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A Review of Quality Assurance Methods to Assist Professional Record Keeping: Implications for Providers of Interpersonal Violence Treatment

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Abstract

Errors have been found to frequently occur in the management of case records within mental health service systems. In cases involving interpersonal violence, such errors have been found to negatively impact service implementation and lead to significant trauma and fatalities. In an effort to ensure adherence to specified standards of care, quality assurance programs (QA) have been developed to monitor and enhance service implementation. These programs have generally been successful in facilitating record management. However, these systems are rarely disseminated, and not well integrated. Therefore, within the context of interpersonal violence, we provide an extensive review of evidence supported record keeping practices, and methods to assist in assuring these practices are implemented with adherence.

Keywords

Quality Assurance; Interpersonal Violence; Record Keeping; Ethics

1. Introduction

The practice of record keeping is an integral part of psychotherapy (American Psychological Association [APA], 2002), and includes documentation of discussions clinical decisions, referrals, consultation, assessment, treatment planning, and progression of mental health services (Mary et al., 2007). According to Luepker (2012), record keeping in mental health settings facilitates communication between therapists and clients, sound diagnoses and appropriate treatment plans, continuity of care, clinical supervision, and especially in the

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United States, completion of contractual obligations with third-party payers. Various levels of oversight have been established to ensure effective record keeping. For instance, in the United States, the Health Insurance Portability and Accountability Act (HIPAA) Privacy Rule assures a higher standard of protection for psychotherapy notes that is distinct from other forms of Patient Health Information (PHI; DeLettre & Sobell, 2009). The American Psychological Association includes ethical standards and principles that are specific to therapeutic record keeping, and hospitals and community agencies in which mental health providers practice outline their own set of documentation standards.

Mental health providers are trained in record keeping practice to meet institutional requirements, facilitate service provisions, comply with laws, and ensure accuracy of billing, payments, and/or funding (APA, 2002). According to the APA Record Keeping Guidelines (2007), the provider assures good care, assists collaborating professionals in delivery of care, ensures continuity of professional service, assures appropriate supervision or training, provides requisite documents for reimbursement, documents decision making, especially in high-risk situations (e.g., interpersonal violence), and responds to complaints. Therefore, record keeping in psychotherapy is an important skill set that is highly regulated.

Accurate and timely record keeping procedures assist in assuring quality mental health services, are guided by ethics and law (Harris et al., 2009), and provide accountability and liability protection for providers (see Mary et al., 2007). Quality record keeping permits supervisors to accurately monitor services (e.g., child and elder maltreatment, suicidal ideation) provided by trainees and/or subordinates (Farkas, Gagne, Anthony, & Chamberlin, 2005). Appropriate documentation of mental health records is vital to examination of the intervention process (Haglund, Hallberg, & Pettersson, 2004). For instance, this process assists in understanding treatment outcomes, continuity of communication between professionals about the process of treatment (Kleschinsky, Bosworth, Neslon, Walsh, & Shaffer, 2009), and ensures treatment planning is consistent with consumer generated goals and progression through therapeutic benchmarks (Mary et al., 2007).

Quality assurance (QA) in mental health services involves monitoring activities and systems to ensure optimum care through identification of quality related problems and implementation of quality related solutions (Nabors, Weist, Tashman, & Myers, 1999). QA ensures that resources are used in an efficient way and enhances trust in the effectiveness of the system (World Health Organization, 2003). QA methods can be focused on various aspects of service implementation and management (McMillen, 2008). For instance, QA procedures can be developed to determine important aspects of supervision, improve accountability in the maintenance of mental health records, or monitor and enhance adherence of therapists to evidence-based treatments (see Sheidow, Donohue, Henggeler, & Ford, 2008).

The management of professional records is an integral part of QA in mental health settings, and structured training in this component is often neglected (Ladbury, 2003; McMillen, Zayas, Books, & Lee, 2008). Whyte (2005) found various types of errors contributed to poor patient care, and many of these errors were determined to be influenced by a lack of audits and on-going training specific to professional record keeping. Documentation errors in

mental health records are especially deleterious when interpersonal violence is involved because multiple systems of care depend on accurate feedback to assure the protection of clients and their families. For instance, homicidal ideation and child maltreatment victimization necessitate careful documentation of safety plans, mandated reporting processes, and monitoring of violence among adult caregivers (e.g., Wekerle, Wall, Leung, & Trocmé, 2007). Zellman (1990) found 44% of clinical psychologists failed to report suspected child abuse, which may lead to deleterious circumstances and have significant implications for appropriate documentation. While more recent research in this area is needed (Wekerle, 2013), Zellman's study suggests providers may avoid documentation of legal mandates. This has important implications for supervisors and administrators, as it suggests QA systems need to assess the omission of appropriate standards of care.

To assist in understanding the process of QA as it pertains to the management of professional mental health records within the context of interpersonal violence, we first briefly review customary documents maintained within mental health records, including potential errors (see Table 1). We then underscore issues affecting QA, such as access, legalities, consequences due to poor management of case records, audits, and empirical research. QA methods are highlighted throughout, including commonly encountered errors, and evidence-supported strategies to enhance accuracy and appropriateness of record content.

2. Record Keeping Documents

2.1. Informed consent

Informed consent is the quintessential document maintained by professionals in the provision of mental health services. It is typically the first document gathered. This document substantiates that the provider and client are in agreement with the treatment to be provided, including its potential benefits and limitations, and consent to be treated. If the client is a minor, consent must be obtained from the parent or guardian and possibly assent from the minor (Piazza, & Baruth, 1990). Consents specify how gathered information will be shared and restricted, costs, the nature and extent of treatment, and are time-limited and content-specific (Center for Substance Abuse Treatment, 1993). When clients have been identified to be victims or perpetrators of violence, and they desire family members or other support systems to assist in their treatment it may be helpful to formally acknowledge their support in the informed consent process (Romero, et.al., 2010). When providing court mandated psychological treatment, perpetrators of violence should be informed during the consent process that judges often request records of progress. This discussion, as well as issues of confidentiality, should be disclosed, including documentation of any discussions along these lines. client should be informed of potential limits to confidentiality. Within treatment related research, informed consent also outlines information about the study, procedures, and the purpose of the study. Failure to obtain or document consent can result in serious consequences, including problems in the therapeutic relationship and legal action.

2.2. Intake forms and demographic information

Intake forms are used to document demographic history and current concerns, and typically include contact information, identifying characteristics, relevant background information (e.g., treatment history, previous diagnoses, medical information, family history), payment information, and reasons for seeking treatment (Heller, Gilliam, Chenail, & Hall, 2010). This information permits providers to confirm diagnoses and determine if services are within their scope of specialization. Intake related forms document client risk factors (i.e. family history) and outcomes from previous treatments received, assisting providers with treatment planning. Intake forms also document methods of contacting clients and emergency or significant others who, with documented written releases to do so from the client, may be contacted in support of clients. Having multiple contacts, and multiple methods of contact (i.e., home phone, cell phone, significant other phone, email, and address) is very important in the care of victims and perpetrators of interpersonal violence, as perpetrators motivation to attend treatment is prone to wane (Crane & Eckhardt, 2013) and contact information may be utilized to enhance engagement (Taft, Murphy, Elliott, & Morrel, 2001).

Intake forms are prone to errors related to accurate information or a lack thereof, which could be due to utilizing an unstructured intake process or use of non-standardized forms. It is important for providers to gather as much relevant information as possible during the intake process. A lack of information can affect treatment, possibly resulting in poor treatment decisions and time inefficiencies. It is also beneficial to ensure accuracy of information throughout treatment. For instance, contact information or medications may change. Correspondence with previous and current mental health providers is the best way to ensure accuracy of information and assists in clarifying outstanding treatment related questions.

2.3. Information releases

Continuity of care generally refers to the efficient transition of services between mental health providers, and assists in verifying treatment information. Releases of information permit professionals to share information with others, both verbal and written. Information sharing is necessary when clients have received previous services, concurrent services necessitate communication across providers, or when information need to be transferred to ensure continuity of treatment (Mary et al., 2007). One release permits providers to obtain information from others (i.e., release to obtain information), and the other permits providers to disseminate information to others (i.e., release to provide information to others).

Providers have numerous ethical, professional, and legal obligations regarding the release of client records (Behnke et al., 2006). They are responsible legally and ethically to ensure that signed releases are on file whenever discussions about clients occur with other agents, and according to the APA Ethics Code (2002) are required to discuss confidential information about their clients only for appropriate scientific or professional purposes. Releases of information ensure appropriate confidentiality of client information by specifying information about the client that can be shared. Mental health providers should be especially cautious in their release of sensitive information about victims of violence to others who

may intentionally, or inadvertently, provide this information to potential perpetrators of violence. may utilize.

Concerning minors, some State laws may differ in their rights to consent to treatment and release of treatment information, and the process of releasing information about minors may be further complicated when minors are involved in the legal system due to interpersonal violence. In these scenarios, mental health providers must be careful in determining when information is appropriate to be shared with parents, court officials, probation officers, and others (see Brody & Waldron, 2000). For example, adults presenting to court for identified child maltreatment or spousal abuse are often required to endorse a release to the court or other supervising agency to confirm their participation in mental health treatment. When client responses to court mandated treatments are mixed, providers must determine what information to disclose, balancing the request of clients with a fair assessment of their effort and performance in treatment.

2.4. Progress notes

Well-documented records about the treatment process are essential to the effective recovery of clients (Hargrave & Hiatt, 2000). Therefore, progress notes are written records of personal communication. They are designed to convey the overall content of the interaction, techniques or interventions utilized by the provider, important comments and responses of the client or others, assessment findings, safety concerns, and progress in meeting therapeutic goals. Most states mandate the time and date of interaction, specify who was involved in the interaction, summary and purpose of provided services, the provider's name, signature and degree (Adler, 2012). The inclusion of relevant information helps to ensure the client is receiving care in an ethically and legally competent manner (Gutheil & Hilliard, 2001).

Progress notes assist providers in documenting critical decisions, including the rationale for diagnosis and treatment, protecting against legal claims related to misdiagnosis and improper treatment (Tan & McDonough, 1990), and demonstrates ability to conceptualize case issues and appropriately evaluate therapeutic progress (Gehart, 2009). Properly documented progress notes also permit providers to quickly review previous session material in directing treatment planning (Harris et al., 2009; Prieto & Scheel, 2002; Somers, Benjamin, & Chenail, 2009).

The use and documentation of progress notes is especially vulnerable to errors. Providers may fail to comprehensively detail treatment, omit dates, signatures, and persons present, misinterpret written content due to sloppiness, and fail to record decisions regarding critical incidents (Falvey & Cohen, 2003). Documentation and appropriate reporting of threats of violence (Tarasoff v. Regents of the University of California, 1976), past victimization of violence, and recommendations along these lines need to be formally recorded to assist in safety management. Interactions between clients and providers occurring outside of formal treatment sessions (e.g., phone contacts) are commonly omitted from professional records. These interactions are often focused on methods of maintaining treatment compliance, emergency management and treatment scheduling. Failure to document such interactions may lead to forgotten appointments, important misinterpretations, and unreturned phone

calls (Eberlein, 1990), compromising effective treatment planning and leading to poor assessment of client functioning, redundancy of ineffective treatments, lack of awareness of relevant treatment events, and may lead to the mismanagement of safety protections (particularly when violence is present) and loss of licensure due to malpractice (Gutheil & Hilliard, 2001). Progress notes are especially vulnerable to errors because they lack a universally agreed upon approach to creating them. Therefore, semi-standardized progress note formats have been developed to assist with improving documentation practices and recording of relevant information.

2.4.1. Semi-standardized progress note formats—In a review of the literature, some of the semi-standardized formats that have been utilized include SOAP (Subjective, Objective, Assessment, Plan), DAP (Data, Assessment, Plan), and STIPS (Symptoms, Topics of discussion, Interventions, Progress and plans, Special client issues). The primary benefit of using a semi-standardized format for documenting progress notes is consistency across client cases, providers, and trainees (Prieto & Scheel, 2002). The SOAP format has been noted to support providers with documenting and assessing clinical information to assist and validate therapeutic decisions (Harris et al., 2009). The STIPS format was created with the intent of enhancing treatment and record documentation skills of trainees; specifically assisting with improved understanding of clients' presenting problems, better monitoring of the treatment processes, and continued evaluation and adjustment of treatment interventions (Prieto & Scheel, 2002). Thus, semi-standardized formats have been found to assist in training and development of trainee skills and help ensure providers are following specific methods of record keeping. Moreover, utilization of semi-standardized formats is unknown and limitations may still exist within semi-standardized formats. For instance, progress notes may look very similar in style and content across clients within an agency or within a client's record, thus failing to provide discernibly useful information. This may lead to increased difficulties when providers and/or supervisors tease out important treatment information.

Although it appears more beneficial to utilize a semi-standardized format, some may argue that they are cumbersome and time consuming, especially for experienced providers. Formats such as STIPS may not be useful for all clinical or training settings (Prieto & Scheel, 2002), and may be impractical once providers are no longer in training. On the other hand, established formats will likely improve record keeping for individuals who have not been trained on specific progress note documentation procedures, especially with regard to consistency. To this end, further research and evaluation of progress notes within mental health services is needed. Future research should focus on methods to improve efficiency and use.

2.5. Treatment planning

Treatment plans typically document diagnoses, symptoms to be treated, treatment goals, and treatment approach. Treatment plans confirm that the practitioner has set a conceptually sound course for treatment. Problems that may arise in treatment plans include poor or absent plans, failure to document discussion of treatment plan with client, vague or irrelevant goals, and poor assessment of client symptoms and concerns. Once services are

initiated providers must document the course of treatment, which should reflect progress specific to the treatment plan. This is achieved through the progress note and is perhaps the most frequent record maintained by providers.

2.6. Termination summary

Completion of treatment occurs for various reasons, including successful completion of treatment program, and provider changes. The termination summary usually contains an overview of assessment results, summary of problems evidenced prior to treatment implementation, interventions implemented, client response to treatment, and future therapeutic plans (Piazza, & Baruth, 1990). Potential problems in this document include failure to maintain continuity of care and legal problems related to inappropriate disclosure of confidential information, and failure to document appropriate treatment progress or completion.

3. Access to Records

A primary concern in ethical record keeping is guaranteeing information contained in client records remains confidential and secure. Providers must be knowledgeable of applicable laws and regulations regarding the retention of client records for mandated periods (Mary, et al., 2007), and effectively manage obligations to ensure that any personnel who handle client records are familiar with confidentiality and methods to secure records (Clark & Abeles, 1994). This may include the use of policies that stipulate keeping records locked and secure at all times in locked cabinets within locked offices or storage rooms (Mary et al., 2007) to protect them from damage, destruction, and improper access.

Bongar (1988) asserted that storage was the most important weakness in client confidentiality, especially with regard to electronic storage of client records. However, at the time of his expressed concerns, computers were relatively primitive. Recent advances in technology have resulted in changes to the storage and access of client records. As such, mental health providers are increasingly switching to electronic record keeping practices (StÅhl, Granlund, Gäre-Anderson, & Enskär, 2011; Steinfeld & Keyes, 2011), although their progress in doing so lags behind the medical field (Drake, Teague, & Gersing, 2005).

There appears to be support in switching to electronic records, as recent investigations have determined relative benefits to electronic filing, including cost effectiveness (Harrison & Palacio, 2006), increased efficiency, and error reduction (Tsai & Bond, 2008). Moreover, in a recent review of record keeping practices, Steinfeld and Keyes (2011) state that utilization of electronic professional records assists with improved accuracy of mental health diagnoses, improved practitioner adherence to evidence-based treatment, and improvements in continuity of care. Indeed, there appear to be many benefits of electronic based record keeping. It is highly probable that the majority of health care providers will eventually be required to utilize electronic based records based on the Economic and Clinical Health Act (Steinfeld & Keyes, 2011).

Van Allen and Roberts (2011) state that many providers are worried about inappropriate access and disclosure of confidential client information using technology (i.e., computers

and email). These concerns are magnified by electronic record keeping regulations that increase civil and criminal enforcement of HIPAA rules (Health Information Technology for Economic and Clinical Health (HITECH) Act, 2009), in an effort to ensure confidential information is not breached. Along these lines, providers must be cognizant of potential problems related to transferring and discussing confidential information via electronic media. For instance, standards of enforcing confidentiality, especially as related to use of technology, may not be consistent between agencies. Indeed, it may be impossible to determine the level of security for a recipient's email. Therefore, potential inconsistencies in security or inattentiveness to confidentiality may permit third parties to inadvertently breach confidentiality.

As previously stated, another potential risk involved in electronic record keeping is computer security. Computers are at-risk for unpermitted access, infection by viruses, or crashes. Thus, the security and integrity of client records may be a risk when client records are stored solely within individual computers or broader computer networks. However, it should be noted that even antiquated paper-based records, could be breached when they are left out of locked storage or when susceptible to inappropriate access. Certainly, whether records are in physical or electronic format, if left accessible to others, the risk of breaching confidentiality and misplacing important documents amplifies.

Currently, the HIPAA Security Rule and APA Record Keeping Guidelines (2007) stipulate that providers must be aware of security risks, perform risk analysis, and strive to be aware of ongoing issues related to use of electronic media. Providers must also seek out continued training and consultation to stay current with security risk management. Even though various agencies have established general ethical principles and laws that apply to providing services and ensuring confidentiality of client information in all contexts, there has yet to be developed, standardized methods to manage issues surrounding electronic records and dissemination of confidential information. To this end, it becomes imperative for providers to be aware of identified risks and implement specific QA protocols within the maintenance and dissemination of client records. For example, when documenting charts or conducting QA it is important to ensure all confidential info is kept secure when accessed and stored immediately upon completing tasks. Hence, standardized QA protocols for documenting client records and subsequent review of records should outline procedures for storing and securing client records, whether in physical or electronic format.

4. The Influence of Legal Implications on Record Keeping

Court mandates sometimes conflict with the responsibility of providers to uphold confidentiality of client records (Behnke et al., 2006). Providers need to be aware records may be subpoenaed, especially records of clients who may be mandated to treatment for interpersonal violence. Providers are mandated reporters, requiring them to break confidentiality when safety is a concern, such as in child or elder maltreatment, suicidal risk, and homicidal intent. When these situations arise, these situations need to be well-documented, including steps taken to assure safety (i.e., suicide risk assessment and/or hospitalization, safety plans, reports to Child Protective Services, and alerting authorities of homicidal intent).

The APA Ethics Code (2002) reports that providers should only include information in client records that is relevant to the purpose for which the respective communication is developed. Indeed, the provision of sensitive information (e.g., illegal behavior, sensitive information about client or relatives, sexual practices) may result in embarrassment, and is seldom required or appropriate for the record (Soisson, VandeCreek, & Knapp, 1987). To further stress the implications of documenting client information, providers must be aware that some state laws provide clients the right to access their records. Additionally, providers may be required or requested to release records or be audited by third-party payers. To address the tension between the needs of the practitioner, client, and legal professionals; providers should write notes as if they expect the client to read them. It is prudent that records not include personal opinions, guesses, or judgments, and providers must assume that their records will be examined and scrutinized.

Providers who fail to be aware of record keeping guidelines create risks for their clients and themselves. When providers are required to participate in court proceedings, either due to malpractice claims or for professional purposes, it is important for the practitioner to appear competent (Harris et al., 2009). Quality documentation prepares providers for court proceedings and improves risk management. To exemplify potential risks, Tan and McDonough, (1990) examined psychiatric claims of improper care for the previous 12-years. They found that 33% of claims involved suicide, attempted suicide, or violence to self or others. Providers who have failed to document progress notes sufficiently have been found in court to act in bad faith (see *Donaldson v. O'Connor*; 493 F. 2d 507; 5th Cir., 1974; as cited in Soisson et al., 1987). Conversely, documentation of relevant treatment details evidences responsible behavior of the practitioner, which is crucial when records are subpoenaed (see *Dalian v. State*, 1970; *Johnson v. United States*, 1976; as cited in Soisson et al., 1987). John Monahan (1993) wrote:

It would be an exaggeration to state that in a court case what is not in the written *record* does not exist--but not much of an exaggeration. The violent event that gives rise to the suit may occur weeks or months after the patient was last seen. The resolution of the case through settlement or trial will be a minimum of several years from the time of the violent event. Memories fade or become compromised when numerous, or innumerable, other clients are seen in the interval. (p. 83).

Indeed, memories are not always accurate and may rely on the assistance of documentation. Hargrave and Hiatt (2000) reported a practitioner's documentation of risk factors was instrumental in being cleared of malpractice in a legal case.

5. Revocation of Service Payments Due to Poor Record Keeping

Although, there are specific record requirements mandated by state and federal governing agencies, providers are also required to adhere to documentation procedures stipulated by insurance providers. Insurance agencies may outline specific content standards. For example, United Behavior Health (UBH) stipulates that treatment record entries must include the date, start and stop time of service, billing codes, notation of session attendees, the responsible clinician's name, professional degree, license, and relevant identification number (Adler, 2012, p. 53). They also report progress notes should include strengths and

limitations of clients in achieving treatment plan goals, treatment interventions that are consistent with treatment goals, follow-up dates, and missed appointments (p. 54). The UBH network manual outlines specific criteria related to treatment plans, discharge from treatment, and other record keeping procedures.

When client records do not meet insurance provider requirements, negative consequences may occur, which could lead to possible revocation of payments (Gutheil & Hilliard, 2001) or an audit of client records. It is the responsibility of the provider to ethically determine what specific documents will be maintained in the record. Since clients have a right to confidentiality, and insurance agencies require information about clients to approve services, providers must be aware of specific insurance guidelines and provide such information only upon appropriate consent from the client.

6. External Auditing of Client Records by Various Organizations

An audit focuses on compliance of record keeping (Pyle, 2000). Typically, audits are conducted by individuals independent of the provider. It is important for providers to be aware that everyone may face scrutiny through various types of audits. From the private practitioner to the grant-funded researcher, everyone can be subject to an audit. Audits are initiated for various reasons including client requests, federal service agency practices, determination of services through insurance companies, Institutional Review Board practices, and investigations by licensing boards. Furthermore, some State laws provide clients with access to their records (e.g., Nevada Revised Statutes [NRS] 433.504). However, any client with a complaint can take steps that may ultimately result in an external audit. Within the United States, clients may file complaints with State licensing boards which may result in requests for records. These audits assist in determining if ethical and legal guidelines were followed.

6.1. Government based audits

Federal service agencies regularly initiate audits (e.g., Medicare, Medicaid, SAMHSA) and generally list criteria for ensuring the quality of records on their websites or in manuals (e.g., client identifiers, documents to be included within records, relevant information within progress notes). Providers that choose to provide services to Medicaid recipients are required to follow additional guidelines beyond more typical State/Federal laws and ethical guidelines. For example, providers in Nevada who provide services to Medicaid recipients must adhere to standards within chapter 400 of the Medicaid Services Manual (MSM, 2011). It is also important to note that these guidelines are regularly updated, and providers are responsible for being up to date with changes in guidelines.

To assist in their audits, the Center for Medicare & Medicaid Services (CMMS) utilizes multiple oversight bodies (i.e., Medicaid Integrity Contractors, State Medicaid agencies, and the Inspector General of the State or the U.S. Department of Health & Human Services) to regularly audit providers. A common goal of these oversight bodies may be to identify overpayments of funding to providers and work to decrease payment for inappropriate Medicaid claims (CMMS, 2009). Auditors will examine records to ensure that a diagnosis was made to authorize or justify services. Additionally, each record should contain a

treatment plan and progress notes that discusses client progress. If these documents are missing or inaccurate, services could be denied and reimbursements could be revoked. Medicaid also stipulates that providers must develop, implement, and maintain their own Quality Assurance program (MSM, 2011, Sec. 403). This is likely due to government agencies being aware of the benefits of utilizing QA procedures, and attempting to assist providers in preventing failed external audits.

6.2. Private insurance based audits

Insurance companies may outline expectations of specific record keeping practices and audit records when complications arise over payment for services or when determining authorization for services to be provided. For example, California's College Health Individual Practice Associations (CHIPA) requires all providers maintain records in a manner that conform to applicable laws and regulations and stipulates specific treatment record content standards (CHIPA Network Manual, 2010, p. 14). Furthermore, they provide circumstances that may lead to an audit including: reviews of facilities without national accreditation, providers servicing a high-volume of clients, routine random audits for quality of care, and audits concerning identified quality of care issues (p. 14). Aside, from listing various guidelines and procedures to adhere to, CHIPA also includes treatment record forms that adhere to auditing guidelines, including use of the SOAP format for progress notes. Thus, insurance agencies have become increasingly aware of poor record keeping practices and have attempted to assist providers in understanding risks and the importance of utilizing specific procedures to prevent poor record keeping and resulting negative consequences.

As previously discussed, UBH stipulates documentation requirements, as well as auditing procedures in their Network Manual. They stipulate that client records must be stored in a secure area, and providers must have an established procedure to maintain confidentiality (Adler, 2012, p. 56). They further state that providers and agencies should maintain an organized record-keeping system that allows for easy access by authorized personnel. Audits by UBH focus on the quality of documentation within client records. They stipulate corrective action and initiate follow-up audits when records do not meet the performance goal (i.e. 85%).

6.3. Research institutions and foundations

Additional oversight bodies consist of research institutions and foundations (e.g., CDC, NIH, Carnegie Corporation). These oversight bodies audit various aspects of research projects they fund. For example, the National Institutes of Health (NIH, 2011) lists various guidelines and procedures to be followed based upon the research being funded, the amount of funding, and the classification of the individual or agency being funded. They specifically stipulate that researchers funded by grants that expend \$500,000 or more in Federal awards during a fiscal year be subject to audit requirements. However, research projects expending less than \$500,000 are not required to have an annual audit, but must make their records available to NIH or other designated officials for review or audit. Funding agencies may also enforce policies that mandate QA procedures within the funded agency. For example, the Substance Abuse and Mental Health Services Administration's Center for Substance Abuse Treatment (CSAT) Treatment Improvement Protocol (1993) states:

Each treatment program must ensure that internal policies and procedures comply with both Federal and State confidentiality and reporting regulations. Once compliance is ensured through the development of policies and staff training, a process of quality assurance monitoring should be developed to routinely review a sample of all program records.

7. Potential Errors and Concerns Regarding Audits

Within auditing, any number of aforementioned errors can create problems for the client and practitioner and possibly result in detrimental consequences. As stated in the APA record keeping guidelines (2007) contracts with third party payers may require specific information, which if absent or impaired may result in return of previously received funds or legal actions. Poor records discovered by as a result of audits from government agencies and insurance companies can result in decertification, penalties, retuning of reimbursements (CMMS, 2009) or loss of license (NRS 641.230). Within the field of research, a problematic audit could result in losing funding for grant funded projects and/or difficulties with obtaining funding for future projects. To this end, QA of client records is an absolute necessity to avoid both financial and legal problems. If auditing information is not used to improve documentation or service delivery, problems will persist within these realms. For that reason, standardized QA procedures are essential to ensure the quality of record keeping and to prepare providers and/or agencies for external audits. Regrettably, there is an absence of work examining QA procedures used to examine the quality of client records.

8. Examination of QA Studies

QA improves providers' protective factors and minimizes risks for unethical behavior (Tjeltveit & Gottlieb, 2010). QA procedures relevant to record keeping have yet to be examined in psychological or interpersonal violence settings. However, similar studies have been conducted in medical settings. Many of these studies have focused on finding optimum methods for preventing errors in record keeping and administration of medications. This is of importance because 11% of psychiatric claims that are specific to improper care involved problems related to medication monitoring and administration (Tan & McDonough, 1990). For instance, Jha and colleagues (1998) compared the efficacy of three QA procedures (i.e., self-report of errors by physicians, physical records reviewed by a trained reviewer, computer monitoring) in reducing adverse drug events (ADE) in medical record keeping. Computer monitoring consisted of a computer-based application using ADE screening rules to detect retrospective errors within medication orders placed through a computer system, while physical record reviews consisted of retrospective examination of client records by a trained reviewer (Jha et al., 1998). Results indicated that more errors were detected by physical record review and, to a lesser extent, computer monitoring, as compared with self-reporting of errors by the professional.

In another medical record QA study, a pharmacy director and nurse practitioner retrospectively reviewed 31 patient records, encompassing the patient's entire hospitalization. They detected 2,194 medication errors across the 31 records, compared with the 9 previously self-reported errors by those managing the records (Grasso, Genest, Jordan, & Bates, 2003). Medication errors were defined through specific guidelines based upon

recommendations from various institutes and contracted consultants (e.g., prescribing, product labeling, order communication, packaging, dispensing, distribution, administration, education, monitoring, and use). Grasso and colleagues (2003) noted the importance of their findings, stating that 58% of errors found were rated as high risk of patient harm. Though there were noted limitations within the aforementioned studies, including retrospective review and lack of independent review by QA staff, their findings are of great importance. Bowie, Sweeney, and Beattie (2004) examined the use of a peer review QA program for community nurses in Scotland. The QA program utilized record keeping criteria outlined by the Nursing and Midwifery Council Quality Improvement Scotland Generic Standards. Nurses randomly selected a sample of records for an assigned nurse peer. Their results suggested that the QA program was effective for monitoring and improving the quality of record keeping. However, the study was limited in discussing QA training methods and study procedures, including use of random assignment. These studies, together, highlight the potential for errors when hospitals or physicians rely solely on self-monitoring.

9. Methods to Enhance the Quality of Client Records

As this review has demonstrated, client records are at-risk for a variety of errors, which if left unmonitored, can create a range of problems. Thus, methods to monitor, evaluate, and improve client records must be examined. Within the medical field (Opila, 1997), found that review of residents' outpatient medical records and periodic feedback from attending physicians, improved documentation. This can also be assumed to be beneficial within interpersonal violence. Pullen and Loudon (2006) also discuss methods to improve client records based on recommendations by the Royal College of Physicians, including documentation of date and time all record entries, signing all letters and entries in the client record, periodically summarizing records of clients in long-term care, writing names in block capitals for handwritten entries, being thorough and concise, and being mindful that the quality of the record will reflect the quality of care received. They further report that the agency should be accountable for the development and training of providers and record keeping should be subject to continued quality development (Pullen & Loudon, 2006).

10. Need for Organizations to Implement QA Programs

Aside from the aforementioned regulations imposed by external auditors, various agencies and State laws indicate providers need to create and maintain their own internal QA programs. The National Committee for Quality Assurance requires managed behavioral health care organizations to regularly assess and improve client records. Although this is a difficult task for large organizations, it has been shown to be beneficial (Caudill, 2005). The state of Nevada (i.e., NRS) outlines requirements for QA programs within managed care organizations stating:

Each managed care organization shall establish a QA program designed to direct, evaluate, and monitor the efficacy of health care services provided to its insured. The program must include a method for analyzing outcomes, peer review, system to collect and maintain information, recommendations for remedial action, and written guidelines that set forth the procedures for remedial action when problems

related to quality of care are identified. Each managed care organization shall maintain written description of the quality assurance program aforementioned, the specific actions used to promote adequate quality of health care services provided and the persons responsible for such actions, and provide necessary staff to implement quality assurance program and evaluate its efficacy (695G.180).

The CSAT (1993), reports that providers must regularly audit client records, especially providers whom work with clients who have been screened or are at-risk for infectious diseases. It is recommended that audits utilize established criteria to determine the correctness of diagnoses and treatment planning, and ensure all documentation is complete and accurate. As previously discussed, QA programs may be encouraged or enforced by various organizations. However, there is not much agreement about how these programs should be structured. Moreover, as new requirements arise, record keeping and QA processes must be updated to reflect changes and improved methods (Hargrave & Hiatt, 2000). In general, procedures for QA should be clearly specified, including frequency and *modus operandi*. Additionally, specific guidelines and checklists, utilizing standardized protocols should be used (Pyle, 2000). Pyle (2000) further suggests that QA should be both preventative and corrective in nature. Preventive actions may include changes in problematic forms, ongoing training, and protocol revisions. While corrective actions involve providing feedback and requiring corrections to be made for errors within a record; which should also be documented.

11. Implications

While internal quality assurance audits of professional mental health records have yet to receive substantial research focus within interpersonal violence settings, this review suggests there is some support to suggest these programs may be utilized to enhance record keeping practices. Mental health providers often report that QA activities are time consuming and costly to implement (Eppel, Fuyarchuk, Phelps, & Phelan, 1991). However, these systems can be implemented in a relatively cost-effective manner, ultimately resulting in cost savings due to significant reductions in errors affecting victims and perpetrators of interpersonal violence (e.g., breaches in confidentiality, legal fees, safety). Along these lines, McMillen and colleagues (2008), outline the importance of implementing QA procedures continuously to enhance therapeutic services and manage risk. When considering how to develop and implement a QA program, within interpersonal violence settings the procedures outlined by Bowie and colleagues (2004) may be useful to consider. Providers are randomly assigned to review records while utilizing a standardized tracking form. In this QA procedure, a list of potential errors are recorded for all forms that are maintained within the client record (e.g., missing signatures, missing information, missing forms, illegible writing). Audits are recommended to occur every 4 to 8 weeks depending on required standards and record keeping proficiency. In managing QA procedures it is important to parsimoniously restrict each audit to 10 minutes, if implemented on a monthly basis utilizing standardized procedures. Although these recommendations are conceptually sound, future research focusing on QA programs is needed to determine their feasibility and utility, especially in settings involving interpersonal violence.

- Record keeping errors in interpersonal violence negatively impact service implementation.
- Quality assurance (QA) programs monitor and review service implementation.
- QA programs facilitate appropriate management of records.
- We review record keeping guidelines and evidence supporting record keeping practices.
- We provide QA methods to assure these practices are implemented with adherence.

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REFERENCES

- Adler, D. United Behavioral Health Network Manual. 2012. Retrieved from <https://www.ubhonline.com/html/guidelines/networkManual/pdf/networkManual.pdf>
- American Psychological Association. Ethical principles of psychologists and code of conduct. *American Psychologist*. 2002; 57:1060–1073. [PubMed: 12613157]
- Behnke S, Ernesto M, Foote WE, Ramos- J, Grossman LR, Hinnefeld B, Krauss DA. Strategies for Private providers Coping With Subpoenas or Compelled Testimony for Client Records or Test Data. *Professional Psychology: Research and Practice*. 2006; 37(2):215–222. doi: 10.1037/0735-7028.37.2.215.
- Bongar B. Clinicians, microcomputers, and confidentiality. *Professional Psychology: Research and Practice*. 1988; 19(3):286–289. doi:10.1037//0735-7028.19.3.286.
- Bowie P, Sweeney BA, Beattie J. The feasibility and potential of organizational peer review audit in community nursing: an example of record keeping. *Quality in Primary Care*. 2004; 12(2):109–117.
- Brody JL, Waldron HB. Ethical issues in research on the treatment of adolescent substance abuse disorders. *Addictive behaviors*. 2000; 25(2):217–28. [PubMed: 10795946]
- California's College Health Individual Practice Association. Network Manual. 2010. Retrieved from http://www.chipa.com/Providers/documents/NetworkManual_OnlineVersion1.pdf
- Caudill J. Requirements and implementation of maintaining patient records: The mental health professional's best protection. *Journal of Aggression, Maltreatment & Trauma*. 2005; 11(1/2):249–262. doi:10.1300/J146v11n0116.
- Centers for Medicare and Medicaid Services. Medicaid Integrity Program Provider Audit Fact Sheet. 2009. Retrieved from: <http://www.cms.hhs.gov/MedicaidIntegrityProgram>
- Center for Substance Abuse Treatment. Screening for Infectious Diseases Among Substance Abusers. Substance Abuse and Mental Health Services Administration; Rockville, MD: 1993. Treatment Improvement Protocol (TIP) Series, No. 6
- Clark BJ, Abeles N. Ethical issues and dilemmas in the mental health organization. *Administration and policy in mental health*. 1994; 22(1):7–17. [PubMed: 11660510]
- Crane CA, Eckhardt CI. Evaluation of a single-session brief motivational enhancement intervention for partner abusive men. *Journal of Counseling Psychology*. 2013; 60(2):180–187. doi:10.1037/a0032178. [PubMed: 23506510]
- DeLettre JL, Sobell LC. Keeping psychotherapy notes separate from the patient record. *Clinical Psychology & Psychotherapy*. Jan 01.2010 17:2. doi. 10.1002/cpp.654.
- Drake RE, Teague GB, Gersing K. State Mental Health Authorities and Informatics. *Community Mental Health Journal*. 2005; 41(3):365–370. doi:10.1007/s10597-005-5009-7. [PubMed: 16131013]

- Eberlein L. Client records: Ethical and legal considerations. *Canadian Psychology/Psychologie canadienne*. 1990; 31(2):155–166. doi:10.1037/h0078894.
- Eppel AB, Fuyarchuk C, Phelps D, Phelan AT. A comprehensive and practical quality assurance program for community mental health services. *Canadian journal of psychiatry. Revue canadienne de psychiatrie*. 1991; 36(2):102–6. [PubMed: 2044026]
- Falvey J, Cohen C. The buck stops here: Documenting clinical supervision. *Clinical Supervisor*. 2003; 22(2):63–80. doi:10.1300/J001v22n02_05.
- Farkas M, Gagne C, Anthony W, Chamberlin J. Implementing Recovery oriented Evidence Based Programs: Identifying the Critical Dimensions. *Community Mental Health Journal*. 2005; 41(2): 141–158. doi:10.1007/s10597-005-2649-6. [PubMed: 15974495]
- Gehart, DR. Mastering competencies in family therapy: A practical approach to theory and clinical case documentation. Cengage Learning; Florence, KY: 2009.
- Grasso BC, Genest R, Jordan CW, Bates DW. Use of chart and record reviews to detect medication errors in a state psychiatric hospital. *Psychiatric services (Washington, D.C.)*. 2003; 54(5):677–81. doi:10.1176/appi.ps.54.5.677.
- Gutheil TG, Hilliard JT. 'Don't write me down': Legal, clinical, and risk-management aspects of patients' requests that therapists not keep notes or records. *American Journal Of Psychotherapy*. 2001; 55(2):157–165. [PubMed: 11467254]
- Haglund L, Hallberg IR, Pettersson M. Psychiatric occupational therapy service--quality assurance. *Nordic journal of psychiatry*. 2004; 58(5):403–7. doi:10.1080/08039480410005972. [PubMed: 15513618]
- Hargrave G, Hiatt D. How MCO saw better treatment records improve outcomes. *Behavioral Health Accreditation & Accountability Alert*. 2000; 5(11):1.
- Harris SM, Brown A, Dakin JB, Lucas B, Riley L, Bulham R. Are Clinical Records Really That Important? The Dearth of Research and Practice Guidelines in MFT Literature. *The American Journal of Family Therapy*. 2009; 37(5):373–387. doi:10.1080/01926180902754729.
- Harrison JP, Palacio C. The role of clinical information systems in health care quality improvement. *The health care manager*. 2006; 25(3):206–12. [PubMed: 16905990]
- Health Information Technology for Economic and Clinical Health (HITECH) Act.. 2009. Retrieved from: <http://www.hhs.gov/ocr/privacy/hipaa/administrative/enforcementrule/hitech/enforcementrule.html>
- Health Insurance Portability and Accountability Act (HIPAA). Security Rule. 2003. Retrieved from: <http://www.hhs.gov/ocr/privacy/hipaa/administrative/securityrule/index.html>
- Heller RJ, Gilliam LS, Chenail RJ, Hall TL. Three Authors, One Client: A Qualitative Description of Marriage and Family Therapy Initial Case Documentation. *Contemporary Family Therapy*. 2010; 32(4):363–374. doi:10.1007/s10591-010-9130-6.
- Jha AK, Kuperman GJ, Teich JM, Leape L, Shea B, Rittenberg E, Burdick E, Seger DL, Vander Vliet M, Bates DW. Identifying adverse drug events: Development of a computer-based monitor and comparison with chart review and stimulated voluntary report: Development of a computer-based monitor and comparison with chart review and stimulated voluntary report. *Journal of the American Medical Informatics Association: JAMIA*. 1998; 5(3):305–314. doi:10.1136/jamia.1998.0050305. [PubMed: 9609500]
- Kleschinsky JH, Bosworth LB, Neslon SE, Walsh EK, Shaffer HJ. Persistence pays off: Follow-up methods for difficult-to-track longitudinal samples. *Journal of Studies on Alcohol and Drugs*. 2009; 70(5):751–761. [PubMed: 19737500]
- Ladbury B. Heart of Child Protection. *Community Practitioner*. 2003; 76(12):443.
- Luepker, ET. Record keeping in psychotherapy and counseling: Protecting confidentiality and the professional relationship. Routledge, NY: 2012.
- Mary A, Cynthia A, Armand R, Galiotta M, Sara J, Lally S, Lovejoy GD, et al. Record keeping guidelines. *The American psychologist*. 2007; 62(9):993–1004. doi:10.1037/0003-066X.62.9.993. [PubMed: 18085845]
- McMillen C, Zayas LE, Books S, Lee M. Quality assurance and improvement practice in mental health agencies: roles, activities, targets and contributions. *Administration and policy in mental health*. 2008; 35(6):458–67. doi:10.1007/s10488-008-0189-4. [PubMed: 18688707]

- Nabors L, Weist M, Tashman N, Myers C. Quality Assurance and school-based mental health services. *Psychology in the Schools*. 1999; 36(6):485. doi:10.1002/(SICI)1520-6807(199911)36:6<485::AID-PITS4>3.0.CO;2-T.
- National Institute of Health. NIH grants policy statement. 2011. Retrieved from http://grants.nih.gov/grants/policy/nihgps_2011/index.htm
- Nevada Department of Health and Human Services. Medicaid Services Manual: Chapter 400. Carson City, NV: 2011. Retrieved from: <http://dhcfp.nv.gov/MSM%20Table%20of%20Contents.htm?Accept>
- Nevada Revised Statutes. §433.504.
- Nevada Revised Statutes. §641.230.
- Nevada Revised Statutes. §695G.180.
- Opila DA. The impact of feedback to medical housestaff on chart documentation and quality of care in the outpatient setting. *Journal of General Internal Medicine*. 1997; 12(6):352–56. [PubMed: 9192252]
- Piazza N, Baruth N. Client record guidelines. *Journal of Counseling & Development*. 1990; 68(3):313.
- Prieto LR, Scheel KR. Using Case documentation to strengthen counselor trainees' case conceptualization skills. *Journal of Counseling & Development*. 2002; 80(1):11–21. doi:10.1002/j.1556-6678.2002.tb00161.x.
- Pullen I. Improving standards in clinical record-keeping. *Advances in Psychiatric Treatment*. 2006; 12(4):280–286. doi:10.1192/apt.12.4.280.
- Pyle H. Auditing clinical data. *Applied Clinical Trials*. 2000; 9(5):65.
- Romero V, Donohue BC, Hill HH, Powell S, Van Hasselt VB, Azrin N, Allen DN. Family behavior therapy for use in child welfare: Results of a case study involving an abused woman formally diagnosed with alcohol dependence, bipolar disorder, and several anxiety disorders. *Clinical Case Studies*. 2010; 9(5):353–368. doi:10.1177/1534650110383306. [PubMed: 23136557]
- Sheidow AJ, Donohue BC, Hill HH, Henggeler SW, Ford JD. Development of an Audio-Tape Review System for Supporting Adherence to an Evidence-Based Treatment. *Professional psychology, research and practice*. 2008; 39(5):553–560. doi:10.1037/0735-7028.39.5.553.
- Soisson EL, VandeCreek L, Knapp S. Thorough record keeping: A good defense in a litigious era. *Professional Psychology: Research and Practice*. 1987; 18(5):498–502. doi: 10.1037//0735-7028.18.5.498.
- Somers CV, Benjamin JD, Chenail RJ. How Master's Students Document Stability and Change Within and Across Progress Notes. *Contemporary Family Therapy*. 2009; 32(1):22–38. doi:10.1007/s10591-009-9105-7.
- Ståhl Y, Granlund M, Gäre-Andersson B, Enskär K. Views on health information and perceptions of standardized electronic records among staff in Child and School Health Services. *Journal of nursing management*. 2011; 19(2):201–8. doi:10.1111/j.1365-2834.2010.01201.x. [PubMed: 21375623]
- Steinfeld BI, Keyes JA. Electronic medical records in a multidisciplinary health care setting: A clinical perspective. *Professional Psychology: Research and Practice*. 2011; 42(6):426–432. doi:10.1037/a0025674.
- Tan MW, McDonough WJ. Risk management in psychiatry. *Psychiatric Clinics of North America*. 1990; 13(1):135–147. [PubMed: 2315200]
- Taft CT, Murphy CM, Elliott JD, Morrel TM. Attendance-enhancing procedures in group counseling for domestic abusers. *Journal of Counseling Psychology*. 2001; 48(1):51–60. doi: 10.1037/0022-0167.48.1.51).
- Tarasoff v. Regents of the University of California, 131 Cal. Rptr. 14 (Cal. 1976).
- Tjeltveit AC, Gottlieb MC. Avoiding the road to ethical disaster: Overcoming vulnerabilities and developing resilience. *Psychotherapy (Chicago, Ill.)*. 2010; 47(1):98–110. doi:10.1037/a0018843.
- Tsai J, Bond G. A comparison of electronic records to paper records in mental health centers. *International journal for quality in health care*: journal of the International Society for Quality in Health Care/ISQua. 2008; 20(2):136–43. doi:10.1093/intqhc/mzm064.

- Van Allen J, Roberts MC. Critical incidents in the marriage of psychology and technology: A discussion of potential ethical issues in practice, education, and policy. *Professional Psychology: Research And Practice*. 2011; 42(6):433–439. doi:10.1037/a0025278.
- Wekerle C. Resilience in the context of child maltreatment: Connections to the practice of mandatory reporting. *Child Abuse & Neglect*. 2013; 37(2-3):93–101. doi:10.1016/j.chiabu.2012.11.005. [PubMed: 23312119]
- Wekerle C, Wall A-M, Leung E, Trocmé N. Cumulative stress and substantiated maltreatment: The importance of caregiver vulnerability and adult partner violence. *Child Abuse & Neglect*. 2007; 31:427–443. [PubMed: 17445887]
- Whyte M. Computerised versus handwritten records. *Paediatric Nursing*. 2005; 17(7):15–18. [PubMed: 16178164]
- World Health Organization. *Quality Improvement for Mental Health: Mental Health Policy and Service Guidance Package*. 2003.
- Zellman GL. Child abuse reporting and failure to report among mandated reporters: Prevalence, incidence, and reasons. *Journal Of Interpersonal Violence*. 1990; 5(1):3–22. doi: 10.1177/088626090005001001.

Table 1

Common Errors Found in Case Record Documents and Examples of Resulting Problems

Document	Common Errors	Examples of Resulting Problems
Informed Consent	<ul style="list-style-type: none"> Missing within record Not administered 	<ul style="list-style-type: none"> Ethical and legal concerns Poor rapport Premature termination
Intake Forms	<ul style="list-style-type: none"> Missing within record Inaccurate information Lack of information Time inefficiencies Poor continuity of care 	<ul style="list-style-type: none"> Impaired quality of care Poor treatment engagement and retention Poor or uninformed treatment decisions
Release of Information	<ul style="list-style-type: none"> Missing within record Not administered Inaccurate completion 	<ul style="list-style-type: none"> Ethical and legal concerns Poor continuity of care
Progress Note	<ul style="list-style-type: none"> Missing within record Omitted information Lack of detail Too much detail Failure to document important decisions or critical incidents Poor handwriting 	<ul style="list-style-type: none"> Ethical and legal problems Failure to assure insurance requirements Improper treatment Poor continuity of care
Treatment Plan	<ul style="list-style-type: none"> Missing within record Poorly documented Poor assessment of client symptoms or concerns Vague or irrelevant goals 	<ul style="list-style-type: none"> Rapport Poor or uninformed treatment decisions Failure to assure insurance requirements Misdiagnosis
Termination Summary	<ul style="list-style-type: none"> Missing within record Omitted information Lack of detail Too much detail 	<ul style="list-style-type: none"> Continuity of care Insurance requirements Failure to document treatment progress or completion
Access to records	<ul style="list-style-type: none"> Breach of confidentiality Failure to retain records for required time period Inaccessible or lost records 	<ul style="list-style-type: none"> Ethical and legal concerns Poor continuity of care