THE CLINICAL PLACEMENT
An Essential Guide for Nursing Students
4TH EDITION

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What we are missing! What opportunities of understanding we let pass by because at a single decisive moment we were, with all our knowledge, lacking in the simple virtue of a full human presence.

–Karl Jasper (cited in Sonneman 1959, p 375)

INTRODUCTION

In this chapter we add another important layer of knowledge, skills and insights to your repertoire of clinical attributes. We describe how you can make meaningful contributions to patient care through sensitive attention to the way you communicate, both with patients and with members of the healthcare team. The relationship between communication and patient safety is then highlighted and the attributes of therapeutic and interprofessional communication discussed. We also describe the ways in which nurses can define and promote their profession by effectively using their ‘nursing voice’. Later in the chapter, the use of information and communication technology and the pitfalls and possibilities of using social media are outlined.

THERAPEUTIC COMMUNICATION

Something to Think About
Words have a magical power. They can bring either the greatest happiness or deepest despair.

–Sigmund Freud—founder of psychoanalysis

Communication connects people and creates social bonds, which in turn facilitate survival. Babies learn to cry to elicit a response from their mother when they are hungry or uncomfortable. Over time they develop words to communicate specific needs. Across the lifespan, we communicate not only our basic physical needs and wants but also our most complex, intimate emotional needs.

No doubt you have chosen a career in nursing because you relate well to people and enjoy communicating. You may think you already have excellent ‘people skills’ and you may wonder why we have included a section on therapeutic communication in our book. Few nursing students understand the real meaning of therapeutic communication—how it differs from social communication and
the impact it has on their patients. Few realise that effective communication can actually be a form of therapy and a key factor in patient safety. Effective communication affects patient outcomes in many ways. Studies have demonstrated a relationship between therapeutic communication and, for example: chronic disease management (Rungby & Brock 2010); compliance with medication and rehabilitation programs (Rossiter et al. 2014); reduction in stress and anxiety; pain management; and self-management (Harms 2007). However, as with all forms of therapy, therapeutic communication requires knowledge, a defined skill set and practice (lots of practice!).

Therapeutic communication occurs when a nurse uses verbal and non-verbal communication techniques in a goal-directed way to ensure that the healthcare needs of patients remain the central focus. Therapeutic communication is built on trust, authenticity, empathy and self-awareness (Rossiter et al. 2014). Nurses who communicate therapeutically listen to understand, establish appropriate professional boundaries and maintain a non-judgemental stance, and are ‘fully present’ with the patient.

When therapeutic communication is used, the nurse responds not only to the content of the patient’s message but also to the feelings expressed through verbal and non-verbal communication. Therapeutic communication requires active listening, attending to the patient, hearing what is being said and what is not being said, and communicating back to the patient in a way that indicates that the nurse has heard and understood the message. This type of communication requires emotional intelligence (see Chapter 4), energy and concentration. It conveys an attitude of genuine caring and concern. The Nursing and Midwifery Board of Australia (NMBA) Registered nurse standards for practice (2016) specify that registered nurses must:

• establish, sustain and conclude relationships in a way that differentiates the boundaries between professional and personal relationships
• communicate effectively, and be respectful of each person’s dignity, culture, values, beliefs and rights.

Therapeutic communication requires you to develop a broad range of skills and techniques such as (Levett-Jones 2018):

• prompting
• instructing
• probing using open-ended and closed questions
• expressing empathy
• the use of silence
• non-verbal behaviours such as touch
• paraphrasing or restating
• seeking clarification
• providing information
encouraging and acknowledging
• confronting
• respect for personal space
• focusing
• reflecting
• summarising.

For nurses to provide effective care and ensure patient safety, it is imperative that the capacity for therapeutic communication is enhanced by suspending personal judgments and biases and authentically demonstrating respect and empathy for the person requiring care (Rossiter et al. 2014). We need to ask the question: How do we as nurses ‘be with’ patients in a way that enhances the therapeutic relationship and that invokes trust and confidence? Remember: If the patient you are caring for doesn’t feel safe with you or doesn’t trust you, they will not tell you everything; likewise, they may not follow through on your instructions for treatment (Rossiter et al. 2014). Refer to Box 5.1 for a list of attributes of a therapeutic relationship.

**Box 5.1. Attributes of a Therapeutic Relationship**

A therapeutic relationship:
• is a partnership between a patient and a nurse, focused on the patient’s healthcare needs or goals
• considers people to be autonomous individuals capable of decision making
• considers the person’s culture, values, beliefs and spiritual needs
• respects patient confidentiality
• focuses on the promotion of self-management and independence
• is based on trust, respect and acceptance.

Source: Levett-Jones 2018

**Something to Think About**

*The greatest problem with communication is the illusion that it has been accomplished.*

—George Bernard Shaw—Irish playwright

**COACHING TIPS**

Therapeutic communication does not just happen. As with all forms of therapy, it is a skill that takes time to learn and deliberate practice to master. However, the benefits for your patient are worth the investment. While a full explanation of therapeutic communication is beyond the remit of this book, you will undoubtedly have opportunities to learn more about this essential nursing skill at university, and you will have many opportunities to practise it when undertaking placements.
Every aspect of patient care depends upon how well health professionals communicate with the patients they care for, and with each other. A groundbreaking study undertaken over a decade ago identified that more than 70 per cent of adverse patient outcomes were caused by communication errors (Joint Commission 2004). It is estimated that this figure is even higher in the complex world of contemporary healthcare (Lapkin et al. 2015).

Interprofessional communication is focused on preventing adverse events and promoting patient wellbeing. Patient-safe communication is the way that competent health professionals work collaboratively to collect and share information and to clarify and verify accurate interpretations of patient information (Levett-Jones et al. 2014). Effective interprofessional communication (between health professionals from different disciplines) and intraprofessional communication (between health professionals from the same discipline) are increasingly recognised as core competencies for all health professionals. Unsafe communication is considered to be a breach of professional standards and a leading cause of litigation (Trede et al. 2012).

It is important to realise that the hierarchical nature of healthcare environments too often works against effective interprofessional and intraprofessional communication. Power differentials and traditional healthcare cultures can make it difficult for health professionals to be assertive and raise concerns when they are worried about patients (Levett-Jones et al. 2014). However, confident and well-educated health professionals can use clearly agreed communication processes that help improve communication and avoid the tendency to speak indirectly or disrespectfully.
COACHING TIPS

It is easy for nursing students to fail to take personal responsibility for interprofessional communication and collaborative practice. However, as Croker et al. (2014, p 51) remind us, ‘we talk about interprofessional collaboration [but]… it is important to remember that it is people as individuals who collaborate, rather than professions’.

Effective interprofessional communication requires a solid foundation of knowledge about, valuing of and respect for other team members (see Fig. 5.1). It is important for nursing students to capitalise on every opportunity to learn about what each member of the team contributes to patient care. From that basis it is possible to meaningfully engage with other staff members using open and direct communication, which facilitates mutual valuing, respect and trust. Effective interprofessional communication occurs when team members interact confidently, listen, give and receive advice, ask questions openly, freely acknowledge the limits of their own knowledge and, when needed, intervene to prevent errors being made by another member of the team (Wilson et al. 2016).

Figure 5.1. The interconnected nature of interprofessional communication and patient safety

COMMUNICATING AS A PROFESSIONAL NURSE

Something to Think About

Envision how things would be if the voice and visibility of nursing were commensurate with the size and importance of the nursing profession.

—Buresh & Gordon 2013, p 13

The public holds nurses in very high regard. Opinion polls indicate that nursing is one of the most highly rated professions in terms of honesty and ethics (Swift 2013). However, when people think of registered nurses, they are more inclined to dwell on their kindness and caring than on their knowledge, expertise or professionalism. The public’s image of the nursing profession is linked to nurses’ ability to articulate their experience, skills and expertise.

Let your eagerness, enthusiasm and commitment to nursing be reflected in your voice and body language. When nurses speak with passion and conviction—rather than in cautious and passive tones—they convince the public that nurses are important professionals who cannot easily be replaced.

—Buresh & Gordon 2013, p 120
**INTRODUCING YOURSELF TO OTHER HEALTH PROFESSIONALS**

Nurses have a choice about the way they present themselves to patients, families, doctors, other clinicians and the general public. They can present themselves in ways that assert their personal and professional identity, or they can remain part of the wider, undifferentiated healthcare service industry. They can highlight their clinical competence or they can conceal it. Each day in the workplace, what nurses say and do will either elicit the respect and collegial treatment their professional standing deserves, or undermine it.

While caring for patients and families or interacting with other members of the healthcare team, nurses convey messages about their own respect for the status of nursing. Some of these messages are explicit; others are more implicit, delivered through presentation, body language, tone of voice and conversational style. For example, if a nurse thinks it is advisable to consult a doctor, they can inform the patient by saying, ‘I’ll discuss this with the doctor’. By using these words, nurses imply that they have clinical knowledge and judgement and see themselves as doctors’ colleagues. Alternatively, nurses can communicate in a more subservient way by saying, ‘I’ll have to ask the doctor what to do’.

When contacting a doctor, a nurse can establish collegiality by beginning the conversation with the words, ‘Hello, Dr Smith, this is Sarah O’Shea, Mrs Johnson’s nurse. She is experiencing chest pain and I think …’ Alternatively, she can apologise for the interruption and cast herself in an inferior role by beginning with, ‘I’m so sorry to bother you, Dr Smith, but this is Sarah, Mrs Johnson’s nurse …’. The way that health professionals communicate with each other during these type of interactions has been shown to have a direct effect on patient safety.

Safe healthcare delivery depends on effective communication between health professionals. There will be times when you need to relay your concerns about a patient’s deteriorating clinical condition to senior staff. These are not times for vague requests and inadequate or incorrect information. You need to become confident and skilled in communicating with members of the healthcare team so you can signal your need for immediate action and support when required. The use of acronyms such as ISBAR has been reported to be effective in streamlining the way health professionals communicate during telephone calls and patient handover and in increasing patient safety. Acronyms provide a framework for communicating in a consistent way and are particularly useful for beginning nurses. Communication tools such as ISBAR (*Identify, Situation, Background, Assessment, Recommendations*) have been implemented to provide a clear structure and to improve health professionals’ confidence when communicating with other staff members (see Table 5.1). Nurses also need to know how to use graded assertiveness when they are concerned about patient safety. Two examples of acronyms that can be used for graded assertiveness are CUS (*I’m Concerned, I’m Uncomfortable, this is not Safe*) and PACE (*Probe, Alert, Challenge, Emergency*). See Box 5.2 for an example of PACE in action.
Challenge
Nurse: I’ve looked at the bloods and his WCC is elevated, his HB is low, his lipase is off the scale and I’m fairly confident that he’s very unwell, possibly septic. You really can’t send this boy home.
Doctor: Listen, I’m telling you he’s fine. Trust me. His WCC is probably up from the cold he had last week and he could just be anaemic, so I’m sending him home.

Emergency
Nurse: I am going to contact the consultant immediately and request referral to the surgical service. It is not safe to discharge this boy.

INTRODUCING YOURSELF TO PATIENTS AND FAMILIES

The way nurses introduce themselves to patients and their families can have a significant effect on how they are perceived. You can introduce yourself with a firm handshake, provide your full name, tell them you are a nursing student (and from which university) and explain your role in the patient’s care. Or you can simply say, ‘Hello, I’m John, and I’m caring for you today’ and leave it at that. Most patients meeting you for the first time have few visual cues about your identity and role. Your introduction is your best opportunity to let people know you are a nursing student with clinical skills and knowledge (Buresh & Gordon 2013).

FIRST-NAME BASIS?

In some clinical contexts it has become common for nurses to use only their first names when introducing themselves to patients, visitors or doctors, and some name badges bear only first names. Although the use of first names may vary depending on the context of practice and the policies of the institution, can you imagine doctors introducing themselves by their first names only? Why, then, is there an imbalance between these two professions? If nurses continue to uphold and reinforce these identification practices, it suggests that nurses regard doctors as superior in the healthcare environment. We know this is not the real intention of nurses who use only their first names. Mostly, they are doing it to develop a friendly and informal relationship with their patients. Unfortunately, this often misconstrues what patients really want and need from a nurse. They do not want you to be their friend; they want a nurse with knowledge and skills.

Your introduction is your best opportunity to let people know that you are a nurse—a serious professional with important clinical knowledge. Being serious and professional is
not synonymous with being distant and aloof. It simply means presenting yourself as a knowledgeable, expert caregiver. This presentation tends to reassure patients rather than alienate them.

–Buresh & Gordon 2013, p 87

For some nurses, it is not unusual to address patients, particularly if they are elderly, using endearments such as ‘sweetie’, ‘pet’, ‘darling’, ‘angel’ or ‘lovey’ (Gardner et al. 2001). However, this ‘elder speak’ is not person-centred language and many people will be offended by being addressed in this manner. A good rule is to simply ask each patient how they would like to be addressed.

DIVERSITY AND ITS IMPACT ON CLINICAL COMMUNICATION

This section is related to the topic of cultural competence discussed in Chapter 3. It is written especially for international students who will need to negotiate the complexities of clinical practice in an unfamiliar country. However, it will also be beneficial to all students because we all work with people from a range of cultural backgrounds. We hope this brief overview complements what you learn in class about the diversity of contemporary practice settings and helps you become accustomed to the many cultural factors that can influence your clinical experience. Without this knowledge, miscommunication is common and learning possibilities are sometimes reduced.

Student Story

‘I think language is the most important thing’

Felisa’s Story (Felisa is from China)

Being an international student I’m supposed to learn the language to be able to communicate with other people like in handover or when I give out medications … I need language. If I have a question, if I need to read … I need language. It is very, very important. I think language is the first of the first, the most important thing.

Source: Dickson 2013, p 96

The nursing workforce has become increasingly diverse over the past decade. Workforce shortages have led to recruitment of nurses from many countries, and in 2011 the number of nurses born overseas was 33 per cent (Australian Bureau of Statistics 2013). Additionally, the percentage of international students in Australian universities is the highest of any Organisation for Economic Co-operation and Development (OECD) country (OECD 2010); in some nursing programs more than 20 per cent of students are from overseas. No longer are nursing students a homogenous white female group; instead, contemporary nursing programs are composed of heterogeneous male and female students from a multitude of cultural backgrounds (Dickson 2013).
The increasing numbers of international students in academic programs have had a positive effect on our ability to appreciate and understand different cultures. The diversity and richness that international students and nurses bring to the academic and clinical environment enhances the learning opportunities of all students and staff. However, while most students may, at some stage, experience difficulties related to their clinical placement, these may be exacerbated by language and cultural differences. If this happens, it is important to reflect and try to analyse the cause of the problem so that appropriate support, guidance and teaching can be provided. Reflect on the stories below and examine the issues of concern. The coaching tips provide practical guidance and advice.

**Receptive Communication**

**Student Story**

‘I wouldn’t have a clue what they are talking about’

*Milky’s Story (Milky is from China)*

Australians are famous for their slang … I understand the medical terms in the lecture and in the university, but if you put me into a group where they speak like slang I wouldn’t have a clue what they are talking about.

Source: Dickson 2013, p 100

Do you sometimes find it hard to understand what your patients or nursing colleagues are saying to you? Local accents, shortened or fast speech and the use of colloquialisms can cause significant difficulties for nurses and students from non-English-speaking backgrounds. Misunderstandings between you and others may occur if you do not readily acknowledge when you have not understood or have only partially understood a conversation. More importantly, patient safety may be jeopardised if you are not perfectly clear about what is being asked of you. Initially, it may be culturally difficult for you to do this, but keep in mind that in Australia it is not considered disrespectful to question an individual in authority or to ask someone to repeat what they have said. Nor is it considered a ‘failure’ on your part if you have not understood something. On the contrary, clinicians will expect you to ask questions and to ask for clarification whenever you need to.

**Student Story**

‘Sometimes it is so hard to understand’

*Manoj’s Story (Manoj is from India)*

Most of the patients are from English-speaking countries, but there are some from other parts of the world such as Poland, The Netherlands, Greece … and their way of speaking is all together different. The Greeks speak English with a different accent and the Polish speak English with a different accent. Sometimes it is so hard to understand.

Source: Dickson 2013, p 110
**COACHING TIPS**

- If you want to confirm your understanding of an instruction or discussion, try paraphrasing—for example, ‘Can I confirm that you’d like me to take Mrs Amir to the shower on a commode because of her low blood pressure?’

- Ask someone to explain any colloquial terms you do not understand (fellow students are usually willing to do this).

- If you are unsure of healthcare terminology related to your patients, ask questions and be prepared to do some research.

- Remember: Nodding or silence following a conversation may be taken to indicate that you fully understood what was being said, even if the reverse is true.

**EXPRESSIVE COMMUNICATION**

**Student Story**

‘Sometimes you want to say something but it just doesn’t come out’

Yvonne’s Story (Yvonne is from Nepal)

Coming from a different background, sometimes I can’t even speak properly . . . at times I just get numb. Because English is not my first language, I have to think before I speak; it makes things difficult and awkward. Sometimes you want to say something but it just doesn’t come out.

Source: Dickson 2013, p 98

Do you sometimes find it difficult or frustrating trying to make yourself understood by patients or nursing colleagues? During your studies you will be expected to become increasingly fluent in the English language, familiar with colloquialisms and conversant with the professional language used to communicate with health professionals. However, you will still need the ability to switch to less formal language when needed—for example, when conversing with patients.

**COACHING TIPS**

- Observing nursing staff communicating effectively with one another and with patients will allow you to clarify expectations and to build on what you already know.

- Thoughtfully reflect on the nurse–patient interactions you observe. Consider what made the interactions effective (or ineffective). How and why was humour used? What colloquialisms and terms need clarification?

- Make the most of opportunities to practise communicating with patients and staff.

Continued on following page
group. Move forward in a group to engage people in the conversation so that you are speaking within a closer range.

Accents have a powerful effect on the listener’s ability to understand what is being said. If you speak with an accent, you may need to slow down your speech to allow the listener to ‘attune’ to the accent initially so that communication is effective.

The following are some examples of inappropriate use of voice:

• speaking so quietly that your patients cannot hear what you are saying
• speaking loudly to patients who do not speak English or have communication impairments (e.g. dysphasia), even though they are not deaf
• nurses calling down the corridor to each other
• nurses discussing social events when providing care to patients or behind curtains (as if they are soundproof)
• a group of nurses laughing loudly at the nurses’ station
• a nurse interrupting another nurse when they are administering medications.
• a nurse asking a patient about bowel movements when visitors are present or loudly enough that other patients can hear.

**COACHING TIPS**

• Assess your voice—is it clear, too loud or too soft for effective communication? Try recording yourself and then listening to how you sound. Also, ask family or friends to give you some feedback about how you sound.

• Walk up to people to communicate rather than speaking loudly.

• Consider the number of people who need to hear you and the type of information that is important to convey. Reflect upon the situation and modify your voice to suit.

• Be aware of how you sound during spoken communication practices. Is your voice squeaky, high-pitched, growling or guttural?

• Consider how fast or slowly you speak, and the associated pitch of your voice.

• If you are concerned about your voice and the effect it has on others, seek feedback and try to improve your speech by attending training sessions or public speaking groups.

**DOCUMENTATION AND LEGAL ISSUES**

Quality documentation, either in patient charts or in electronic medical records, is essential to patient safety; it is a way of recording the care given to
unreliable, causing it to be a high-risk area for patient safety (see Box 5.3). It is estimated that 20 per cent of healthcare errors are related to a breakdown in the transfer of information during handover (Iedema 2014).

Handover may be held in the staffroom or conference room, with nurses from the previous shift joined by nurses for the next shift. However, it has become increasing common for handover to be undertaken at the patient’s bedside. This approach promotes person-centred care and partnerships between patients and healthcare providers (Jeffs et al. 2014). By conducting handover at the bedside, the patient can correct errors, add important information and ask questions, thereby increasing patient satisfaction (Kerr et al. 2011).

As a nursing student, you need to make the most of opportunities to be present at patient handovers and to learn as much as possible about the correct processes. Whenever possible, capitalise on opportunities to provide patient handovers yourself, and ask your educator or mentor for feedback on your progress.

**Box 5.3. High-Risk Scenarios in Clinical Handover**

A systematic review by Wong et al. (2008) identified some of the high-risk patient handover processes that can result in discontinuity of care, adverse patient outcomes and legal claims of malpractice.

- **Interprofessional handover**: between operating theatre and post-anaesthesia care (recovery) staff and between ambulance and emergency department staff.

- **Interdepartmental handover**: between emergency department and intensive-care staff and emergency department and ward staff (especially where interdepartmental boundaries or responsibilities are unclear).

- **Shift-to-shift handover**: risks related to the lack of a clear structure, policy or procedures for handover; interruptions and information overload caused by overly long and detailed handovers.

- **Hospital-to-community and hospital-to-residential care handover**: risks related to poor hospital-to-community discharge processes and incomplete or inaccurate communication resulting in clinical errors and rehospitalisations.

- **Providing verbal handover only**: depending on the nurse’s memory, can cause a loss of information or inaccurate information transfer.

- **The use of non-standard abbreviations**: can cause misunderstandings between health professionals.

- **Patient’s characteristics**: complex patient problems receive poorer quality handover than more defined patient conditions.
**COACHING TIPS**

- Be on time for shift handovers and remain for the entire process.
- Take notes and ask questions about anything you are unsure of.
- Use a standard format to present your handover report.
- Be respectful of the people you are discussing. Avoid the use of judgmental language, and do not label or stereotype your patients or make negative comments about them.
- Use correct terminology, professional language and only easily understood and recognised abbreviations.
- Avoid repetition and irrelevant data.
- Discuss with your clinical educator or mentor any issues that need clarification immediately following the handover.
- Compare and contrast the different handover techniques you encounter during clinical placement.

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**TELEPHONES AND THE INTERNET**

Telephones and computers are essential for workplace communication, and there are guidelines and clinical policies that govern their use. Ward or unit telephones and computers are the property of the healthcare institution, and financial costs are associated with their use. Unless it is essential for you to make a personal phone call or to send an urgent email, remember that the telephones and computers are for business use only. Using a telephone for personal calls may prevent other healthcare staff from using it to give or receive information relevant to patient care. Similarly, spending time on the ward computer prevents others from using it for more important patient-care purposes.

When you start on each new ward, ask what the policies are regarding telephone and internet access. In some facilities students are not to answer telephones or to give out patient information, and in many situations internet access is restricted to permanent staff only.

**TELEPHONE GUIDELINES**

When you use the telephone you'll be expected to use appropriate telephone etiquette. This includes:

- answering the telephone promptly
- beginning the conversation with your name, designation and location
- discontinuing any conversation or activity before answering the telephone (e.g. eating or typing) and avoiding walking and talking while on the phone
- speaking clearly and distinctly, using a pleasant and professional tone of voice
• informing the caller when you are putting them on ‘hold’ and pressing the ‘hold’ button so they do not overhear other conversations that may be held close to the locality of the phone
• telling callers what your actions will be before you undertake them (e.g. ‘I am going to transfer you to another number’)
• always being courteous, friendly and ready to assist the caller
• passing on messages promptly—it is best to write the messages down rather than relying on your memory
• following facility requirements for telephone medication orders.

Box 5.4 provides some more guidelines for using the telephone.

### Box 5.4. Telephone Order Guidelines

- When phoning a doctor, be organised. Have the information about the patient ready so you can answer any questions.
- Make sure you are aware of the patient’s clinical condition, recent vital signs and other assessments before you make the call.
- Structure the phone call using the acronym ISBAR.
- When receiving phone orders, use clarifying questions to avoid misunderstandings.
- Clearly determine the name, room number and diagnosis of the patient who you are discussing.
- Repeat any prescribed orders back to the doctor.
- Follow agency policies; most require medication orders given by phone to be heard and signed by two nurses.
- Document the telephone order, including the date and time, the name of the nurse(s) and doctor and the complete order.
- Have the doctor co-sign the order within the timeframe required by the institution (usually 24 hours).

Source: Crisp & Taylor 2012

Using your mobile phone during clinical placements also needs to be carefully considered, and under no circumstances should you use your phone to take photos of or make comments about patients (further information is included about social media in the next section). Making and receiving calls or text messaging should be done only in your breaks. You will be expected to leave your mobile phone in your bag or locker and not carry it with you while you are undertaking patient care. Consider the following scenario.

### Student Story

‘They were only to help me remember’

**Nikos’ Story**

Nikos had been allocated to the special care nursery for his clinical placement. He was very excited and enthusiastic about this placement because it was an area he had
HOW YOU COMMUNICATE

Student Story (Continued)

selected for his graduate year. During the course of his placement, Nikos came across a baby who had a severe birth deformity. To help him to remember the condition, he took a series of photos using his mobile phone so he could add them to his professional portfolio.

At his debrief session, Nikos shared the photos with the other students and his clinical educator. Nikos had not sought written consent to take photos of the baby, and by using his mobile phone in this way he had unknowingly contravened both his educational and healthcare institutions’ policies as well as a number of laws related to privacy and confidentiality.

COACHING TIPS

- Develop a courteous and effective telephone etiquette. Speak clearly and not too fast.
- Be mindful of the type of information you can divulge, and to whom, over the telephone.
- Find out who you are speaking to at the beginning of the call.
- Know the protocols for taking patient-care orders, test results and medication orders over the phone, and adhere to these conventions strictly.
- Maintain confidentiality and privacy when answering telephones or using mobile devices during a placement.
- Send and check text messages only in your breaks.
- Leave your placement location details (ward phone number) with your significant other in case of an emergency.
- Keep your contact details up to date in your university student records—telephone and email are sometimes used by lecturers to contact you.

USE OF SOCIAL MEDIA

Social media is changing the nature and speed of healthcare interactions between patients, health professionals and healthcare organisations. Social media tools such as blogs, wikis, podcasts, instant messaging, video chat and social networks are re-engineering the way health professionals and patients interact. Given the rapid changes in the communication landscape brought about by social media, it is important for nursing students to have a solid understanding of these technologies and their effect on health communication.

The increasing use of social media as a means of communication presents many legal and ethical issues in nursing education and clinical practice. What might be considered harmless chat or gossip has, when posted using social media, often led to disciplinary processes, legal proceedings, exclusion from
university and termination of employment. Derogatory comments about fellow students, patients, staff or healthcare institutions when discussed in social media sites such as Facebook or Twitter are a breach of university and healthcare codes of conduct. The Australian Health Practitioner Regulation Agency (AHPRA) (2014) social media policy (available by searching the NMBA website at <www.nursingmidwiferyboard.gov.au>) helps health professionals to understand their obligations when using social media. You should also be aware that social networking websites are being used by some employers and recruiters to screen potential employees.

### Something to Think About

How often do nurses breach professional guidelines and privacy laws in using social media?

- 27 per cent of nurses admit to using social media to share stories about working life.
- 41 per cent of nurses say colleagues from their ward have used social media inappropriately.
- 32 per cent of these posts contained information about patients.
- 12 per cent of the posts contained photographs of patients.

Source: Ford 2011

### Coaching Tips

Laurie Bickhoff is the author of *Defining Nursing*, an excellent blog that addresses contemporary practice and professional issues (see <www.definingnursing.com/what-is-defining-nursing>). Laurie writes extensively about nurses’ use of social media and has provided the following coaching tips for using social media:

- Everything you post should be considered public. If you wouldn’t shout it at the supermarket, you shouldn’t post it online.
- Know that anything you post on social media reflects directly on the professionalism of all nurses. It is not just your reputation that is at risk but that of your colleagues, the ward and the healthcare organisation as well.
- Think before posting—would you be comfortable if your patient, lecturers, boss, family, AHPRA or the police saw what you had posted?
- A breach of social media etiquette constitutes immoral and unethical behaviour; it is a breach of patient privacy laws and a breach of professional standards.
- Maintain confidentiality at all times—ensure patients and other people cannot be identified in your posts without their consent.
- Avoid defamation (i.e. unfounded or misinformed reports about someone).

Continued on following page
It is important to remember that even though some health professionals misuse social media, there are also many positive benefits to its use. Professional blogs, Facebook pages and Twitter accounts provide a wealth of educational materials and are a highly effective way of networking. As long as you are aware of and guided by professional policies related to the use of social media, you will be able to benefit from the vast number of professional opportunities afforded by this exciting form of communication technology.

Source: Bickhoff 2013

COACHING TIPS (Continued)

- Maintain privacy—your own as well as that of your patients and colleagues. Use password protection and in-built privacy and safety features.
- Know the social media policy at your university and workplace.
- Consider how you would feel if the post was about you or someone you care about.
- Don’t post photographs of yourself engaging in activities that you know would be deemed inappropriate by the nursing profession or by your university.
- Don’t make comments on your website that bring your university or clinical placement venues into disrepute.
- Ensure any photos taken in a workplace and posted on social media sites meet legal and ethical standards (i.e. confidentiality, privacy, informed consent).

Student Story

‘I swear I’ll just walk out and not come back’

Tamara’s Story

Tamara, a third-year nursing student, was allocated a clinical placement on a medical ward of a private hospital. Tamara’s mother worked at the same private hospital but in a different unit. Tamara was disappointed to be allocated the medical ward because she had requested a paediatric placement. She expressed her dissatisfaction on Facebook, naming both the organisation and some of the staff who worked there. Many of Tamara’s comments were inappropriate and unprofessional. In one of the posts she stated:

‘F@*K! If they give me that smelly old guy with wrinkly genitals who won’t speak English to wash again … I swear I’ll just walk out and not come back!’

Tamara’s Facebook posts were seen by work colleagues of her mother and, ultimately, the director of nursing, who contacted the university. Tamara’s placement was cancelled and she was advised never to apply for a position at that healthcare facility.

Positive Aspects of Social Media

It is important to remember that even though some health professionals misuse social media, there are also many positive benefits to its use. Professional blogs, Facebook pages and Twitter accounts provide a wealth of educational materials and are a highly effective way of networking. As long as you are aware of and guided by professional policies related to the use of social media, you will be able to benefit from the vast number of professional opportunities afforded by this exciting form of communication technology.
SELF-DISCLOSURE

Self-disclosure is an act of revelation. While there might be rare occasions when self-disclosure may be considered appropriate in nursing, it should always be well thought-out and not done to satisfy your own needs (e.g. to gain sympathy or attention). Before you engage in self-disclosure, reflect on your own agenda and motivation. Is self-disclosure a genuine act to help others or a way to satisfy your own needs?

Some clinical placements provide the opportunity for you to attend group meetings. During these meetings clients often disclose personal information about themselves, and at times you may be tempted to share your own experiences about a similar problem. Be cautious! The invitation by the group leader to be a part of the group is in your capacity as a nursing student. It is not for you to discuss your personal circumstances, health conditions or life history. The intention is for you to learn from the group discussions and to focus on the therapeutic interactions that occur. In group meetings, attention should not be drawn away from the clients.

The same principles apply if you have the opportunity to be involved in a case conference. Objective, informed discussion that focuses on clients is the purpose of the meetings. Don’t be tempted to disclose personal information about yourself, even if it seems relevant. Be aware of where boundary violations may occur (NMBA 2010).

COACHING TIPS

- Before you join a group counselling session, seek guidelines from the group leader about your role in group meetings.
- Show respect and listen attentively to all members of the group.
- Arrive on time for the group session, and wait until the end to leave.
- Avoid talking to fellow students during a group therapy session. The focus is on the patients. Short conversations with a colleague are viewed as disrespectful and can often make patients or other group members angry.
- Do not disclose any personal information. This includes your medical, psychological or personal history.
- Save questions until after the meeting—it is not a question-and-answer session.
- Always thank the group members for allowing you to participate in their session.
- Ensure you maintain confidentiality after the session and do not discuss anything revealed by group members.
RECEIVING AND PROVIDING EFFECTIVE FEEDBACK

Effective feedback is an important component of student learning both during and following clinical placements (Cees 2012). Feedback that is effectively delivered and thoughtfully received has the potential to facilitate improvement and personal and professional growth (Rudland et al. 2013). Effective feedback processes provide information about past performance and strategies for future learning. The degree to which feedback facilitates change, learning and future performance depends on many factors, including the perception and acceptance of the feedback by the recipient, the way feedback is conveyed and the personal characteristics of those involved. Feedback should not be viewed as a bureaucratic process or a tool for control. It is not about being punitive but an opportunity to develop insights and self-awareness. Quality feedback enhances self-esteem and motivates learning. Reflect carefully and thoughtfully on the feedback you receive, and use it to improve your future performance (see the sections on reflective practice and on seeking feedback in Chapter 4).

Mechanisms for providing feedback may be formal, informal, formative or summative (Hung et al. 2012):

- **Formal feedback** mechanisms may include hard-copy or online appraisal documents that incorporate a rating scale, or forms that request open-ended comments.

- **Informal feedback** may be conversations that occur between you and your mentor or educator regularly about your placement experience and clinical performance.

- **Formative feedback** does not accrue marks or a grade but consists of activities designed to determine a student’s level of skill or knowledge and advice and strategies for improvement.

- **Summative feedback** generally accrues a mark or grade and provides a final result for a student’s academic or clinical performance.

Regardless of the feedback provided, it should be timely and specific. Another term that is gaining popularity is ‘feeding forward’; this approach places greater emphasis on providing direction and advice that can be used to improve future performance.

**FEEDBACK ON STUDENT PERFORMANCE**

You should expect to receive regular feedback from the nurses you work with and from your educator. This may be in the form of a formal evaluation of your clinical performance or as opportunistic feedback that provides you with immediate information about your performance of a specific task or situation.

Feedback needs to be given in an environment that is conducive to listening and comprehending (quiet and away from the distraction of other people).