

**Guidelines**



**Expert caring makes  
a difference®**

# **Professional Boundaries for Registered Nurses**

**Guidelines for the Nurse-Client Relationship**

**May 2011**

Approved by the College and Association of Registered Nurses of Alberta (CARNA) Provincial Council, May 2011.

Permission to reproduce this documents is granted. Please recognize CARNA.

College and Association of Registered Nurses of Alberta  
11620 – 168 Street  
Edmonton, AB T5M 4A6

Phone: 780.451.0043 (in Edmonton) or 1.800.252.9392 (Canada-wide)

Fax: 780.452.3276

Email: [practice@nurses.ab.ca](mailto:practice@nurses.ab.ca)

Website: [www.nurses.ab.ca](http://www.nurses.ab.ca)

## Table of Contents

<b>PROFESSIONAL BOUNDARIES ARE AN ESSENTIAL PART OF GOOD NURSING CARE.....</b>	<b>3</b>
<b>PART ONE: PROFESSIONAL BOUNDARIES AND THE NURSE-CLIENT RELATIONSHIP .....</b>	<b>5</b>
Continuum of Professional Behavior	5
Professional Boundaries	6
Boundary Crossings	7
Boundary Violations	8
Sexual Misconduct	9
<b>PART TWO: EXPECTATIONS FOR APPROPRIATE PROFESSIONAL BEHAVIOR ....</b>	<b>9</b>
Key Principles Protect the Nurse-Client Relationship	9
Guidelines for Professional Boundaries	10
<b>PART THREE: TAKE ACTION WHEN A PROFESSIONAL BOUNDARY IS IN QUESTION .....</b>	<b>14</b>
Boundary Signs	14
Boundary Signs for Professional Relationships	14
Protect the Best Interests of the Client	15
Act Early to Avoid Harm	16
<b>CONCLUSION .....</b>	<b>17</b>
<b>GLOSSARY .....</b>	<b>19</b>
<b>REFERENCES.....</b>	<b>22</b>
<b>ACKNOWLEDGEMENTS .....</b>	<b>23</b>
<b>APPENDIX A: DIFFERENCES BETWEEN PROFESSIONAL AND SOCIAL RELATIONSHIPS .....</b>	<b>24</b>
<b>APPENDIX B: OVERVIEW OF THE ALBERTA PROTECTION OF PERSONS IN CARE ACT .....</b>	<b>25</b>

**APPENDIX C: PROFESSIONAL BOUNDARY VIOLATIONS: FORMS OF ABUSE .... 27**

Physical Abuse	27
Verbal Abuse	27
Emotional Abuse	28
Sexual Abuse	28
Financial Abuse	29
Insensitivity to Religious and Cultural Beliefs and Values	29
Neglect	30

**APPENDIX D: PROFESSIONAL BOUNDARIES SCENARIOS: TEACHING TOOLS.. 31**

## Professional Boundaries Are an Essential Part of Good Nursing Care

The College and Association of Registered Nurses of Alberta (CARNA) regulates the practice of all registered nurses in Alberta to support the provision of safe, competent, ethical nursing care. These guidelines provide information and guidance for registered nurses, other professionals and the public about appropriate **professional boundaries**<sup>1</sup> for **nurse-client relationships**. The guidelines also apply to registered nurses in teaching relationships with students, working with research participants, managing staff and in working relationships with coworkers.

It is crucial for all health-care professionals to recognize the differences between **therapeutic relationships** and other types of non-professional relationships. **Boundary violations** can harm the **client**, the professional and even possibly others. While the incidence of boundary violations reported to CARNA is very low, they should never occur in a therapeutic relationship. The potential for harmful boundary incidents is decreased when there is good understanding of the issues involved.

The ability to establish and maintain therapeutic boundaries with clients is an essential component of safe, competent, ethical nursing care. Therapeutic relationships are different from social relationships such as friendship or dating (see Appendix A). Several nursing **competencies** relate to the ability to recognize and **respect** the **boundary signs** in nurse-client relationships. Registered nurses are expected to:

- understand and apply the **nursing practice standards**
- interpret the legal requirements of nursing licensure, legislation and scope of practice
- avoid personal bias when collecting, interpreting and communicating information about those in their care
- promote the client's participation, choice and control in meeting their health-care needs
- identify one's own strengths and limitations through self-evaluation

---

<sup>1</sup> Words or phrases in bold italics are listed in the Glossary. They are displayed in bold italics upon first reference.

- demonstrate an ethical approach to practice and comply with the CNA *Code of Ethics for Registered Nurses* (2008)

These guidelines:

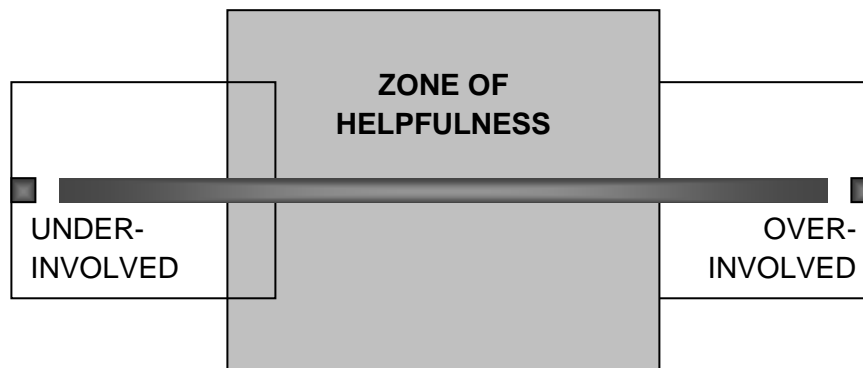
- define what professional boundaries mean for registered nurses
- distinguish between ***boundary crossings***, which registered nurses should monitor in their relationships with clients, and boundary violations, which are unacceptable in any nurse-client relationship
- outline expectations for appropriate professional relationships with clients
- identify the actions that registered nurses or anyone else should take when a professional boundary is in question
- provide examples that can be used for discussion of teaching between registered nurses, nurse educators and their students, and others

## Part One: Professional Boundaries and the Nurse-Client Relationship

### Continuum of Professional Behavior

A continuum provides a picture of therapeutic versus non-therapeutic behavior in the nurse-client relationship. The continuum puts *under-involvement* at one extreme end of behavior and *over-involvement* at the other.

#### A Continuum of Professional Behavior



*Every nurse-client relationship can be plotted on the continuum of professional behavior illustrated above. (National Council of State Boards of Nursing, 2004)*

Under involvement includes distancing from the client, disinterest in the client or their care and **neglect**. Over involvement includes boundary crossings, boundary violations and professional sexual misconduct. 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. The majority of interactions occur within the zone of helpfulness.

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 purpose of this document, professional boundaries are defined as follows:

## Professional Boundaries

**Professional boundaries are the spaces between the nurse's power and the client's vulnerability.** They separate the therapeutic behavior of the registered nurse from any behavior which well intentioned or not could lessen the benefit of care to clients<sup>2</sup>. The **power** of the nurse comes from the professional position and the access to private knowledge about the client. Establishing boundaries allows the nurse to address this power differential and allows a safe connection to meet the client's needs. Professional boundaries set limits to the nurse-client relationship, which establishes a safe therapeutic connection between the professional and the person who seeks care.

The Canadian Nurses Association's (CNA) *Code of Ethics for Registered Nurses* (2008) and the CARNA *Nursing Practice Standards* (2005) set out clear expectations for therapeutic and professional nurse-client relationships. Laws create some boundaries; other limits are set by CARNA as a licensing body and others by practice setting policy. Still other expectations of conduct are established by the individual professional. These expectations influence how we behave with people as clients.

Healthy boundaries keep the nurse-client relationship a safe one where the client and registered nurse are both respected. The client's human dignity, autonomy and privacy are safeguarded, and the registered nurse is recognized as a professional with certain **obligations** and rights. In fact, a critical element for resolving boundary issues is to set limits that respect both the client as a person who needs care and the registered nurse as a person providing professional care.

Health professionals should never forget that clients let us into their homes and their hearts. We protect the **trust** of clients and their families by careful attention to the professional boundaries of our relationships with them. It is understandable for clients and families to feel that health professionals exercise power over their well-being. The registered nurse needs to respect how people's health-care experiences affect their feelings of personal power in their situation. Relationships with clients have both the power to heal and the power to harm.

---

<sup>2</sup> The term 'client' can refer to patients, residents, families, groups, communities and populations.



## Boundary Crossings

***Boundary crossings are brief excursions across boundaries that may be inadvertent, thoughtless or even purposeful if done to meet a specific therapeutic need. They are actions and behaviours that deviate from an established professional boundary.***

Boundary crossings can result in a return to established boundaries but should be evaluated by the nurse for potential client consequences and implications. Repeated boundary crossings should be avoided (NCSBN, n.d.).

Boundary crossings are actions and behaviours that deviate from an established professional boundary. These actions and behaviours may be acceptable and useful in clinical decision-making to meet the client's therapeutic needs when considered in the whole context of the situation. These gray zones exist because nurse-client relationships are two-way. This means that the best course of action is not always obvious. Even where the action or behaviour appears appropriate, it is not acceptable when it benefits the registered nurse's personal needs rather than the needs of the client. Boundary crossings must be kept to a minimum.

A registered nurse or client may intentionally cross a professional boundary for a period of time to establish or maintain a therapeutic relationship. The key is to recognize what is a helpful crossing, and what is not. For instance, in a long-standing relationship, a registered nurse who knows that a client finds a hug comforting, shows compassion and support through such touch. On the other hand, touching of clients in personal ways, may feel abusive to some people. Similarly, sharing a personal story that is relevant to a specific need of a client and to the context of the situation can be therapeutic, but discussing one's personal life at the expense of the client's concerns is not.

Sometimes a client may have expectations of registered nurses that are not shared by the nurses' college, professional association, employer or other groups. Failure to meet all of a client's expectations does not necessarily mean the nurse has crossed a professional boundary, but it may mean that the registered nurse and client need better communication. Unmet expectations may point out unacceptable shortcomings in the care received. Healthy professional boundaries are flexible within the bounds of relevant law and sound professional judgment. When a client legitimately perceives shortcomings in their health care, the registered nurse's role is to help the client gain the care that is needed.

## Boundary Violations

**A boundary violation is an act of abuse in the nurse-client relationship.** Boundary violations can result when there is confusion between the needs of the nurse and those of the client. Such violations may be characterized by excessive personal disclosure by the nurse, secrecy or even a reversal of roles. Boundary violations can cause distress for the client, which may not be recognized or felt by the client until harmful consequences occur (NCSBN, n.d.).

Registered nurses must have a sound understanding of the complexities of professional boundaries. Boundary violations can occur when a professional is not in touch with their own boundaries, or has not taken necessary steps to understand the client's boundaries. Understanding a client's boundaries takes good communication and sensitivity to private issues for each client. Some activities and behaviours are therapeutic and acceptable in certain circumstances if, in the registered nurse's professional judgment, they help to meet the client's therapeutic needs. An act or behaviour that appears appropriate becomes unacceptable if its outcome benefits the registered nurse at the expense of the client.

**Abuse** of clients is an ethical violation of the registered nurse's professional code of ethics. Abuse is defined as the misuse of power or a betrayal of trust, respect or **intimacy** between the registered nurse and the client that the registered nurse or others know may cause, or could be reasonably expected to cause, physical or emotional harm to a client. This refers to all types of abuse including physical, verbal, emotional, sexual, financial, and/or neglect. In Alberta, the *Child, Youth and Family Enhancement Act* (2004) requires that children believed to be in need of protection be reported to Social Services, and the *Protection for Persons in Care Act* (97/2010) requires the abuse of adults to be reported (see Appendix B).

Abuse of clients in any form is unacceptable, and may result in discipline in the work setting or by the professional college, as well as possible criminal charges in certain circumstances. Registered nurses who become aware of abuse must act to protect the client's welfare.

Confused, mentally ill or severely physically disabled clients may be particularly vulnerable to abuse. Examples of the different forms of abuse that characterize professional boundary violations are found in Appendix C.

## Sexual Misconduct

***Professional sexual misconduct is an extreme form of boundary violation and includes behavior that is seductive, sexually demeaning, harassing or reasonably interpreted as sexual by the client (NCSBN, n.d.).***

Romantic or sexually intimate relationships between registered nurses and clients are never appropriate during the course of a therapeutic professional relationship.

Sexual misconduct is an extremely serious violation of the nurse's professional **responsibility** to the client. It is a breach of trust (NCSBN, n.d.).

## Part Two: Expectations for Appropriate Professional Behavior

### Key Principles Protect the Nurse-Client Relationship

Professional boundaries separate therapeutic behavior of the registered nurse from any behavior which, well intentioned or not, could lessen the benefit of care to clients. The following key **principles** provide the framework for discussion and decision-making related to professional boundaries.

- 1. The obligation to maintain healthy professional boundaries lies with every registered nurse, not with the client. Social relationships are not therapeutic ones.** Personal social relations do not promise healing benefit, and are not guided by professional standards of nursing practice or codes of ethics. The registered nurse is responsible for ensuring that professional caring and social relationships are not confused with one another.
- 2. When people seek health care, they are vulnerable.** If a client expresses discomfort about a relationship with a registered nurse, during or after the care takes place, inform them how they can address their concern within the practice setting, or to the appropriate professional college, or the police as required.
- 3. Boundary crossings should be dealt with by the individuals involved on a case-by-case basis,** using agency policy and resources, these guidelines and confidential CARNA consultation as required.
- 4. Boundary violations are acts of abuse that betray a therapeutic nurse-client relationship.** Boundary violations are issues of unprofessional conduct that must

be reported in practice settings and to the professional college to protect client care. These guidelines provide direction for appropriate action.

5. **We can never presume to know another person's boundaries unless they tell us. Boundaries are unique to each person.** What one person experiences as acceptable behavior may be received as a boundary violation by another person. The best policy is therefore to proceed carefully and, when in doubt, ask questions.
6. **Competent and caring professionals can make unintentional mistakes with clients' boundaries.** If you are in doubt about a boundary, base your actions on protecting the therapeutic relationship with the client. Honest mistakes are less likely to turn into a boundary violation if the professional recognizes that a boundary has been breached and asks the client how their boundaries can best be protected.
7. **When you question a professional boundary with any client, seek help.** Mistakes do not necessarily cause boundary violations. It is ignoring mistakes that leads to further and more serious problems. Talk to someone you trust.

## Guidelines for Professional Boundaries

### Prior Relationship with Client

A registered nurse's prior personal relationship with a client (or their significant others) should not infringe on meeting the client's therapeutic needs. Where a prior relationship with a client or their significant other(s) exists, the registered nurse should determine whether the personal relationship could interfere with the provision of care. Where possible, ask the client for their opinion as well. If there is any question about the professional relationship, alternate arrangements for care should be made.

### Romantic or Sexually Intimate Relationships

Romantic or sexually intimate relationships between registered nurses and clients are never appropriate during the course of a therapeutic professional relationship. The consequences of sexual relationships with professionals can be long term for vulnerable clients. Registered nurses must prevent the formation of inappropriate relationships. Some key things to remember include:

- There is no arbitrary time limit that makes it safe for a professional to have a romantic or sexual relationship with a former client. The rule of thumb is that where any doubt exists, the registered nurse should seek impartial advice before proceeding.

- In some instances, registered nurses may have a social relationship with a former client if it is anticipated that there is no further requirement for their nursing care.

Personal relationships with former clients, or continued relationships that existed prior to giving nursing care, must be justified in terms of the public's need for trust in nursing as a profession. The registered nurse should consider the client's overall health status including competence, mental and emotional well-being, the potential for confusion between a therapeutic and a personal relationship, and any harm to the client or significant others which confusion could cause. However, if a former nurse-client relationship was a psychotherapeutic one, the registered nurse must **not** engage in romantic or sexual relationships at any future point unless an impartial professional judges that the relationship would not have a negative impact on the client's well-being.

### Gift Giving

A registered nurse must not receive personal gain of any kind at the client's expense, even where this is the express wish of the client. If either the registered nurse or another person questions whether a professional relationship has become a personal one, it is time to seek impartial assistance to determine if professional boundaries are being respected.

Gift-giving is a complex phenomenon and gifts are given for many reasons. The act of giving care may feel like an imbalance of power for many clients and families who sometimes feel indebted towards health-care providers. Gift-giving, as an act of reciprocity, can be part of the therapeutic process for people who receive care. Registered nurses should exercise professional judgment when deciding to accept a gift by paying attention to what the gift means to the client, specific agency policies, the *CNA Code of Ethics for Registered Nurses (2008)* and the *Nursing Practice Standards (CARNA, 2005)*.

In all cultures, gifts are sometimes given from the care receiver to the caregiver. Decisions about gifts should be guided by the following principles:

- Cash gifts should never exchange hands between registered nurses and clients.
- Gifts of gratitude and gifts of obligation may be acceptable in appropriate circumstances. The former type of gift may be an essential part of the client's recovery process and the latter type is often a normative courtesy.
- If a registered nurse feels coerced or manipulated by the offer of any gift, it should 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 client may

need reassurance or it may be that the registered nurse should assess for other unmet needs.

- Gifts that might be misunderstood by either the registered nurse or the client can be handled with tact and appreciation. For instance, offers of money, trips or other tangible benefits would not be acceptable for a registered nurse. However, clients who wish to give thanks in this manner may be allowed by agency policy to donate funds to a charity of their choice.
- Clients should never form the impression that their care is dependent upon donations of any kind. Where agency policies explicitly prohibit gift-giving, registered nurses may encourage administration to reconsider mechanisms that allow for gift-giving without compromise of either the agency or the professionals providing care.

The potential for **financial abuse** can be avoided if registered nurses guide their actions about gifts offered by clients by decisions which safeguard both the client's finances and their well-being. Where it contravenes agency policy to accept a particular type of gift, the registered nurse can try to arrange for an alternative gift that is acceptable to both the client and the agency. However, agency policies do not always protect all clients from harm in the situation of offering gifts. Where the policy does not provide adequate protection in the judgment of the registered nurse, advice from the professional college should be sought to determine how the client's financial and emotional interests are best protected.

### Legal Agent

There are circumstances where a client and registered nurse may decide that a pre-existing social relationship is more important than the caregiving one. For instance, a client may want to designate a registered nurse who is a friend they know well, to act as their agent for personal directives in the event of incapacity (Alta. Reg. 99/2008 [Personal Directives Regulation]) or the Executor for their Will. If a registered nurse agrees to be a client's agent, healthy boundaries are best safeguarded by not providing direct care to that client.

### Self-Disclosure

Self-disclosure is the sharing of personal information to improve understanding between individuals. A registered nurse may use self-disclosure when it is judged that the information might therapeutically benefit the client. However, personal relationships such as friendships or romantic involvements also begin with mutual disclosures. The formation of an inappropriate personal relationship with a client can also result in

**emotional abuse** and severe harm to the client and/or significant others. The following principles about self-disclosure should guide the nurse-client relationship.

- Self-disclosure by the registered nurse must always be provided for the client's welfare. It is never acceptable when it is for the purpose of meeting the registered nurse's needs.
- The registered nurse should ensure that personal information is related to the client's interests. Where the benefit of the disclosure to the client is unclear, it is best to err on the side of caution and refrain from the disclosure.

If the registered nurse questions whether disclosures are occurring because of unmet needs or difficulties in the client's personal relationships, the appropriate action is to discuss this concern with the client. The registered nurse can support the client to obtain counseling or other services to deal with personal issues, rather than encouraging the client to form a substitute personal relationship with the registered nurse.

### **Social Media**

Social Media such as Facebook, Twitter and MySpace, YouTube, and blogs are increasingly being used for communication purposes, education, information sharing, networking and learning tools. (CNPS, 2010). It is estimated that Facebook has 400 million active users (Lee, K. & Bacon. L., 2010). With the ease of communication through technology come questions related to online friendships with clients, protection of privacy and confidentiality, and professional boundaries. Guidelines for professional boundaries outlined in this document are applicable to online relationships as well. The following provides additional guidance related to social media:

- Registered nurses should separate the use of social media for professional and social purposes.
- Client information or pictures should never be posted on social media sites even if the registered nurse believes it is anonymous data that is being shared. At all times client privacy and confidentiality must be protected.
- Registered nurses should use high levels of security on social media sites. Information is rapidly and easily distributed through "friend of a friend" connections.
- When a client requests that a registered nurse be an online friend, the nurse must carefully examine the context of the situation, the therapeutic client-nurse relationship, the vulnerability of the client and the implications of the request for the nurse and the client. A number of potential problems can arise, such as inappropriate self-disclosure, client dependence on the nurse, the nurse meeting

their own needs through the client and compromising patient privacy and confidentiality.

Nurses should always consider if what they are putting on their social media site is professional and projects the image they want friends, colleagues, clients and managers to have of them. If it has been posted or transmitted electronically, assume it is permanent (Bernis-Dougherty, A., 2010).

## Part Three: Take Action When a Professional Boundary is in Question

### Boundary Signs

All registered nurses should reflect upon professional boundaries and the therapeutic relationships with their clients. Boundary signs are warning signals that professional boundaries are in question, or have already been crossed. Boundary signs warn the registered nurse to stop and take another look at a relationship with a client.

### Boundary Signs for Professional Relationships

Warning signs that professional boundaries of the nurse-client relationship may be jeopardized 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 client's progress is limited
- noticing more physical touching than is appropriate or sexual content in interactions with the client
- favoring one client's care at the expense of another's
- keeping secrets with the client
- selective reporting of client's behaviour (i.e., negative or positive client behaviour)
- swapping client 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 client after discharge
- denying the fact that the client is a client
- 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***

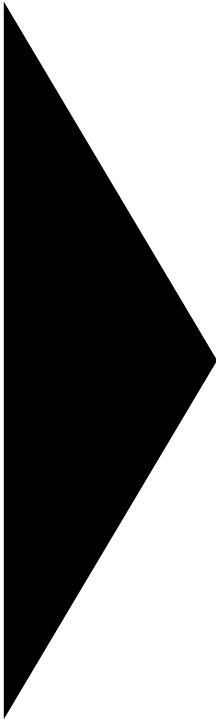
(Coltrane & Pugh, 1978)

## Protect the Best Interests of the Client

If you are concerned about a professional relationship with a client, you must act to protect the welfare of the client. The following decision-making framework can help you safeguard your relationships with clients.

Ask yourself:

- Is it consistent with the CNA *Code of Ethics for Registered Nurses* (2008)?
- Is it consistent with CARNA *Nursing Practice Standards* (2003) and *Entry-to-Practice Competencies for the Registered Nurses Profession* (2006)?
- Is it consistent with your duty to act in the best interest of your client?
- Does it promote client autonomy and self-determination?
- Is this a behaviour or interaction you would want other people to know you had engaged in with a client?



If the answer is 'no' to any of these questions, refrain from the behaviour. Discuss your concerns with CARNA, a supervisor or a colleague.

Adapted from the 1998 Registered Nurses' Association of Nova Scotia document: *Professional Boundaries and Expectations for Nurse-Client Relationships* (revised 2002.)

## Act Early to Avoid Harm

When you have a concern about the professional boundaries of a fellow registered nurse, client protection must be your first concern. Follow these steps to safeguard the client and the registered nurse from harm:

- Determine the facts. Avoid hasty judgments. Focus on the client's welfare when assessing the facts and get each party's point of view, particularly the client's perceptions. Wherever possible, discuss your concerns with the registered nurse involved.

- If you are unable to talk to the registered nurse directly, the next best step is to speak with the immediate supervisor. Explain your reasons for concern, and stick to observable facts and their relationship to client care. Always follow appropriate agency mechanisms for reporting observed incidents of boundary violations, including adequate documentation.
- Identify the actions you expect will occur to resolve the situation. If discussion confirms your concerns and you believe that there may be a professional boundary violation, offer your assistance to get your colleague help within your setting. CARNA Nursing Practice Consultants can also provide confidential consultation on how to proceed.
- Ensure that clients, families or other health-care professionals are aware of who to contact if they have any concerns regarding therapeutic nurse-client relationships. They need to know who they can talk to in the agency, or the appropriate professional college or the police as required.
- Do not allow a problem situation to persist uncorrected. Discuss concerns about the individual's conduct with the college and professional association. Early intervention prevents client harm and protects the registered nurse's professional status.
- If a written complaint is warranted, notify the registered nurse. Confidential consultation with CARNA Nursing Practice Consultants enables you to determine if a written complaint about the registered nurse's conduct is appropriate. Employers or others who determine that a written complaint is necessary should tell the registered nurse that, in conjunction with any appropriate disciplinary action, a report will be made to CARNA to protect public safety.

Analyzing and resolving professional boundary issues takes time and thoughtful discussion. Appendix C provides examples that can be used for discussion or teaching between registered nurses, nurse educators and their students and others.

## Conclusion

Professional boundaries separate therapeutic behaviour of the registered nurse from any behaviour which, well intentioned or not, could lessen the benefit of care to clients. These guidelines outline the professional boundaries of therapeutic relationships between registered nurses and clients who place trust in their care. The ethical limits of relations between registered nurses giving care and those persons who receive nursing care are defined, and boundary violations are described. Information on resources to

help registered nurses and others with questions about professional boundaries is also provided.

Professional boundary issues also arise for registered nurses in teaching relationships with students, working with research participants, managing staff, and in working relationships with co-workers. Registered nurses in any role must ensure that professional boundaries are respected by applying these guidelines to their nursing practice as appropriate for their role. Guidance for appropriate conduct should also be sought in policies for faculty conduct in educational institutions, in research guidelines for researchers, and in personnel policies, labour law and collective agreements for managers and staff.

*For more information about professional boundaries for registered nurses, contact:*

*College and Association of Registered Nurses of Alberta  
11620 - 168 Street  
Edmonton, AB T5M 4A6  
Phone: (403) 451-0043 or 1-800-252-9392 (Canada-wide)  
Fax: (403) 452-3276  
E-mail: [carna@nurses.ab.ca](mailto:carna@nurses.ab.ca)*

## 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 could be reasonably expected to cause, physical, emotional or spiritual harm to a client.

**Accountability** – The ability to explain rationale for actions taken that is consistent with the responsibility for which the nurse is contracted (CARNA, 2005).

**Beneficence** – The principle that outlines a person’s duty to act to benefit another (CARNA, 2010).

**Boundary Crossing** – Brief excursions across boundaries that may be inadvertent, thoughtless or even purposeful if done to meet a specific therapeutic need. They are separate actions and behaviours that deviate from an established professional boundary.

**Boundary Sign** – Actions, behaviours 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** – An act of abuse in the nurse-client relationship.

**Client** – The person(s) to whom nursing activities are directed; may encompass groups, family and/or communities. The term ‘client’ can refer to patients, residents, families, groups, communities and populations.

**Competencies** – The specific knowledge, skills, judgment and interpersonal attributes required for a registered nurse to be considered competent (CARNA, 2006).

**Emotional Abuse** – Verbal and non-verbal behaviours that demonstrate disrespect for the client and that are reasonably perceived by competent clients, registered nurses or others to be emotionally harmful. Such behaviours include sarcasm, intimidation, teasing or taunting, retaliation, manipulation, inappropriate posturing or gestures, threatening, blaming and disregard for the client’s modesty.

**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.

**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.

**Neglect** – Exhibiting behaviours towards clients that may be reasonably perceived by the client, nurses or others to be a breach of the professional's duty of care.

**Non-Maleficence** – The duty to do no harm and to protect others from harm (CARNA, 2010).

**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.

**Nursing Practice Standards** – Statements which outline acceptable requirements for determining the quality of nursing care a client receives (CARNA, 2005).

**Obligation** – A directive which spells out what actions a given value requires under particular circumstances.

**Physical Abuse** – Touching or exhibiting behaviours towards clients of a nature that may reasonably be perceived by clients, nurses or others to be violent, threatening or to inflict physical harm.

**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 (CARNA, 2010).

**Professional Boundaries** – the spaces between the nurse's power and the client's vulnerability.

**Respect** – regard for persons as fellow human beings with legitimate needs, wishes and beliefs.

**Responsibility** – Obligation to provide for the needs for nursing care in accordance with professional and legal standards (CARNA, CLPNA, CRPNA, 2010).

**Sexual Abuse** – touching clients in a manner that may be reasonably perceived by clients, nurses or others to be sexually or otherwise demeaning, seductive, suggestive, exploitative, derogatory or humiliating and touching of an abusive nature. It includes initiating, encouraging or engaging in sexual intercourse or other forms of sexual physical contact with clients.

**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 the knowledge, skills and attributes of the other.

**Value** – Something which is esteemed for its own sake; broad ideals which establish correct directions for action.

**Verbal Abuse** – Communication that may reasonably be perceived to demonstrate disrespect for the client and which is perceived by the client or others to be demeaning, seductive, exploitive, insulting, derogatory or humiliating.

## References

- Bermis-Dougherty, A. (2010, February). Professionalism and social networking: Social networking offers many benefits for physical therapists and physical therapist assistants. But it's important to avoid the pitfalls. *PT in Motion*, 40-47.
- British Columbia Rehabilitation Society. (1992). *Boundaries workshop material*. Vancouver, BC: Author.
- Canadian Nurses Association. (2008). *Code of ethics for registered nurses*. Ottawa, ON: Author.
- Canadian Nurses Protective Society. (2010). *Social media*. Ottawa, ON: Author.
- Child, Youth and Family Enhancement Act*, S.A. 2004, c-12.
- College and Association of Registered Nurses of Alberta. (2005). *Nursing practice standards*. Edmonton, AB: Author.
- College and Association of Registered Nurses of Alberta. (2006). *Entry-to-practice competencies*. Edmonton, AB: Author.
- College and Association of Registered Nurses of Alberta. (2010). *Ethical decision-making for registered nurses in Alberta: Guidelines and recommendations*. Edmonton, AB: Author.
- College and Association of Registered Nurses of Alberta, College and Association of Licensed Practical Nurses & College of Registered Psychiatric Nurses of Alberta. (2010). *Decision-making standards for registered nurses in the supervision of health care aides*. Edmonton, AB: Author.
- College of Registered Nurses of Nova Scotia. (2002). *Professional boundaries and expectations for nurse-client relationships*. Dartmouth, NS: Author.
- Coltrane, F., & Pugh, C. D. (1978). Danger signals in staff/patient relationships in the therapeutic milieu. *Journal of Psychiatric Nursing and Mental Health Services*, 16(6), 34-36.
- Lee, K. & Bacon, L. (2010). Social networking: Confidentiality and professional issues. *British Journal of Midwifery*, 18(8), 533-534.
- Mental Health Act*, Alta. Reg. 148/2004.



- Milgrom, J. (1992). *Boundaries in professional relationships: A training manual*. Minneapolis, MN: Walk-In Counseling Centre.
- National Council of State Boards of Nursing. (2004). *A nurses guide to the importance of professional boundaries*. Chicago, IL: Author.
- National Council of State Boards of Nursing. (n.d.). *Professional boundaries: A nurse's guide to the importance of appropriate professional boundaries*. Chicago, IL: Author.
- Nurses Association of New Brunswick. (2000). *Standards for the therapeutic nurse-client relationship*. Fredericton, NB: Author.
- Personal Directives (Ministerial) Regulation*, Alta. Reg. 99/2008.
- Persons with Developmental Disabilities Community Governance Act*, Alta. Reg. 181/2006.
- Protection for Persons in Care Amendment Act*, S.A. 97/2010, c. 21.

## Acknowledgements

The College and Association of Registered Nurses of Alberta of Alberta (CARNA) gratefully acknowledges the Practice Review Committee, an AARN regulatory committee under the Nursing Profession Act, for the development of the 1997 AARN document: *Professional Boundaries: A Discussion Paper on Expectations for Nurse-Client Relationships*.

## Appendix A: Differences between Professional and Social Relationships

Characteristic	<i>Professional Relationship (nurse-client)</i>	Non-Professional Relationship (casual, friendship, romantic)
<b>Remuneration</b>	<i>nurses paid to provide care to client</i>	no payment for being in the relationship
<b>Length of relationship</b>	<i>time-limited for the length of the client's need for nursing care</i>	may last a lifetime
<b>Location of relationship</b>	<i>place defined and limited to where nursing care is provided</i>	place unlimited; often undefined
<b>Purpose of relationship</b>	<i>goal-directed to provide care to client</i>	pleasure, interest-directed
<b>Structure of relationship</b>	<i>for nurse to provide care to client</i>	spontaneous, unstructured
<b>Power balance</b>	<i>unequal power - nurse has more power due to authority, knowledge, influence and access to privileged information about client</i>	relatively equal
<b>Responsibility for the relationship</b>	<i>nurse responsible for establishing and maintaining professional relationship, not client</i>	equal responsibility to establish and maintain
<b>Preparation for the relationship</b>	<i>nurse requires formal knowledge, preparation, orientation and training</i>	does not require formal knowledge, preparation, orientation and training
<b>Time spent in relationship</b>	<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)		

## Appendix B: Overview of the Alberta Protection of Persons in Care Act

### Abuse Must Be Reported

The Government of Alberta has taken steps to place registered nurses and others under a legal obligation to report abuse. This change in the law reflects an understanding of the harm that can occur as a result of boundary violations.

The *Protection for Persons in Care Act* came into force in January of 1997 and was updated July, 2010. This Act requires registered nurses to report abuse of adults. The new Act still applies to service providers that receive funds from the Government of Alberta, directly or indirectly, for the provision of care or support services. Service providers include nursing homes, hospitals, group homes, seniors' lodges, shelters and other supportive living settings. In the Act, care or support services means any services that relate to a client's health, or physical or psychological well-being.

The new Act also applies to mental health facilities designated under the *Mental Health Act*. Additional service providers are specified in the regulations, including:

- operators of supportive living accommodation
- a person that provides care or support services, other than family-managed supports, to individuals with developmental disabilities and receives funding under the *Persons with Developmental Disabilities Community Governance Act* for the provision of those services
- a person that provides day programs, residential and care or support services funded by Alberta Health Services, including, without limitation, addictions and mental health treatment and rehabilitation centres

The *Protection for Persons in Care Act* defines abuse as follows:

- (2) In this Act, "abuse" means an act or an omission with respect to a client receiving care or support services from a service provider that
  - (a) causes serious bodily harm,
  - (b) causes serious emotional harm,
  - (c) results in the administration, withholding or prescribing of medication for an inappropriate purpose, resulting in serious bodily harm,
  - (d) subjects an individual to non-consensual sexual contact, activity or behavior,

- (e) involves misappropriating or improperly or illegally converting a significant amount of money or other valuable possessions, or
- (f) results in failing to provide adequate nutrition, adequate medical attention or another necessity of life without a valid consent, resulting in serious bodily harm.

This definition of abuse would encompass **physical abuse**, **verbal abuse**, emotional abuse, **sexual abuse** and financial abuse.

### Duties of Service Providers

The Act reflects a commitment to improve the safety, security, and wellbeing of adults who access care or support services in Alberta.

The Act sets out the following duties:

- All service providers, employees of service providers and others who provide care or support services to clients must take reasonable steps to protect clients from abuse while providing care or support services, and to maintain a reasonable level of safety for clients.
- When notified of a report of abuse, service providers must take all reasonable steps to provide for the immediate safety, security and wellbeing of the client and any other clients who may be at risk of abuse.
- All service providers are required to make the information in this Act available to all clients, volunteers, employees and contractors.
- All service providers must require a criminal records check from every successful employment applicant, every new volunteer and any other individual engaged by the service provider to provide care or support services.

A registered nurse who fails to report is guilty of an offence and may be fined up to \$10,000 and service providers up to \$100,000.

The Government of Alberta has established a toll-free line (1-888-357-9339) where abuse may be reported.

## Appendix C: Professional Boundary Violations: Forms of Abuse

### Physical Abuse

Physical abuse involves touching or exhibiting behaviours towards clients of a nature that may reasonably be perceived by clients, registered nurses or others to be violent, threatening or to inflict physical harm. Inappropriate behaviours include actions like hitting, scratching, pushing, kicking, using force, biting, pinching, slapping, shaking and/or handling a client in a rough manner. Points to consider include:

- It is appropriate for staff to take actions to protect themselves from harm in a situation where violent behaviour occurs. Protective actions should not be mistaken for physical abuse. Registered nurses who work with potentially violent clients need the knowledge, skills and support within their settings to protect themselves and clients. This includes access to sufficient training, personnel, equipment and facilities to keep the environment safe with violent clients.
- CARNA supports the policy of *least restraint* in all client care settings. Harmful effects of the overuse of restraints include skin breakdown, immobilization, urinary incontinence, increased agitation, physical and mental deterioration, and even death. All possible alternatives to restraints should be exhausted before deciding to use a restraint. For example, a simple alteration in the environment of the wandering client, such as locked doors to off-limit areas, may keep the client and others safe, yet still allow as much freedom as possible.
- Staffing decisions can have significant impact on the safety and welfare of clients. Registered nurses who believe that staffing problems are contributing to poor or unsafe care or to the incorrect use of restraints must document and report their concerns and provide the best care possible within the circumstances.

### Verbal Abuse

Verbal abuse is communication that may reasonably be perceived to demonstrate disrespect for the client and which is perceived by the client or others to be demeaning, seductive, exploitive, insulting, derogatory or humiliating. To guard against misunderstandings with clients, registered nurses should keep in mind that:

- The client's preferences for words and terms should guide the registered nurse's interactions within appropriate limits. This does not require the registered nurse to

use terms that are offensive. On the other hand, the registered nurse should not use words or terms other than those that would be acceptable in formal, public exchange.

- Flippant use of terms such as ‘dear’, ‘sweetheart’ and others can be potentially offensive, demeaning and disrespectful. Addressing people casually without their permission can be a mistake and should be discouraged.
- Abusive comments about clients are equally unacceptable whether they are made.

## Emotional Abuse

Emotional abuse involves verbal and non-verbal behaviours that demonstrate disrespect for the client and that are reasonably perceived by competent clients, registered nurses or others to be emotionally harmful. Such behaviours include sarcasm, intimidation, teasing or taunting, retaliation, manipulation, inappropriate posturing or gestures, threatening, blaming and disregard for the client’s modesty. Abuse can also arise from insensitivity to the client’s culture, race, religious practices, economic status or education. It is also abusive to discount the client’s preferences with respect to sex and family dynamics; or to consciously withhold information that could contribute to the client’s well-being.

The potential for emotional abuse may be decreased by attention to the principles outlined for protecting healthy boundaries. It is key to remember that emotional boundaries are not necessarily noticeable to others. A client might try to communicate that a conversation feels hurtful or that a way of touching is upsetting to them by pulling away or making other efforts to increase physical distance, such as lack of eye contact or changes in tone of voice.

## Sexual Abuse

Sexual abuse involves touching clients in a manner that may be reasonably perceived by clients, registered nurses or others to be sexually or otherwise demeaning, seductive, suggestive, exploitative, derogatory or humiliating and touching of an abusive nature. It also includes initiating, encouraging or engaging in sexual intercourse, or other forms of physical sexual contact with clients.

## Financial Abuse

Financial abuse involves actions that result in monetary, personal or other material benefit, gain or profit to the registered nurse, or in monetary or personal material loss for the client. These actions may occur with or without the informed consent of a client. Unacceptable behaviours include borrowing money or property from a client, misappropriation or misuse of money or property, and withholding finances through trickery or theft. Coercive actions to force the sale of a house or possessions, to force a change of a will, or to obtain a client's money or property are also prohibited; as is abuse of trusteeship, of bank accounts, of power of attorney or of guardianship. Points to consider in avoiding the potential for financial abuse are:

- Financial transactions between registered nurses and clients must be limited to those that may be legitimately required by conditions of employment. For instance, agency policy may allow the registered nurse to purchase items on the client's behalf under specific conditions. Or, registered nurses in self-employed practice that are not publicly funded may set legitimate fees that are fully disclosed and agreed to prior to the provision of nursing services. The key to acceptable practice is ensuring that such financial transactions occur within acceptable agency or practice policy, and that policy is fully discussed with, and understood and agreed to by clients.
- Assessing a client's personal income per agency policy to determine access to care is different from probing inappropriately into a person's overall assets. There are limits to what the registered nurse or any other professional has the right to ask clients about their financial situation. When in doubt, check with your agency or the college and professional association before proceeding.
- The best way for registered nurses to avoid any impression of financial abuse is to follow the principles on gift-giving discussed in these guidelines. Contact your employer or CARNA where any question is not resolved through use of these guidelines.

## Insensitivity to Religious and Cultural Beliefs and Values

The registered nurse must not demonstrate behaviours towards a client which may be perceived by the client as being suggestive of thoughtlessness or disrespect for the client's culture and/or religious beliefs.

## Neglect

Neglect involves exhibiting behaviours toward clients that may be reasonably perceived by the client, registered nurses or others to be breach of the professional's duty to care. Neglect occurs when registered nurses fail to meet the basic needs of clients who are unable to meet them themselves. Neglect includes such actions as deliberate withholding of basic necessities or care, such as clothing, food, fluid, needed aids of equipment and medication, or inappropriate activities such as withholding communication, confining, isolating or ignoring the client, not attending to pain, denying the client care, or denying the client privileges. The following points should also be kept in mind:

- Withholding food and/or other treatments is not neglect where the client's wishes for end-of-life treatment are being honoured after comprehensive medical evaluation. Registered nurses or others with questions about end-of-life measures should contact CARNA if they have any concerns about the potential for neglect.
- Chronic lack of resources and/or qualified staff can foster silent, growing neglect of clients as a group over time. Registered nurses in all roles have a professional responsibility to document and report conditions in the practice setting that contribute to the neglect of clients (CNA, 2008; CARNA, 2005.) Failure to report unacceptable environments for clients contributes to ongoing neglect, and is unacceptable behaviour for professionals. Ongoing neglect can become what amounts to abandonment of the client.



## Appendix D: Professional Boundaries Scenarios: Teaching Tools

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 the questions which 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 client?
- Is the nurse's behavior therapeutic for that client? Why/Why not?
- Does the nurse's behavior make it more or less likely that the needs of all of the clients 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?

### I. 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.*

## **II. 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 because she felt her strongest skills were in the psycho-social 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 CARNA about her concerns.*

### **Commentary on Scenarios I and II**

Neither client in the scenarios above benefited from the overly 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 the 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 in particular, 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.

### **III. New in Town: Right Relationships for the Right Reasons**

*Judith was pleased with her new job. Full-time jobs were scarce for new nursing 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 medical-surgical 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 the local stampede 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.*

### **Discussion Questions and Commentary on Scenario III**

- 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?

Judith wasn't sure that there was anything wrong with seeing Will socially. However, she wanted to discuss it with someone in confidence. She called her college and professional association to discuss her decision. They used the table on professional and non-professional relationships outlined in Appendix A of *Professional Boundaries for Registered Nurses: Guidelines for the Nurse-Client Relationship* 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 likely have reached a very different conclusion 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.

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

### **IV. Caring for Dying Patients and 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 has 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 could stay the night with her in case her husband should die in the night.*

#### **Discussion Questions and Commentary on Scenario IV**

- If Pamela stays, would this be a boundary violation? A boundary crossing? High level compassionate care? How are we to decide?
- What are the possible benefits of 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?

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.

### **V. Appropriate Self-Disclosure: Sharing for the Client's Benefit**

*It was just past shift change and Maria, a registered nurse in Labour and Delivery, was transferring her newly assigned patient, Betty, to the antepartum 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."*

### **Commentary on Scenario V**

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..."*

### Discussion Questions and Further Commentary on Scenario V

- 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?

Refer to Appendix B - Professional Boundary Crossings, in *Professional Boundaries for Registered Nurses: Guidelines for the Nurse-Client Relationship* for information on principles about self-disclosure.

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.

### VI. Nursing in a Rural Community

*Joan and Marcy are registered nurses who practise 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 a.m. to 4:30 p.m. or 11:00 a.m. to 7:00 p.m. After hours, Joan and Marcy take one week turns at being on-call for emergencies. The volunteer ambulance personnel 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.*

### Discussion Questions and Commentary on Scenario VI

- 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?

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 registered 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.

### VII. 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 unlikable due to his ‘groping’; he often touched them in a sexually embarrassing manner with his only controllable arm. Although his mental capacity 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 resident’s 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.*

### **Discussion Questions and Commentary on Scenario VII**

- Do you think that *difficult* or *unlikable* 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?

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.