Professional boundaries in learning disability care

In this article...
- Why professional boundaries are important
- Characteristics of professional relationships
- Advice on keeping within boundaries

Professional boundaries are clearly defined and are based on professional codes of conduct and therapeutic intervention; however, many of the healthcare workers in our learning disability services are non-registered support staff. It is equally important, if not more important since they probably spend more direct one-to-one time with patients, for them to understand and adhere to professional boundaries.

This article gives examples of how South Tyneside Foundation Trust learning disability services support the education and training of staff working within the community and domiciliary care services in maintaining boundaries with patients.

What are boundaries?
There has been recognition of the need for professional boundaries since the beginning of the nursing profession. Lystra Gretter, author of the Florence Nightingale Pledge, in 1893 wrote:
“[I] will abstain from whatever is deleterious and mischievous… maintain and elevate the standard of my profession… will hold in confidence matters committed to my keeping… in the practice of my calling… and devote myself to the welfare of those committed to my care.” (McBurney and Filoromo, 1994)

Boundaries are defined by the NMC (2012) as “the limits of behaviour which allow a nurse or midwife to have a professional relationship with a person in their care” and by the National Council of State Boards of Nursing (1996) as “the spaces between the nurse’s power and the patient’s vulnerability”.

The relationship between a nurse and the person in their care is a professional

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5 key points
1 Staff in learning disability services work with vulnerable patients and the risk of professional boundary violations is relatively high
2 Boundary violations may range from accepting gifts from patients or families to inappropriate touching or sexual behaviour
3 Healthcare workers providing direct patient care need to be aware of professional boundaries
4 South Tyneside Foundation Trust’s learning disability service has introduced training and reflection for healthcare workers on professional boundaries
5 Consideration of warning signs and use of case scenarios can help staff to reflect on their own relationships with clients

Nurses and other staff in learning disability care may unwittingly or deliberately breach professional boundaries. Education and discussion can help manage this
Boundary issues range from giving or receiving a gift from patients, to picking up groceries for a housebound patient, to social contacts with former patients or their relatives, to having a sexual relationship with patients. While there is guidance for registered health professionals regarding maintaining professional boundaries (NMC, 2012), including sexual boundaries (Council for Healthcare Regulatory Excellence (CHRE), 2009), there does not appear to be anything specific for non-qualified healthcare workers.

Within the community learning disability services at South Tyneside Foundation Trust, we have recognised a need to adopt these principles for non-registered healthcare workers who come into contact with clients and their families. To support their understanding and training, we have developed a framework for one-to-one discussion and supervision, including use of case scenarios. This supports staff in:

» Identifying the differences between professional and personal relationships;
» Understanding professional boundaries;
» Picking up on early signs of boundary issues and taking appropriate action.

Table 1 shows examples of characteristics of professional and personal relationships, that are discussed with the healthcare worker.

Discussions about relationships focus on meeting the health needs of the person in their care. A healthcare worker crosses a professional boundary when they behave in any way that oversteps their professional role with a client in their care, or with a client’s family member or anyone else involved in the client’s care to create a personal relationship. In professional relationships an intimacy may develop as a result of the person receiving the care sharing personal information, feelings and vulnerabilities. This should not be confused with social intimacy.

Perry (2011) argues staff who work in acute care often benefit from having the physical boundaries of a facility to help remind them of their professional boundaries, and from the fact that professional relationships are usually developed in a public arena.

Working within the community learning disability services, most of our staff are home-care providers. This may place them in situations and circumstances where adhering to professional boundaries is more difficult as we cannot always control what happens in a patient’s home. Therefore, it is vital we guide and support our staff not only to protect the patient and family, but also to protect the clinician and the organisation.

The relationship between nurses or healthcare workers and clients is one of unequal power, as the professional carer has authority, knowledge, access to privileged information and influence. It is the responsibility of health professionals to be aware of this imbalance to maintain clear boundaries (CHRE, 2009).

Reasons for power imbalances are:

» That the person in care may have to disclose personal information in order to be diagnosed and have treatment;
» Often it is the health professional who influences the level of intimacy or physical contact during the therapeutic and diagnostic processes;
» The health professional knows what it is that constitutes appropriateness associated with professional practice, but the person receiving the care may not know what is appropriate (CHRE, 2009).

The appropriate use of power in a caring manner enables the healthcare worker to work with the patient to meet the patient’s needs. However, any misuse of that power is considered abuse. Abuse can also mean betraying a patient’s trust, or violating the respect or professional intimacy inherent in the relationship. Abuse may be verbal, emotional, physical, sexual, and financial or take the form of neglect.

Given the imbalance that is inherent in the carer-client relationship within learning disability services, clients often find it difficult to negotiate boundaries or recognise when to defend themselves against boundary violations. The client may be unaware of the need for professional boundaries and therefore may at times initiate behaviour or make requests that overstep the boundaries, so it is up to the healthcare worker to ensure boundaries are respected and maintained.

Crossing these relationship boundaries may not always be clear cut and can sometimes be considered “grey zones” of clinical decision-making where the best course of action is not always obvious (College of Registered Nurses of Nova Scotia, 2002).

Grey zones also exist because such relationships are two-way. For example, a healthcare worker may disclose to a patient that her car is in need of repair but she doesn’t know how she is going to pay for this as her husband is out of work. She mentions that if she doesn’t get her car fixed that she will have difficulty getting to work. The patient then begins to worry about the healthcare worker’s situation, then offers to loan her the money for the repair. This disclosure was inappropriate as it was meeting the needs of the healthcare worker and not those of the patient. The patient may have felt the healthcare worker was looking to her for financial assistance and this caused unnecessary worry for the patient.

As the expectations of the relationship changes and expectations become unclear

<table>
<thead>
<tr>
<th>Characteristic</th>
<th>Professional relationship (carer-client)</th>
<th>Personal relationship (casual, friendly, romantic, sexual)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Behaviour</td>
<td>Regulated by a code of ethics and professional standards</td>
<td>Guided by personal values and beliefs</td>
</tr>
<tr>
<td>Renumeration</td>
<td>Carer is paid to provide care to client via contract of employment</td>
<td>No payment for being in the relationship</td>
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<tr>
<td>Purpose of relationship</td>
<td>Goal-directed to provide care to client</td>
<td>Pleasure, interest-directed</td>
</tr>
<tr>
<td>Power balance of relationship</td>
<td>Unequal: carer has more power due to authority, knowledge, influence and access to privileged information about client</td>
<td>Relatively equal</td>
</tr>
<tr>
<td>Responsibility for relationship</td>
<td>Carer (not client) responsible for establishing and maintaining professional relationship</td>
<td>Equal responsibility to establish and maintain</td>
</tr>
</tbody>
</table>

Source: College of Physical Therapists of British Columbia (2009)
## Discussion

### TABLE 2. PROFESSIONAL BOUNDARIES FOR CAREGIVERS

<table>
<thead>
<tr>
<th>Type of boundary crossing</th>
<th>Staying with boundaries</th>
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<tbody>
<tr>
<td><strong>Sharing personal information</strong></td>
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<td>● It may be tempting to talk to your client about your personal life or problems. Doing so may cause the client to see you as a friend instead of seeing you as a health professional. As a result, the client may take on your worries as well as their own.</td>
<td>● Use caution when talking to a client about your personal life. Do not share information because you need to talk or to help you feel better. Remember that your relationship with your client must be therapeutic, not social.</td>
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<tr>
<td>● Not seeing behaviour as symptomatic</td>
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<td>● Sometimes caregivers react emotionally to the actions of a client and forget that these actions may be symptomatic – that is, caused by a disorder or disease. Personal emotional responses can cause a caregiver to lose sight of their role or miss important information from a client. In the worst cases, they can lead to abuse or neglect of a client.</td>
<td>● Be aware that a client’s behaviour is the result of a disease or disorder. Know the client’s care plan. If you are about to respond emotionally or reflexively to the negative behaviour of a client, step back and reproach the client later. Note that the client may think their action is the best way to solve a problem or fill a need. Ask yourself if there is a way to solve problems and help the client communicate or react differently.</td>
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<tr>
<td><strong>Touch</strong></td>
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<td>● Touch is a powerful tool. It can be healing and comforting or it can be confusing, hurtful or simply unwelcome. Touch should be used sparingly and thoughtfully</td>
<td>● Use touch only when it will serve a good purpose for the client. Ask your clients if they are comfortable with your touch. Be aware that a client may react differently to touch from what you intended. When using touch, be sure it is serving the client’s needs and not your own.</td>
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<tr>
<td><strong>Gifts, tips and favours</strong></td>
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<tr>
<td>● Giving or receiving gifts or doing special favours can blur the line between a professional and a personal relationship.</td>
<td>● Follow trust policy on gifts. Practise saying no graciously to a client who offers a gift that is outside your trust’s limits on what is acceptable. It is acceptable to tell clients that you are not allowed to receive gifts or tips. To protect yourself, report offers of unusual or large gifts to your team leader. Don’t buy gifts for your clients.</td>
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<tr>
<td>● Accepting a gift from a client may be taken as fraud or theft by another person or family member.</td>
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<tr>
<td><strong>Over-involvement</strong></td>
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<td>● Signs may include spending inappropriate amounts of time with a particular client, visiting the client when off duty, trading assignments to be with the client and thinking that you are the only caregiver who can meet the client’s needs.</td>
<td>● Focus on the needs of those in your care, rather than their personalities. Do not confuse the needs of the client with your own needs. Maintain a helpful relationship, treating each client with the same quality of care and attention. Ask yourself – are you becoming overly involved in the client’s personal life? If so, discuss your feelings with your team leader.</td>
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### Understanding boundaries in the carer-client relationship

It is important for healthcare workers to be aware when a professional relationship is slipping into the non-professional realm and to take immediate action.

Table 2 gives some examples, by no means exhaustive, of some boundary violations. It attempts to offer guidance on how crossing from professional to personal can be avoided when the healthcare worker is aware of their own behaviour. Therefore ensuring the relationship with the patient is a professional one. A more comprehensive version of this is used in the regular one-to-one discussions and annual personal development planning with staff across our services.

Another measure that is helpful for healthcare workers to determine their relationship with a client is to measure their relationship against the continuum of professional behaviour (Fig 1). The central “zone of helpfulness” is where the majority of client interactions should occur for effectiveness and client safety. Over-involvement with a client, on the right side of this zone, indicates boundary crossings, boundary violations and professional misconduct. Under-involvement, on the left side, includes distancing and neglect and can be detrimental to the client and the carer.

Every carer/client relationship can be plotted on this continuum of professional behaviour and it is an effective tool that the carer can use, with their supervisor, to consider their behaviour.

Box 1 lists some indicators (by no means exhaustive) that may act as warning bells to carers that their behaviour has stepped outside of a professional relationship with the client (Smith et al, 1997). Ticking any of these this would suggest that you have crossed the line from professional to personal and your relationship with the client is becoming or has become blurred – no matter how innocent your intent.

Discussions based upon Tables 1 and 2 and Box 1 are used with healthcare workers during personal development planning and training, and to also reflect on decision-making skills, which may affect professional boundaries. Smyth (1996) advocates that nurses should reflect on their own interactions with patients to understand why they acted or responded the way that they did. Personal values, culture or beliefs can affect how we interact with others and how we respond when others don’t always have the same values or opinions as our
own. We have found it useful to reflect on our own thoughts and feelings when reflecting on practice.

The following are examples of the case scenarios we have used to prompt discussion and examine responses.

**Scenario 1**
You are a healthcare worker working on a hospital ward. A person with a learning disability with a chronic disease was admitted a month ago and you have become particularly attached to him. His family can only visit infrequently. On his birthday you buy him a present costing £20 and make a cake. He is thrilled. You feel good.

**Should you do this, if so why?**

**Answer scenario 1**

In your enthusiasm to do something special for the person with a learning disability, you independently singled out an individual client.

You did not carefully consider the broader implications of giving a gift to this person. As a result, another client on the ward may have felt excluded. Also the giving of a gift can be seen as an attempt by you to create a special, personal relationship beyond the boundaries of the carer-client relationship. The reaction of the family may create an element of mistrust if the family is concerned about you putting them at a disadvantage and alienating them from their family member’s affection.

**Scenario 2**
You have been caring for an older couple at home periodically for many years. Often they serve you a cup of tea and a cookie before you go to your next client.

You consider it your coffee break and it gives the couple some much-needed social contact. One day the woman gives you the teacup and saucer to take home. She says: “Because it is yours. You always use it. We are giving away things we can’t take to the nursing home.”

When you mention the incident to a colleague, she says: “You should never accept the cup and saucer. It may have no monetary value, but it may have value for the family. It is unlikely you would be accused of theft, but it is beyond the realm of possibility. You need to explore the intent of the gift with the couple. Perhaps they view you as their own child and expect an ongoing personal relationship with you. Perhaps it is part of terminating the carer-client relationship. You can then respond to their intent and gracefully decline, explaining you will always have the memories of the couple, but cannot accept the gift. In this scenario you must follow trust policy and can quote it to the couple.

If anyone becomes aware that another healthcare worker has, or even may have, breached boundaries then this must be reported to a person of proper authority. The NMC (2012) reinforces nurses’ professional duty to take action to ensure the people in their care are protected, and that any allegations of abuse or suspected abuse are thoroughly and carefully investigated and reported appropriately.

**Conclusion**

Boundaries must be maintained to ensure safe and effective care is delivered. Our initiative provides a structured framework for exploring the concepts of professional boundaries, and promotes reflective practice and improved decision-making when working with a vulnerable client group.

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**References**


Holland K (2013) Professional Boundaries in Nursing. tinyurl.com/prof-bounds-nurs


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**BOX 1. EXAMPLES OF WARNING BELLS FOR CARERS**

- Frequently thinking of the client when away from work
- Frequently planning other clients’ care around that client’s needs
- Seeking social contact with or spending free time with the client
- Sharing personal information or work concerns with the client
- Feeling so strongly about the client’s goals that colleagues’ comments or the client’s or their family’s wishes are disregarded
- Hiding aspects of the relationship with the client from others
- More physical touching than is appropriate or required for the situation
- Romantic or sexual thoughts about the client

Source: Smith et al (1997)