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EFFECTIVE COMMUNICATION

for Nursing Associates





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Professional communication

NMC FUTURE NURSE STANDARDS OF PROFICIENCY FOR NURSING ASSOCIATES

This chapter will address the following platforms and proficiencies:

Platform 1: Being an accountable professional

At the point of registration, the nursing associate will be able to:

- 1.9 communicate effectively using a range of skills and strategies with colleagues and people at all stages of life and with a range of mental, physical, cognitive and behavioural health challenges.
- 1.10 demonstrate the skills and abilities required to develop, manage and maintain appropriate relationships with people, their families, carers and colleagues.
- 1.14 demonstrate the ability to keep complete, clear, accurate and timely records.

Platform 3: Provide and monitor care

At the point of registration, the nursing associate will be able to:

- 3.11 demonstrate the ability to recognise when a person's condition has improved or deteriorated by undertaking health monitoring. Interpret, promptly respond, share findings, and escalate as needed.
- 3.18 demonstrate the ability to monitor the effectiveness of care in partnership with people, families and carers. Document progress and report outcomes.

Platform 4: Working in teams

At the point of registration, the nursing associate will be able to:

- 4.4 demonstrate the ability to effectively and responsibly access, input and apply information and data using a range of methods including digital technologies, and share appropriately within interdisciplinary teams.

(Continued)

(Continued)

- 4.8 contribute to team reflection activities, to promote improvements in practice and services.

Annexe A: Communication and relationship management skills

At the point of registration, the nursing associate will be able to safely demonstrate the following skills:

4. Communication skills for working in professional teams:

Demonstrate effective skills when working in teams through:

- 4.1 active listening when receiving feedback and when dealing with team members' concerns and anxieties.
 - 4.2 timely and appropriate escalation.
 - 4.3 being a calm presence when exposed to situations involving conflict.
 - 4.4 being assertive when required.
 - 4.5 using de-escalation strategies and techniques when dealing with conflict.
5. Demonstrate effective supervision skills by providing:
 - 5.1 clear instructions and explanations when supervising others.
 - 5.2 clear instructions and checking understanding when delegating care responsibilities to others.
 - 5.3 clear constructive feedback in relation to care delivered by others.
 - 5.4 encouragement to colleagues that helps them to reflect on their practice.

Chapter aims

By the end of this chapter, you will be able to:

- discuss the ways in which we share information.
- explore the correct use of the telephone and verbal, in-person, handovers.
- understand the importance of note keeping.
- understand the dangers of social media.
- gain some insight into confidentiality.

Introduction

In the previous chapter, we looked at the ways in which we communicate and some of the theories we can use in communicating. Now we are moving on to professional communication and its significance in the role of the nursing associate. In this chapter,

the variety of ways in which information is shared, delivered or interpreted will be explored. This will include learning to share information by email and text message, using technological advancements in communication, and the possible dangers of social media. This chapter will also include case studies to illustrate how giving information, using correct telephone etiquette, verbal handovers and maintaining confidentiality can be applied in practice. The four themes of *The Code* (NMC, 2018a) will also be discussed because nursing associates will be required to uphold them in order to register and practise in the UK.

Definition

So, you want to be a professional? Let's look at what this means. Being a professional means that you are a member of a group of people who perform or engage in skilled and learned activities which require a specialist knowledge. For nursing associates, there is an additional element to being a professional, and that is being registered with the professional regulatory and statutory body, which in our case is the NMC; specifically, we are bound to promote professionalism and trust (NMC, 2018a), and when we register with the NMC, we agree to conform to the technical and ethical standards of the profession.

As you have already seen at the start of this chapter, the NMC puts a significant emphasis on registrants being able to practise effectively (NMC, 2018a) and communicate not only with patients, clients and their significant others, but as part of a local team of colleagues from a variety of specialisms and professional backgrounds, as well as to a wider healthcare community, including volunteers, charities and inter-agency collaborations, who all require professional communication.

Communicating professionally in a healthcare setting requires an understanding of the variety of roles and responsibilities of the multidisciplinary team (MDT). It also means building appropriate relationships to allow for the exchange of knowledge and skills. This will enable the effective delivery of care to our service user/patient group (Kenaszchuk et al., 2010).

As nursing associates, you will form a unique and recently explored route in communication within the professional team and between patients and clients. The newness of the nursing associate role can be a challenge when integrating into established teams and long-established healthcare professional roles. From the very beginning of its development, it was thought that the nursing associate role would be the essential bridge between registered nurses and doctors and those being cared for, not only in terms of the more direct nature of your caring role with patients and clients, but essentially in terms of communication.

Nursing associates work cooperatively with the registered nurses and other healthcare professionals in providing and monitoring care delivery. During a four-day inpatient stay in hospital, it is estimated that the patient will have contact with at least 50 different employees, from catering and housekeeping staff to nurses, technicians and doctors (O'Daniel and Rosenstein, 2008). As the professional healthcare worker with the biggest potential for actual hands-on working with patients and clients, the nursing associate role is to coordinate and facilitate contacts with your patient and service user group. This should be done in a way which ensures safety, dignity, respect, compassion and, of course, care.

Sharing information in a professional way

Recognising someone as a professional is to acknowledge their conduct, experience, quality and study of their topic, which in this situation is healthcare. As nursing associates, you are a professional in your own right and are able to make a significant contribution to effective clinical practices.

Communicating as a team of professionals is essential. When healthcare professionals fail to communicate effectively, it has a direct effect on the safety of patient care. There are many ways in which this can happen. A lack of critical information or the misinterpretation or misunderstanding of information, for example, from unclear telephone orders or poor handwriting and grammar, can mean critical information is lost or overlooked. As registrants with the NMC (2018a), we are bound to preserve safety, so it is essential that we get our communication right.

Spelling and grammar

There is an old saying that you can't read a doctor's writing. Thankfully, now with the engagement of technology and typing, messages are more clearly communicated and miscommunications are limited. However, there are still situations where handwriting is commonly used. Handwriting must be legible, words must be spelled correctly, and all writing must contain accurate grammar and punctuation. If you are unsure what has been written, you must check with the person who wrote it before any action is taken or any medication is given. As you can appreciate, if you give the wrong drug because you have misread it and did not check, there would be severe consequences.

Verbal orders via the telephone

Verbal orders are when a prescriber gives an oral/verbal instruction, usually via the telephone to a nurse to record or amend a prescription and then administer it. Verbal orders are associated with a high number of medication errors and should only be used in exceptional circumstances. As an example, if you confuse Doxepin (oral tricyclic anti-depressive, standard dose of 75 milligrams (mg)) and Digoxin (a potent drug which treats atrial fibrillation and heart failure, where the standard daily dose is 125 micrograms (mcg)), the consequences would be grave.

Verbal orders are permitted for use only when any delay in administering a medication would compromise patient care (Royal Pharmaceutical Society, 2019). A study in a large psychiatric hospital asked 50 nurses if they would take a verbal order from a doctor over the telephone; 26% said they would not take the verbal order. On questioning, only 12% of the 50 nurses that were asked were aware of the current guidance. A further 12% stated that they lacked confidence in taking a verbal order or were unsure of the exact procedure, while 62% were unable to correctly describe how to take a verbal order (Hall et al., 2014).

It is important to follow your employer's policy for verbal orders, which will be found on either hard copy in the place of work or via the local intranet. Where verbal orders are permitted, the prescriber ordering the change is responsible for writing the new prescription or amending the details of the prescription as soon as possible, ideally

within 24 hours. If this is not possible, the prescriber is responsible for ensuring that the patient's records are updated electronically (Royal Pharmaceutical Society, 2019).

As nursing associates, and so as a NMC registrant, you could be in the position of taking a verbal order. It is therefore essential that you get that order checked with another registrant before any medication is administered. If in any doubt, check again. Activity 2.1 asks you to practise your pronunciation skills and challenges your ability to listen to the names of different drugs that are in common use.

Activity 2.1 Communication: listening and pronunciation

This activity is best done with a colleague; take turns to read out loud the following pairs of drug names and write down what you hear:

1. Doxepin (Dox - ee - pin)

Digoxin (Dij - ox - in)

2. Clobazam (Clo - baz - am)

Clonazepam (Clon - as - a - pam)

Both drugs are used for the treatment of epilepsy, but they both have very different doses.

3. Sulfadiazine (Sul - fa - die - a - zeen)

Sulfasalazine (Sul - fa - sall - a - zeen)

Sulfadiazine is indicated for the prevention of rheumatic fever, whereas Sulfasalazine is used in the treatment of:

- mild to moderate and severe ulcerative colitis and maintenance of remission active Crohn's disease;
- rheumatoid arthritis.

4. Mercaptamine (Mer - cap - ta - mean)

Mercaptopurine (Mer - cap - toe - purr - in)

Mercaptamine is used for the treatment of proven nephropathic cystinosis (a rare disorder of the kidneys, which develops in young children). Mercaptopurine is used for the treatment of leukaemia.

Can you think of any other drug names which may cause confusion? Reflect on your experience of listening and reading the drug names out loud. More information on drug safety and drug name confusion can be found on the gov.uk website at the end of the chapter.

As this is a verbal activity, there is no suggested model answer.

Lookalike and soundalike medications are a particular problem, and healthcare is littered with long and complicated names for medications, conditions and procedures. Taking the time to practise, breaking down these words and getting them checked if you are not sure, is good practice.

It does, however, highlight the risks in taking instructions over the telephone. It would be very easy to mishear an order and put a patient at risk. The mistake may be seen as innocent, and no harm would be intended; however, as a registered nursing associate, you would remain accountable for the error regardless of the intention and may still face disciplinary action.

Verbal handovers in person

As you have seen following Activity 2.1, translating verbal orders and instructions can be difficult. Despite this, verbal handovers are a crucial communication tool and are essential to the delivery and coordination of care during the patient journey. The effectiveness of verbal handovers – how they are done, what should be included in them and what skills are required to deliver a verbal handover – have been studied and discussed at length for many years. As a result, there have been many changes to the verbal handover, but none of them to date can offer the perfect solution.

The evidence from this research, however, suggests that a structured handover, which puts patients at the centre, gives rise to increased patient safety and care continuity. A further advantage is job satisfaction for the nurse or nursing associate (Ballantyne, 2017).

Essentially, a verbal handover is ‘the transfer of professional responsibility and accountability for some or all aspects of care for a patient or group of patients, to another or professional group on a temporary or permanent basis’ (National Patient Safety Agency et al., 2004). There is a tendency to think about handover only happening at the shift change time, but we hand over the care and management of a patient in a variety of other situations too. Other situations where we hand over the care of a patient includes moving patients between departments when a patient needs a chest x-ray, for example, or when they are admitted to a ward from urgent care. Another common handover takes place when discharging to a nursing home or home and into the care of the community team, or directly to the patient or their carer.

We have focused here on verbal handovers because they are the typical form of handover. As with taking orders by telephone, which we saw in the previous section, there are some problems with verbal handovers. Some of the information can get lost through interference and not heard correctly.

Types of in-person verbal handovers

Office-based (closed handovers)

In a healthcare setting, when we think about a handover, we usually think of all of the nursing staff being huddled together in the ward office or any other private environment, often with a cup of tea in hand and on a mismatch of chairs. This type of handover is setting the scene for the upcoming shift. The benefits include minimising disruptions, ensuring patient confidentiality and allowing for an open discussion of sensitive topics. These topics might include test results and treatment plans which have not yet been

discussed with the patient, but also might include issues such as concerns over domestic violence or mental capacity.

However, it does not include the patient, who is central to the discussion; it does not take into account the patient's feelings in real time and does not allow them to ask questions, or to be fully up to date in clinical decision making. There is also a staffing issue with an office-based handover, as it relies on there being someone available to provide care and be present on the ward for the duration of the handover. This would usually be the most junior members of the team, such as healthcare support workers and students.

In the community setting, the clinical handover may only happen on a weekly basis as part of the multidisciplinary team meeting. This leaves a crucial communication gap with those members of staff working out in the community, so it is important that there is some daily contact among the team, even if this is via the phone, and there must be agreed communication avenues for the escalation of concerns (Pearce, 2018). It is also a means of professional and emotional support for the nurses, who will be working alone for most of their working day.

Bedside handovers

Since 2015, there has been an increase in handovers taking place at the patient's bedside. These were developed in order to emphasise the involvement the patient has in their care. This is not to deny that there are benefits in an office-based handover. These bedside handovers, however, are reflective of our duty to prioritise people (NMC, 2018a), the patient's demand for information and the increased availability of information from internet sources. Patients are encouraged to inform themselves about their conditions so that they are in a better position to understand and discuss their healthcare needs.

A bedside handover is the perfect opportunity to give a full summary of the care the patient has received that day. The nurse and the patient can also discuss any clinical developments or changes and the nurse can ask the patient how they feel. Significantly, we also need to consider the language we use. If we are using technical terms, it can be very awkward if the patient does not understand the terminology; equally, we do not want to dumb down the language used and patronise the patient (Pearce, 2018). With the use of medical language, it is essential that we allow the patient and their significant others to ask questions to help clarify their understanding. Remember, there are no stupid questions; there are only stupid answers.

We do need to be mindful of our environment when we are discussing sensitive issues with a patient. There is an obvious issue of patient confidentiality with bedside handovers and the ability of the person in the next bed being able to hear the handover. The patient under discussion must be able to consent to this bedside handover. In an open ward environment, all the other patients are listening, and this could lead to sensitive topics being brushed over or not discussed at all, which would have a detrimental effect on patient care.

Outside of the issue of confidentiality, bedside handovers are problematic, due to the general hubbub of the clinical environment; phones will ring and buzzers will alarm; staff and visitors will come and go. The general daily interference takes its toll on the concentration of the staff in the handover and it may also limit the opportunities for the patients to ask any questions.

What we hand over

Regardless of the location of the handover, getting order in what is handed over is important. Using a familiar and logical format to a handover allows the listener to anticipate the type of information that will be given. It enables those giving the information to deliver a confident, structured and efficient handover without items being repeated or missed.

The tool most commonly used within the NHS is the SBAR tool.

S	<p>Situation</p> <p>Asking: What is going on with the patient?</p>	<p>An introduction (no need to do this if you are known to the listener):</p> <ul style="list-style-type: none"> • My name is (x) • I am a Nursing Associate on/in (state ward or clinical environment) <p>The reason for the communication</p> <p>I have a query about some medication that has been prescribed (as an example)</p> <p>Or</p> <p>I would like to hand over this patient to you.</p>
B	<p>Background</p> <p>Asking: How did the patient come to be here?</p>	<p>Brief history:</p> <ul style="list-style-type: none"> • State patient's name in full and what they may like to be called • Their age • Any other relevant past medical history • State when they were admitted (state date), from (state how they came into your care: from Accident and Emergency, or GP referral, for example), what they were admitted with (state general reason) • State what therapy/procedure/investigations they have had and when (how long ago).
A	<p>Assessment</p> <p>Asking: What is the problem?</p>	<p>Summary:</p> <ul style="list-style-type: none"> • State outcome/result of therapy/procedure/investigations • Note any changes in their condition • State a summary of their observations/urine output/bowels (open/ or not)/pain status/diet and hydration/level of alertness (if being measured) <ul style="list-style-type: none"> ○ can use the A–E assessment tool for this* ○ AVPU** ○ NEWS (2)*** • State any social issues (if relevant) • Make a general summary of their care at this current time. <p>(For example, if their temperature has gone up and they look flushed and hot, you could comment that you think they might have an infection.)</p>
R	<p>Recommendations</p> <p>Asking: What is going to happen next for this patient?</p>	<p>Plan:</p> <ul style="list-style-type: none"> • State what interventions are needed (if any) (such as take blood/ repeat the chest x-ray/call the doctor) • Include any recommendations from wider multidisciplinary team (such as physiotherapy twice a week/referral to occupational therapy) • State date/time for next review of the patient.
<p>Encourage questions and get listener to repeat key information to ensure that it is understood.</p>		

Figure 2.1 Work-based learning.

The SBAR tool (see Figure 2.1) originated from the US Navy and was adapted for use in healthcare by Dr M. Leonard and colleagues from Kaiser Permanente, Colorado, USA.

Additional information from SBAR

1. A to E assessment consists of a summary of the following:
 - A – Airway
 - B – Breathing
 - C – Circulation
 - D – Disability
 - E – Exposure
2. AVPU (see Figure 2.1) to the assessment of states of consciousness:
 - A – Alert
 - V – Verbal
 - P – Pain
 - U – Unresponsive
3. NEWS (see Figure 2.1) is the National Early Warning Score. NEWS₂ is for use in acute care settings or ambulance settings.

The NEWS score is calculated from information from the patient's respiratory rate, oxygen saturations, whether they are on oxygen, their temperature, the systolic blood pressure, heart rate and the level of consciousness.

In Activity 2.2, you are being asked to look at some general information that would be given as part of an SBAR handover.

Activity 2.2 Case study

How would you hand over this patient using the SBAR tool (you might want to think about the order of the information in the case study to make the handover more logical)?

A patient had a total abdominal **hysterectomy** and **bilateral salpingo oophorectomy**. Her name is Mrs Choudhary; she had the operation one week ago, and she likes to be called Swarda. Her ECG was fine, but she has a raised temperature. She is 57 years old and has a Robinson drain in on the right side. Urine output dropped. Her pain is relieved with patient-controlled analgesia and she has not had her bowels open. She is nil by mouth and has a nasogastric tube (plugged) and an IV with fluid (dextrose and saline). Wound draining a lot. All started with abdominal pain for two weeks.

An outline answer is provided at the end of the chapter.

Keeping notes and medical records

Thinking about the previous section and the case study specifically in Activity 2.2, and making reference to the jargon buster activity in Chapter 1, it is not hard to see why medicine has developed its own form of code or shorthand. Writing everything out in full without the agreed abbreviations would be very time consuming, not only to write but also to read. If you found yourself in an emergency and you needed a summary of the patient quickly, the medical shorthand in the notes helps you navigate the situation quickly. Now try Activity 2.3.

Activity 2.3 Communication

Try to decode these two patient record notes:

- 57 o+, 1/7 post TAH BSO, PCA insitu, i/c Robinson (R)
wound +++ >temp ECG NAD, <PU, IV (Dex/Sal), NBM, NGT, BNO, TEDs
- 35 O->, 6/7 post RTC # Bil Tib/Fib, O₂ 50% resp 25, 2° turns, PMH asthma, nebs QDS

An outline answer is provided at the end of the chapter.

As you have seen from Activity 2.3, there is a benefit to using medical shorthand. It must not be offensive and must be easily translatable, for a court of law or for an application for access to medical records request (Access to the Medical Act (1990)). If you keep pocket notes to remind you of the tasks you have to complete, these must not have any identifiable details on them which would be in breach of the General Data Protection Regulations (GDPR) (HMSO, 2018). These handwritten pocket notes must be transcribed into the relevant medical notes within 24 hours and securely destroyed.

As a nursing associate, you will be responsible for writing in the nursing notes; essentially, you must provide a factual, consistent, accurate and clear account of the care provided and the condition of the patient. Using a standardised format will help with consistency and the quality of the record and should include assessments, plans and the implementation of the plan and the evaluation of care. As much as these aspects are situation and patient specific, there are some general rules to follow:

- It sounds simple, but make sure that you are writing in the correct notes. Check the patient's person data. Question, is this the right name? Is this the right date of birth? Is this their correct address? It is rare, but it does happen that you have two patients in at the same time with the same name.
- Notes must be promptly recorded. However, if you do have to add something after the fact, you need to state that it is a 'retrospective account'.
- What you add to records must not be erased or deleted without notice. Never scribble out notes or cover up. If you write something in error, you must state

‘written in error’, including the date, time, your signature and your position of nursing associate.

- Similarly with alterations, you must state ‘altered record’ followed by the date, time, signature and position.
- Limit the jargon and abbreviations in nursing notes. No meaningless phrases, irrelevant information, no speculation or offensive comments.
 - Avoid phrases such as ‘appeared well’, ‘all care given’, ‘care as per care plan’, ‘slept well’.
- The notes must be accurately dated and timed using the 24-hour clock (for example, 14:00 instead of 2 p.m.) and signed with your signature alongside a printed version of your name and your role, as the record keeper.
- If the record is handwritten, it must be readable when photocopied. Use dark ink (ideally black) and keep notes out of direct sunlight.
- If a problem is identified, you must state what you did about it.
- You must provide clear evidence of the care delivered.

Just because something has not been written down does not mean that it did not happen. Often, what you fail to write is as telling as what you do write. For example, if you made a drug error and did not record it anywhere, it does not mean that the drug error did not happen. It just means that you kept it a secret and were dishonest. Own your mistakes wherever possible, so that you and others can learn from them and make sure that they don’t happen again.

The use of social media

When done right, the use of social media sites, in whatever form, can be a fantastic way of keeping in touch with old friends, new trends and relevant nursing and professional issues. It has the potential to be a positive, rewarding and informative experience.

However, with the increasing number of NMC registrants being subject to charges at fitness to practise panels for the inappropriate use of social media, it is clear that of the estimated 355,000 registered nurses and midwives using Facebook (Osborne, 2012), some of us are getting it really quite wrong. In Activity 2.4, you are asked to think about professional conduct and boundaries when it comes to using social media sites.

Activity 2.4 Case study: social media

You are working in the community and have been visiting a 31-year-old man. He is paraplegic after a sporting injury. He lives with his parents, and you have provided care with his bowel and catheter care on a weekly basis for the last nine months. After your last visit, you notice that he has sent you a friend request via one of your social media platforms. You are due to visit him again in two days’ time. What do you think is the best response to his friend request?

An outline answer is provided at the end of the chapter.

As we have seen in Activity 2.4, social media is difficult to control and predict. Seven staff from the Great Western Hospital in Swindon were suspended in 2009 after posting pictures of themselves playing a viral game called ‘the lying down game’, which involved being photographed lying face down in unusual places. The doctors and nurses from the A&E department photographed each other in a variety of places, which included resuscitation trolleys, ward floors and on the Wiltshire air ambulance helipad. These pictures were then posted on a social media site where they were seen by the hospital management (Press Association, 2009).

The NMC (2010), in their guidance on the responsible use of social media, stated that:

Nurses, midwives and nursing associates may put their registration at risk, and students may jeopardise their ability to join our register, if they act in any way that is unprofessional or unlawful on social media, including (but not limited to):

- sharing confidential information inappropriately;
- posting pictures of patients and people receiving care without their consent;
- posting inappropriate comments about patients;
- bullying, intimidating or exploiting people;
- building or pursuing relationships with patients or service users;
- stealing personal information or using someone else’s identity;
- encouraging violence or self-harm;
- inciting hatred or discrimination.

As human beings, we are not perfect, and our petty annoyances often need to be aired and shared. But you must be cautious when using the remoteness of a computer or social media site to share any grievances, even if they are shared as a private message. Inappropriate private behaviour is still inappropriate behaviour and will be treated as such if it breaches the NMC ruling.

Being in a trusted position as a nursing associate, you are free to access personal and private details of the patients and clients you work with. Any inappropriate disclosure of those details, or the use of those details for your personal use, is against the law. General Data Protection Regulation (GDPR) (2018 amended 2019) clearly states how personal information can be shared, and it is important that you follow the strict data protection principles.

You must make sure of the following:

- The information must be used fairly, lawfully and transparently.
- Sharing of information must be for a specified or explicit purpose.
- Personal data should be used in a way that is adequate, relevant and limited to only what is necessary.
- The information must be accurate and, where necessary, kept up to date.
- Any information shared should be kept for no longer than is necessary.
- Information should be handled in a way that ensures appropriate security, including protection against unlawful or unauthorised processing, access, loss, destruction or damage.

There is stronger legal protection for more sensitive information, such as information relevant to ethnicity, race, health, sex or sexual orientation and any political or religious beliefs.

In addition to GDPR, under Article 8 of the European Convention of Human Rights (1998), we have a right to privacy, and as healthcare professionals, you have an obligation not to abuse your power when it comes to accessing information. Activity 2.5 explores a nurse's or nursing associate's inappropriate use of a patient's personal information.

Activity 2.5 Critical thinking

A registered adult nurse was struck off the NMC register in August 2018, while working in a hospital in Lancashire. The nurse accessed a patient's personal details and used them to follow that patient on more than one social media forum. The nurse made contact with the patient to invite them to their house and then on holiday. The nurse had previously touched the patient inappropriately while in their care and at the NMC hearing, the registrant admitted that their actions were sexually motivated.

Think about how you would feel if you were the patient. What impact does the nurse's actions have on the hospital they worked in?

An outline answer is provided at the end of the chapter.

Protect yourself

As explored in Activity 2.5, it is important to maintain professional boundaries when using social media. It is also essential that you are aware of how you share your information on social media too, so you can protect yourself.

As nursing associates, some of your personal information is freely available to the public or whoever wants to find us. A quick, free search using my first name and surname on the NMC website will give the reader my middle name (it is Louise, by the way), my general location, when I joined the register and when I qualified as a teacher of nurses.

When you think about our accessibility, we can also consider our vulnerability too. If you look down your lists of friends on any particular social media platform, how many of them would you consider to be actual friends, who you could trust with your information and your pictures? Are you certain that of those friends, their friends are just as reliable?

It is easy for posted content to get out of your control very quickly, and before you may know it, you are the next viral sensation. It is important that you consider whom you associate with and what you may endorse by association. Even historical posts can be resurrected and used out of context to cast a shadow over your professionalism.

We just need to think of the case of Rebecca Leighton, who was a nurse falsely accused of poisoning some patients while employed at Stepping Hill Hospital in 2011. During the investigation, some of the UK newspapers found photographs of Miss Leighton on a social media site and used the pictures out of context in newspaper articles. The pictures chosen painted an image of her which was one of recklessness, aggression and someone who was flirty. One image in particular would appear to have been taken at a

fancy-dress party, where she was a cowboy. The toy gun was prominent in the picture, which leads the reader to associate her with a weapon, next to photographs of some of the victims. These images lead to her being dubbed ‘The Angel of Death’, and she was reported as being so scared for her life that she could not go out. Although innocent, she had a trial by media, assisted by her own pictures from a social media site. The actual killer was Victorino Chua, who was sentenced to life in prison in 2015.

In Activity 2.6, we look into simple steps you can take to protect yourself on social media platforms.

Activity 2.6 Critical thinking

Review the following social media posts and consider what risks you think the poster might be taking. What steps could they take to protect themselves better?

“I’m soooo excited! We have just signed the contract for our new house. Moving in next weekend. Fingers crossed! Have a look at our fab new pad.”

Link to the estate details of the house (what you see is the colour photograph of the house, with the full address and post code, plus the floor plan)

Figure 2.2 Sample social media post (a).

“Jim and I are looking forward to our short break in the Cotswolds this weekend. Kids are being packed off to Grandma’s and the dog is at my sister’s. They are all set to get pampered, so it’s our turn for some pampering. 4 nights in this place!”

Link to a nice hotel in the Cotswolds.

Figure 2.3 Sample social media post (b).

An outline answer is provided at the end of the chapter.

There are some common-sense approaches to using social media safely. Wherever possible, separate your personal and professional life by using different social media platforms for personal and professional use. If you identify yourself as a nursing associate, you must remain professional at all times, acting responsibly to uphold the reputation of the profession. Make sure your privacy settings are high and limit who can see what you post.

Do not accept friend requests or pursue relationships with either current or former patients, service users or their family members and friends. Never discuss work online; this includes conversations about or with patients and comments or complaints about colleagues, and do not post photographs. Remember, social media is not the place to air grievances or escalate a complaint, and everything you post online is public, even with the strictest privacy settings.

If you are not happy with a post appearing on the front page of a newspaper, don’t post it.

Chapter summary

Adhering to the 4Ps of promoting professionalism and trust, preserving safety, prioritising people and practising effectively, as described by the NMC (2018a), we can ensure that we deliver effective, patient-centred, professional communication, which is the key to our success as healthcare professionals and for the safety of those in our care. We have explored how we use and share information and discussed the different processes we use, which includes considering the need to keep information confidential.

Through the exploration of handover excellence, there have been suggestions and trials for voice-recorded handovers and written/typed handover sheets which were printed and handed out to the nursing staff. Neither of these other methods were robust enough to ensure confidentiality. With the introduction of GDPR (2018), producing such materials would be in breach of these regulations because of inadequate security measures. We will explore this topic further in Chapter 3.

Significantly, we looked at the use of social media and have recognised that it is important to realise that even the strictest privacy settings have limitations. This is because once something is online, it can be copied and redistributed. Protect your professionalism and your reputation. If you are unsure whether something you post online could compromise your professionalism or your reputation, you should think about what the information means for you in practice and how it affects your responsibility to keep to the NMC Code.

Activities: Brief outline answers

Activity 2.2 Case study (page 30)

S	<p>Situation</p> <p>Asking:</p> <p>What is going on with the patient?</p>	<p>An introduction (no need to do this if you are known to the listener):</p> <ul style="list-style-type: none"> • My name is (state your name) • I am a Nursing Associate on ward 5A <p>The reason for the communication</p> <p>I would like to hand over this patient to you.</p>
B	<p>Background</p> <p>Asking:</p> <p>How did the patient come to be here?</p>	<p>Brief history:</p> <ul style="list-style-type: none"> • Mrs Choudhary is a 57-year-old lady who likes to be called Swarda. • She was admitted one week ago from A&E, following a two-week history of severe abdominal pain. • She had a total abdominal hysterectomy, and bilateral salpingo oophorectomy one week ago.

(Continued)

Figure 2.1a (Continued)

A	<p>Assessment</p> <p>Asking: What is the problem?</p>	<p>Summary:</p> <ul style="list-style-type: none"> • ECG completed and no abnormalities detected • Urine output decreasing • Temperature increase • Pain controlled with patient-controlled analgesia • Bowels not open • IVI with fluid running. Dextrose and saline • Nasogastric tube (Spigotted) and nil by mouth • Wound oozing a lot • Robinson drain in place on the right-hand side • Her temperature has gone up and urine output down.
R	<p>Recommendations</p> <p>Asking: What is going to happen next for this patient?</p>	<p>Plan:</p> <ul style="list-style-type: none"> • Regular observations • Check for bowel sounds and possibly encourage drinking and eating • Continue with intravenous fluids • Review wound and swab for infection • Physiotherapist recommends sitting her out in a chair and encourages deep breathing • Ensure the anti-embolism stocking continues to be worn • Consider antibiotics.
<p>Encourage questions and get listener to repeat key information to ensure it is understood.</p>		

Figure 2.1a

Activity 2.3 Communication (page 31)

1.
 - 57-year-old lady;
 - one-day post operatively following total abdominal hysterectomy and bilateral salpingo oophorectomy;
 - patient-controlled analgesia in place;
 - Robinson wound drain in place on the right side of the wound;
 - wound oozing a large amount of ‘fluid’;
 - high temperature (pyrexia);
 - an Electrocardiogram showed no abnormalities detected;
 - urine output reduced, but has intravenous dextrose and saline fluids;
 - nasogastric tube in place;
 - bowels not opened;
 - anti-embolism stocking worn.

2.
 - 35-year-old man;
 - admitted six days ago following a road traffic collision;

- fractured tibia and fibula in both legs;
- on 50% oxygen, respiratory rate of 25 breaths per minute;
- patient to be turned two-hourly;
- past medical history of asthma and needs nebulisers four times a day.

Activity 2.4 Case study: social media (page 32)

The NMC recommends not to make friend connections with patients either currently in your care or as ex-patients. How are you going to turn down an offer of friendship without hurting his or his parents' feelings while trying to maintain a caring and therapeutic relationship?

The first thing is not to reject the request before you see him, as he may feel rejected and have two days to dwell on a rejection before seeing you again.

Do not just ignore the request and pretend it didn't happen; it would end up feeling awkward.

The best course of action would be to talk to him about the request. Thank him for it and tell him that you are pleased he feels comfortable in your company and he respects you as a friend. You will, however, have to politely decline his request. As a professional nursing associate, you are bound by a code of ethics, and this does not allow you to form personal/friendship relationships with those you are caring or have cared for.

Be sure to make him understand this is not a rejection and it is nothing personal about him; it is just what is expected of you as a professional.

Activity 2.5 Critical thinking (page 34)

Think about how you would feel if you were the patient

I think it would be fair to say that you would feel vulnerable, betrayed and most likely scared. Having someone who you initially thought of as a trusted individual essentially become your stalker must make you terrified by such an invasion of your privacy. If she had a family, no doubt this fear would extend to protecting them. After all, if this nurse was prepared to breach their duty of care and act illegally, what else could they do?

What impact does the nurse's actions have on the hospital they worked in?

Certainly, for the individual this particular nurse had under observation, it would be easy to see how her trust in medical professionals would be severely affected. If the particulars about the stalking were printed in the local paper, or on social media, this would have ramifications for the hospital and the staff working in it. The public in general would quite rightly have concerns about the information they share and in trusting healthcare personnel in the hospital.

As nursing associates, you have an obligation to uphold the integrity of the profession.

Activity 2.6 Critical thinking (page 35)

“Devastated! The police have just left. Our house was broken into while we were away in the Cotswolds. Thankfully the kids can stay at Grandma’s until we can get all this mess cleaned up. Police said it looked like they knew where to go, must have been stalking this place for weeks. So creepy when you think about it.”

Figure 2.3a

By posting details like your address, or even a photo of yourself by your street’s name, it gives people more information about yourself than you would rather share. So, be aware of your surroundings. Don’t share plans in advance, if you can help it. Think about the pictures you post and how they would look out of context.

Knowledge review

Now that you have worked through the chapter, how would you rate your knowledge of the following topics?

	Good	Adequate	Poor
1. the ways in which we share information			
2. the correct use of the telephone and			
3. verbal in-person handovers			
4. the importance of note keeping			
5. the dangers of social media			
6. confidentiality			

If you are unsure of some aspects, what are you going to do next?

Further reading and useful websites

For NMC guidance on the responsible use of social media sites:
www.nmc.org.uk/globalassets/sitedocuments/nmc-publications/social-media-guidance.pdf

For more information on human rights and equality:
www.equalityhumanrights.com/en/human-rights-act/article-8-respect-your-private-and-family-life

For recent updates on reported drug names or appearance, read the government safety updates:

www.gov.uk/drug-safety-update/recent-drug-name-confusion

For more information on the Access to Medical Records Act (1990):

www.legislation.gov.uk/ukpga/1990/23/contents

For further information on GDPR (2018):

www.gov.uk/data-protection