Admiral Nurses are specialists who support families who are affected by dementia. At the time of writing, there were 305 working across different healthcare settings in the UK, all of whom are supported by the charity Dementia UK.

In 2019, Dementia UK recognised that Admiral Nurses needed more support with the structure and consistency of their record keeping to ensure high standards were met and the complexity of their work was reflected. This article describes the use of a practice development approach to support Admiral Nurses in their record keeping practice. As a result of the project, best-practice guidance and a framework for writing was developed. Actively involving the Admiral Nurses in this process led to a positive response to the record-keeping framework supporting sustainable change.

In this article...
- Why record keeping is a vital skill for nurses
- A project to develop consistency in record keeping among a group of specialist nurses
- Development of guidance to create sustainable change

Just for the record: a framework for specialist nursing documentation

Admiral Nurses are specialists who support families who are affected by dementia. At the time of writing, there were 305 working across different healthcare settings in the UK, all of whom are supported by the charity Dementia UK.

In 2019, Dementia UK recognised that Admiral Nurses needed more support with the structure and consistency of their record keeping. As specialists in their field, they need to model high standards of practice in a range of areas including exemplary documentation. The challenge, as for other health professionals, is that due to factors such as increased time pressure, budget constraints and expanding roles, Admiral Nurses need a documentation method that is quick and efficient (Pelletier et al, 2005). It should also allow for the provision of clear, succinct, legible information and evidence of critical thinking (Blair and Smith, 2012).

Record keeping
The quality of nursing documentation is a central issue for healthcare organisations in the UK and overseas (Blair and Smith, 2012). Record keeping is a significant part of nursing work and serves as a communication medium between patients, their families and health professionals across the multidisciplinary team (Jefferies et al, 2010) to facilitate the continuity of safe, effective patient care. The importance of record keeping is highlighted in the Nursing and Midwifery Council’s (2018) code of conduct as being integral to each of the professional standards. It is generally accepted that documentation is now both a professional and a legal obligation for all nursing staff.

Despite the recognition of the importance of record keeping and documentation being a part of everyday work, nursing staff find the process difficult (Wang et al, 2011; De Marinis et al, 2010), which has the potential to be detrimental to patient care. Omissions in nursing records can have serious consequences for those involved in care (Sutcliffe et al, 2004): as an example, poor-quality documentation can lead to errors and poor, or even fatal, outcomes (Merrifield, 2017).

Keywords
Record keeping/
Consistency/Specialist nurses

This article has been
double-blind peer reviewed
“There is currently little evidence to support a specific standard or framework for record keeping”

Frequently cited issues underpinning poor record keeping include time constraints, inadequate organisational support, under-staffing and a desire to prioritise patient care (Blair and Smith, 2012; Oli and Sowummi, 2012; De Marinis et al, 2010), all of which contribute to the low priority given to the task of documentation (Jef-feries et al, 2010). The evidence suggests that it is not just problems associated with workload that negatively affect the ability of nursing staff to record notes but that a lack of guidance for documenting care is also a significant contributor (Blair and Smith, 2012; Wang et al, 2011; De Marinis et al, 2010).

Although the need to keep accurate, informative and holistic patient records is acknowledged by the bodies that govern healthcare practice, there is currently little evidence to support a specific standard or framework for record keeping, particularly for specialist nurses. This lack of guidance:

- Leaves nursing staff writing to a structure they have developed themselves (Madden, 2019);
- Leads to disparity between content;
- Does a disservice to the breadth and depth of nursing work;
- Reduces the quality of nursing documentation.

**Practice development**

Dementia UK provides initial and ongoing support to Admiral Nurses recruited into services. This includes the consultant Admiral Nurse team, which supports the implementation of Admiral Nurse services and provides professional and practice development (PPD). It became apparent through PPD discussions and reflection that Admiral Nurse documentation lacked consistency and varied in quality; the cause of this was a lack of guidance provided by Dementia UK.

It was proposed that Admiral Nurses be supported to develop their record-keeping practice, including learning how to reflect the complexity of interventions as well as their specialist skills, knowledge and professional judgment. It was agreed that a consistent approach to record keeping across Admiral Nursing practice would also help to meet the exemplary standards desired by the NMC.

**Creating change**

Practice development is a structured methodology and approach to healthcare improvement that has nine core principles incorporating practical, philosophical and theoretical factors (McCormack et al, 2013; Manley et al, 2008). It underpins the work of the PPD team, which helps to foster person-centred, evidence-based and sustainable practice change for Admiral Nurses. These nurses work in various types of host organisation, specialist settings and geographical locations, which adds to the complexity; for this reason, practice development has an important part to play.

Admiral Nurses frequently describe having difficulties finding the time to address practice issues, particularly with the existing complexity and challenges in the healthcare system. However, this is essential if quality is to remain a priority. Practice development approaches enable reflective learning and action-oriented opportunities in the context of challenging work environments and cultural complexities (Garbett and McCormack, 2002).

**Information gathering**

It was decided that to provide Admiral Nurses with record-keeping guidance, information gathering should be led by a range of people in Dementia UK who had a vested interest in the topic. A working group was set up that was led by the PPD team; it included consultant Admiral Nurses, practice development facilitators, an Admiral Nurse from the national helpline and the governance lead.

Practice development theory recognises that change in workplaces is optimised through collaborative, inclusive and participative processes (McCance and McCormack, 2017). In keeping with this, it was essential for the working group to reflect a values-based approach to changes in practice and to explore and include the perspectives of Admiral Nurses. This was achieved through 17 UK-wide monthly practice development groups that Admiral Nurses attend, which are held to engage them in critical and creative thinking.

Over a two-month period (May-June 2019) members of the PPD team led record-keeping sessions for the practice development groups in their region. The team’s approach to gathering the views of Admiral Nurses involved the use of:

- Creative learning activities (Manley, 2017);
- Time to reflect;
- Time to question;
- Time to challenge.

Using principles of fourth-generation evaluation (Guba and Lincoln, 1989), a claims, concerns and issues exercise (Box 1) was carried out to gain the nurses’ views and perspectives about record keeping. As this is an evaluation method that incorporates the opinions of stakeholders to plan ongoing activity, it was felt to be an appropriate process to use and one that was well regarded by the Admiral Nurses.

Information was gathered during the sessions and sent to the working group for analysis. Ethical approval was not needed for this practice development activity, but consent was gained from each nurse to confirm that they were happy for their comments to be shared anonymously.

**Analysis**

The information gathered from the claims, concerns and issues exercise of the practice development groups was captured on flip charts. It was then typed up by the members of the PPD team leading the sessions and sent to the working group. It was read independently by two members of the working group who then came together to discuss the main issues and draw overall themes.

It was evident at this point that, not only did Admiral Nurses document practice in a variety of ways, but also that they experienced similar challenges in record keeping. This can be seen in the results of the claims, concerns and issues exercise,
outlined in Box 2. The three overarching themes from the exercise were:

- The complex nature of the work to be documented;
- The need for a consistent record keeping framework;
- The need to incorporate the Admiral Nurse competency framework.

The Admiral Nurse competency framework (Bit.ly/DUKANFramework) is used to aid nurses’ professional development, identify gaps in knowledge and articulate the specific and unique skills that Admiral Nurses need. It draws on Department of Health (2016) guidance and professional issues highlighted by Health Education England (2015) and is unique to Admiral Nurses, reflecting the specialist nature of their work.

Subthemes drawn from the exercise highlighted that Admiral Nurses were also concerned about how to show their level of specialism and avoid writing huge amounts of text.

**Best-practice guidance**

As a result of the analysis, best-practice guidance was developed as a structured framework for Admiral Nurses to use when record keeping. The framework (Box 3) was underpinned by Rolfe et al’s (2001) reflective model and mirrored their guidance, offering a clear example of how everyday record keeping can provide an opportunity for reflection.

Reflection is an important part of nurses’ practice to help them think about, plan and deliver safe care that is of high quality. The hope was that the framework would support the Admiral Nurses’ ability to reflect critically when documenting psychological, social, cultural and spiritual aspects, along with the biomedical aspects of record keeping. The reflective model underpins the template all nurses are expected to complete as part of their revalidation requirements for the NMC (Bit.ly/RCNRevalidReq), and should also prompt them to consider the interventions used and highlight on what evidence they are based.

The distinct role of working with families and the complexity that brings should be described using language from the Admiral Nurse competency framework; however, it must still be easily understood by those reading it.

The framework was turned into a set of resources to be shared, including:

- An information sheet;
- A pocket book;
- An example sheet to show how the framework and guidance fit together.

**Box 2. Claims, concerns and issues identified by participants**

**Claims about positive practice in documentation**

- Helps provide clarity about intervention/Admiral Nurse input
- Examples of good practice include: using headings, key points (using bullet points), summary of actions/interventions and a plan
- Can help identify risks
- Concise and brief
- Being timely – as soon as possible after the event
- ‘Plan’ to include next steps and what’s been agreed
- Should include evaluation/feedback on what went well/ worked
- Need to ensure spelling is checked/can use Word document first

**Concerns about how documentation is written/difficulties related to this**

- If notes are too long, they take too much time, others can’t easily use them and they don’t highlight key issues
- If notes are too brief, they may miss vital information or not represent the quality/depth of the input
- Notes that are rushed or have poor spelling and grammar don’t reflect well on practice
- Do notes really reflect the level of Admiral Nurse competency and skills?
- Can be difficult to articulate interventions that are not task oriented and to describe psychological support
- Lack of consistent approach between individual nurses, teams and/or settings
- Lack of time, space and/or access to equipment to write notes can be an issue in some settings
- May not always be objective – there is a need to document facts

**Issues – questions about documentation**

- How can we demonstrate expertise?
- How can we demonstrate therapeutic interventions?
- How do we incorporate the Admiral Nurse competency framework into note writing?
- How do we know when enough is enough?
- How do we ensure we have captured all the important information?
- Can a template be developed to support the above?

The guidance developed from this process was shared with a small sample of Admiral Nurses (n=21) and clinical staff at Dementia UK (n=16) for feedback. All comments received were positive, stating that the resources were clear, the framework would be a great way to encourage nurses to write in a way that incorporates reflection, and was a really useful tool to use with Admiral Nurses to help them self-evaluate record keeping on an ongoing basis.

After its positive reception by this small group, the framework was launched more widely via a structured practice development session run across all 17 groups in January 2020. This included a formal introduction and sharing of the framework, guidance, examples and resources, with opportunity to explore scenarios for record keeping and group-work discussion.

**Evaluation**

Evaluation, of both processes and outcomes, is a key part of any practice development project (McCormack et al, 2013) so the original plan was to evaluate the use of the framework and resources after six months; however, the coronavirus pandemic meant this was delayed. When the framework and resources had been in use for 12 months, a survey was sent to all 295 Admiral Nurses in post at that time, asking them if they had been using the framework, how effective they had found it in meeting their needs and about any changes it had made to their record-keeping practice.

The survey achieved a response rate of 37% (n=108). Of the respondents, 64% (n=69) stated they attended the practice development session when the record-keeping framework was launched and 63% (n=68) felt the framework was useful. The majority (72%, n=79) found the materials useful. Seventy-five per cent (n=81) of respondents stated that they were regularly using the framework; the 25% who were not gave varying reasons, for example, that their host organisation had its own paperwork.
Discussion
Communication and documentation in healthcare has long been a significant issue, with concerns raised about safety and clinical outcomes associated with poor record keeping (Foronda et al, 2016; Vermier et al, 2015). The ongoing concerns about the quality of record keeping and the need for nursing staff to be able to articulate the complex work they do, means that committing time to developing the quality and consistency of record keeping is an important investment for healthcare providers to make.

Implementing change in healthcare systems to improve the quality of patient care is considered complex, messy and daunting (Rycroft-Malone, 2004; Chin, 2003). However, to optimise outcomes, the working group applied practice development principles and evidence-based approaches to plan a collaborative and inclusive process that would value the contributions of all to achieve sustainable change. Admiral Nurses have been actively included throughout this development work and the response from them has been very positive. Chin (2003) referred to the use of a practice development framework to support sustainable change, and the process to date indicates that the changes made through our use of this process will continue.

Achieving consistency in record keeping across a discipline makes communication a lot easier (Wood, 2010) and is likely to have a positive effect on clinical and practice outcomes.

Conclusion
Dementia UK will continue to reflect on, and encourage, this new record-keeping practice through ongoing practice development activities. We would highly recommend other health professionals make use of this practice development approach to enhance record keeping.

Box 3. Admiral Nurse record-keeping framework

| Purpose (what?) | This section should provide context. |
| Current situation (in your view) and impact of your input since the last visit (if appropriate) |
| Why are you there? Who is present? What help/support is currently needed (clinical judgement)? Risk (if any) |

| Intervention (so what?) | This section should detail your contribution based on theory/evidence. |
| Language and content should be considered. Biopsychosocial assessment, whole-systems approach, sharing knowledge, empowering others |
| What psychosocial interventions were used, eg, solution-focused approach, cognitive behaviour therapy methods. On what theories/evidence are you basing your work? |

Plan (now what?)
This section should explain what is going to happen next.

Who is doing what, when? Will there be another visit? Is there a change in the casework zone or is the case closed? Demonstrate clinical judgment. Use of bullet points for actions is appropriate

References
De Marinis MG et al (2011) ‘If it is not recorded, it has not been done?’. Consistency between nursing records and observed nursing care in an Italian hospital. Journal of Clinical Nursing; 19:11-12, 544-552.
Department of Health (2016) Challenge on Dementia 2020: Implementation Plan, DH.