

Therapeutic Nurse-Client Relationship, Revised 2006

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Nursing standards are expectations that contribute to public protection. They inform nurses of their accountabilities and the public of what to expect of nurses. Standards apply to all nurses regardless of their role, job description or area of practice.

— *College of Nurses of Ontario*

Introduction

At the core of nursing is the therapeutic nurse-client relationship. The nurse¹ establishes and maintains this key relationship by using nursing knowledge and skills, as well as applying caring attitudes and behaviours. Therapeutic nursing services contribute to the **client's**² health and well-being. The relationship is based on trust, respect, empathy and professional intimacy, and requires appropriate use of the power inherent in the care provider's role.

This document replaces the 1999 *Therapeutic Nurse-Client Relationship* practice standard, and provides greater clarity and direction on:

- giving gifts to and receiving gifts from clients;
- accepting power of attorney on behalf of clients;
- setting appropriate **boundaries** for the relationship;
- identifying and dealing effectively with unacceptable and/or abusive behaviour in nurse-client relationships; and
- exercising professional judgment when establishing, maintaining and terminating a therapeutic relationship.

The College of Nurses of Ontario's (the College's) practice standards apply to all nurses, regardless of their role or practice area. The College publishes practice standards to promote safe, effective, ethical care, and to:

- outline the generally accepted expectations of nurses and set out the professional basis of nursing practice;
- provide a guide to the knowledge, skill, judgment

- and attitudes required to practise safely;
- describe what each nurse is accountable for in practice; and
- provide guidance in the interest of public protection.

Components of the nurse-client relationship

There are five components to the nurse-client relationship: trust, respect, professional intimacy, empathy and power. Regardless of the context, length of interaction and whether a nurse is the primary or secondary care provider, these components are always present.

Trust. Trust is critical in the nurse-client relationship because the client is in a vulnerable position.³ Initially, trust in a relationship is fragile, so it's especially important that a nurse keep promises to a client. If trust is breached, it becomes difficult to re-establish.⁴

Respect. Respect is the recognition of the inherent dignity, worth and uniqueness of every individual, regardless of socio-economic status, personal attributes and the nature of the health problem.⁵

Professional intimacy. Professional intimacy is inherent in the type of care and services that nurses provide. It may relate to the physical activities, such as bathing, that nurses perform for, and with, the client that create closeness. Professional intimacy can also involve psychological, spiritual and social elements that are identified in the plan of care. Access to the client's personal information, within the meaning of the *Freedom of Information and Protection of Privacy Act*, also contributes to professional intimacy.

Empathy. Empathy is the expression of understanding, validating and resonating with the

¹ In this document, *nurse* refers to a Registered Practical Nurse (RPN), Registered Nurse (RN) and Nurse Practitioner (NP).

² Bolded words are defined in the glossary on page 4.

³ (Hupcey, Penrod, Morse & Mitcham, 2001)

⁴ Based on a 1998 interview with Carla Pepler, NP, and Cheryl Forchuk, RN.

⁵ (American Nurses Association, 2001; Milton, 2005)

meaning that the health care experience holds for the client. In nursing, empathy includes appropriate emotional distance from the client to ensure objectivity and an appropriate professional response.⁶

Power. The nurse-client relationship is one of unequal power. Although the nurse may not immediately perceive it, the nurse has more power than the client. The nurse has more authority and influence in the health care system, specialized knowledge, access to privileged information, and the ability to advocate for the client and the client's

significant others.⁷ The appropriate use of power, in a caring manner, enables the nurse to partner with the client to meet the client's needs. A misuse of power is considered **abuse**.

Therapeutic Nurse-Client Relationship, Revised 2006 includes four standard statements with indicators that describe a nurse's accountabilities in the nurse-client relationship. Use the decision tree on page 11 to determine whether an activity or behaviour is appropriate within the context of the nurse-client relationship.

Glossary

This section defines terminology as used in this practice standard.

Abuse. Abuse means the misuse of the power imbalance intrinsic in the nurse-client relationship. It can also mean the nurse betraying the client's trust, or violating the respect or professional intimacy inherent in the relationship, when the nurse knew, or ought to have known, the action could cause, or could be reasonably expected to cause, physical, emotional or spiritual harm to the client. Abuse may be verbal, emotional, physical, sexual, financial or take the form of neglect. The intent of the nurse does not justify a misuse of power within the nurse-client relationship. For behaviours considered abusive, refer to Appendix A on page 16.

Boundary. A boundary in the nurse-client relationship is the point at which the relationship changes from professional and therapeutic to unprofessional and personal. Crossing a boundary means that the care provider is misusing the power in the relationship to meet her/his personal needs, rather than the needs of the client, or behaving in an unprofessional manner with the client.⁸ The

misuse of power does not have to be intentional to be considered a boundary crossing.

Client. A client may be an individual, family, group or community.

Client-centred care. In this approach, a client is viewed as a whole person. Client-centred care involves advocacy, empowerment and respect for the client's autonomy, voice, self-determination and participation in decision-making.⁹ It is not merely about delivering services where the client is located.

Culture. Culture refers to the shared and learned values, beliefs, norms and ways of life of an individual or a group. It influences thinking, decisions and actions.¹⁰

Psychotherapeutic relationship. A psychotherapeutic relationship involves planned and structured psychological, psychosocial and/or interpersonal interventions aimed at influencing a behaviour, mood and/or the emotional reactions to different stimuli.¹¹

Significant other. A significant other may include, but is not limited to, the person who a client identifies as the most important in his/her life. It could be a spouse, partner, parent, child, sibling or friend.

⁶ (Kunyk & Olson, 2001)

⁷ (Newman, 2005)

⁸ (Smith, Taylor, Keys & Gornto, 1997)

⁹ (Registered Nurses' Association of Ontario, 2002)

¹⁰ (Leininger, 1996)

¹¹ (World Health Organization, 2001)

Standard Statements

There are four standard statements, each with accompanying indicators, which describe a nurse's accountabilities in the nurse-client relationship. The indicators are not all-inclusive; rather, they're broad statements that nurses can modify to their particular practice reality. The indicators are not listed in order of importance.

1) Therapeutic communication

Nurses use a wide range of effective communication strategies and interpersonal skills

to appropriately establish, maintain, re-establish and terminate the nurse-client relationship.

Indicators

The nurse meets the standard by:

- a) introducing herself/himself to the client by name and category¹² and discussing with the client the nurse's and the client's role in the therapeutic relationship (for example, explaining the role of a primary nurse and the length of time that the nurse will be involved in the client's care, or outlining the role of a research nurse in collecting data);
- b) addressing the client by the name and/or title that the client prefers;¹³
- c) giving the client time, opportunity and ability to explain himself/herself, and listening to the client with the intent to understand and without diminishing the client's feelings or immediately giving advice;¹⁴
- d) informing the client that information will be shared with the health care team and identifying the general composition of the health care team;
- e) being aware of her/his verbal and non-verbal communication style and how clients might perceive it;
- f) modifying communication style, as necessary, to meet the needs of the client (for example, to accommodate a different language, literacy level, developmental stage or cognitive status);
- g) helping a client to find the best possible care solution by assessing the client's level of knowledge, and discussing the client's beliefs and wishes;
- h) considering the client's preferences when encouraging the client to advocate on his/her own behalf, or advocating on the client's behalf;
- i) providing information to promote client choice and enable the client to make informed decisions (see the College's *Consent* practice guideline);
- j) listening to, understanding and respecting the client's values, opinions, needs and ethnocultural beliefs and integrating these elements into the care plan with the client's help;
- k) recognizing that all behaviour has meaning and seeking to understand the cause of a client's unusual comment, attitude or behaviour (for example, exploring a client's refusal to eat and finding that it's based in the client's **cultural/religious** observations);
- l) listening to the concerns of the family and **significant others** and acting on those concerns when appropriate and consistent with the client's wishes;
- m) refraining from self-disclosure unless it meets a specific, identified therapeutic client need, rather than the nurse's need;
- n) reflecting on interactions with a client and the health care team, and investing time and effort to continually improve communication skills; and
- o) discussing, throughout the relationship, ongoing plans for meeting the client's care needs after the termination of the nurse-client relationship (for example, discharge planning with the client and/or referral to community organizations).

¹² For more information, refer to the College's *Professional Misconduct* reference document at www.cno.org/publications.

¹³ (Bowie, 1996)

¹⁴ Based on a 1998 interview with Carla Pepler, NP, and Cheryl Forchuk, RN.

2) Client-centred care

Nurses work with the client to ensure that all professional behaviours and actions meet the therapeutic needs of the client.

Indicators

The nurse meets the standard by:

- a) actively including the client as a partner in care because the client is the expert on his/her life,¹⁵ and identifying the client's goals, wishes and preferences and making them the basis of the care plan;
- b) gaining an understanding of the client's abilities, limitations and needs related to his/her health condition and the client's needs for nursing care or services;
- c) discussing expectations with the client and the realistic ability to meet those expectations in the context of the client's health and the available resources;
- d) negotiating with the client both the nurse's and the client's roles, as well as the roles of family and significant others, in achieving the goals identified in the care plan;
- e) recognizing that the client's well-being is affected by the nurse's ability to effectively establish and maintain a therapeutic relationship;
- f) acknowledging biases and feelings that have developed through life experiences, and that these attitudes could affect the nurse-client relationship;
- g) reflecting on how stress can affect the nurse-client relationship, and appropriately managing the cause of the stress so the therapeutic relationship isn't affected;
- h) demonstrating sensitivity and respect for the client's choices, which have grown from the client's individual values and beliefs, including cultural and/or religious beliefs (see the College's *Culturally Sensitive Care* practice guideline);
- i) acknowledging difficulty establishing a therapeutic relationship with a client, and requesting a therapeutic transfer of care when the relationship is not evolving therapeutically (for example, when a nurse is unable to establish a trusting relationship with a client, she/he may consult with the manager to request that another nurse provide care);
- j) committing to being available to the client for the duration of care within the employment boundaries and role context;¹⁶ and
- k) engaging the client in evaluating the nursing care and services that the client is receiving.

¹⁵ (Registered Nurses' Association of Ontario, 2002, p. 19)

¹⁶ (Forchuk et al., 2000; Peplau, 1991)

3) Maintaining boundaries

Nurses are responsible for effectively establishing and maintaining the limits or boundaries in the therapeutic nurse-client relationship.

Indicators

The nurse meets the standard by:

- a) setting and maintaining the appropriate boundaries within the relationship, and helping clients understand when their requests are beyond the limits of the therapeutic relationship;
- b) developing and following a comprehensive care plan with the client and health care team that aims to meet the client's needs;
- c) ensuring that any approach or activity that could be perceived as a boundary crossing is included in the care plan developed by the health care team (for example, a health care team in a mental health setting may determine that having coffee with a particular client is an appropriate strategy that all nurses will consistently use when counselling the client);
- d) recognizing that there may be an increased need for vigilance in maintaining professionalism and boundaries in certain practice settings¹⁷ (for example, when care is provided in a client's home, a nurse may become involved in the family's private life and needs to recognize when her/his behaviour is crossing the boundaries of the nurse-client relationship);
- e) ensuring that she/he does not interfere with the client's personal relationships;
- f) abstaining from disclosing personal information, unless it meets an articulated therapeutic need of the client (for example, disclosing a personal problem may make the client feel as if his/her problems/feelings are being diminished or that the client needs to help the nurse);
- g) continually clarifying her/his role in the therapeutic relationship, especially in situations in which the client may become unclear about the boundaries and limits of the relationship (for example, when an identified part of a nurse's role includes accompanying a client to a funeral to provide care);
- h) ensuring that co-existing relationships do not undermine the judgment and objectivity in the therapeutic nurse-client relationship¹⁸ (for example, a nurse providing care to a child who is a close friend of her/his child needs to be aware of the potential effect the dual relationship has on nursing care);
- i) abstaining from engaging in financial transactions unrelated to the provision of care and services with the client or the client's family/significant other;
- j) consulting with colleagues and/or the manager in any situation in which it is unclear whether a behaviour may cross a boundary of the therapeutic relationship, especially circumstances that include self-disclosure or giving a gift to or accepting a gift from a client;
- k) ensuring that the nurse-client relationship and nursing strategies are developed for the purpose of promoting the health and well-being of the client and not to meet the needs of the nurse,¹⁹ especially when considering self-disclosure, giving a gift to or accepting a gift from a client;
- l) documenting client-specific information in the client's record regarding instances in which it was necessary to consult with a colleague/manager about an uncertain situation (non-client related information, such as a letter of summary or incident report, should be documented on the appropriate confidential form); and
- m) considering the cultural values of the client in the context of maintaining boundaries, including situations that involve self-disclosure and gift giving.

¹⁷ (Walker & Clark, 1999)

¹⁸ (Nadelson & Notman, 2002)

¹⁹ (Peternej-Taylor & Yonge, 2003)

Giving and accepting gifts

The nurse meets the standard by:

- a) abstaining from accepting individual gifts unless, in rare instances, the refusal will harm the nurse-client relationship. If the refusal could be harmful, consult with a manager and/or the College and document the consultation before accepting the gift;
- b) accepting a team gift or an individual gift if the refusal of which has been determined to be harmful to the therapeutic relationship, only after considering:
 - that the gift was not solicited by the nurse,
 - that the client is mentally competent,
 - the client's intent and expectation in offering the gift (that is, will the client expect anything in return, or will the nurse feel a special obligation to that client over others?),
 - the appropriateness of the timing²⁰ (for example, on discharge versus Valentine's Day),
 - the potential for negative feelings on the part of other clients who may not be able to, or choose not to, give gifts, and
 - the monetary value and appropriateness of the gift; and
- c) giving gifts to clients only as a group of nurses or from an agency/corporation after determining that:
 - the client is clear that the nurse does not expect a gift in return;
 - it does not change the dynamics of the therapeutic relationship; and
 - there is no potential for negative feelings on the part of other clients or toward other members of the health care team.

²⁰ (Walker & Clark, 1999)

4) Protecting the client from abuse

Nurses protect the client from harm by ensuring that abuse is prevented, or stopped and reported.

Indicators

The nurse meets the standard by:

- a) intervening and reporting, when appropriate,²¹ incidents of verbal and non-verbal behaviours that demonstrate disrespect for the client;
- b) intervening and reporting behaviours toward a client that may be perceived by the client and/or others to be violent, threatening or intended by the nurse to inflict physical harm;
- c) intervening and reporting a health care provider's behaviours or remarks toward a client that may reasonably be perceived by the nurse and/or others to be romantic, sexually suggestive, exploitive and/or sexually abusive;²²
- d) not entering a friendship, or a romantic, sexual or other personal relationship with a client when a therapeutic relationship exists;
- e) ensuring that after the nurse-client relationship has been terminated and the nature of the relationship has been **psychotherapeutic** or for the provision of intense psychosocial counselling, the nurse:
 - must not engage in a personal friendship, romantic relationship or sexual relationship with the client or the client's significant other for one year following the termination of the therapeutic relationship, and
 - may, after one year, engage in a personal friendship, romantic relationship or sexual relationship with a client (or the client's significant other) only after deciding that such a relationship would not have a negative impact on the well-being of the client or other clients receiving care, and considering the client's likelihood of requiring ongoing care or readmission (if the client returns for further care at the facility, the nurse must declare to her/his manager the nature of the relationship and decline the assignment of the client);
- f) being cautious about entering into a personal relationship, such as a friendship or romantic or sexual relationship, with a former client or a former client's significant other after the termination of a therapeutic relationship if:
 - it is determined that such a relationship would not have a negative impact on the future care of the client,
 - the relationship is not based on the trust and professional intimacy that was developed during the nurse-client relationship, and
 - the client is clear that the relationship is no longer therapeutic;
- g) not engaging in behaviours toward a client that may be perceived by the client and/or others to be violent, threatening or intending to inflict physical harm;
- h) not engaging in behaviours with a client or making remarks that may reasonably be perceived by other nurses and/or others to be romantic, sexually suggestive, exploitive and/or sexually abusive (for example, spending extra time together outside of the client's care plan);
- i) not exhibiting physical, verbal and non-verbal behaviours toward a client that demonstrate disrespect for the client and/or are perceived by the client and/or others as abusive;
- j) not neglecting a client by failing to meet or withholding his/her basic assessed needs;
- k) not engaging in activities that could result in monetary, personal or other material benefit, gain or profit for the nurse (other than the appropriate

²¹ There may be circumstances when a client does not offer his/her consent to share information regarding abuse with the police or other authorities; for example, spousal abuse.

²² The *Regulated Health Professions Act, 1991* sets out provisions for the mandatory reporting of sexual abuse of a client by a regulated health care provider to the appropriate regulatory college.

- renumeration for nursing care or services), the nurse's family and/or the nurse's friends, or result in monetary or personal loss for the client; and
- l) not accepting the position of power of attorney for personal care or property²³ for anyone who is or has been a client, with the exception of those

clients who are direct family members of the nurse. Should a person for whom the nurse has been named power of attorney become a client, the nurse must declare to the manager that she/he is the client's power of attorney and decline the client assignment.

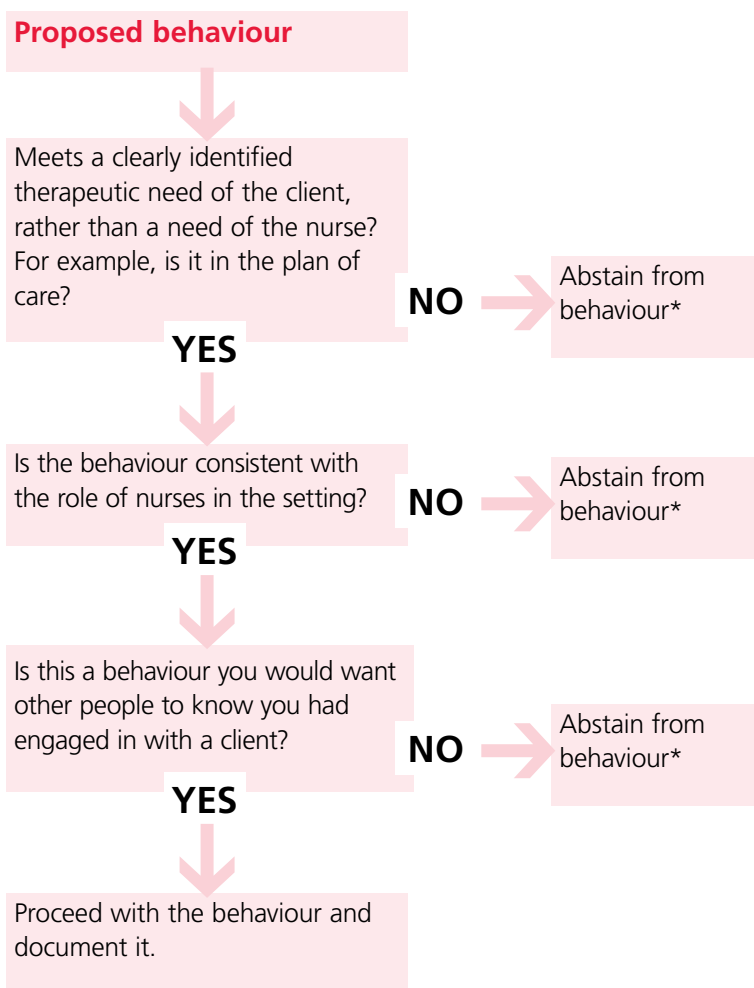
²³ Property includes bank accounts and other financial matters.

How To Apply this Standard

Decision tree

Use this tool to work through a personal situation to determine whether a particular activity or behaviour is appropriate within the context of the nurse-client relationship. The decision tree should be used while considering all of the components of the nurse-

client relationship and the behavioural expectations contained within this document. The tool may also be useful for self-reflection and peer input as part of the self-assessment process, and for guiding client care discussions in your practice setting.



Exploratory questions

- Is the nurse doing something that the client needs to learn how to do for himself/herself?
- Can other resources be used to meet the need?
- Whose needs are being met?
- Will performing the activity cause confusion regarding the nurse's role?
- Is the employer aware that nurses are performing this activity?
- Does the employer have a policy regarding nurses performing this activity?
- Will the employer's insurance cover the nurse when performing this activity?

* Consult with the health care team, manager and/or College to determine how to best address the client's unmet needs.

Warning signs of crossing a boundary

There are a number of warning signs that indicate that a nurse may be crossing the boundaries of the nurse-client relationship.²⁴ Nurses need to reflect on the situation and seek assistance when one or more of the following warning signs are present:

- spending extra time with one client beyond his/her therapeutic needs;
- changing client assignments to give care to one client beyond the purpose of the primary nursing care delivery model;
- feeling other members of the team do not understand a specific client as well as you do;
- disclosing personal information to a specific client;
- dressing differently when seeing a specific client;
- frequently thinking about a client when away from work;
- feeling guarded or defensive when someone questions your interactions with a client;
- spending off-duty time with a client;
- ignoring agency policies when working with a client;
- keeping secrets with the client and apart from the health care team (for example, not documenting relevant discussions with the client in the health record);
- giving a client personal contact information unless it's required as part of the nursing role; and
- a client is willing to speak only with you and refuses to speak with other nurses.

When a colleague's behaviour crosses a boundary

If a nurse believes that a colleague is crossing a therapeutic boundary, the nurse needs to carefully assess the situation. Address with the colleague:

- what was observed;
- how that behaviour is perceived;
- the impact on the client; and
- the College's practice standards.

If the nurse is unable to speak with the colleague directly or the colleague does not recognize the problem, the next step is to speak to the colleague's supervisor. The nurse should put the concerns in writing and include the date, time, witnesses and some type of client identification, such as initials or a file number. If the situation is not resolved, further action is needed. This action should include informing the client of his/her rights and sending a letter describing the concerns to the next level or the highest level of authority in the agency, or reporting the matter to the College.

If a nurse witnesses another nurse or a member of the health care team abusing a client, the nurse must take action. College research indicates that when someone intervenes in an incident of abuse, the abuse stops. After intervening, a nurse must report any incident of unsafe practice or unethical conduct by a health care provider to the employer or other authority responsible for the health care provider. When an unregulated care provider abuses a client, the nurse must intervene to protect the client and notify the employer.

In all cases, the nurse must inform the client of his/her right to contact police and begin criminal proceedings.

Certain legislation requires further reporting of abuse. The *Regulated Health Professions Act, 1991* requires regulated health professionals to report the sexual abuse of a client by a regulated health professional to the appropriate college. The *Child and Family Services Act, 1990* requires reporting suspected child abuse to the Children's Aid Society.

²⁴ (Registered Nurses Association of British Columbia, et al., 1995)

Maintaining a Quality Practice Setting

As partners in care, employers and nurses share responsibility for creating an environment that supports quality practice. These strategies will help employers and nurses develop and maintain a quality practice setting that supports nurses in providing safe, effective and ethical care.

A quality practice setting will:

- promote reflective practice;
 - support client-centred care;
 - provide resources, including appropriate staffing, to support nurses in establishing therapeutic relationships;
 - provide resources to support the provision of culturally sensitive care;
 - promote positive collegial/interprofessional relations by role modelling and promoting an organizational culture of respect;
 - recognize whether the setting is at increased risk for potential boundary violations and have policies in place on issues, such as accepting gifts from clients, to guide and support nurses in meeting College standards;
 - support staff requesting a change of assignment due to stress or boundary issues;
 - support staff activities that help relieve stress;
 - have expert resources to assist nurses in situations in which establishing a therapeutic relationship is particularly challenging;
 - have zero tolerance for abuse;
 - debrief after critical incidents to provide support to staff and determine the cause, a possible solution and how to prevent a recurrence;
 - have a known procedure for reporting abuse of clients and/or staff members;
 - ensure reports of abuse are investigated and addressed;
 - ensure that proactive visible leadership and clinical supervision is available to support nurses in developing therapeutic relationships and maintaining boundaries;
- endeavour to have consistent caregivers and continuity of care to promote the establishment of trust and comfort; and
 - provide nurses with appropriate documentation forms and consultation methods to resolve ethical and boundary issues.

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Appendix A: Abusive Behaviours

Abuse can take many forms, including verbal and emotional, physical, neglect, sexual and financial. Examples of such abusive behaviours are listed below.

Verbal and emotional includes, but is not limited to:

- sarcasm;
- retaliation or revenge;
- intimidation, including threatening gestures/actions;
- teasing or taunting;
- insensitivity to the client's preferences;
- swearing;
- cultural/racial slurs; and
- an inappropriate tone of voice, such as one expressing impatience.

Physical includes, but is not limited to:

- hitting;
- pushing;
- slapping;
- shaking;
- using force; and
- handling a client in a rough manner.

Neglect includes, but is not limited to:

- non-therapeutic confining or isolation;
- denying care;
- non-therapeutic denying of privileges;
- ignoring; and
- withholding:
 - clothing,
 - food,
 - fluid,
 - needed aids or equipment,
 - medication, and/or
 - communication.

Sexual includes, but is not limited to, consensual and non-consensual:

- sexually demeaning, seductive, suggestive, exploitative, derogatory or humiliating behaviour, comments or language toward a client;
- touching of a sexual nature or touching that may be perceived by the client or others to be sexual;

- sexual intercourse or other forms of sexual contact with a client;
- sexual relationships with a client's significant other; and
- non-physical sexual activity such as viewing pornographic websites with a client.

Financial includes, but is not limited to:

- borrowing money or property from a client;
- soliciting gifts from a client;
- withholding finances through trickery or theft;
- using influence, pressure or coercion to obtain the client's money or property;
- having financial trusteeship, power of attorney or guardianship;
- abusing a client's bank accounts and credit cards; and
- assisting with the financial affairs of a client without the health care team's knowledge.

Appendix B: Nursing a Family Member or Friend for Paid Employment

In some instances, nurses, especially those working in small communities, may be required to care for a family member, friend or acquaintance as part of their professional employment. These situations should be limited to circumstances in which there are no other care providers available. The client should be stabilized and, if possible, care transferred. If a nurse's sexual partner²⁵ is admitted to an agency where the nurse is providing care or services, the nurse must make every effort to ensure that alternative care arrangements are made. Until alternative arrangements are made, however, the nurse may provide care.

If it isn't possible to transfer care, a nurse must consider the following factors.

Input from the client. A client may feel uncomfortable receiving nursing services from someone with whom he/she has or had a personal relationship.

Self-awareness/reflection. Carefully reflect on whether you can maintain professionalism and objectivity in caring for the client, and whether your relationship interferes with meeting the client's needs. Also, ensure that providing care to a family member or friend will not interfere with the care of other clients, or with the dynamics of the health care team. Discuss the situation with your colleagues and employer before making a decision.

Maintaining boundaries. When providing nursing care for a family member, friend or acquaintance:

- be aware of the boundary between your professional and personal roles;
- clarify that boundary for the client;
- meet personal needs outside of the relationship; and
- develop and follow a plan of care.

Confidentiality. It is important not to disclose information about a client to other family members and/or friends without the client's consent, even after the nurse-client relationship has ended.

²⁵ If a nurse's sexual partner is also the nurse's client, the care could be considered sexual abuse and reported to the College, as outlined in the *Regulated Health Professions Act, 1991*.

Notes:

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