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<RRH>E-professionalism and nurse education</RRH>

<BOOK-PART-META><LBL>**20**</LBL>

<TITLE>**E-professionalism and nurse education**</TITLE>

<SUBTITLE>**The Awareness to Action (A2A) educational framework**</SUBTITLE></BOOK-PART-META>

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<BODY><HEAD1><TITLE>**Introduction**</TITLE></HEAD1>

In the UK, all professionally registered nurses are required to operate within the scope of the Nursing and Midwifery Council (NMC) Code of Conduct (2018). Internationally, there are a range of different regulators of the nursing profession. For example, American Nurses Association, Nursing and Midwifery Board of Ireland, National Council of State Boards of Nursing, British Columbia College of Nursing Professionals and Australian Nursing and Midwifery Federation. Professional codes published by regulators outline the conduct that patients, the public and professional bodies expect of registered professionals and students and thus underpin the values of the nursing profession. Operating within the scope of the NMC (2018) requires awareness and understanding of how the professional and personal context may impact on the individual ability to uphold the values of the profession.

Registered nurses and pre-registration nurses are held accountable to their professional regulator. Therefore, their employer/university must act ethically and within legal frameworks (Caulfield, 2005). This means professionals need to be able to justify their actions, decisions and omissions whether in practice, outside of the workplace or in the online environment. Consequently, the concept of e-professionalism (also used interchangeably with e-accountability), defined as "the attitudes and behaviours reflecting traditional professional paradigms that are manifested through digital media" (Cain & Romanelli, 2009: p. 1) has posed emerging issues for nursing (Thompson et al., 2008; Cain et al., 2009.

This chapter discusses the concept of e-professionalism (or e-accountability) and the socialisation of student nurses into the nursing profession. The argument is made for active and reflective educational interventions and tools to raise awareness of and facilitate the behaviours

that reflect e-professionalism. Student nurses (and nurses) need to become unconsciously competent in the management of their digital footprint (i.e. the information and data trail that exist about individuals every time they engage with the internet in some way).

The chapter offers strategies for nurse education, including learning from a series of research projects: (1) 42-month realist ethnography; (2) development of an educational intervention for student nurses (and nurses) (Ryan, 2017); and (3) validation and evaluation of a decision-making tool to facilitate consistent decisions about online behaviours, collectively known as the Awareness to Action (A2A) framework.

<HEAD1><TITLE>**Background to e-professionalism and student nurses**</TITLE></HEAD1>

Several recent studies have emphasised the issue of unprofessional behaviours in the online social networks (OSNs) such as Facebook, with many students expressing confusion about what is acceptable (Ginory et al., 2012; Henry & Molnar, 2013; Mamocha et al., 2015. Twenty-one per cent of students are reported to have shared clinical images without obtaining permission (O'Sullivan et al., 2017), while 25% of profiles presented "unprofessional" content (Nason et al., 2016). Nursing students are generally thought to "use social media irresponsibly" and to "lack accountability" (Nyangeni et al., 2015). Thirty-eight NMC competency hearings have been linked to unprofessional behaviours on Facebook: boundary violation (communication with or "friending" patients); information sharing (details about the workplace); breach of confidentiality; and failure to uphold the reputation of the profession (Ryan, 2017a, 2017b). More recently, in several legal cases student nurses have been investigated for breaches of confidentiality and inappropriate photographs posted on OSN (Westrick, 2016).

Professional guidance warns nurses of the implications of OSN presence due to the wide range of individuals who may be able to view and "[mis-]interpret" profiles and posts (Ryan, 2016). Guidance documents present advice in a range of ways, and while there are clear "violations" (such as those above), a grey area still exists where unprofessional versus unacceptable behaviours occur, for example, photos of drinking alcohol during a social occasion (Ryan, 2016). Conversely, such behaviour does not reflect poorly on an individual, with patients and members of the public stating that "nurses are entitled to a life outside of work" (Ryan et al., in press). Members of the public stress the need for student nurses and

nurses to be more "aware" of what they share publicly for their own safety but also in the interests of patient confidentiality.

In terms of healthcare student awareness and understanding of online professionalism, most students expressed that professional–personal–social domains should be separate. However, comments such as "we should be held accountable, but I have a right to a personal life" suggest the presence of conflicting values (White et al., 2013; Maloney et al., 2014; Usher et al., 2014). While (online) self-efficacy is shown to improve as they approach the end of their training (Ness, 2013; Alber et al., 2016), it has already been argued that "self-efficacy" does not necessarily equate to "actual behaviours" (Ryan, 2017). There are clearly issues of boundary management, with confidence not necessarily meaning competence. The lack of definition of "physical boundaries" in OSNs (e.g. leaving the workplace or university) exacerbates these concerns. Discrepancies between what "should" be shared, "could" be shared, and what should be challenged and/reported in student nurse, clinical and academic nurse groups further complicate matters (Ryan, 2017). Conversely, such evidence suggests the need for educational interventions to promote "unconscious competence" in the way the profession operates online. Students agree that they should be held accountable for online behaviours (Cain et al., 2009; Finn et al., 2010; Hall et al., 2013) (Kumar, 2014). However, large numbers of students and organisations report observing unprofessional behaviours; some even report doing this themselves (Langenfeld et al., 2014; Levati, 2014; Wang et al., 2019).

The conflict between self-awareness/efficacy and actual behaviour is reflected in perceived awareness of professionalism, self-awareness and behaviours, which did not always correspond (Ryan, 2017b; Alber et al. 2016; Wissinger & Stiegler, 2019). This disconnect is likely to impact on the way in which boundaries exist and information is shared in OSNs (Ollier-Malaterre et al., 2013). Furthermore, it is known that many student nurses use OSN more frequently than academics and are considered "digital natives" (i.e. having been born post-1995 and having been "socialised" into a world that is "online") (Prensky, 2001; Frazier et al., 2014; Duke et al., 2017). Thus, a lack of knowledge, confidence and competence of those in educational roles, many of whom are digital immigrants (i.e. they were socialised into the online environment in later life, born "post-1995"; Prensky, 2001), along with lack of consensus, compound this problem (Lahti & Salminen, 2017; Ryan, 2016, 2017).

More recently, the concept of "patient-targeted Googling" (PTG) and "healthcare-professional targeted Googling" (HCPTG) has become a topic for debate. PTG is defined as "clinicians' practice of searching the internet for information about their patients" (Gershengoren, 2019: p. 134). Research literature suggests that, in psychiatry, counselling and medicine, up to 53% of students and professionals engage in PTG (Ben-Yakov et al., 2015; Eichenberg et al., 2016; Omaggio et al., 2018; Thabrew et al., 2018).

There are clear ethical dilemmas associated with such activity. Many students and professionals engage in PTG, while others consider it unethical (Thabrew et al., 2018; Weijs et al., 2019). Professionals have also been reported to conduct PTG without informing patients or asking for consent (Harris & Kurpius, 2014; Kuhnel, 2018; Gershengoren, 2019). Arguably, the information obtained via PTG is publicly available, but the question remains whether, without clear rationale of the benefit to the patient, or patient consent, this is an invasion of privacy. If there is an ongoing therapeutic relationship, in this case with adolescent patients, there may be justification for obtaining information via PTG (Jent et al., 2011). However, this behaviour risks damaging patient–professional trust (Harris & Kurpius, 2014).

Other concerns include the use of potential "misinformation" in decisions about patient care (Jent et al., 2011), the currency, lack of clarity, context and confirmability of information found on the internet and how people might misrepresent themselves on social media sites (Jent et al., 2011; Ryan, 2017a). Currently, there is significant debate about the nature of PTG and, in the absence of education, training and guidance, many professionals are conflicted about how this should be managed, when and if it should be employed (i.e. before, during or after monitoring patient care) (Chester et al., 2017; Omaggio et al., 2018).

Less documented in literature, doctor-targeted Googling or HCPTG) refers to the practice of patients or members of the public searching for information about their healthcare professional(s) on the internet (Chester et al., 2017; Omaggio et al., 2018; Thabrew et al., 2018). "Information" in the literature most commonly refers to that shared publicly on social media profiles such as Facebook or LinkedIn. However, it could also be information contained in online reviews of organisations or organisation staff profile pages.

HCPTG is less commonly referenced (Chester et al., 2017); however, Bosslet et al. (2011) identified 43% of US physicians and student physicians have received friend requests on social media from patients and Wang et al. (2019) suggest that in nursing this figure is closer to 50%. Ryan (2017) identified several student nurses who had been searched for and/or

contacted by patients or relatives on Facebook, which suggests a need for effective nurse education interventions relating to privacy settings, information sharing, appropriate use of OSN platforms for personal and professional purposes and actions they should take in such circumstances.

Registered nurses are accountable to their employer; student nurses are further accountable to their training provider. This type of accountability refers to the need to abide by university and placement policy, procedure and corporate values. Many universities and organisations now have policy and/or guidance relating to the internet and the use of social media (NMC, 2016; Ryan, 2016; Open University, 2019). However, there is evidence to suggest that just having these in place and telling students that they exist is simply not enough to embed e-professionalism in a curriculum (Duke et al., 2017; Mariano et al., 2018). The need for reflective and active interventions that facilitate awareness, acknowledgement of "risk" and navigate the complex nature of OSN is identified widely in research literature (Ramage & Moorley, 2019; Wissinger & Stiegler, 2019). DeGagne et al. (2019) further discuss the need for "cyber-civility", promoting socially acceptable values that might or might not be unprofessional; for example, sexually suggestive material posted publicly. Hence, there is a wider need for promoting "ethical" behaviour that reflects social and professional values and culture.

Pre-registration student nurses are undertaking an educational programme aimed at facilitating their professional socialisation into nursing. As part of this, they are required to develop their professional accountability in order to demonstrate and uphold the values of the profession. However, the values of the professional are (in part) subjectively applied and may conflict with the values of the person. It is argued that prior to Facebook these were more easily managed as there were clear "physical presence" boundaries and changes in behaviours to comply with the "norms" or "values" of life modes. It is also known that, despite the existence of professional codes of conduct, nurses and pre-registration nurses are being held to account for unprofessional behaviours in the OSNs. Correspondingly, they are also held to account for actions and omissions in the physical environment. Is this due to the subjective nature of acceptability, "accountability" or "professional values"? Or is there more clarity needed based on the "values" of the profession? Is it OSN/online social media (OSM) that is the "problem" or are there deeper mechanisms influencing professional behaviours?

In educating nursing students, it is not only of interest to the professional body and education institutions but also to those in the profession to be able to understand and explain the impact and nature of the relationship that OSN/OSM has had.

To summarise, despite professional guidance and organisational policy being in place for several years, there is evidence to suggest that: (1) students need further guidance and input from educators; and (2) the nursing profession has not reached explicit consensus about what accounts for "unprofessional" behaviour.

<HEAD1><TITLE>**E-professionalism and professional accountability**</TITLE></HEAD1>

Internationally, guidance documents for the professional use of OSNs do exist; for example, those produced by NMC (2016), Nursing and Midwifery Board of Ireland (2013) and Nursing and Midwifery Board Australia (2014). However, the type of advice, structure and level of detail varies, with much of the content reflecting what professional codes of conduct already state (Ryan, 2016). Where nurses and nursing students are aware of the guidance available there are some behaviours and actions that achieve consensus as being unprofessional, such as a breach of confidentiality. However, there are other behaviours where this is less clear, for example, photos of drinking alcohol and being intoxicated (Ford, 2011; Levati, 2014; Barnable et al., 2018).

There is also evidence to suggest that self-assessed online behaviour does not reflect in "actual" online behaviours. For example, awareness of privacy settings does not mean that they are used effectively (Ross et al., 2013; Alber et al., 2016; Ryan, 2017). This suggests that there are still grey areas of understanding relating to what constitutes e-professionalism in nursing. As part of their educational journey, pre-registration student nurses should be learning or "socialising" themselves into the professional values associated with being "registered".

<HEAD1><TITLE>**Professional socialisation and the learning journey**</TITLE></HEAD1>

Socialisation is "the process by which the objective world of reality is internalised and becomes subjectively meaningful" (Jarvis, 1983: p. 88). Individuals learn, interact, develop and adapt to accepted "social norms and values" as they grow into and throughout adulthood. Socialisation is a fluid, unique and individual process depending on the environment and people someone is exposed to and how the person responds to these. Social trust is enhanced by operating within

accepted social norms, acceptable behaviours and values. In the virtual network, these may be more complex, but widely different from those typically found in the physical environments, due to the enhancement across three levels of social capital and because boundaries between personal, public and professional spheres are less defined in OSNs than is the case in the physical world.

Professional socialisation is the process by which individuals acquire knowledge, skills and values relating to their profession (Mackintosh, 2006). For nursing students, this includes understanding the concept and demonstration of professional accountability and how personal and professional identity in which behaviours and values reflect those of the profession is developed. The outcome of professional socialisation is that:

<DISP-QUOTE>newcomers … make sense of their surroundings and … acquire the kinds of knowledge which would enable them to produce conduct which allowed … that group [professional body, qualified practitioners] to recognise them as competent.

<ATTRIB>(Howkins & Ewens, 1999: p. 1)</ATTRIB></DISP-QUOTE>

Professional socialisation begins upon entry to pre-registration nurse education and the journey is influenced by prior life experiences, individual motivations and external factors and continues throughout the professional career (Weidman et al., 2001; Lai & Lim, 2012). Educational establishments are therefore required to facilitate the development of knowledge and skills for reflection, on-going professional development and accountability, to enable the desired outcomes of professional socialisation: development of professional identity, ability to practise within a professional role and demonstration of professional and organisational commitment (Dinmohammadi et al., 2013). Nurse educators are responsible for providing learning activities which improve the knowledge, skills and attitudes explicitly related to professional accountability and the core values of the nursing profession, providing an understanding that actions and professional standards are inextricably linked (Fahrenwald et al., 2005; Krautscheid, 2014).

<HEAD1><TITLE>**Online social networks**</TITLE></HEAD1>

OSN refers to people connecting online through a range of platforms, enabling users to share personal or professional information on a profile, their online presence and the "platform" for this. OSM places emphasis on social relationships but is better used to describe the "media" by which those relationships exist, such as videos, photos and blogs. Hence, OSNs represent the platform for the online presence and the relationships associated with them, while OSM is a facilitator and method of communication that links the online presence. Globally, the most used

OSNs are Facebook, YouTube, WhatsApp, Facebook Messenger, WeChat and Instagram (Statista, 2019).

Ryan (2017a) introduces the concept of "online socialisation" and argues that socialisation, professional socialisation and becoming socialised "online" are interdependent with the relationship between them being individual, complex and evolving (ICE):

- individual: becoming socialised is influenced by values, experiences and culture
- complex: as a result of OSNs and the interaction between the online and offline world
- evolving: continuously exposed to learning and experiencing the online and offline world, they are also *becoming* socialised as a professional.

Rejon and Watts (2014) and Rejon (2014) have previously suggested that OSNs may have a role to play in professional socialisation and more recent research indicates that students are using OSNs such as Facebook and WhatsApp messaging groups to stay in contact with each other about their academic programme and practice placements (Ryan, 2017). This suggests that OSNs do have an impact on the professionally accepted values, behaviours and skills, particularly for pre-registration nursing students on their journey of professional socialisation.

<HEAD1><TITLE>**The role of nurse education**</TITLE></HEAD1>

Pre-registration student nurses are in the early stages of their professional career, still developing their own understanding and practice around professional accountability, and on their own journey of professional socialisation. Understanding the values and accepted norms of the nursing profession is not always easy and yet is "required" for an individual to be accountable. Conversely, *being* accountable is an inherent component.

As individuals registered on professionally recognised programmes of education, students are accountable, and are thus required to uphold the values of the profession outlined by the regulator, enshrined within the four pillars of accountability (Caulfield, 2005). Professional guidance and codes of conduct often provide examples of professional and unprofessional behaviours and attributes for professional accountability, including the values of the profession through academic conduct and personal behaviour. Codes of conduct emphasise the importance of personal behaviour and conduct outside of the workplace (including OSNs) and in maintaining a positive reputation of the nursing profession, which confirms registered professionals are accountable for opinions, behaviours and actions in OSN/OSM.

While individuals may believe their privacy settings limit what is shared widely, in reality it is difficult to know how far a post will reach, and who it may be visible to. Furthermore, the complex nature of OSNs does not guarantee information will not be shared with patients or the public. Personal opinions and data shared to OSN timelines may potentially be shared much more widely than if discussed verbally in the "family/personal" domain.

If nurses can be held accountable for their actions then, in theory, their behaviours should reflect those values of the profession. Conversely, these values may conflict with their personal values, personal values which, prior to OSN/OSM, would only have been shared within the family/personal domain. This poses a dilemma: the right to a personal "life" versus the requirements of the profession. It also raises further questions: what is acceptable? and what is unprofessional?, when? and in what circumstances? And, what are the online social norms accepted by the nursing profession?

<HEAD1><TITLE>**Introducing the Awareness to Action framework**</TITLE></HEAD1>

As discussed, there are some clear boundaries about what is professional and unprofessional, such as breaches in confidentiality. Professional guidance often makes further reference to political, religious and moral opinions not being shared inappropriately. However, such a stipulation is subjective: what one person (based on his or her own experiences, thoughts and values) believes to be acceptable may not be acceptable to another. Conversely, OSNs such as Facebook are often viewed as a personal domain where individuals feel they should be able to have their own opinions and beliefs; they are more than a nurse. Arguably this means that the boundary between unprofessional and unacceptable is opaque, leading to confusion and inconsistency when making decisions about what, how, when and in what context an individual can be held to account. This section discusses the A2A framework; the two tools in the A2A framework can be used as the basis for reflective discussion and "'active" learning on the topic of e-professionalism.

<HEAD1><TITLE>**Being reactive: Awareness to Action decision-making tool**</TITLE></HEAD1>

One component of the A2A framework is the A2A 3Cs decision-making tool. As part of current research evidence and the programme of research previously discussed, it is known that there are four pillars of accountability (Caulfield, 2005) and that there are three components or "Cs" to be considered as part of online actions, incidents or events (Ryan & Cornock, 2018): clarity, context and confirmability. The A2A tool (Ryan, 2017; Ryan et al., in press) enables nurses

and nursing students to assess particular behaviours and incidents on OSNs under each of the 3Cs and asks them to consider whether there is evidence of a breach under one or more of the four pillars of accountability: professional, legal, employer and/or ethical (Caulfield, 2005). In the ethical component, this is assessed by the principles of Beauchamp & Childress (2004): justice, autonomy, beneficence and non-maleficence. By evidence, this means that there has to be an explicit guideline or policy that can be applied; the scenarios later in this chapter provide examples of this. A recent project to validate this tool showed excellent reliability, consistency and internal validity (Ryan & Cornock, 2018a, in press). Each of the 3Cs needs to be met for a person to be "held to account" and indicates what, if any, consequence should be pursued; they should be considered in sequence, with the latter dependent on the former (i.e. if the first (clarity) does not evidence a breach, then the final two do not need to be assessed).

Clarity asks the assessor, "Does the behaviour explicitly breach policy and/or guidelines?"

1. <NL>*Professional:* is there any evidence of a professional breach? For example, a breach of patient confidentiality or professional code?

2. *Legal:* is there explicit evidence of criminal activity or civil violations, such as fraud, theft or breach of government legislature?

3. *Employer:* is there evidence that the behaviour is a breach of contractual obligation or employer policy and procedure? For example, being on a leave of sickness absence and showing photos of being on holiday or bullying against staff members?

4. *Ethical*: consider the behaviour in the context of justice, autonomy, beneficence and non-maleficence.</NL>

Context asks the assessor: "Can you explain/describe the context of the situation, when and where it occurred?"

1. <NL>*Professional:* was the offender in a professional capacity at the time and place? What would be expected of another professional of this standing in this circumstance?

2. *Legal:* is the action legal in time and place? Is this explicit and not implied?

3. *Employer:* can the action or behaviour be associated directly with the workplace? For example, does the person name his or her employer or place of work?

4. *Ethical:* are the consequences acceptable given the context of the situation? What was the intent? Who was it accessible to and what would the consequences be? Were there exceptional circumstances?</NL>

Confirmability asks the assessor: "Can you be sure that it was the professional who committed this activity while that person was in a professional capacity? Can you confirm the consequences and the outcome?"

1. <NL>*Professional:* is the person clearly identifiable as a professional from the online information? Can you confirm that the person shared the content him- or herself or whether it was someone else?

2. *Legal*: was the action legal at the time it occurred? Has the illegal activity already been punished?

3. *Employer:* can you be sure that the individual was working for that employer at the time? Could the information be dated but just shared recently?

4. *Ethical*: can you confirm when, how and what the impact of the consequences were? Did harm come to anyone? If so, what level of harm and what was the intent?</NL>

<HEAD1><TITLE>**A2A 3Cs: example scenario A**</TITLE></HEAD1>

A scenario where a nurse shared images of a patient's leg with a chronic leg ulcer in a closed professional group was met with debate; there are clearly identifiable ethical, legal, professional and employer issues and the post was eventually removed by group moderators. However, the scenario failed to evidence a clear professional breach at the first stage, when considering clarity; as such it would perhaps recommend "no intervention or a reflective activity" for the individual in question. Interestingly, the public participants in Ryan et al. (2019) felt that, as long as the nurse was acting within the "best interests" of the patient, consent was obtained from the patient and this was documented (as was care), the patient remained

anonymous and all other options for treatment had been explored, this was innovative, efficient and acceptable use of OSN/OSM. This does suggest that there is a lack of *consensus* within and outside of the profession about what actions nurses should be held to account for.

<HEAD2><TITLE>***Consider clarity***</TITLE></HEAD2>

<HEAD3><TITLE>*Professional: outcome – no breach*</TITLE></HEAD3>

There was no evidence that the nurse breached confidentiality. She had documented consent from the patient. The picture did not show the patient's face or identifiable information.

All discussions and activity related to such decisions need to be documented as per professional guidance, including guidance on the use of social media/internet where this is available.

<HEAD3><TITLE>*Legal: outcome – no breach*</TITLE></HEAD3>

There was no evidence of criminal or civil law being broken as consent was obtained and documented according to General Data Protection Regulations (GDPR) (Information Commissioners Office, ICO, 2018) and Data Protection Act (UK Government, 2018).

All discussions and activity related to such decisions need to be documented as per legal frameworks in the practising country and within the parameters of the usage policy of the OSN platform being used.

<HEAD3><TITLE>*Employer: outcome – no breach*</TITLE></HEAD3>

This was a closed professional group. The nurse identified with the profession, but the employer was not identifiable from the image shown so there is no way of identifying if it breached any organisational policy on use of the internet.

However, employer policy should be consulted before pursuing such activity to ensure that it is not in breach. If there was a policy in place that was explicit about this then it would suggest that stage 2, context, would need to be considered.

- <BL>*Ethical:* outcome – no breach. However, there are some points for reflection, noted above.
- *Justice* – the use of a professional OSN group may be efficient and successful in reaching a wide range of other nurses and their associated experience.

- *Autonomy* – assuming the situation was explained to the patient and patient consent was documented then there is no evidence of a breach in this scenario.
- *Beneficence* – all treatment options had been exhausted; the nurse had consulted with colleagues on a face-to-face basis with no success or improvement. The patient wanted to 'get better'.
- *Non-maleficence* – the nurse needs to consider the potential "harm". Can the nurse confirm the information or suggestions received are from reliable sources? If not, then these need to be discussed with senior staff or peers before implementation.</BL>

There is also the component of "unintended consequence". For example, could someone copy, edit and share the image more widely?

Here there is a potential "risk" but considering the other "pillars of accountability" and that there is no evidence that harm came to the patient, then this is limited.

<HEAD1><TITLE>**A2A 3Cs: example scenario B**</TITLE></HEAD1>

Example scenario B considers the concept of PTG. A woman in her 20s with low mood presents to a mental health nurse who has been a qualified practitioner for 10 years and explains that she had separated from her boyfriend 3 months ago and requested some medication to help with her anxiety. She explains that she had previously taken diazepam. During the discussion the patient talks about her living situation and financial circumstances; she explains that she does not drink alcohol or take any illegal substances. Once the patient leaves, the nurse, out of curiosity and because she feels suspicious of the information provided, searches for the patient using an internet search engine. She finds the patient's Facebook page and it states that she is still in a relationship; there are recent photos and there are also pictures from the previous weekend that show her drinking (what looks like) a glass of wine. At their next meeting, the nurse questions the patient about what she found, and the patient becomes very upset, storms out and makes a complaint. The nurse's defence was that the information was public, and she wanted to find out whether the patient was lying.

<HEAD2><TITLE>***Consider clarity – possible breach***</TITLE></HEAD2>

<HEAD3><TITLE>*Professional*</TITLE></HEAD3>

The nurse did not necessarily breach any confidentiality of the patient. However, professionally

it is not considered "good practice" to use a patient's personal information or access a patient's personal details unless there is a clinical, safety-related or justifiable need to do so.

From the perspective of professional guidance and the need to employ an evidence-based approach to decisions. However, research evidence to dateis generally considers it unjustifiable to search for a patient out of "curiosity" or because a patient might be lying (Clinton et al., 2010; Harris & Kurpius, 2014; Eichenberg et al., 2016; Kuhnel, 2018; Omaggio et al., 2018). This literature on the topic of PTG also recommends that, wherever possible, patient consent is obtained and documented for such activity.

Conversely, many professional guidance documents state that nurses should maintain a therapeutic relationship; the actions of the nurse damaged this.

The nurse did not document this as part of the patient's care and is not able to strongly justify how this was for the benefit of the patient.

<HEAD3><TITLE>*Legal*</TITLE></HEAD3>

There is some legal debate surrounding PTG. However, in using the internet to search for information that is publicly available it is not likely that any criminal or civil laws have been broken.

However, it might be that a disciplinary review panel and professional body review considers that the use of personal information obtained through a professional capacity and would not have been available otherwise (such as a patient's name) is a possible breach of the Data Protection Act (UK Government, 2018) or similar.

<HEAD3><TITLE>*Employer*</TITLE></HEAD3>

This would depend on whether there was any employer policy in place on the topic of internet use and/or PTG. Employers typically have a policy that reflects the requirements for confidentiality, GDPR (ICO, 2018) and data protection (UK Government, 2018).

<HEAD3><TITLE>*Ethical*</TITLE></HEAD3>

Justice – it is difficult to determine a clinical or patient need other than the nurse's curiosity. Her intent was not necessarily in the "best interests" of the patient.

Autonomy – the patient was not consulted and did not provide consent. Her reaction and complaint imply that she was not pleased with the actions of the nurse.

Beneficence – it is difficult for the nurse to justify how this has been of benefit to the patient or her care. She explains that she was curious and felt that the patient was lying but the internet should not have been the first route of action here.

Non-maleficence – the patient did become upset and submitted a complaint. Also, she had visited the clinic for "low mood" and this might have a negative impact on this. The nurse might not have intended to cause harm, but this could be considered an unintended consequence of her actions.

<HEAD2><TITLE>***Consider context – possible breach***</TITLE></HEAD2>

<HEAD3><TITLE>*Professional*</TITLE></HEAD3>

The nurse was acting in a professional capacity but only through "curiosity" and "because the patient might be lying".

<HEAD3><TITLE>*Legal*</TITLE></HEAD3>

This is less easy to define. However, as the nurse conducted this on the employer's premises it might be possible to identify when and what search was conducted. This would also help to identify how the patient's personal information was used. It would be useful to consider what another nurse of the same level of training would do in the same circumstances.

<HEAD3><TITLE>*Employer*</TITLE></HEAD3>

This is directly related to the nurse's employment as she conducted the activity on the premises and in her capacity as an employee.

<HEAD3><TITLE>*Ethical*</TITLE></HEAD3>

The patient is upset and has made a complaint so, ethically, the nurse has potentially caused harm with little justification. The actions in the circumstances are not supported by research evidence in this context. There was no evident risk of harm to the patient, for example.

However, we do need to consider that the information the patient shared online (however naively) was publicly accessible information. Conversely, there needs to be some consideration that the information she presented online might not be "accurate" or timely. Regardless of this, it did not serve any benefit towards her care.

<HEAD2><TITLE>***Consider confirmability – possible breach***

Therefore, this scenario could lead to disciplinary, performance management and/or referral to the professional body.</TITLE></HEAD2>

<HEAD3><TITLE>*Professional*</TITLE></HEAD3>

The nurse conducted this search during her working hours. She also admitted her actions to the patient and the employer in her attempt to justify these.

<HEAD3><TITLE>*Legal*</TITLE></HEAD3>

There are emerging guidelines and frameworks on the topic of PTG but these are not (in the UK) part of a legal framework. It would be reasonable to consider case law at the time of the event to establish what the precedent is.

<HEAD3><TITLE>*Employer*</TITLE></HEAD3>

This could be established through the nurse's admittance and through the IT department/internet history. The employer will likely investigate this as part of the complaints process.

<HEAD3><TITLE>*Ethical*</TITLE></HEAD3>

This would need to be assessed through discussion with the patient and a possible clinical discussion. There would be an investigation associated with the patient's complaint.

<HEAD1><TITLE>**Being proactive: Awareness to Action educational tool**</TITLE></HEAD1>

From current literature, discussed earlier in this chapter, it is known that there is a need for more active and reflective educational interventions for nurse education on e-professionalism. Conversely, Olliere-Malaterre et al. (2013) describe the need to promote a "hybrid approach" to managing boundaries in the online domain. Ryan (2017) identified a model by which this reflects a student nurse's ability to become "unconsciously competent" (Kruger & Dunning, 1999) through the use of "hybrid boundary management. *Hybrid boundary management* involves the competent application of custom privacy settings so that certain types of OSM are only shared with close friends or family, using appropriate OSN platforms for their intended purpose (e.g. LinkedIn for professional purposes and Facebook for personal use), regular assessment of privacy settings and publicly accessible information and challenging behaviour where needed.

It is recognised that becoming "unconsciously-competent" is a learning process and certain events might challenge an individual's ability to comply with this, for example, when exposed to emotive images or subjects that trigger strong opinions or emotions. However, lifelong learning theory (Jarvis, 2006 and evidence discussed in this chapter suggest that

repeated exposure to concepts facilitates reflection and experiential (lifelong) learning. Conversely, it is also known that sites such as Facebook change their privacy and security settings intermittently, and this tool supports individuals to consider how these changes may have affected what they share and who they share it with.

Hence, based on a review of the available evidence earlier in this chapter and that discussed in Ryan (2017), the "proactive" component of the A2A framework consists of the following parts and may be used by an individual or as small-group activity (Figure 20.1 outlines the suggested process and role of each part) to promote personal reflection and repeated exposure to the principles of *hybrid boundary management*:

part 1: a checklist and traffic light scoring system on an individual's "awareness" and perceived self-efficacy about what he or she shares on his or her OSN profile with a checklist of questions

part 2: a checklist and reflective process that requires review of a public and personal OSN profile to identify "actual" behaviours

part 3: a risk assessment score that combines the difference between "awareness and action"

recommendations document: this provides actions that can be taken to reduce the "risk" of unprofessional behaviours

action plan: this requires the individual to identify areas of moderate and high risk and note what actions can be taken to avoid this risk. This activity also requires individuals to plan when they will conduct the A2A assessment again (e.g. 3, 6 or 12 months) based on their level of assessed "risk".

<FIG><LBL>*Figure 20.1.*</LBL> <CAPTION>*Awareness to Action (A2A) assessment process.*</CAPTION></FIG>

The A2A awareness tool can be used for professional development, either on entry to nursing or during nurse training. For example, at the beginning of each stage and towards the end of a programme of study, for registered nursing staff or as part of the "recommended

actions" in the A2A decision-making process (reactive component, discussed previously). This is an ongoing and evolving process that can be repeated at entrance to and throughout nurse training but also during the professional career.

While this assessment seeks to facilitate reflection of self-efficacy (awareness) of online behaviours versus "actual" behaviours, it also serves to prompt discussion about what *being professionally accountable* means in reality. Furthermore, group discussion as part of conducting the assessment will serve to negotiate and confirm the values of the profession in relation to online socialisation – what is simply unacceptable or what is clearly unprofessional and requires action.

The nursing profession is not well socialised into the online environment at this point and there is a clear lack of consensus about acceptable, professional and unprofessional behaviour. Rogers (2003) represents this concept as "critical mass"; innovations (or values, in this case) are unlikely to be advantageous if there are only a small number of adopters; these are not yet "the norm". Hence the benefit of a generic A2A assessment, adopted as part of nurse education more widely, could help to set these "norms" and thus, professional values, creating consensus and consistency.

<HEAD1><TITLE>**Conclusion: becoming unconsciously competent**</TITLE></HEAD1>

From the background research and evidence on the topic of e-professionalism discussed in this chapter, it is known that there are a range of legal, ethical, employer and professional issues associated with the use of OSN. What is also known is that there is a need for reflective and active interventions to facilitate nurses' knowledge and activity associated with e-professionalism (especially student nurses being socialised into the profession and as the "future" for promoting and establishing these values in the context of "online").

This chapter presents the A2A framework that consists of two components: a proactive: A2A assessment tool and a reactive A2A decision-making tool. The first can be used as part of individual or group educational activities for student nurses, and indeed nurses in the educational sector to raise awareness of e-professionalism but also the behaviours associated with it. The second can be used when assessing online incidents or behaviours as part of formal "review" processes or as an educational intervention to generate debate about example

scenarios. It seeks to promote consensus, consistency and an evidence base for decision making when considering online behaviours.</BODY>

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