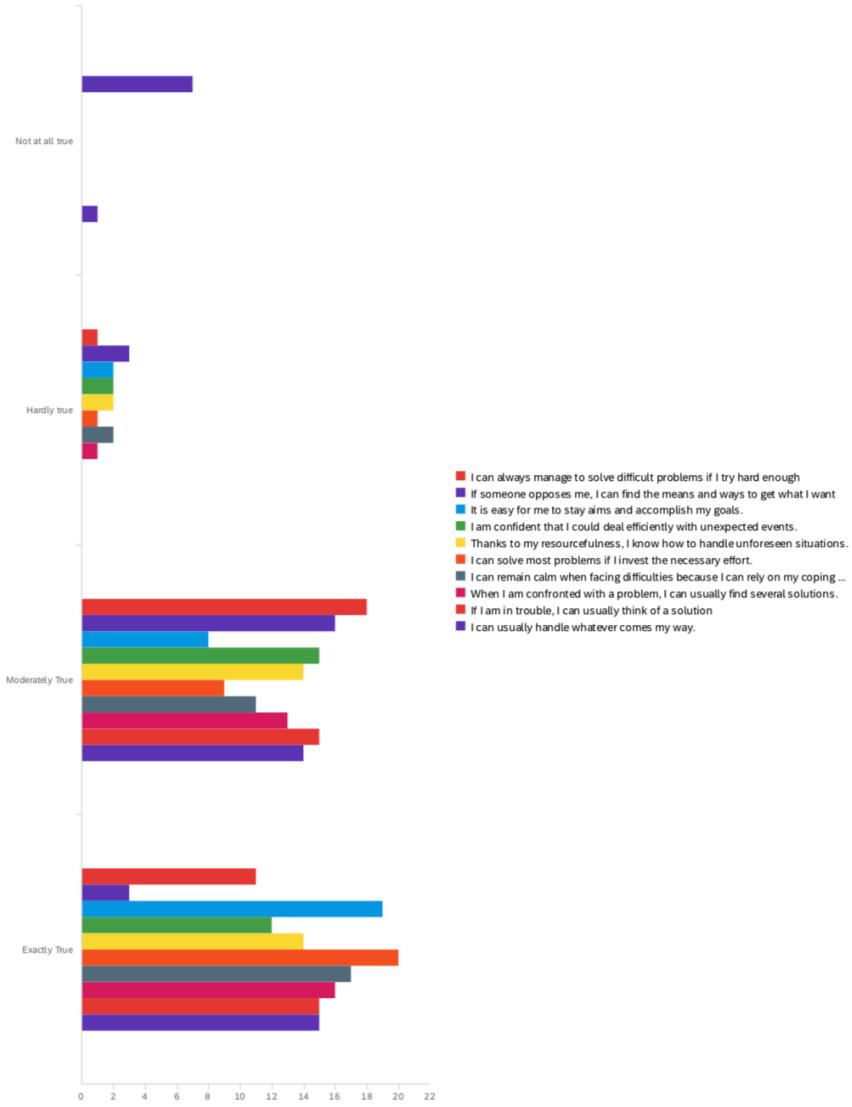


Figure 3:



Pre-test and Posttest Analysis

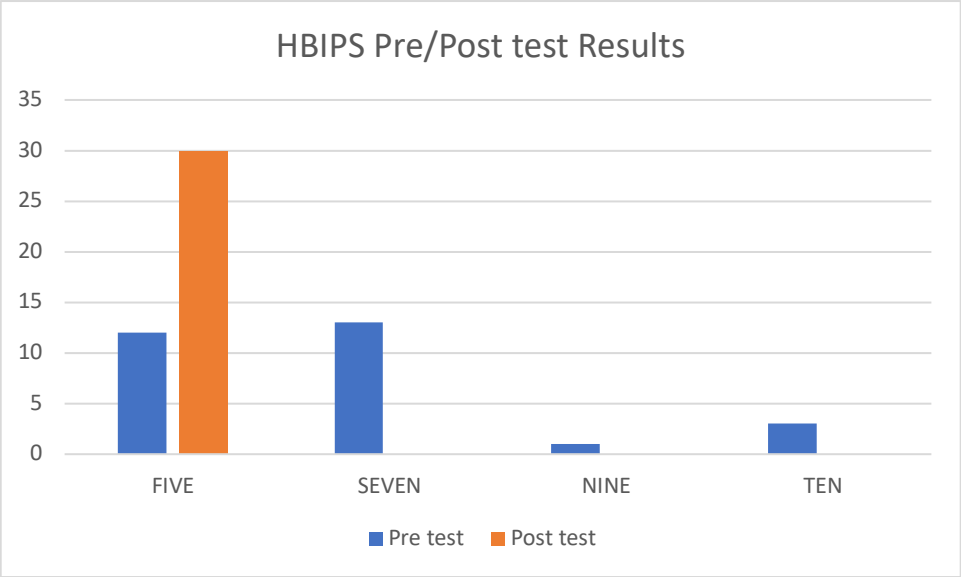
During the pre-test participants were asked a series of ten statements pertaining to their perceived self-efficacy. Overall majority of the participants responded to the statements as moderately true or exactly true. This indicates that nurses in the unit have a perceive themselves to have a positive self-efficacy, thus likely to adhere to improving documentation requirements. Further breakdown of the General Self-Efficacy scale is displayed in the figure below.



Participants also engaged in answering statements on how often they adhere to HBIPS measures such as documentation substance abuse screening within first 24 hours of admission, offer practical counseling, provide smoking cessation patch script upon discharge and fill out the behavioral health transit record and verify if patients are sent home with multiple antipsychotics. In total 73% of nurses reported always documenting substance abuse within first twenty-four hours of admission, 3% reported sometimes. 56% of participants reported always providing a

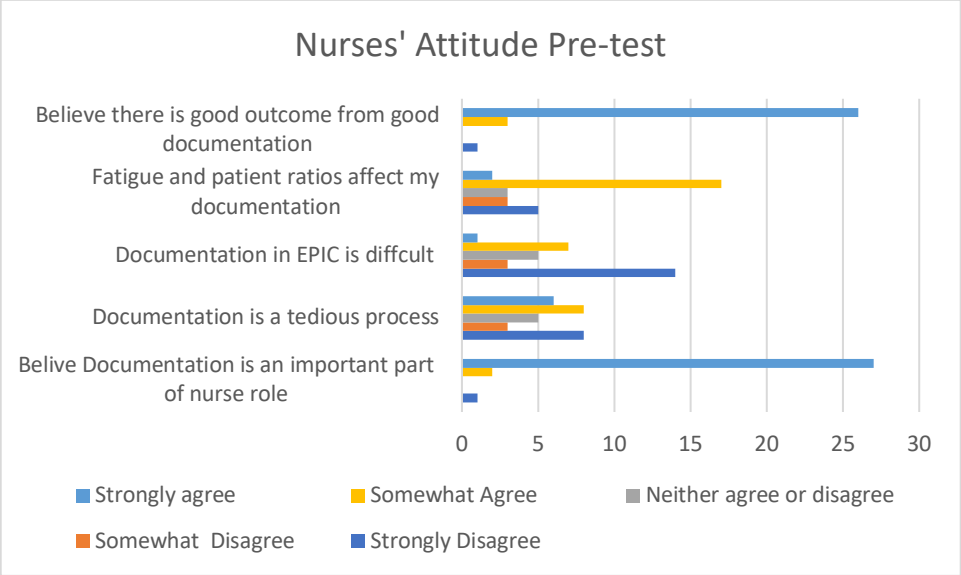
smoking cessation patch upon discharge, while 10% reported never adhering to it. In regard to verifying on the if patients are being discharge on multiple antipsychotics 80% of nurses reported always, and 10% reported to never verifying.

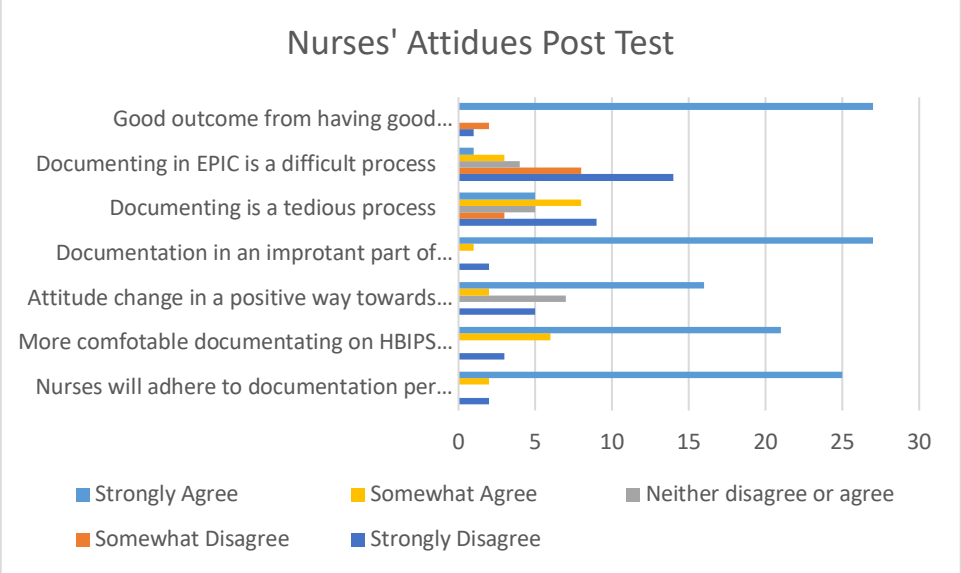
When asked general knowledge questions on HBIPS, 53% of participants (16/30) was unaware of what all is included in screening for substance abuse. A total of 100% of participants answered correctly that documentation is a fundamental clinical routine that improves safety of care. Only 41.4 % (n=12/30) participants knew the number of core measures within HBIPS. After partaking in the educational in-service, posttest resulted in 100% of participants knowing the number of core measures in HBIPS and steps in screening for substance abuse.



Furthermore, the pre-test asked statements pertaining to nurses' attitude about documentation. Overall a total of 97% of participants strongly believe that documentation is an important role as a nurse, while 27% (n= 8/30) believe documentation to be a tedious process. 46.7 % disagrees that documentation in the EPIC system is a difficult process, however 23.3% suggest that it is a difficult process. Additionally, 56.7 % of participants somewhat agree that fatigue and patient ratio's affect their documentation. A total of 86% of participants strongly

agree that there is a good outcome with having quality documentation. Following the educational in-service, 86.2% of nurses strongly agreed to adhering to quality documentation, and 90% agreed to feeling more comfortable documenting according to the HBIPS requirements. An overall of 59% agreed that their attitude changed about documentation, while 23.3% of participants neither disagree or agreed, and 16% of nurses' attitudes did not change about documentation. A sum of 96% believed that there is a good outcome from having good documentation. Figure displays the results of nurses' attitudes about documentation.





Moreover, the pre-test included questions relating to knowledge about quality nursing documentation. 96% of participants identified what documentation can be utilized for, while 83% participants understood the characteristics good and effective documentation is. Participants increased their knowledge by engaging in the educational in-service. 100% (n=30/30) understood the characteristics of good and effective documentation and utilization of documentation. A table displaying the pre- and post-test results of quality nursing documentation questions is illustrated in figure.

Documentation Questions	Pre- Test	Posttest	% Change
Documentation Utilization	96%	100%	4%
Characteristic of documentation	83%	100%	17%

VIII. Discussion

The importance of documentation cannot be overemphasized enough due to how it enhances communication amongst healthcare teams, patient safety, clinical decision making and ultimately providing improved patient outcomes. Quality nursing documentation is encouraged by the American Nursing Association (ANA) in all aspects of nursing care from bedside to the administrative office, including nurses and advanced practice registered nurses. Poor quality nursing documentation has been attributed to negative attitudes and knowledge deficits entailing nursing documentation. Results from this QI project demonstrated that having an educational in-service discussing the protocols and requirements for documentation can improve nurses' attitudes and adherence to quality nursing documentation. Overall, 86% of nurses strongly agreed to adhering to quality documentation after engaging in the educational-in-service. In addition, more than half of nurses' attitudes changed in a positive way towards documentation.

Furthermore, the QI project centered on the theoretical framework of self-efficacy. In general, self-efficacy refers to our perceived ability to succeed and achieve goals. It is vital for nurses and healthcare professionals to have a high sense of self-efficacy, in order to provide quality care. Results displayed that nurses in Memorial Regional Hospital Behavior Health Unit had a high self – efficacy, thus indicating they are more likely to adhere to quality nursing documentation.

The American Health Information Management Association (AHIMA) suggest that education in-service or programs are one of the most effective ways to improve the documentation implementation (Vahedi et al, 2018). Subsequently, Tavakoli et al (2015) , published that one of the main reason for low quality of documentation was lack of education. Tinesly et al (2014), acknowledged that documentation can be improved by education and is more effective if re-enforced with feedback. This QI study supports these studies by showcasing an improvement to nurses' attitude and adherence to quality nursing documentation.

IX. Implications for Advance Practice of Nursing

Evidenced based practice interventions combined with advanced knowledge can lead to positive changes within the clinical practice. As vital stake holders, advance practice registered nurses (APRN) play a key role in improving quality of healthcare. With regards to documentation, advanced practice registered nurses are required to maintain accurate and confidential records. Along the with the line of duty of promoting healthcare, APRNs are educators for patients and peers. Evidence is emerging that standard structured nursing documentation supports precise and complete information in practice and improves quality care (Jekins et al., 2019). Thus, it is essential for APRNs' to educate and provide a strong foundation in documentation to nurses who will progress into expert clinicians and administrators.

Limitations

Limitations of the study included the small sample size (n=30). Nursing workload played a role in the number of participants willing to participate. Interruptions were made if nurses had to attend to patient care, prolonging the time of the educational in-service and posttest. In addition, due to COVID-19 pandemic restrictions, large class size groups were not permitted. Therefore, educational-in-service had to be given to participants before shift, during their lunch break and after their scheduled shift.

Dissemination

With the everchanging healthcare, evidence-based research is needed to deliver quality care. Results from this QI study will be displayed and shared with members of the Memorial Behavioral Health Unit and at other facility units. It will also be submitted for a poster presentation at nursing conferences locally. This QI study will also be presented at the Doctor of Nursing Practice Symposium hosted by Florida International University. A manuscript of the Project will be submitted to the Journal of Healthcare Quality, with the goal to utilize knowledge gained from the QI project and share it with clinicians to help transform practice and improve quality nursing documentation.

X. Conclusion

Nursing documentation is an important indicator for developing and providing quality care (Alkouri et al., 2016). Current healthcare system requires nursing documentation to ensure continuity of care, provide legal proof of care provided, and is consistent within healthcare core measures and protocols. Educational training and programs have been proven to be effective

with quality documentation. This QI project highlighted deficiency in quality nursing documentation and the necessity to provide an education- in-service for documentation in an inpatient behavioral health unit. Eighty-six percent of nurses strongly agreed to adhere to quality nursing documentation after the educational in-service and ninety percent agreed to feeling more comfortable documenting according to the HBIPS requirements. More than fifty percent of nurses' attitude changed in a confident way about documentation. Overall, the educational in-service displayed a positive impact on nurses' attitude and adherence to documentation. Hence, this project can inspire new innovate approaches for improving quality nursing documentation.

Reference

Albsoul, R., Fittzgerald,G., Fincane, J. & Borkoles, E. (2019). Factors influencing missed Nursing care into public hospitals in Australia: An exploratory mixed methods study *The International Journal of Health Planning and Management*, 34(4), 1820-1832. https://doi.org/10.1002/hpm.2898.

Alkouri, O., Alkhatib, A.J., & Kawafhah, M. (2016). Importance and implementation of nursing Documentation: Review study. *European Scientific Journal*, 12(3), 1857-7881. https://doi.org/10.19044/esj.2016.v12n3p101

American Association of Nurse Practitioner. (2021). *Standard of practice for nurse practitioners*. Retrieved from https://www.aanp.org/advocacy/advocacy-resourse/position-statements

Ausserhofer,B., Zander, B. Busse, R., Schubert, M., Geest, S.D. & Rafferty, A.M. (2014). Prevalence, patterns and predictors of nursing care left undone in European Hospitals: Results from the multicounty cross-sectional study. *British Medical Journal of Quality and Safety*, 23(2), 126-135. https://doi.org/10.1136/bmj

Bell, S.K., Delbanco, T., & Elmore, J. (2020). Frequency and types of patient -reported errors in electronic health record ambulatory care notes. *JAMA*, 3(6), 5867. https://doi.org/10.1001/jamanetworkopen.20205867

Brereton, R.(2017). Alcohol and other drug education for hospital staff: A integrative literature review. *Issues in Mental Health Nursing*, 38(1), 42-60. https://doi.org/10.1080/01612840.2016.1248876.

Brooks, N. (2021). How to undertake effective record -keeping and documentation. *Nursing Standard*. https://doi.org/10.7748/ns.2021.e11700.

Cherry, K. (2018). *Self- efficacy and why believing in yourself matters*. Retrieved from

https://verywellmind.com/what-is-self-efficacy-2795954.

Davis, C.P. (2021). *Medical definition of substance abuse*. Retrieved from https://medicinenet.com/substance_abuse/definition.htm.

Ebrahimpor, F. & Pelarak,F. (2016). Modified use of team -based learning to teach nursing documentation. *Electron Physician*, 8(1), 1764-1769. https://doi.org/10.19082/1764

Hallin, K. (2014). Nursing students at a university: A study about learning style Preferences. *Nurse Education Today*, 34(12), 1443-1449. https://doi.org/10.1016/j.nedt.2014.04.001

Jenkins, M. & Davis, A. (2019). Transforming nursing documentation. *IOS Press*, 264(1), 625-628. https://doi.org/10.3233/SHTI190298

Johns Hopkins Medicine. (2021). *Substance abuse/ chemical dependency*. Retrieved from https://www.hopkinsmedicine.org/health/conditions-and-diseases/substance-abuse - chemical-dependency.

Joint Commission National Quality Measures. (2021). *Hospital based inpatient psychiatric services.* Retrieved from https://manual.jointcommision.org/releases/TJC2021A/hospitalbasedinpatient- psychiatricservices.html

Jones, T.L., Hamilton, P. & Murry, N. (2015). Unfinished nursing care, missed care, and implicitly rationes care: State of the science review. *International Journal of Nursing Studies*, 52(6), 1121-1137. https://doi.org/10.1016/j.ijnurstu.2015.02.012.

Joubert, P. & Bhagwan, R. (2018). An empirical study of the challenging roles of psychiatric nurses at in-patient psychiatric facilities and its implications for nursing education *International Journal of African Nursing Sciences*, 9 (1), 49-56.

https://doi.org/10.1016/j.ijans.2018.01.001

Kebede,M., Endris,Y. & Zegeye,D. (2016). Nursing care documentation practice: The unfinished Task of nursing care in University of Gondar Hospital. *Informatics for Health and Social Care*, 42(3), 290-302. https://doi.org/10.1080/17538157.2016.1252766.

LaMorte, W. (2019). *The social cognitive theory*. Behavior Changes Model. Retrieved from https://sphweb.bumc.bu.edu/otlt/MPH-Models/SB/BehavioralChangeTheories/BehavioralChangeThories5.html

Matholoadakis, A., Rousalovia, I., Gagnat A.A., Saad, N. & Hardavela, G. (2016). How To keep good clinical records. *Breathe,* 12(10), 371-375. https://doi.org/10.1183/20734735.018016

McCarthy, B., Fitzgerald, S. Oshea, M., Condon, C., Collins, H., Clancy, M., Sheehy, A. Denieffe, S., Bergin, M, & Savage, E. (2018). Electronic nursing documentation interventions to promote or improve patient safety and quality care: A systematic review *Journal of Nursing Management*, 27 (3), 459-501. https://doi.org/10.111/jonm.12727.

Mountain, C., Reed,R., & OLeary-Kelly, C. (2015). Electronic medical record in the stimulation in the stimulation hospital: Does it improve accuracy in charting vital signs, intake and output. *Computer Informatics Nursing*, 33(4): 166-171. https://doi.org/10.1097/CIN.0000000000000144

Mykkanen,M., Miettinen, M. & Saranto,K. (2016). Standardized nursing documentation supports evidence based nursing management. *Studies in Health Technology and Informatics*, 225(1), 466-470. https://doi.org/10.3233/978-1-61499-658-3-466.

Ofi,B. & Sowumni, O. (2012). Nursing documentation: experience of the use of the nursing

Model in selected hospitals in Ibadan, Oyo State Nigeria. I*nternational Journal of Nursing Practice,* 18(1), 354-362. http://dx.doi.org/10.1111/j.1440-172X.2012.02044.x

Okasiu, E., Kaliwani, F., Wanyana, G. & Coetzee, M. (2015). Improving the quality of nursing Documentation: An action research project. *Curationis,* 38(1). http://dx.doi.org/10.4102/curationis.v37i1.1251

Perry, P.& Potter, A. (2014). *Canadian fundamentals of nursing (5th ed.)*. Toronto: ON OT Elsevier Canada.

Petripin, A. (2020). *Self- efficacy and nursing*. Retrieved from https://nursing-theory.org/theroies-and-models/self-efficacy-theory.php

Prideaux,A. (2013). Issues in nursing documentation and record-keeping practice. *British Journal of Nursing*, 20(22). https://doi.org/10.12968/Bjon.2011.20.22.1450

RAMM, K., Vreeke, E.M., Volkert, P.A, Franckle, A.L, & Delnoji, D.M. (2017) The development of the nursing subset of the patient problems to support interoperability. *BMC Medical Informatics and Decision Making*, 17(1), 158.

Rooddehghan, Z., Yekta,Z.P, & Nasarabdi, A.N. (2018). Ethics of rationing of nursing care *Nursing Ethics*, 25(5), 591-600. https://doi-org.ezproxy.fiu.edu/10.117/0969733016664973

Ramukumba, M. & Amouri, S. (2019). Nurses' perspectives of the nursing documentation audit process. *Journal of Interdisciplinary Health Sciences*, 24(1), 1121. https://doi.org/10.4102./hsag.v24i0.1121.

Schwarzer, R. (2012). The general self-efficacy scale. Retrieved from https://www.researchgate.net/publication/298348466_The_General_Self-Efficacy

_____Scale_GSE/citation/download

Selvi,T. (2017). Documentation in nursing practice. *International Journal of Nursing Education,* 9(4), 121-123. https://doi.org/10.5958/0974-9357.2017.00108.8

Steel, J., Georgiou, A. & Balandin, S. (2019). A content analysis of documentation on communication disability in hospital progress notes; diagnosis, function, and patient safety. *Clinic Rehabilitation*, 33(5), 943-956. https://doi-org.ezproxy.fiu.edu/10.1177/0269215518819717

Stewart, K. Doody, O. & Bailey, M. (2017). Improving the quality of nursing documentation in palliative care setting: A qualitative improvement initiative. *International Journal of Palliative Nursing*, 23(12), 577-585. https://doi.org/10.12968/ijpn.2017.23.12.577

Tajabadi, A., Fazlollah,A.., Afsaneh, S. & Mojtaba,V. (2019). Unsafe nursing documentation A qualitative content analysis. *Nursing Ethics*, 27(5), 1213-1224. https://doi-org.ezproxy.fiu.edu/10.1177/0969733019871682.

Tasew, H., Mariye, T. & Teklay, G. (2019). Nursing documenatation practice and associated factors among nurses in public hospitals, Tigray, Ethiopia. *BMC Research Notes*, 12(1), 612. https://doi.org/10.1186/s13104-019-4661-x

Tavakoli, N., Jahanbakhsh, M., Akbari, M., Baktashiam, M., Hasanzadeh, A. & Sadeghpour, S. (2015). The study of impatient medical records on hospital educations: An Interventional study. *Journal of Education and Health Promotion*, 4(1), 38. https:doi.org/10.4103/2277-9531.157218.

Tinsley, J.A. (2014). An educational intervention to improve residents charting. *Academic*

Psychiatry, 28(2) 136-139. https://doi.org/10.1176/appi.ap.28.2.136

Vahedi, H.S., Mirfakhrai, M., Vahidi, E. & Saeedi, M. (2018). Impact of an educational intervention on medical records documentation. *World Journal of Emergency Medicine* , 9(2), 136-140. https://doi.org.10.5847/wjem.j.1920-8642.2018.02.009

Vermeulen, J.M., Doedens, P., Cullen, S., Van -Tright, M., Herman, R., Frankel, M. & Marcus, S. (2018). Predictors of adverse events and medical errors among adult inpatient of psychiatric unit of acute care general hospitals. *Psychiatric Services*, 69(10), 1087-1094. https://doi.org/10.1176/appi.ps.20180010

Wei, H., Sewell, K., Woody, G., & Rose, M. (2018). The state of the science of nurse work environments in the United States: A systematic review. *International Journal of Nursing Sciences*, 5(3), 287-300. https://doi.org/10.1016/j.ijnss.2018.04.010.

Wilson, S., Hauck, Y., Bremner, A. & Finn, J. (2012). Quality of nursing in Australian pediatric hospitals: A Delphi approach to identifying indicators. *Journal of Clinical Nursing*, 21(1) 1594-1605. https://doi.org/10.111/j.1365-2702.2011.04004.

Winatal, N.A & Hariyati S.T. (2021). Nurse satisfaction level using electronic nursing documentation. *Enfermeria Clinica*, 31(2),109-112. https://doi.org/10.1016/j.enfcli.2020.12.002

Appendix A:

IRB Approval Letter: Florida International University

` FIU | FLORIDA INTERNATIONAL UNIVERSITY

MEMORANDUM

Office of Research Integrity

Research Compliance, MARC 414

To: Dr. Derrick Glymph

CC: File

From: Elizabeth Juhasz, Ph.D., IRB Coordinator EJ

Date: August 13, 2021

Protocol Title:

"Nursing Documentation in a Hospital Inpatient Behavioral Health Unit: A Best Practice Implementation Project "

The Florida International University Office of Research Integrity has reviewed your research study for the use of human subjects and deemed it Exempt via the **Exempt Review** process.

IRB Protocol Exemption #: IRB-21-0356 **IRB Exemption Date:** 08/13/21 **TOPAZ Reference #:** 110540

As a requirement of IRB Exemption you are required to:

1. 1) Submit an IRB Exempt Amendment Form for all proposed additions or changes in the procedures involving human subjects. All additions and changes must be reviewed and approved prior to implementation.
2. 2) Promptly submit an IRB Exempt Event Report Form for every serious or unusual or unanticipated adverse event, problems with the rights or welfare of the human subjects, and/or deviations from the approved protocol.

3) Submit an IRB Exempt Project Completion Report Form when the study is finished or discontinued.

Special Conditions: N/A
For further information, you may visit the IRB website at http://research.fiu.edu/irb. EJ

Appendix B: Approval Letter from Memorial Hospital

July 29, 2021

Florida International University
Office of Research Integrity

To Whom It May Concern:

This letter is to certify that Nicole Francois has been granted permission to conduct the quality improvement project titled "*Nursing Documentation in an Inpatient Behavioral Health Unit: A Best Practice Implementation Project*" at Memorial Regional Hospital. Further, Memorial Regional Hospital acknowledges that the results of this project will be used to fulfill the requirements for the Doctorate of Nursing Practice program at Florida International University.

Sincerely,

Leslie Pollart
Chief Nursing Officer
(954) 265-4114
LPollart@mhs.net

Appendix C: Quality Improvement Pre-Test Questions

ADULT CONSENT TO PARTICIPATE IN A RESEARCH STUDY: Nursing Documentation in a Hospital Inpatient Behavioral Health Unit: A Best Practice Implementation Project

SUMMARY INFORMATION The research design is a Quality Improvement project to determine if an educational in-service in a behavioral psychiatric unit will improve nurses' attitude and adherence to documentation and reduce documentation errors . The project manager will use surveys/questionnaires and (pre-test/post) to evaluate outcomes. Things you should know about this study:

Purpose: The purpose of the study is to investigate the effect of educational in-service in a behavioral psychiatric unit will improve nurses' attitude and adherence to documentation and reduce documentation errors. It will also seek to assemble evidence-based research and interventions that will assist nurses with quality nursing documentation.

Procedures: If you choose to participate, you will be asked to complete a demographic questionnaire and complete a pre/posttest questionnaire including a self-efficacy scale. Also, you will attend a educational in-service on nursing documentation management presented with a PowerPoint presentation.

Duration: The project will run for about 1 week. Participation in this study will consist of one, 30-minute educational in-service, and 15 minutes to complete demographics, pre/posttest questionnaires.

Risks: There are minimal risks involved with this project as would be expected in any type of educational intervention.

Benefits: The main benefit to you from this research is to enhance your knowledge of quality nursing documentation.

Alternatives: There are no known alternatives available to you other than not taking part in this study.

Participation: Taking part in this research project is VOLUNTARY. You are free to participate in the study or withdraw your consent at any time during the study. You will not lose any benefits if you decide not to participate or if you quit the study early. The investigator reserves

the right to remove you without your consent at such time that he/she feels it is in the best interest.

Compensation & Costs: There are no costs to you for participating in this study.

Researcher Contact Information: If you have any questions about the purpose, procedures, or any other issues relating to this research study you may contact Nicole Francois by phone at 786-382-1438 or via email at nfran041@fiu.edu.

IRB Contact information: If you would like to talk with someone about your rights of being a subject in this research study or about ethical issues with this research study, you may contact the FIU Office of Research Integrity by phone at 305-348-2494 or by email at ori@fiu.edu.

- I accept and consent to take part in this Quality Improvement Study
- I do not accept, and do not consent to take part in this Quality Improvement Study

Q2: What's your ethnicity?

- White
- Black or African American
- American Indian or Alaska Native
- Asian
- Native Hawaiian or Pacific Islander
- Other

Q3: What is your age?

- 20 – 29 Years old
- 30-40 Years old
- 41- 50 Years old
- 51-60 years old
- > 60 years
- Do not want to share my age

Q4: What is your gender?

- Male
- Female
- Non-binary / third gender
- Prefer not to say

Q5: How long have you been a registered nurse?

- < 1 year
- 1 – 2 years
- 3 -5 years

- 6-9 years
- 10 – 15 years
- > 15 years

Q6: Do you have a current national certification?

- Certified in Critical Care Nursing (CCRN)
- Certified in Mental Health Nursing
- Certified in Pediatric Nursing
- Other

Q7: How long have you worked in the psychiatric unit?

- < 1 year
- 1 – 2 years
- 3 -5 years
- 6-9 years
- 10 – 15 years
- > 15 years

Q8: What is your highest level of education?

- ASN
- BSN
- MSN
- Doctorate
- Non-Nursing Bachelors

Q9: Are you currently enrolled in school? If yes, what is the level of education of the program?

- BSN
- MSN
- Doctorate
- PhD
- Non- nursing Bachelor's/ Masters
- Currently not enrolled in school

Q10: Overall, do you feel that you have been provided an adequate amount of documentation education for patients who present with mental health illnesses?

- Extremely inadequate
- Somewhat inadequate
- Neither adequate nor inadequate
- Somewhat adequate
- Extremely adequate

Q11: Instructions: This scale will be completed before joining the educational in-service. It is a series of statements regarding your perceived self-efficacy (belief). Check the box, in which best applies to you. There is no right or wrong answers. This scale is completely anonymous, and results will be collected as a group.

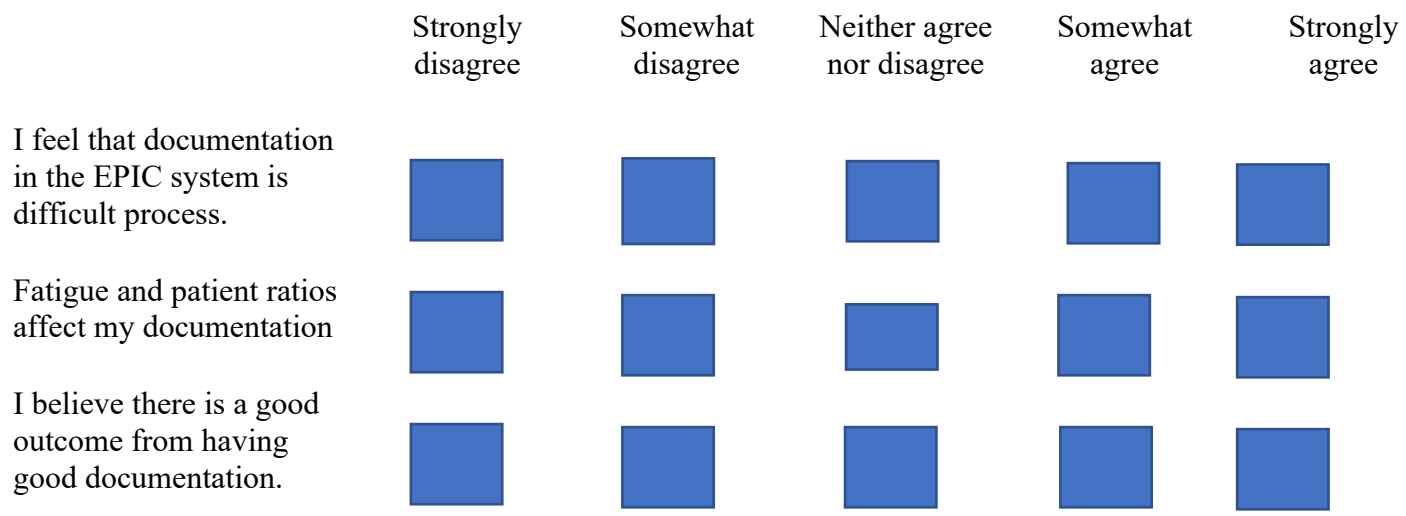
	Not all true	Hardly true	Moderately True	Exactly True
I can always manage to solve difficult problems if I try hard enough				
If someone opposes me, I can find the means and ways to get what I want				
It is easy for me to stay aims and accomplish my goals.				
I am confident that I could deal efficiently with unexpected events.				
Thanks to my resourcefulness, I know how to handle unforeseen situations.				
I can solve most problems if I invest the necessary effort.				
I can remain calm when facing difficulties because I can rely on my coping abilities.				
When I am confronted with a problem, I can usually find several solutions.				
If I am in trouble, I can usually think of a solution				
I can usually handle whatever comes my way.				

Q12: As nurses, how often do you....

	Always	Most of the time	About half the time	Sometimes	Never
Document substance abuse screening within first day of admission					
Provide a smoking cessation patch upon discharge to patients who are smokers					
Offer practical counseling to patients with substance abuse					
Fill out the Behavioral Health Transition record.					
Verify on the Behavioral health Transition Record , if patients were discharged with two or more antipsychotic medications .					

Q13: This scale is will be completed before and after the educational in-service. It is a series of statements regarding your opinion towards documentation. There is no right or wrong answers.

	Strongly disagree	Somewhat disagree	Neither agree nor disagree	Somewhat agree	Strongly agree
I believe that documentation is important part of my role as a nurse					
I consider documentation as a tedious process.					



Q14: How many core measures are within the Hospital- Based Inpatient Psychiatric Services (HBIPS)

- Five
- Seven
- Nine
- Ten

Q15: Select all that apply: Screening for substance abuse should include...

- Type of Drug
- Amount
- Frequency of use
- Problems due to past usage
- If taken alone or with group of individuals

Q16: Tobacco screening should be obtained between the 24 hours of admission

- True
- False

Q17: Documentation is a written or electronically generated record that describes the health history, health status, and delivery of care to patients.

- True
- False

Q18: Documentation is considered a fundamental clinical routine that improves safety of care.

- True
- False

Q19: Documentation is utilized for

- Communication with healthcare teams and other disciplines
- Credentialing
- Legal Matters
- Research
- All of the above

Q:20 Select all that apply: Good and effective documentation is

- Accurate
- Factual
- Complete
- Timely
- Organized
- Compliant with health laws and facility standards

Appendix D: QI Post-Test Questions

Q1: What's your ethnicity?

- White
- Black or African American
- American Indian or Alaska Native
- Asian
- Native Hawaiian or Pacific Islander
- Hispanic
- Other

Q2: What is your age?

- 20-29
- 30-40
- 41-50
- 51-60
- > 60
- Do not wish to share my age

Q3:What is your gender?

- Male
- Female
- Non-binary / third gender
- Prefer not to say

Q4: How many core measures are within the Hospital- Based Inpatient Psychiatric Services (HBIPS)

- Five
- Seven
- Nine
- Ten

Q5: Select all that apply: Screening for substance abuse includes...

- Type of substance
- Frequency of Use
- Problems due to past usage
- If taken with alone or with a group

Q6: Tobacco screening should be obtained between the 24 hours of admission

- True
- False

Q7: Documentation is utilized for

- Credentialing
- Legal Matters

- Research aspects
- Communication between healthcare team and other disciplines.
- All of the above

Q8: Documentation is a written or electronically generated record that describes the health history, health status, and delivery of care to patients.

- True
- False

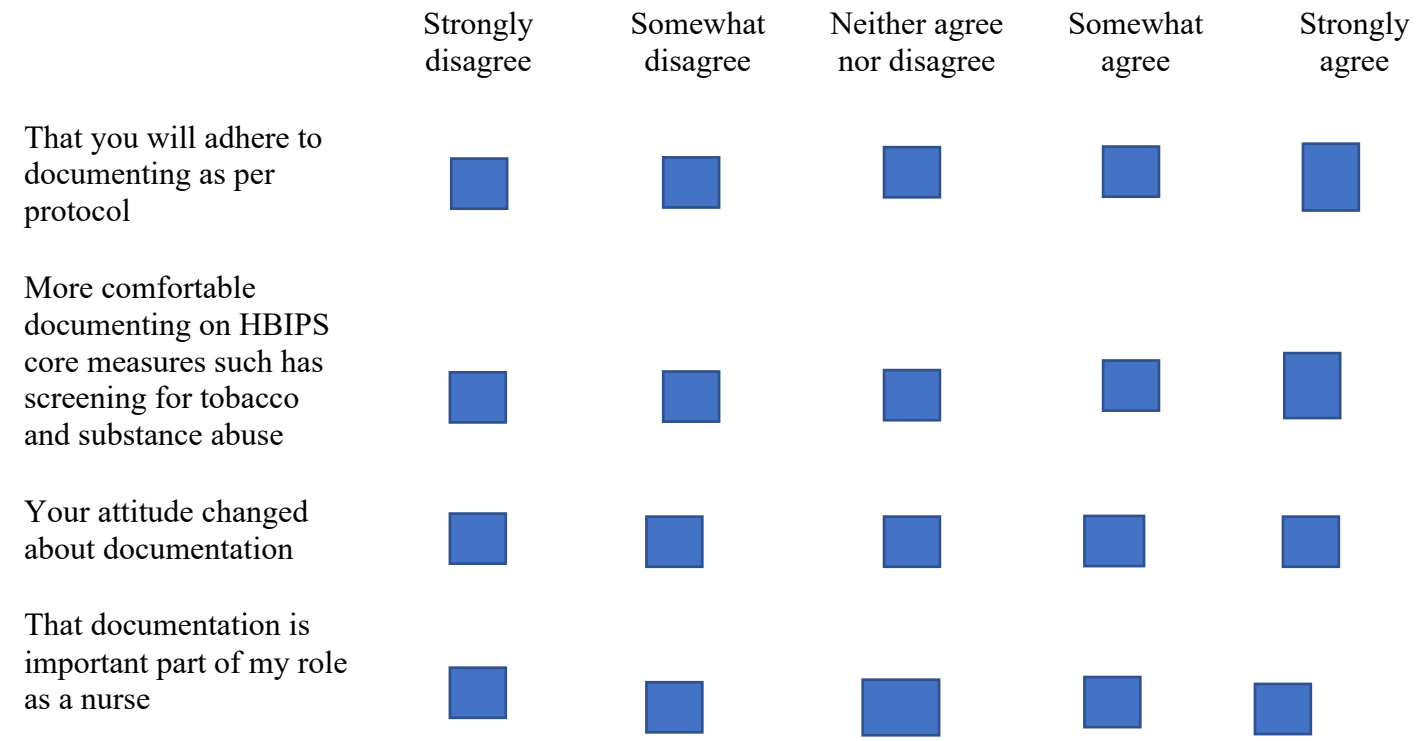
Q9: Documentation is considered a fundamental clinical routine that improves safety of care.

- True
- False

Q10: Select all that apply: Good and effective documentation is

- Accurate
- Factual
- Complete
- Timely
- Organized
- Compliant with health laws and facility standards

Q11: After attending the educational in-service ... do you feel



	Strongly disagree	Somewhat disagree	Neither agree nor disagree	Somewhat agree	Strongly agree
That documentation is a tedious process	■	■	■	■	■
I feel that documentation in the EPIC system is difficult process.	■	■	■	■	■
There is a a good outcome from having good documentation.	■	■	■	■	■