OVERVIEW ON PROFESSIONAL BOUNDARIES IN HOMECARE

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1. **DEFINITION OF PROFESSIONAL BOUNDARY:** Invisible, unspoken physical and emotional line that defines the nature of the relationship.
2. Boundaries are what keep the professional borders of the relationship in place.
3. The professional homecare provider has the responsibility of defining and maintaining the consistency of the boundaries because he/she is the person in power.

**BOUNDARIES CREATE A MUTUALLY RESPECTFUL, TRUSTING, SAFE AND SECURE PROFESSIONAL RELATIONSHIP**

4. Since a patient’s home is not an institutional setting, the atmosphere can feel more casual. However, a more informal setting does not mean that boundaries can or should be looser. Homecare providers are visitors in the patient’s home and have been hired to provide professional services.

**TYPES OF BOUNDARIES THAT CAN BE CROSSED**

1. **ROLE BOUNDARIES:** Helpful to ask yourself the following questions:
   A. Is this what a nurse/therapist does?
   B. What would my expectations be of a professional coming into my home if I was the patient and what would make me feel the most comfortable?
   C. What would my expectations be of a professional taking care of a relative?
   D. Do my words match my actions and is the patient clear about what intervention will be carried out next?

   **YOU DO NOT WANT THE PATIENT GUESSING ABOUT WHAT YOU ARE DOING OR WHY YOU ARE DOING IT**

2. **TIME BOUNDARIES:**
   A. Treatment offered in a structured and scheduled way in one’s home increases trust and decreases anxiety. Therefore, notification of any changes or delays in appointments is equally important. In addition, flexibility when feasible to meet the needs of the patient related to scheduling, increases trust when care is received at home.
B. Any loss of objectivity, such as going “above and beyond” for a particular patient, like staying much later than the typical time frame when there is not a crisis, can blur the professional boundary.

3. PLACE AND SPACE BOUNDARIES: Helpful to ask yourself the following questions:
   A. Do I respect the physical space of the patient, caregiver, and other family members at all times during the visit? For e.g. Do I ask permission to sit on a chair or use the sink?
   B. Do I stay an arm’s distance apart from the patient, caregiver, and others while talking and assessing the patient?

4. MONEY, CLOTHING, GIFTS BOUNDARIES: Helpful to ask yourself the following questions:
   A. Do I avoid accepting gifts from a patient or spending my own money on a patient?
   B. Do I avoid offering to drive a patient to another location?

5. LANGUAGE BOUNDARIES: Helpful to ask the following questions:
   A. Do I speak to the patient and caregiver in a calm and professional manner, paying attention to tone and volume of voice so that I do not speak in a condescending, angry, and directive manner?
   B. Do I choose respectful and objective words to convey my messages and focus on the patient’s goals/agenda first and foremost?

6. SELF-DISCLOSURE AND PHYSICAL CONTACT BOUNDARIES: Helpful to ask the following questions:
   A. Do I avoid offering personal information to the patient? Do I step outside of the patient’s home to take or make an outside phone call?
   B. Do I avoid making statements about other patients, co-workers, my employer, or my family?
   C. Do I respect the patient’s right to refuse any treatments and do I tune into the patient’s verbal and nonverbal language possibly indicating discomfort with an issue during the visit?

TRIGGERS/FACTORS THAT CAN CAUSE BOUNDARY BREACHES BY PATIENT OR PROVIDER

1. Patient has a known history psychiatric/mental health problems that impact their own boundaries or their interpretation of others’ actions or statements. For e.g. Diagnosis of Schizophrenia, Manic phase of Bipolar Illness, history of physical or emotional trauma.

2. Patient with personality characteristics that are indicative of having poor boundaries, poor social skills, lack of impulse control, etc. For e.g. Diagnosis of substance abuse/addiction, evidence of anger or volatile family relationships, frequent phone calls or complaints to staff and a seeming lack of awareness on the part of the patient of being intrusive or demanding.

3. Provider assumes the patient is more stable emotionally than he/she truly is and is suddenly caught off guard by a volatile or reactive response from a patient.
IF YOU ARE EVER FEELING UNCOMFORTABLE ABOUT A PATIENT’S BEHAVIOR/REACTION, OR YOU SUSPECT THAT THE PATIENT IS FEELING UNCOMFORTABLE, DO NOT IGNORE IT. IT IS IMPORTANT TO TALK WITH A CLINICAL MANAGER, PSYCH/MH CNS, AND FELLOW TEAM MEMBERS. THERE IS MORE POTENTIAL FOR MISCOMMUNICATION WITH THE PATIENT AND ERRORS TO OCCUR IF YOU DO NOT GET HELP TO CLARIFY THE ISSUES.

IT IS ALSO VERY IMPORTANT TO ADDRESS ANY CONCERNS ABOUT THE BEHAVIOR OF A FELLOW TEAM MEMBER. UNPROFESSIONAL BEHAVIOR REFLECTS NEGATIVELY NOT ONLY ON THE INDIVIDUAL BUT ALSO ON THE ENTIRE TEAM.

POSSIBLE RESULTS OF BOUNDARY BREACHES

1. Relationship between the patient and homecare provider becomes confusing and possibly unethical.
2. Because of the power differential in the patient/provider relationship, it can be hard for the patient to question or speak out about the actions of the homecare provider. This is especially true of elderly patients.
3. There are also patients who can impulsively and incorrectly misinterpret the motives or actions of the provider.
4. The power shifts and can become “more equalized.” The patient can lose respect for the provider which will increase the challenge of working with the patient. The patient can also generalize one provider’s unprofessional behaviors to all of the other team members. Consequently, trust is that much harder to build with other team members in the future.