

Professional Boundaries and Expectations
for
Nurse-Client Relationships



College of Registered Nurses
of Nova Scotia

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Abstract

The mission of the College of Registered Nurses of Nova Scotia (the College: CRNNS) is “Registered nurses regulating their profession to promote excellence in nursing practice.” The purpose of this document is to **stimulate discussion about expectations for the professional behavior of registered nurses in nurse-client relationships and to provide a framework within which registered nurses can reflect on their actions and determine what constitutes appropriate behaviour.** The focus of discussion is on recognizing and respecting professional boundaries in nurse-client relationships, and on what may be done when professional boundaries are crossed.

Professional boundaries separate the therapeutic behavior of a registered nurse from any behavior which, well intentioned or not, could reduce the benefit of nursing care to patients, clients, families, and communities. Recognizing and respecting professional boundaries may be straight forward in some instances, but very complex in others.

The CRNNS’ beliefs about therapeutic nurse-client relationships are outlined. Signs that should alert nurses to the presence of a professional boundary issue are discussed, and examples of instances where professional boundaries have been crossed or violated are provided. Scenarios that illustrate several points about professional boundaries for educational purposes are also included. Finally, options and solutions for professional boundary issues are proposed, including the resources and assistance available to registered nurses and to Nova Scotians.

In January 2002, a new Registered Nurses Act was proclaimed in Nova Scotia, changing the name of the Registered Nurses’ Association of Nova Scotia to the **College of Registered Nurses of Nova Scotia**. In this document, all references to the Registered Nurses’ Association of Nova Scotia (RNANS) should now be equated with the College of Registered Nurses of Nova Scotia (CRNNS).

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Introduction

The mission of the College of Registered Nurses of Nova Scotia (the College: CRNNS) is “Registered nurses regulating their profession to promote excellence in nursing practice.” In 1996, CRNNS staff were directed to develop a discussion paper on sexual misconduct in nursing. The research for that paper indicated that sexual misconduct is only one of a range of boundary issues which nurses deal with in their professional lives and for which few guidelines exist. This discussion paper is designed to describe the nature of the nurse-client relationship and provide a framework within which registered nurses can identify both appropriate professional behaviour and issues which require resolution.

Every registered nurse in Nova Scotia receives several documents on initial registration. These include:

- the *Registered Nurses Act* (2001) and *Regulations Pursuant to the Registered Nurses Act*
- the *Standards for Nursing Practice* (RNANS, 1996)
- the *Canadian Nurses’ Association Code of Ethics for Registered Nurses* (CNA, 1997)

The *Registered Nurses Act* (2001) and *Regulations* (2001) define the regulatory functions of the College, and the *Standards for Nursing Practice* (RNANS, 1996) outline the requirements for professional nursing practice. Registered nurses, student nurses, and others, especially those receiving care, can use the standards to determine the quality of nursing care which is being provided.

Professional Boundaries Defined

The term *boundary* includes the notion of limits, lines or borders (Avis, Drysdale, Gregg, Neufeldt, & Scargill, 1983). Professional requirements for practice are met when the registered nurse demonstrates the knowledge, skills and attitudes of therapeutic behavior which are outlined in the practice standards and competencies. For the purposes of this discussion paper, professional boundaries are defined as follows:

Professional boundaries are the defining lines which separate the therapeutic behavior of a registered nurse from any behavior which, well intentioned or not, could reduce the benefit of nursing care to patients, clients, families, and communities.

Recognizing and respecting professional boundaries may be straight forward in some instances. However, a review of literature on this topic and a survey of the work done in other jurisdictions indicates that professional boundaries are a very complex issue.

Professional Boundaries and the Nurse-Client Relationship

Professional boundaries can be thought of as limits to the nurse-client relationship which allow for a safe, therapeutic connection between the professional and the client. Laws create some boundaries and other limits are set by licensing agencies. However, many expectations of conduct are established by the individual professional.

The nurse-client relationship is intended to be a therapeutic or helping relationship and it is the nurse's responsibility to set and maintain personal and professional boundaries. The therapeutic relationship can be viewed on a continuum from therapeutic to non-therapeutic behavior in the nurse-client relationship. The continuum puts *under-involvement* at one extreme of behavior and *over-involvement* at the other. In the centre of the continuum, the *zone of helpfulness* represents therapeutic interactions between professionals and their clients. Every nurse-client interaction can be plotted on the continuum with the majority of interactions occurring within the zone of helpfulness, as indicated below.

Under-Involvement	<i>Zone of Helpfulness</i>	Over-Involvement
Cold, distant	<i>Therapeutic relationship</i>	Boundary Violations
Adapted from National Council of State Boards of Nursing (NCSBN), 1995.		

Foundations of the Therapeutic Nurse-Client Relationship

Registered nurses form therapeutic relationships with clients to: a) gain an understanding of the clients' needs for care; and b) create an environment in which care can be provided safely, effectively and ethically. Awareness of their own behavior and of the client's needs allows professionals to focus on the person or persons receiving care, and to accurately evaluate the outcomes of care.

In any professional-client relationship there is an imbalance of power in favour of the professional. This is caused by the professional's additional knowledge base and is reinforced, in health care services, by the inherent vulnerability of a client needing care. Interactions in registered nurse-client relationships are characterized by *trust*, *respect*, *intimacy*, and *power*. Registered nurses must appreciate that these characteristics are the basis for their relationships with clients, and guide their professional actions and behaviors accordingly.

Trust	As a rule, clients are in vulnerable positions and trust the nurse to provide them with competent and professional care.
Respect	A nurse treats clients with respect for their individual needs and values.
Intimacy	The nature of nursing practice creates an atmosphere of physical, emotional, and psychological intimacy.
Power	The nurse-client relationship is one of unequal power; the nurse has authority, knowledge, access to privileged information and influence.

The obligation to maintain standards of professional competence and ethics always lies with the nurse, whatever the context and nature of the nurse-client relationship. Any act of abuse by the nurse is a betrayal of this relationship. "An overriding principle is that nurses' interpersonal relationships with their clients (or their significant others) must not have a negative effect on meeting their client's therapeutic needs, or in any way infringe on those needs" (Registered Nurses' Association of British Columbia et al., 1995, p. 8).

Irons (1991) has discussed five principles to guide the development of professional relationships and assist registered nurses and others to distinguish professional, therapeutic relationships from those of a non-professional nature (NCSBN, 1995). The principles are:

- *have respect for human dignity*
- *avoid personal gratification at the client's expense*
- *do not interfere in a client's personal relationships*
- *promote client autonomy and self-determination*
- *promote a fiduciary relationship (based on trust)*

Non-Professional Relationships

Non-professional relationships are social relationships which may be casual, friendly, or romantic in nature. Social relationships serve the interests of both parties and are for the purpose of mutual interest and pleasure. In contrast to the nurse-client relationship, outlined on the previous page, both parties are responsible for establishing and maintaining social relationships (RNABC et al., 1995, p. 9; Nurses Association of New Brunswick, 1995, p. 2).

Differences between Professional and Non-Professional Relationships

The National Council of State Boards of Nursing (1996) has identified the ability to establish and maintain therapeutic boundaries with clients as an essential competency. All nursing competencies, including the establishment of therapeutic boundaries, are achieved by thinking about one's actions, asking necessary questions, and putting principles into practice. It helps to ask questions about boundaries even when it turns out that there is no issue of concern. We learn as much about boundaries in appropriate relationships as when we recognize possible problems. Several characteristics have been identified which help to demonstrate the differences between professional and non-professional relationships. These characteristics, which are identified below, provide a framework which registered nurses can use for making decisions about appropriate relationships.

Comparison of Professional and Non-Professional Relationships

Characteristic	<i>Professional Relationship (nurse-client)</i>	Non-Professional Relationship (casual, friendship, romantic)
Remuneration	<i>Nurses paid to provide care to client</i>	No payment for being in the relationship
Length of relationship	<i>Time-limited for the length of the client's need for nursing care</i>	May last a lifetime
Location of relationship	<i>Place defined and limited to where nursing care is provided</i>	Place unlimited; often undefined
Purpose of relationship	<i>Goal-directed to provide care to client</i>	Pleasure, interest-directed
Structure of relationship	<i>For nurse to provide care to client</i>	Spontaneous, unstructured
Power balance	<i>Unequal power - nurse has more power due to authority, knowledge, influence and access to privileged information about client</i>	Relatively equal
Responsibility for the relationship	<i>Nurse, not client, responsible for establishing and maintaining professional relationship</i>	Equal responsibility to establish and maintain
Preparation for the relationship	<i>Nurse requires formal knowledge, preparation, orientation, and training</i>	Does not require formal knowledge, preparation, orientation and training
Time spent in relationship	<i>Nurse employed under contractual agreement that outlines hours of work for contact between the nurse and client</i>	Personal choice for how much time is spent in relationship

(British Columbia Rehabilitation Society, 1992; Milgrom, 1992)

The following example indicates some of the issues to consider when contemplating a social relationship with a former patient.

New in Town: Right Relationships for the Right Reasons

Judith was pleased with her new job. Full-time jobs were scarce for new graduates and this was a good one. She enjoyed the friendliness and sense of community found in a rural hospital. The only drawback was being alone - she missed her friends and family. A few weeks after Judith began her job on the med-surg floor of County Hospital, she admitted a new patient, Will, with diagnoses of appendicitis and diabetes. Like Judith, Will was new to the community.

Will recovered quickly and his hospitalization was uneventful. He was required to stay six days until his diabetes had stabilized. During his hospitalization, Will enjoyed talking with Judith as she went about his care. Three months after Will's hospitalization, he and Judith met accidentally at a local dance. They were pleased to see each other and spent the evening together dancing and talking. At the end of the evening, Will asked Judith if he could see her again and invited her out the next week.

Issues to consider:

- Would Judith be violating professional boundaries if she accepted the date with Will? Why or why not?
- How long - if at all - should Judith wait before accepting a date with Will?
- What factors should Judith consider in making her decision?

Discussion

Judith wasn't sure that there was anything wrong with seeing Will socially. However, she wanted to discuss it with someone in confidence. She contacted her professional association/college to discuss her decision. They used the table on professional and non-professional relationships outlined above (RNABC et al; 1995) to talk about her situation.

Judith decided that the amount of time that had passed since her initial professional relationship with Will was not important. However, she saw that being able to tell the difference between that relationship and a social one with him in the present was essential. By looking at the differences between professional and non-professional relationships, she determined that seeing Will now was an appropriate, social relationship. She decided to accept his invitation.

Judith's decision would probably have been very different if Will's hospitalization had been for a chronic mental illness. She would not have judged the balance of power between them to be equal, and she would not have been able to avoid using her nursing knowledge in the personal relationship. Recently, an Ontario court decided that a psychiatric nurse's decision to move in with an outpatient being treated for depression was just cause for dismissal (Featherstone, 1996). The nurse also received a reprimand from her licensing body, the College of Nurses of Ontario.

In Ontario, the College of Nurses allows nurses to initiate or engage in a social relationship with a client if it is anticipated that the client will not require future care of the nurse. However, if the nature of the nurse-client relationship was psychotherapeutic, the nurse must not engage in romantic or sexual relationships for one year post termination. Even then, a relationship should only occur if, in the nurse's judgment, the relationship would not have a negative impact on the client's well being. Registered nurses and Nova Scotians need to carefully consider when personal relationships between nurses and former clients are, and are not, acceptable and why.

Points to Ponder

- *Do you think that there should be clear guidelines for registered nurses and the public regarding personal relationships between nurses and former clients? Why?*
- *If you do favor guidelines, should they be based on:*
 - *strict time limits (e.g. may have a personal relationship after a set period of time)*
 - *principles (e.g. may have a personal relationship where all the conditions of a social relationship are evident, and none of the conditions of a professional relationship exist)*
 - *both?*
- *If you do not favor guidelines, why not?*

Obviously, failure to recognize crucial differences between therapeutic and personal relationships may lead to boundary violations which harm the patient, the nurse and potentially others. Therefore, it is critical that registered nurses and others recognize the signs which indicate when professional boundaries may have become blurred.

Boundary Signs

All registered nurses have professional responsibilities in nurse-client relationships. These responsibilities include paying careful attention to warning signals that professional boundaries are in question, or have already been crossed. The *boundary signs* listed below may be considered warning signals that the nature of a relationship is changing. While each situation is unique, the presence of one or more of these boundary signs tells the registered nurse to stop and reassess a particular relationship with a patient or client. By paying attention to boundary signs, many issues can be resolved before a boundary is crossed or the care of a client is adversely affected. Whether the crossing of a boundary is initiated by the client or the nurse, **it is the registered nurse's responsibility to identify and deal with professional boundary issues professionally and therapeutically.**

Some of the warning signs that professional boundaries need to be reviewed include:

- *Frequently thinking of the client when away from work.*
- *Frequently planning other clients' care around the client's needs.*
- *Spending free time with the client.*
- *Sharing personal information or work concerns with the client.*
- *Feeling responsible if the patient's progress is limited.*
- *Noticing more physical touching than is appropriate or sexual content in interactions with the patients.*
- *Favoring one patient's care at the expense of another's.*
- *Keeping secrets with the patient.*
- *Selective reporting of client's behavior (i.e. negative or positive client behavior).*
- *Swapping patient assignments.*
- *Communicating in a guarded and defensive manner when questioned regarding interactions/relationships with the client.*
- *Changing dress style for work when working with the client.*
- *Receiving of gifts or continued contact/communication with the patient after discharge.*
- *Denying the fact that the client is a patient.*
- *Acting and/or feeling possessive about the client.*
- *Giving special attention/treatment to this client which differs from that given to other clients.*
- *Denying that you have crossed the boundary from a therapeutic to a non-therapeutic relationship. (Coltrane & Pugh,1978)*

The following sections discuss, and provide examples of, boundary crossings, boundary violations and mechanisms for addressing these issues if you or a colleague find yourself in these situations.

Boundary Crossings

Registered nurses may sometimes decide to deviate from an established boundary for a therapeutic purpose. Appointment changes, disclosure of bits of personal information and small gifts are some examples of crossing professional boundaries. These crossings are brief, intentional excursions across the line and there is a clear return to the established limits of the professional relationship within a short period of time. In such instances of boundary crossings, the following assumptions are made about expectations for professional behavior:

- *The nurse possesses the required knowledge, skill, and judgment.*
- *The nurse intervenes appropriately.*
- *The nurse respects client preferences.*
- *The nurse maintains the therapeutic relationship (RNABC et al., 1995).*

Boundary crossings are considered *gray zones* of clinical decision-making, where the best course of action is not always obvious. Some activities and behaviors are therapeutic and acceptable in certain circumstances, but they have the potential to cross the boundaries of the nurse-client relationship. These acts or behaviors may be acceptable if, in the nurse's professional judgment, they assist with meeting the client's therapeutic needs. This judgment is based on the nurse's knowledge and skill regarding appropriate behavior in the therapeutic relationship. An act or behavior that appears appropriate becomes unacceptable if its purpose is to benefit the nurse at the expense of the client (NANB, 1995, p. 6).

Gray zones also exist because nurse-client relationships are two-way. People receiving nursing care sometimes have expectations of registered nurses which are inconsistent with those of professional associations, their employers, or other groups. These expectations should be taken into account, as they may point out unacceptable shortcomings in the care received. The shortcomings may be those of the registered nurse, other members of the health care team, the agency itself, or the health care system overall. When there are shortcomings in a health care experience, the situation can become quite complex. The following example of a client in need illustrates how complicated "doing the right thing" can become.

Caring for Dying Patients and their Families: A Delicate Balance

Pamela is a registered nurse who works in palliative home care. She has been caring for Mr. Smith, who is terminally ill with cancer, for two months. Over this time, Pamela has visited the Smith family often. Initial visits were twice weekly. However, as his condition deteriorated, the frequency of home care visits increased to daily. During this time, Pamela has developed a close working relationship with the Smith family.

The Smith family is close knit and supportive. Their three children live in a nearby city and visit once or twice a week. Mrs. Smith is caring for her husband with some assistance from home care aides. Mr. Smith wants to stay at home to die, and Mrs. Smith very much wants that to be possible. However, Mrs. Smith is afraid of being alone with her husband when he dies, and the children can't stay with her all the time.

Pamela has been trying to get extra support for the Smith family, requesting more frequent home care visits and the provision of 24 hour care when it is determined that Mr. Smith's death appears imminent. However, the supervisor indicates that there just are not sufficient funds to provide that level of care to Mr. Smith. She is told that if Mr. Smith requires 24 hour care then he should enter the hospital.

Over the last two days, Mr. Smith's condition has deteriorated a great deal. When Pamela suggests hospitalization, both he and Mrs. Smith refuse. Mrs. Smith asks if Pamela won't stay the night with her in case her husband should die in the night.

Issues:

- *What is the nurse's role as client advocate in this situation?*
- *If Pamela stays, would this be a boundary crossing or high level compassionate care? How are we to decide?*
- *What are the possible benefits to staying with Mrs. Smith as requested - for the Smiths; for Pamela's satisfaction with the nursing care she believes that they deserve?*
- *What are the possible harms - for the Smiths if the need continues for several days; for Pamela if she neglects herself, her family, or other clients to meet this need?*
- *What does her employer believe about such requests, and what steps do they take to ensure that their employees are aware of these expectations?*
- *Are there other options that Pamela could explore with the Smith family?*

Discussion

It is evident that there are several questions Pamela needs to consider in her response. No one is "in the wrong" in this situation. The family's need is important, and so is that of the nurse. Some nurses would respond by donating increasing amounts of personal time and energy, even to the point of personal exhaustion. This action may result in a decreased ability to provide needed care over time. It is also possible that extra care for this family occurs at the expense of other families and the rest of the health care team

The Smith's situation is one where the registered nurse and client have run up against a professional boundary. The family and nurse may both know appropriate lines for their relationship, but circumstances increase the pressure for that line to be blurred or crossed. Examples like this demonstrate some of the ethical dilemmas which arise when the care which clients need, or prefer, is not available through publicly funded health services.

Some of the other activities and behaviors that have the potential to cross the boundaries of the nurse-client relationship are *self-disclosure* and *giving or receiving gifts*. These practices are discussed briefly below.

Self-Disclosure

Self-disclosure is the sharing of personal information to improve understanding between persons. A nurse may choose to use self-disclosure when it is determined that the information will therapeutically benefit the client. Self-disclosure by the nurse must always be provided for the client's welfare. It is never acceptable when it is for the purpose of meeting the nurse's needs.

The responsibility of the nurse is to ensure that personal information is well related to the client's interests. Where the benefit to the patient of the disclosure is unclear, it is best to err on the side of caution. In the following examples, both appropriate and inappropriate use of self-disclosure are presented.

Appropriate Self-Disclosure: Sharing for the Client's Benefit

It was just past shift change and Maria, a staff nurse in Labour and Delivery was transferring her newly assigned patient, Betty, to the anti-partum unit. Betty had been admitted earlier that day with vaginal bleeding, ruptured membranes and premature labour. She was 24 weeks pregnant and was fearful that she would lose this pregnancy too. It would be her third miscarriage in less than three years. Betty and her husband wanted this baby more than anything else.

As Maria helped Betty get settled into her new room she noticed that Betty seemed despondent and far away. Maria made a point of sitting down opposite Betty and taking her hand. Maria said to Betty, "You are having a really rough time, I can imagine that you are afraid that you will lose this baby, too. I can appreciate your feelings, because I also lost two babies the same way. It was one of the hardest things I ever dealt with."

Discussion

Self disclosure is appropriate here. Maria's remarks about her own experience may help the client talk about herself and the problem situation. Her comments are limited and could encourage Betty to continue to talk about her fears. This brief excursion across the professional boundary is temporary and focused.

What happens next, however, is a crucial point in the therapeutic relationship. If the client finds it easier to talk, good nursing care has been given. If the conversation turns back to the nurse, the focus of the boundary crossing has been lost, and the nurse-client relationship is no longer helpful.

Inappropriate Self-Disclosure: Losing the Therapeutic Connection

Betty seemed to visibly relax. She turned to Maria and asked, "How did you get through it? I'm afraid that I will never have my own baby. I want this one so much, I'm further along than I ever got before."

Maria remembered the pain she experienced a year ago as she recalled the events following her second miscarriage. She said to Betty, "I hope things work out well for you. My husband and I sort of gave up trying. First we talked about adoption but then got discouraged when we found out how long the waiting lists were. So this spring we thought we would give it one more chance..."

Issues:

- *How do self-disclosures that are helpful differ from those that are not?*
- *If the nurse doubts the value of a particular disclosure, what is a wise course of action?*
- *Should professionals just err on the safe side and never give out details of their own lives for any reason?*

Discussion

Kadner (1994) states that a nurse discloses in a therapeutic relationship when the information “is of vital interest for the client to receive” (p. 217). The point is to ensure that the client “is not short-changed” (p. 217) by being subjected to all of the nurse’s thoughts. When Betty asked Maria how she got through her miscarriages, Maria should have maintained her focus on helping Betty with her problem. She could have responded in a way that let Betty know that she wanted to listen. Maria became caught up in the need to tell her own story, and did not realistically consider its usefulness to the client. She lost her focus and added to the burden of an already overwhelmed, grieving woman. For these reasons, the second exchange was an inappropriate self-disclosure.

Giving and Receiving Gifts

The act of giving care to the client can create an imbalance of power and clients and families sometimes feel indebted towards health care providers. Gift giving, as an act of reciprocity, can be part of the therapeutic process. Sensitivity to cultural practices and beliefs is critical for all health professionals. In all cultures, gifts are sometimes given from the care receiver to the care giver. Forbidding the practice and insisting that nurses refuse and return gifts may be harmful to the care-giving relationship (Morse, 1991).

Gift giving is a complex phenomenon and gifts are given for many reasons. Gifts of gratitude and gifts of obligation are acceptable in appropriate circumstances. Gifts of gratitude may be an essential part of the patient’s recovery process, while gifts of obligation are a normative courtesy. If a nurse feels coerced or manipulated by the offer of any gift, it may be refused. The underlying reasons for the gift should then be tactfully explored with the client, and care should be altered as needed. For example, the patient may need reassurance or it may be that the nurse should assess for other unmet needs. Morse recommends that nurses use professional judgment when deciding to accept a gift (Morse, 1991, p. 613). Professional judgment should be guided by the *CNA Code of Ethics for Registered Nurses* (1997), the *RNANS Standards for Nursing Practice* (1996) and specific agency policies.

Gifts that might be misunderstood by either the nurse or the client can be handled with tact and appreciation. For instance, an offer of money would not be acceptable to a nurse. However, clients and families who wish to give thanks in this manner may be encouraged to donate funds to a charity of mutual choice between the client and the nurse. Clients must **never** be given the impression that their care is dependent upon donations of any kind. Where agency policies explicitly prohibit gift-giving of any kind, nurses may encourage administration to reconsider mechanisms that allow for gift-giving without compromising either the agency or the professionals providing care.

The following scenario illustrates some of the issues which can arise from gift-giving.

Gifts from Patients: When is it Acceptable?

Mary, Vicki, Lucy and Joan are registered nurses working on the dementia floor of a long term care facility. They take turns looking after Mr. Ward who is in the late stages of Alzheimer’s disease. At Christmas time, Mrs. Ward brings in chocolates for Vicki and Joan but nothing for Lucy or Mary. They don’t think much of it at the time but the same thing occurs on Valentine’s Day and again at Easter. Lucy and Mary are starting to feel that Mrs. Ward finds the care provided by Vicki and Joan better than the care they provide. This offends them professionally and hurts them personally. Also, they are beginning to wonder if Vicki and Joan should be accepting so many presents, even though none of them have much financial value.

Issues:

- *Are Vicki and Joan crossing a boundary in accepting a gift from Mrs. Ward? What about accepting multiple gifts?*
- *How should Lucy and Mary deal with their personal and professional concerns?*
- *What are the benefits of addressing this issue with Vicki and Joan?*
- *What are the potential disadvantages of doing so?*

Points to Ponder

- *Who should agencies consult with in creating policies about gifts from clients? Should they consult clients and families, the health professionals, lawyers?*
- *Do you think it is ever right for a registered nurse to accept a gift? Do you think it is ever wrong to refuse a gift? Why or why not?*
- *Is it ever appropriate for professionals to give gifts to patients? Why or why not?*
- *What about a birthday cake for a resident, a shower for the bone-marrow transplant patient who is getting married, toiletries or clothes for the patient who does not have their own? Are any of these actions acceptable or unacceptable? Why or why not?*

Giving and Caring: Finding the Right Limits

Yonge & Molzahn (1996) researched the exceptional caring practices of several registered nurses. They cite Mayerhoff (1971) who explains the idea of knowledgeable caring as follows:

To care for someone, I must know many things. I must know, for example, who the other is, what his powers and limitations are, what his needs are, and what is conducive to his growth; I must know how to respond to his need and what my own powers and limitations are. Such knowledge is both general and specific. (p.xxx)

Setting arbitrary rules about boundaries can be over-simplified, usually to the detriment of the clients and communities that registered nurses serve. On the other hand, Mayerhoff (1971) wisely points out that we can only truly help when we know the limits of our own powers, both personal and professional. Using principles, talking to others and questioning current practices are more difficult than simple rules. As with most other situations in life, however, these actions may lead to better decisions when boundaries are at stake. The following situation illustrates these points.

Nursing in a Rural Community

Joan and Marcy are registered nurses who practice in a health centre in Northern Alberta. Because of the small size of the community, 1200 people, nearly everyone in town knows one another. Joan's and Marcy's formal working hours rotate between Monday to Friday 8:30 to 4:30 or 11:00 a.m. to 7:00 p.m.. After hours, Joan and her colleague Marcy take one week turns at being on-call for emergencies. The volunteer ambulance and the other nurse if available back up the on-call nurse in instances of multiple emergencies, which are rare events.

It is Marcy's week on call. Joan is home making supper when she gets a phone call from Judy, her neighbour. Judy's four year old son, Jeremy, just fell off the couch, cutting his face on the coffee table as he went down. Judy says, "there's blood all over his chin", he's screaming, and she wants to know: What should she do?

Rather than tell Judy to call Marcy, Joan decides to deal with the request for help herself. She asks Judy for details about the injury and when she is unable to get a clear picture of Jeremy's status she says she will run over to her house and have a look at him.

Issues:

- *Has a professional boundary been crossed or violated in this scenario? If so, by whom?*
- *Are the community's expectations of the nurses reasonable? Are the nurses' expectations of themselves reasonable?*
- *Do the nurses and the community have a common understanding of what an emergency is?*

Discussion

Joan and Marcy realized that if they did not face their concerns about calls during time off, they would keep getting calls, and it could just get worse. Although they did not want to upset the community, many of whom were their friends, they felt that they needed to do something in order to get some time off. They met with the Town Council, and together decided to post a notice in the Health Centre and on the front door that from now on, all calls after hours would be referred to the nurse on call. They also put a notice to this effect in the local newspaper, and spoke with as many members of the community as possible, to spread the word and explain their actions. Some people reacted poorly, expressing the belief that "When we need you, you've got to be there." Much to their surprise, however, more people indicated their understanding, and promised to try to stick to the plan that had been developed. Joan and Marcy realized they would also need to stick to their plan and keep explaining it to the community. They also agreed to support each other so that they could set realistic limits on their practices and stay in a community they both loved.

It is not simple to determine the limits of one's professional practice and personal life. The approach of these nurses ensured that the community still got needed nursing care - but not at the unreasonable expense of anyone concerned.

Determining Appropriate Professional Behaviors

Each nurse-client relationship is unique. There is no one formula that correctly judges boundary crossings as good or bad, without considering all aspects of the therapeutic relationship in each situation (AARN, 1996). Appropriate behavior must be based on general considerations such as the professional's intent, respect for confidentiality, client-patient advocacy, and adherence to the CNA *Code of Ethics for Registered Nurses*.

Professional Boundary Violations

Boundary crossings may be insignificant in a single instance, but there is the potential to progress to a boundary violation if there is an increase in the frequency or severity of the crossing (NCSBN, 1995, p. 37). The nurse bases the nurse-patient relationship on the therapeutic needs of the patient, not on the needs of the nurse. Boundary violations are clearly unethical and need to be recognized as unacceptable. We must understand why boundary violations are unacceptable in order to prevent unnecessary occurrences.

Boundary violations occur when there is confusion of the professional's needs with the client's needs. The professional may use rationalization to justify the behavior. A boundary violation is typically characterized by: a reversal of roles; secrecy; the creation of a double bind* for the client; and the indulgence of personal privilege by the professional (NCSBN, 1995, p. 37).

*** A double bind is created for a patient when their situation is compromised both by continuing and discontinuing a relationship with a professional.**

When a nurse uses a relationship to meet a personal need, at the expense of the client, the relationship violates the limits of a therapeutic connection. Boundary violations may be considered abuse (NANB, 1995, pp. 7-9; RNABC et al., 1995, pp. 15-17). **Abuse of patients is professional misconduct according to the definition under Section 2(ag)(iii) of the Registered Nurses Act (2001, c. 10, s. 1) and is an ethical violation of the registered nurse's professional code of ethics (CNA, 1997).**

Examples of Boundary Violations

Abuse is the misuse of power or a betrayal of trust, respect, or intimacy between the nurse and the client which the nurse or others know may cause, or could be reasonably expected to cause, physical or emotional harm to a client (RNABC et al., 1995). Whether deliberate or inadvertent, abuse of clients in any form is unacceptable and should not be tolerated. Examples of different types of abuse are given below.

Physical Abuse involves touching or exhibiting behaviors towards clients that may be reasonably perceived by the clients, nurses, or others to be violent or to inflict physical harm. Inappropriate behaviors include, but are not limited to: hitting, scratching, pushing, kicking, using force, biting, pinching, slapping, shaking, and/or handling a client in a rough manner.

Physical Restraints in patient care **may** be considered to be physical abuse. The College believes that policies of *least restraint* should be used in all client care settings (CRNNS, 1995). Least restraint practice means that **all possible alternative interventions are exhausted** before deciding to use a restraint. Harmful effects of the overuse of restraints are unacceptable and include skin breakdown, immobilization, urinary incontinence, increased agitation, physical and mental deterioration and even death. The use of restraints is justifiable when all other possible measures to prevent harm to the patient or others have not worked. The nurse then uses the least restrictive step needed to keep the patient and others safe. For example, a simple alteration in the environment of the wandering patient, such as locked doors to off-limit areas, may keep the client and others safe, yet still allow as much freedom as possible.

Resource allocation decisions can have significant impact for the safety and welfare of patients and clients receiving health care (AARN, 1995; Caulfield, 1994; Jackman, 1995/96). Registered nurses who believe that inadequate staff or other resource problems are contributing to poor or unsafe care, including the incorrect use of restraints, have specific responsibilities. These responsibilities include documenting and communicating their concerns, providing the best care possible within the circumstances and advocating for necessary improvements (AARN, 1995; McLean, 1995).

Points to Ponder

- *Do you think that policies on restraint are clearly communicated and well followed in the health facilities you are familiar with?*
- *Do you think that inadequate staffing, lack of knowledge or lack of other resources ever contribute to poor or unsafe care?*
- *What would you do if you witnessed inappropriate use of restraints?*

Verbal Abuse is communication of an abusive nature. It includes behavior or remarks toward clients that may be reasonably perceived by the client, nurse, or others to be demeaning (sexually or otherwise), seductive, exploitive, insulting, derogatory, and/or humiliating (CNO, 1994).

Emotional Abuse involves using verbal and non-verbal behaviors that demonstrate disrespect for the client and that are reasonably perceived by the client, nurses, or others to be emotionally harmful (CNO, 1994). Such behaviors include, but are not limited to, sarcasm; intimidation; teasing or taunting; retaliation; manipulation; inappropriate posturing or gestures; insensitivity to the client's culture, race, religious practices, economic status, or education; insensitivity to the client's preferences with respect to sex and family dynamics; and consciously deciding to withhold information that could contribute to the client's well-being. Flippant use of terms of endearment such as "dear", "sweetheart", and others can also be potentially offensive, demeaning, and disrespectful. Addressing people casually without their permission can be a mistake, and should be discouraged.

Points to Ponder

- *Do you think that policies on verbal and emotional abuse are clearly communicated and followed in the health facilities you are familiar with?*
- *What would you do if you witnessed verbal or emotional abuse?*

Sexual Abuse involves touching clients in a manner that may be reasonably perceived by the client, nurses, or others to be of a sexual nature. It also includes initiating, encouraging, or engaging in sexual intercourse or other forms of physical sexual contact with clients (CNO, 1994). The consequences of sexual relationships with professionals can be long term for vulnerable patients and clients.

Financial Abuse involves taking actions, with or without the informed consent of a client, that results in monetary, personal, or other material benefit, gain, or profit to the nurse, or in monetary or personal material loss for the client. Such behaviors include, but are not limited to: borrowing money or property from a client; misappropriation or misuse of money or property; withholding of finances through trickery or theft; forced sale of house or possessions; forced change of will; influence, pressure, or coercion to obtain the client's money or property; abuse of trusteeship, of bank accounts, of power of attorney, or of guardianship (RNABC et al., 1995).

Points to Ponder

- *Should there be guidelines for registered nurses regarding financial abuse of clients? What would you include in such guidelines? All of the above? Other issues?*
- *Should these guidelines be clearly stated in professional guidelines? Institutional policy? Both? Elsewhere?*

Neglect involves exhibiting behaviors toward clients that may be reasonably perceived by the client, nurses, or others to be a breach of the professional's duty to care. Neglect occurs when nurses fail to meet the basic needs of clients who are unable to meet their needs themselves. Such behaviors include, but are not limited to: deliberate withholding of basic necessities or care, such as clothing, food, fluid, needed aids of equipment, and medication. Neglect also occurs through inappropriate activities such as withholding communication, confining, isolating or ignoring the client, denying the client care, or denying the client privileges (RNABC et al., 1995). The following scenario illustrates how neglect can emerge in a difficult nurse-client relationship. Professionals dealing with difficult patients need to recognize boundary signs that say it is time to get help.

Neglect: A Common Price of Avoidance

Diane A., RN, was a young nurse on a Long Term Care Unit where high quality resident care was highly embraced by management and staff. This value was difficult for Diane to maintain when working with Mr. Y., a 58 year old resident with many problems including a stroke, chronic lung disease, and possible brain damage. It wasn't possible to fully determine his mental competence, but Mr. Y. required total assistance for all of his basic needs, including taking his medications. He still possessed adequate swallowing abilities, but the nurse needed to place the pills with fluids in his mouth to ensure that he received his medications when required.

While providing personal care to Mr. Y., staff found him to be unlikeable due to his "groping"; he often touched them in a sexually embarrassing manner with his only controllable arm. Although his mental competence was questionable, he could communicate experiences of physical pain caused by his disabilities, and he regularly needed pain medication to keep his comfort level at its best.

Diane felt repulsed by this residents' behavior, and felt unable to do anything constructive about it. When pain medication was warranted, she avoided Mr. Y. by waiting as long as her conscience would allow. Whenever possible, she would pass the request on to the RN on the next shift in order to avoid him entirely.

Issues:

- *Do you think that "difficult" or "unlikeable" patients and clients are more vulnerable to being neglected?*
- *Do you think that Diane's problems with Mr. Y had other solutions? What would you have done?*
- *What should Diane's colleagues do if they realize this neglect is occurring?*

Discussion

Inappropriate sexual behavior may be an indicator of undetected physical problems (Philo, Richie, & Kaas; 1996). In Mr. Y's case, there are several possible medical explanations for his behavior. The underlying physical causes of Mr. Y's actions may not be completely understood, but it is possible that the nursing home staff can develop a plan to reinforce appropriate behavior and limit distressing touching. Being able to provide the best care to Mr. Y without subjecting the staff to unacceptable touching depends on understanding his condition, planning individualized care, and having enough skilled staff to carry out the care plan.

Boundary Violations: Solutions and Options

Some Competencies Related to Professional Boundaries

In Nova Scotia, registered nurses are required to:

- *be accountable and responsible to the public for competent, safe, and ethical nursing practice*
- *possess and continually acquire competencies relevant to their own area of nursing practice*
- *demonstrate competencies relevant to their own area of nursing practice*
- *advocate for clients in their relationship with the health care system (CRNNS, 1996)*

The purpose of this section is to provide registered nurses and others with guidance in dealing with situations where violations of a nurse-client relationship are suspected. Violations of professional boundaries may take many forms. In considering the following scenarios please refer to the CRNNS *Decision-Making Framework* on page 17.

I am involved in a situation that I believe violates professional boundaries.

You find yourself "caught" in a situation that you now believe violates professional boundaries. It may be that you find yourself saying, "I don't know how I got into this", but, you do know that it is not ethical. What should you do? As indicated in the excerpts from the CNA *Code of Ethics for Registered Nurses* below, and in the CRNNS *Decision-Making Framework*, **your primary concern must always be the welfare of the client.**

- “Nurses give primary consideration to the welfare of clients” (CNA, 1997, p.20).
- “Nurses....advocate health care environments that are conducive to ethical practice and to the health and well-being of clients and others in the setting” (CNA, 1997, p.22).
- “Nurses provide care directed first and foremost towards the health and well-being of the client” (CNA, 1997, p.8).

Regardless of your own apprehensions, you must act to restore the best interests of the client. You may choose to discuss the situation with a trusted nurse colleague who can help you to make ethical choices or you may notify a supervisor, who may remove you from the situation and institute measures that will benefit the client.

It is also a good idea to discuss your concerns with the College. Professional staff may be consulted in confidence at the CRNNS provincial office (902-491-9744 or toll free at 1-800-565-9744) to assist you to deal effectively with the situation.

Clients, families, or other health care professionals may also have concerns that professional boundaries have been violated. Even if they are only questioning the situation, they need to know that they can discuss their concerns with someone in the setting. If that is not a suitable option for any reason, there should be no hesitation in contacting the CRNNS Professional Practice & Policy Services for confidential consultation.

My colleague/employee is involved in a situation that I believe violates professional boundaries.

You believe that your co-worker is not maintaining the best interests of a particular client. What should you do? In making a decision you should consider the following:

- “When nurses have reasonable grounds for concern about the behaviour of colleagues.....they carefully review the situation and take steps, individually or in partnership with others, to resolve the problem” (CNA, 1997, p.20).
- Nurses support other nurses who act in good faith to protect clients from incompetent, unethical or unsafe care, and advocate work environments in which nurses are treated with respect when they intervene” (CNA, 1997, p.21).
- “Nurses intervene if others fail to respect the dignity of clients.” (CNA, 1997, p.13)

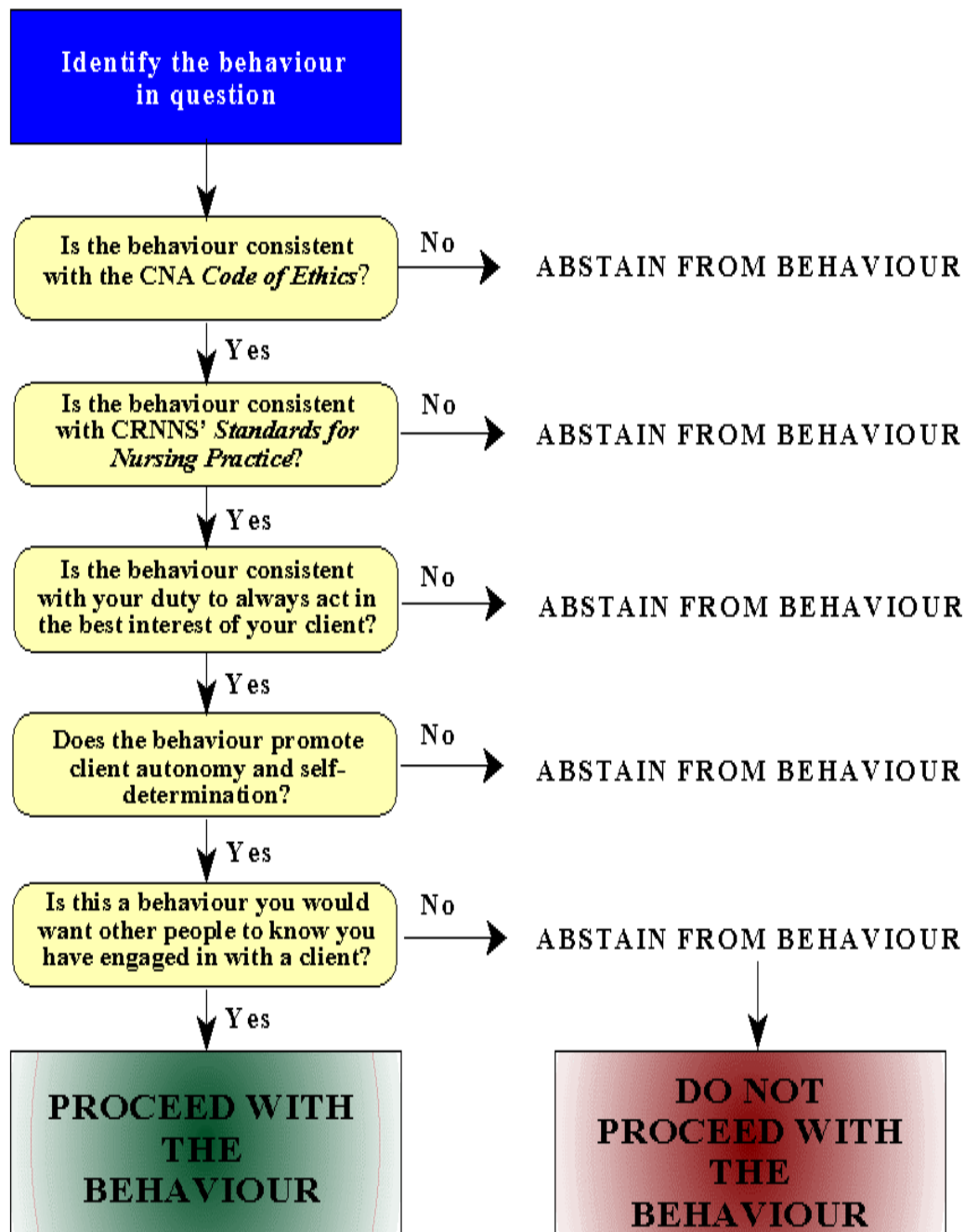
The nurse is obliged to ascertain the facts of the situation before deciding on the appropriate course of action. In deciding on a course of action, relationships in the health care team should not be disrupted unnecessarily. If a situation can be resolved, without peril to present or future clients, by direct discussion with the colleague involved then that discussion should take place. If for any reason you are unable to confront the nurse directly, the next best step is to speak with the immediate supervisor. Whoever you speak with, clarify aspects of the situation that are unclear, and ensure accurate interpretation of the facts of the situation. Explain your reasons for concern, and stick to observable facts and their relationship to patient care. Always be certain to follow appropriate agency mechanisms for reporting such incidents.

If discussion confirms your concerns and you continue to believe the situation violates professional boundaries, explain your expectation that the situation will be resolved. If appropriate, offer your assistance. CRNNS staff can also provide guidance on how to proceed in such a situation.

If the situation is not adequately resolved following discussion, take further action. For instance, the client with an unresolved complaint needs to be informed of their right to pursue the concern with the agency, the College or the police, as appropriate. If the situation remains uncorrected, registered nurses hold a professional responsibility to identify concerns about the individual’s conduct to the College of Registered Nurses of Nova Scotia. Confidential consultation with the College will enable you to determine if a written complaint about the nurse’s conduct is appropriate. Should a written complaint be necessary, the nurse involved should be notified that such a report is pending or proceeding.

Regardless of who is involved in a violation of professional boundaries, it is always the responsibility of registered nurse(s) aware of the situation to act in the best interests of the client. The College can provide needed assistance and support to clients, families, and other professional groups with boundary concerns, and should be contacted. The *Decision-Making Framework* which follows may be helpful in determining if a behaviour is appropriate.

**DECISION-MAKING FRAMEWORK
FOR APPROPRIATE PROFESSIONAL BEHAVIOUR**



Conclusion

The nurse-client relationship is a therapeutic and professional one that is established to meet the health care needs of the client. To properly acknowledge the trust, respect, intimacy, and power which characterize the therapeutic nurse-client relationship, registered nurses need to be knowledgeable about professional boundaries and accountable for maintaining them.

Boundary violations are **never** acceptable. They harm the nurse-patient relationship and contravene the nurse's professional code of ethics. In dealing with boundary violations, the primary consideration of the registered nurse is the welfare of the patient.

Boundary crossings need to be evaluated on a case-by-case basis. Certain boundary crossings may be therapeutic. Decisions to cross professional boundaries for therapeutic reasons should be deliberate, time-limited choices which clearly contribute to clients' care in a beneficial manner. Where the benefit of a boundary crossing is not clear, the registered nurse must exercise professional judgment to ensure the patient's welfare.

As you think about the examples that have been discussed in this paper, consider the following questions:

- *Are there areas of professional boundaries that are best left to the professional judgment of individual registered nurses? Why or why not?*
- *Are there boundary crossings which should be dealt with by agency policy (e.g. gift-giving)? How should such policies be developed - who should be involved?*
- *Should professional guidelines for boundary violations be based on rules (e.g. personal relationships are permitted after a specific period of time) or on principles (e.g. personal relationships are appropriate when certain conditions are met (the time period depends on the circumstances))?*

Registered nurses can gain better understanding, recognition, and respect for professional boundaries by talking with colleagues, with the College, and most important of all, with the public they serve. Discussing professional boundary issues openly will assist in the attainment of safe, competent, ethical nursing care for all Nova Scotians.

Glossary

Abuse - the misuse of power or a betrayal of trust, respect, or intimacy between the nurse and the client which the nurse knows may cause, or be reasonably expected to cause, physical or emotional harm to a client (CNO, 1994)

Accountability - the ability to explain rationale for actions taken that is consistent with the responsibility for which the nurse contracted (AARN, 1991a)

Beneficence - the principle that outlines a person's duty to act to benefit another (AARN, 1996)

Boundary crossing - an action or behavior which deviates from an established boundary in the nurse-client relationship. Such actions/behaviors may be acceptable in the context of meeting the client's therapeutic needs; even where the action or behavior appears appropriate, it is not acceptable when it benefits the nurse at the expense of the client (CNO, 1994)

Boundary sign - actions, behaviors, or thoughts which are warning signals that professional boundaries in a particular nurse-client relationship are in jeopardy or may already have been crossed

Boundary violation - actions or behaviors by a professional which use the relationship with the client to meet a personal need of the professional at the expense of the client

Competency - the ability to demonstrate the requisite knowledge, skills and attitudes of registered nurses beginning to practice (AARN, 1991)

Double bind - a double bind is created for a patient when their situation is compromised both by continuing and discontinuing a relationship with a professional

Emotional abuse - verbal and non-verbal behaviors that demonstrate disrespect for the client and that are reasonably expected by the client, nurse, or others to be emotionally harmful (RNABC et al., 1995)

Ethical violation - a breach of professional behavior which results in unacceptable care, or deliberate wrong-doing in care (CNA, 1991, under revision)

Financial abuse - actions taken with or without the informed consent of the client that result in monetary, personal, or other material benefit, gain, or profit to the nurse, or in monetary or personal material loss for the client (RNABC et al., 1995)

Intimacy - meaningful knowledge and understanding of another based on a relationship of trust; in the nurse-client relationship, intimacy is therapeutic, time-limited, and client-focused

Non-maleficence - the duty to do no harm and to protect others from harm (AARN, 1996)

Non-professional relationship - a social relationship established and maintained by both parties for the purpose of mutual interest and pleasure (RNABC et al., 1995)

Non-therapeutic relationship - a relationship that is not established or maintained to provide professional care

Nurse-client relationship - a relationship established and maintained by the nurse through therapeutic interactions which enable the nurse to provide safe, competent, ethical nursing care

Patient/client - the person(s) to whom nursing activities are directed. This term may encompass groups, family, and/or communities (AARN, 1991a)

Physical abuse - touching or exhibiting behaviors towards clients of a nature that may reasonably be perceived by clients, nurses, or others to be violent or to inflict harm (RNABC et al., 1995)

Power - the capacity to possess knowledge, to act, and to influence events based on one's abilities, well being, education, authority, place, or other personal attributes and privileges

Principle - a governing, foundational law of conduct to guide one's thinking and actions (AARN, 1996)

Professional boundaries - those lines which separate therapeutic behavior of a professional from behavior which, whether well intentioned or not, could detract from achievable health outcomes for patients and clients receiving nursing care

Respect - regard for persons as a fellow human beings with legitimate needs, wishes, and beliefs

Responsibility - the obligation to fulfill the terms of implied or explicit contractual agreement in accord with professional and legal nursing standards (AARN, 1991)

Sexual abuse - touching clients in a manner that may be reasonably perceived by clients, nurses, or others to be of a sexual nature (RNABC et al., 1995); initiating, encouraging, or engaging in sexual intercourse or other forms of sexual physical contact with clients (CNO, 1994)

Standards for nursing practice - statements which describe the desirable and achievable level of performance expected of registered nurses in their practice (RNANS, 1996, p.1).

Therapeutic relationship - a relationship established and maintained with a client by the nurse through the use of professional, knowledge, skills and attitudes in order to provide nursing care expected to contribute to the client's health outcomes

Trust - the faith placed in another based on one's perceptions of their knowledge, skills, and attributes

Value - something which is esteemed for its own sake; broad ideals which establish correct directions for action (CNA, 1991, under revision)

Verbal abuse - behavior or remarks towards clients that may reasonably be perceived by clients, nurses, or others to be demeaning, seductive, exploitive, insulting, derogatory, or humiliating (CNO, 1994)

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Appendix A: Additional Professional Boundary Scenarios

The scenarios which follow are provided as examples for teaching or discussion between registered nurses, nurse educators and their students, and others. They are not intended to have only “one right answer”; several interpretations are possible depending on which questions are asked. Commentary on the scenarios provides one possible interpretation for each example. Please use the following questions and others of your own to provoke discussion on the factors to be considered:

What are the needs of the patient?

Is the nurse’s behavior therapeutic for that patient? Why/Why not?

- *Does the nurse’s behavior make it more or less likely that the needs of all of the patients will be met? Why/Why not?*
- *Are there boundary signs that might alert the nurse to a possible boundary issue?*
- *What are the differences between advocating for clients and interfering with clients’ lives?*
- *What would help the nurse differentiate between a helpful relationship and a potentially harmful one in each of these instances?*
- *Should boundary issues such as these be addressed by agency policy? the nurse’s professional judgment? Why/Why not?*

Peter: A Very Special Child

Janice H., RN worked on a locked unit for disturbed children. One of the absolutes on the unit was that the entire team worked with a consistent approach with the children. This was because the children were quick to pick up on inconsistencies and try to manipulate the system to obtain their own desires. Getting their needs met through manipulation prevented the children from learning to trust that they could get what they needed by healthy interactions with staff.

Peter, aged 11, was a freckle-faced patient on the unit. His parents were separated and he normally lived with his mother. They survived on the little she earned every month in her part time job washing dishes at a small cafe in the inner city.

One day Janice arrived on the unit and noted that Peter was walking around in bare feet and that his jeans were ripped and threadbare. She spoke with Peter’s mother who said that she had no money to buy necessities for Peter. Janice, who had a particular fondness for her little patient, went to the mall that evening and bought a pair of warm, fuzzy slippers and a pair of the latest style of jeans. The next morning she gave these items to Peter who threw his arms around her and gave her a sloppy kiss on the cheek.

Much to Janice’s surprise, her colleague Bernice marched up to her that afternoon and asked if they could talk. Bernice informed Janice that she had been almost unable to work with Peter that day, because he refused to do anything unless Janice told him to do it. Peter told Bernice that the only nurse that cared at all for him was Janice, because she bought him nice things. Bernice asked Janice why she had bought the items when there was a social worker on the unit whose job is to look after such things. Janice thought about what Bernice had said and realized that she was right. She decided that she should not have purchased the items for Peter, but should have referred Peter’s mother to the social worker for help.

Issues to Consider:

- Does every resident get this item? Why or why not?
- Are there toiletries and clothing available as needed for any patient who may need them, or just for special ones the nurses are fond of?

Nursing staff in one agency took thoughtful action by asking auxiliary volunteers to put together “care packages” of toiletries. These supplies could then be given to any residents unable to provide their own.

Penny R.: Losing the Line Between Helper and Friend

Mary Beth W. was a new registered nurse on the psychiatric unit of the regional hospital. She had graduated two years previously from a community college, and had been working on a casual basis on several medical-surgical units of the hospital. She was delighted when she got a position on the psychiatric unit, however, because she felt her strongest skills were in the psychosocial area and that she would really be helping people who most needed her help.

Mary Beth was the primary nurse for Penny R., a patient with a long history of severe depression and maladaptive behavior. Over Penny's four month stay in the hospital, Mary Beth learned about Penny's childhood and abusive marriage. Mary Beth was not quite accustomed to hearing the kind of lurid details that Penny felt she needed to share with Mary Beth, but she knew that Penny needed to work through these things by talking about them. Mary Beth noted the improvement in Penny and, finally, the day arrived for her to be discharged from hospital. The plan was for Penny to continue with her counseling at an outpatient psychiatry day program.

Two days later, Mary Beth bumped into Penny in the hospital cafeteria. Penny was looking fragile and said that, although her treatment was going well, she was having difficulty with finding a place to live and she was very lonely. Mary Beth offered to assist Penny with apartment hunting and invited her home that evening for dinner and to discuss the plans. Penny accepted. Within two weeks, Penny was a regular visitor to Mary Beth's and had become an accepted member of Mary Beth's circle of friends.

One of Mary Beth's best friends, Steve, was a self-starter, always involved in a "get rich quick" scheme of one sort or another. Steve introduced Penny to the products and the program. Penny, who still wasn't thinking too clearly, accessed her minimal life-savings, purchased the distributor package of products, and began to work toward "getting rich quick". Because Penny knew almost no one in the community, her efforts were unsuccessful and she was left penniless and terribly unhappy. She spoke with her therapist about her plight and the therapist was very concerned that another health care professional had indirectly caused Penny to get into this situation. The therapist suggested that this was inappropriate behavior on behalf of the nurse, and that Penny should speak with the College about the concerns.

Commentary on Scenarios

The nature of boundary crossings and violations may be related to the patient setting. Gallop (1993) argues that psychiatric nursing differs from other domains of nursing. The Canadian Mental Health Association (1992) estimates that as many as 10% of mental health service providers take advantage of consumers. Most evidence is anecdotal reporting of complaints to professional associations and survey studies of the general public and professional groups.

While the majority of concerns about taking advantage of patients has come from the area of mental health care, difficulties may also occur in settings where clients reside for a period of time. These include physical rehabilitation centers or settings where patients require repeated episodic care, such as renal dialysis, for example. As well, community and home settings, where there is less supervision and more nurse/client exposure, may lead to problems in maintaining the professional relationship. Boundary violations can happen in a variety of situations, and can occur gradually over time, or suddenly in a moment of opportunity (NCSBN, 1995).

One common form of boundary violation is the dual role, where the professional assumes an additional role in the life of the client, such as that of a friend. The consequences for crossing boundaries can be traumatic for both the patient and the nurse (Trudeau & Gafner, 1988). Even non-sexual dual relationships are potentially exploitive. Conflicts between roles occur when expectations or responsibilities of one role conflict with another. Such situations may result in the professional losing objectivity and neglecting the well being of the client.

The continuum of professional behavior from under to over helpful (discussed on p. 5) illustrates that harm can occur on either end of the continuum (NCSBN, 1995). Neither patient in the scenarios above benefited from the over helpful actions of the nurses concerned. In Penny's case, real harms are evident. She has lost money and considerable trust in health professionals; she has also lost important progress in her therapy.

In Peter's case, trust may be restored through the committed efforts of all the staff, including Janice. But unnecessary distress has been created for both Peter and other nursing staff. Peter believes that the only nurse who cares about him is Janice, and Janice feels she has lost a lot of trust with her co-workers as part of a team. She knows she does not go to these lengths for every client in similar need. She thinks more about why she went so far for Peter, when other options were available.

In the end, Janice concludes that the clothes themselves were not so much the problem as the message she seemed to give Peter along with the clothes. She wonders if her gift was intended to do more than tell Peter that he was special, something she wants every child to feel. She realizes that the problem may be that she wanted, too much, to be special to Peter herself.

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