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NURSING LEADERS' ETHICAL DECISION-MAKING ABOUT PROFESSIONAL BOUNDARIES AND NURSE-PATIENT RELATIONSHIPS: A MIXED METHODS EXPLANATORY SEQUENTIAL DESIGN

by

PAMELA T. SCOTT

A DISSERTATION

Presented to the Faculty of the University of the Incarnate Word
in partial fulfillment of the requirements
for the degree of

DOCTOR OF PHILOSOPHY

UNIVERSITY OF THE INCARNATE WORD

May 2019

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My achievement of this academic milestone is attributed to the many wonderful people who willingly shared their wisdom, guidance, and support throughout the life of this endeavor.

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Pamela T. Scott

DEDICATION

To my family, for your unwavering support and faith in me, I am deeply indebted to you. In memory of my father, the life lessons you lived merit the lessons of life worthy of emulating. My heartfelt gratitude and love is forever yours. Thank you for journeying this venture with me.

NURSING LEADERS' ETHICAL DECISION-MAKING ABOUT PROFESSIONAL BOUNDARIES AND NURSE-PATIENT RELATIONSHIPS: A MIXED METHODS EXPLANATORY SEQUENTIAL DESIGN

Pamela T. Scott

University of the Incarnate Word, 2019

The purpose of this mixed methods explanatory sequential design study was to ascertain nursing leaders' knowledge and skill in ethical decision-making when evaluating and managing professional nurse-patient relationship boundaries. It was also the purpose of this study to better understand nursing leaders' perceptions of moral, cognitive, and organizational factors influencing their ethical decision-making in evaluating and managing professional nurse-patient relationships, with the intent of generating a theory grounded in the views of the participants as a final outcome of the study. The two theories, virtue ethics and self-efficacy, comprise the ethicality construct of the conceptual framework explaining the nurse leaders' beliefs about themselves and their ability to conduct ethical decision-making. The professional boundaries construct of the conceptual framework delineates the attributes and expectations of nursing as a profession, thus further explaining the nurse leaders' role in ascertaining ethical professional boundaries among nurses and patients. Participants in the quantitative phase of this study included 28 female and 13 male nurse leaders selected by a convenience sampling approach from San Antonio Military Medical Center, Brooke Army Medical Center, Fort Sam Houston, Texas. The participants were asked to complete a researcher-designed Ethical Decision-Making Survey Instrument consisting of two scenario-based vignettes with six Likert questions per vignette and

a demographic questionnaire. The Ethical Decision-Making Survey Instrument was designed to assess nurse leader's ethical decision-making about nurse-patient relationships and professional boundaries. Data analysis revealed by 48 bivariate Pearson product-moment correlation coefficients that the greater the number of years of work experience as an RN and the greater the number of years of work experience as a nurse manager, the more comfortable a nurse manager felt speaking with a nurse about his/her behavior regarding nurse-patient professional boundary transgressions. Additionally, the greater number of years of work experience as a nurse manager, the more knowledge she/he believed she/he had to appropriately manage nurse-patient professional boundary transgressions. Calculating six paired-samples t-tests revealed significantly greater mean scores for a nurse leader's belief that nurses violate boundaries and exhibit unethical behavior in the scenario depicting a nurse involved in a personal relationship with a patient than a flirtatious relationship. Calculating 48 mixed between-within subjects, ANOVAs (Analysis of Variances) revealed substantial main effects for nurse manager's ethical decision-making in determining violations of nurse-patient professional boundary breaches and the unethicality of the behavior, revealing higher scores on the scenario depicting a nurse involved in a personal relationship with a patient than a nurse involved in a flirtatious relationship with a patient. The qualitative phase was designed to further explain the results of the quantitative analysis. Participants in the qualitative phase of this study included seven female and zero male nurse leaders initially selected through purposeful sampling followed by a snowball sampling approach from San Antonio Military Medical Center, Brooke Army Medical Center, Fort Sam Houston, Texas. The participants were interviewed utilizing 12 guided open-ended questions with the aim of assessing moral, cognitive, and organizational factors influencing ethical decision-making about nurse-patient relationships and professional

boundaries. Thematic analysis revealed the following themes: (a) ascribing conscience, (b) codifying knowledge repertoire, (c) summoning support systems, and (d) weighing elements affecting judgment. Each theme is discussed in depth and supported by exact participant quotations. The study culminates in a grounded theory. The study concludes with implications for nursing leadership, health care organizations, and nursing academia. As a result of the study findings, recommendations are highlighted that may promote a skill set conducive to improving nursing leader's ethical decision-making about nurse-patient relationships and professional boundaries.

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Chapter One – Statement of the Problem

Nursing, held in the public eye as the most trusted profession in the United States, is an affirmation of its advocacy for honesty and staunch ethical standards (American Nurses Association [ANA], 2009, 2014; Olshansky, 2011). Nursing has held this top-rated position since 1999, maintaining an average ranking of 82%, a "very high or high" standing in Gallup's (2018) annual *Honesty/Ethics in Professions* survey. With one year's exception in 2001 following the September 11th terror attacks in which firefighters exceeded nursing as the most trusted discipline, the public has unwaveringly perceived nursing as the profession with the highest level of honesty and ethical standards (Riffkin, 2014). Celebrating this significant achievement in alliance with a newly revised, published Code of Ethics for Nurses prompted the ANA to promote ethical practice and designate 2015 as the "Year of Ethics" (ANA, 2015b).

Sustaining top honors in capturing public trust is a reflection of consistently delivering care in accordance with nursing's professional doctrine. Nursing's doctrine, written as standards of care and standards of practice and established as legally mandated rules and regulations, sets expectations for care, prescribes principles, and delineates policy. Practicing within policy, which directly supports the best interests of the public, validates nurses' reputations as "the strongest advocates for patients who are vulnerable and in need of support" (ANA, 2015a, p.9). Advocacy, "the act of informing and supporting a person so that he [*sic*] can make the best decisions possible for himself" (Kohnke, 1990, p. 56) is referred to as the "philosophical foundation and ideal of nursing" (Gadow, 1990, p. 42) and, as such, "uniquely defines the essence of nursing practice" (MacDonald, 2006, p. 120). Advocacy actions in nursing practice are "predicated on the relationship" (Snowball, 1996, p. 71) formed between the nurse and patient, expressing a powerful sense of support for the patient and producing a strong bond.

Building a good nurse-patient relationship—a bond not only developed through the delivery of expert care but strengthened by care that is compassionate, empathetic, and benevolent in nature—enhances the trust established between a nurse and a patient. This complex and multifaceted bond, beneficial to the comfort and well-being of the patient, puts the patients' needs first and is developed within the framework of a therapeutic relationship.

As nursing is a relationship-based profession, characterized by getting to know a patient and their individual needs, building a good relationship requires establishing a level of trust. This relationship creates a culture of caring that allows the patient to share values, fears, and desires. Beneficial to understanding the patient's needs, it provides a catalyst for nursing to actively engage the patient in all aspects of their care and is invaluable to the healing process. This relationship, therapeutic in nature, enables nurses to provide physical, emotional, and spiritual care that supports the patient throughout their continuum of care, and "is time-limited and based on nursing professional knowledge, commitment, and genuine concern for the patient" (Witt, 2011, p. 141).

The therapeutic relationship hinges on a nurse's ability to stay focused on meeting the needs of the client rather than meeting mutual needs. It requires nurses to assess self-knowledge and understanding of emotional responses to patient needs, in order to recognize the difference in a therapeutic relationship and a personal relationship. Being able to put the patient's needs ahead of personal needs assures the level of trust cultivated in a therapeutic relationship.

"The intimate nature of nursing means that the potential for blurring of these relationship boundaries is high" (Witt, 2011, p. 141). As such, the relationship between patient and nurse is guided by a professional code of ethics that safeguards the patient and the professional; however,

because patients are in a vulnerable place, they are not held accountable for keeping the relationship therapeutic; that is the nurse's responsibility.

Professional relationships, directed by a profession's code of ethics and morally guided by an individual's ethical disposition, establish a protected space between a professional's power and a client's vulnerability. Controlling or limiting this difference in power is maintained by safeguarding the boundaries of both the patient and the professional. If this space is compromised, the safe connection between the patient and the professional is broken, potentially extending beyond the limits of professional boundaries, with resulting boundary violations, putting patients at risk of harm.

Context of the Study

At best, personal morals and professional standards of care prevent inappropriate nurse-patient relationships; however, as a means of protecting the public from inappropriate behavior, individual state legislation regulates professional behavior through nursing practice acts and professional codes of ethics. In Texas, "Chapter 301 of the Texas Occupations Code (TOC) contains the Nursing Practice Act (NPA) which creates the Board of Nursing (BON) and defines its responsibility for regulating nursing education, licensure and practice" (Texas Occupations Code Chapter 301, 2017, p. 3). Nursing's responsibility to the patient is legally bound by a NPA and a Professional Code of Ethics (ANA, 2015a, p. vi) which specifies that the nursing profession has a duty to protect the public from violations in professional boundaries. These boundaries, explicitly prescribed in writing, are addressed through multiple regulatory agencies at both the state and national level. At the state and national level, the NPA creates the BON, which in turn is given legal authority to make rules which implement and interpret the NPA. The rules define the Board's responsibility for regulating nursing education, licensure, and practice.

Established standards of practice and ethics codes regulate acceptable professional behaviors, delineating nurse-patient boundaries supportive of therapeutic relationships essential to the patient's healing process.

The Nursing Code of Ethics, developed as a guide for "carrying out nursing responsibilities in a manner consistent with quality in nursing care and the ethical obligations of the profession" (ANA, 2015a, p. viii) were developed by the ANA, a national level professional organization representing America's nurses. The ANA, dating back to 1911, advanced the roles, duties, and practices of the nursing profession as it expanded its mission in establishing standards, guidelines, and principles defining values for nurses. Based on these values a *Code for Nurses* was first established in 1985. In 2001, a comprehensive revision of the Code was accepted by the ANA House of Delegates and the Congress of Nursing Practice and Economics resulting in an approved Code of Ethics for Nurses with Interpretive Statements. On January 1, 2015, the first code revision since 2001 was released following a four-year process to ensure modern clinical practice, evolving conditions, and transformations in health care were reflected in the new Code of Ethics for Nurses with Interpretative Statements (ANA, 2015b). According to the ANA, the Code "is nonnegotiable and … each nurse has an obligation to uphold and adhere to the code of ethics" (ANA, 2015a, p. vii).

With origins traced to the ANA, the National Council of State Boards of Nursing (NCSBN), founded in 1978, pulled away from the ANA to create its own organization. Recognizing the ANA's primary position in representing professional nurses, the NCSBN created a separate entity in order to ensure the safeguarding of the public. The NCSBN (2015a), in alliance with state boards of nursing, collaborate in providing regulatory guidance for public health, safety and welfare. As a collective regulating body, the NCSBN sets the standard of

nursing care, which is codified by law and implemented through education, licensure, practice, and discipline. Guiding and governing nursing care through regulatory decision-making for public protection is the responsibility of the boards to ensure care does not give rise to harm.

Protecting and promoting the welfare of the people is the mission of each state's BON. Congruent with national regulatory standards, individual states are legally bound to uphold standards of professional nursing care as delineated in the NPA and Code of Ethics for Nurses. The Texas BON, established in 1909, regulates nursing practice, education, and disciplinary actions as delineated in the NPA. The Texas BON is clear on its stance in regard to good professional character, unprofessional conduct, and grounds for disciplinary action. According to the Texas Administrative Code (2018a):

> The Board defines good professional character as the integrated pattern of personal and occupational behaviors that indicate an individual is able to consistently conform his/her conduct to the requirements of the Nursing Practice Act, the Board's rules, and generally accepted standards of nursing practice. An individual who provides satisfactory evidence that he/she has not committed a violation of the Nursing Practice Act or a rule adopted by the Board is considered to have good professional character related to the practice of nursing.

Accountability for one's own behavior is reflected in the ability to "recognize and honor the interpersonal boundaries appropriate to any therapeutic relationship or health care setting" (Texas Administrative Code, 2018a). Additionally, the Texas Administrative Code (2018c) speaks to the unprofessional conduct in which disciplinary action is warranted. Based on the rule, "actual injury to a client need not be established" (Texas Administrative Code, 2018c). Violating professional boundaries of the nurse-client relationship includes, but is not limited to, "physical, sexual, emotional or financial exploitation of the client or the client's significant other(s)"; as well as "engaging in sexual conduct with a client, touching a client in a sexual manner, requesting or offering sexual favors, or language or behavior suggestive of the same" (Texas

Administrative Code, 2018c). Grounds for disciplinary action are defined in Sec. 301.452. Subchapter J, Prohibited Practices and Disciplinary Actions, Texas BON, which maintains that "unprofessional conduct in the practice of nursing that is likely to deceive, defraud, or injure a patient or the public" is cause for review and disciplinary action (2017b, p. 61).

Any licensed professional reported to the Texas BON for suspected accusations of violations in nurse-patient relationships is grounds for investigation by the Texas BON and potential disciplinary action if accusations are found substantiated. If substantiated, the nurse may face termination from an employer, discharge from an educational program, potential mandatory remediation, and potential loss of licensure. Additionally, the nurse may face criminal charges from the victim and/or the victim's family.

Conceptual Framework

Ethicality construct. The nursing profession is legally governed by rules, regulations, and ethics codes; as well as by the standards of nursing professional associations that serve to protect patients and set norms for nurses. However, it cannot be overlooked that nurses as individuals bring personal value systems to the profession. When disparities between the nursing professions' standards and a nurse's value system occur, in situations such as professional boundary transgressions, it is mandated by the Texas BON that a nursing leader will intervene.

Nursing leaders are expected to uphold the professions standards; they are also accountable to uphold personal value systems in congruence with the professions and have the added burden of holding staff accountable in abiding by the standards of the nursing profession. Therefore, when nursing leaders are faced with professional boundary breaches by staff nurses, they have a duty to intercede to protect the patient from harm. In so doing, nursing leaders have at their disposal the nursing professions standards to utilize for direction, but also have their

personal principles that guide their interventions. Nursing leaders' ethical decision-making in their perceptions of and actions toward nurse-patient relationship transgressions is a values-based process, in which a moral deliberation and an impulse to act are required. As this is a values-based process, this study is guided by the theoretical perspectives of virtue ethics theory and self-efficacy theory.

Virtue ethics theory, one of three major approaches in normative ethics, "focuses not on the moral status of rules or actions but on the moral status of persons, and on individual moral character" (Rowan & Zinaich, 2003, p. 41). Though the Nursing Practice Act and Nursing Code of Ethics prescribes standards to protect patients from harm of boundary transgressions, nurses have stated they lack formal education of boundary standards and believe the guidelines lack clarity; therefore, deontology and consequentialism does not suffice. Beauchamp and Childress (1994) acknowledged that "morality includes more than obligation" (p. 452).

From a modern perspective, virtue ethics is focused on the moral virtues, such that the virtues are primarily defined as character traits, dispositions, or habits. Virtue ethics theory implies that morality is a combination of character traits and personal dispositions that influence moral deliberation and action (Storch, Rodney, & Starzomski, 2004). As virtue ethics does not focus on a single foundational principle, it purports developing "those traits of character (virtues) that help moral agents function well in situations calling for moral judgment" (Cooper, 2004, p. 35).

From the perspective of Aristotle's classical position, focus is more on the "intellectual virtue of prudence, the virtue of ethical decision-making" (Devettere, 2016, p. xvii). Classical virtue ethics purports that wisdom is the key to figuring out what is reasonable when faced with personal choices involving what is good or bad. "Prudence is the decision-making virtue … it is

about making good choices for our lives and for the common good" (Devettere, 2016, p. xvii). Asking oneself the question, 'What would a prudent nurse do?' when faced with situational and/or ethical dilemmas is a question nurses are taught at all levels of nursing academia; as well as a question they ask themselves frequently throughout their careers.

While fulfilling obligations and duties are necessary, it is simply not sufficient. Virtue ethics theory is more about the virtues than obligation and duties. Character traits (moral virtues), personal dispositions, and prudential reasoning (intellectual virtues) combined allow for moral judgment; that is, moral deliberation and action. To understand the influence on moral deliberation and action,

> we need to know what kind of person is involved, how the person thinks of other people, how he or she thinks of his or her own character, how the person feels about past actions and also how the person feels about actions not done. (Storch, Rodney, & Starzomski, 2004, p. 67)

Self-efficacy theory, which is part of the social cognitive theory developed by Bandura (1986), refers to "beliefs in one's capabilities to organize and execute the courses of action required to produce given attainments" (Bandura, 1997, p.3). Such a belief occurs within an interdependent context; per Bandura (1997), it is affected by the interaction of personal factors, behaviors, and environmental events that operate as causal factors exerting influence on self-efficacy beliefs. Causal factors exerting influences on nursing leader's self-efficacy beliefs have diverse effects on moral agency. Nursing leaders as moral agents are accountable for deciding on courses of actions and for carrying through on those actions to resolve nurse-patient relationship boundary breaches. Unless nurse leaders' believe they can produce desired affects by their actions, they have little incentive to act to resolve boundary breaches. According to Bandura (1997),

> efficacy beliefs … are formed partly on the basis of judgment of one's knowledge and skills, but efficacy beliefs contribute to performance independently of actual skills or past performance. Because efficacy beliefs are based on cognitive processing of multiple sources of information, actual skills often account for a relatively small amount of the variance in beliefs of personal efficacy. (p. 60)

How nurse leaders perceive their sense of self-efficacy can influence their approach in acting on moral dilemmas. Hannah and Avolio (2010) propose that a "leader's character is defined not only by what the leader thinks but also by his or her motivation to act to address ethical dilemmas" (p. 292). In other words, a nurse leader may recognize a nurse-patient relationship boundary breach is not ethical, but whether the nurse leader has the impetus to act on that judgment may be dependent on self-efficacy. According to Rest, Narvaez, Bebeau, and Thoma (1999), the "defining Issues Test, the most commonly used measure of cognitive moral development, typically explains less than 20% of the variance in actual ethical choices or behavior" (p. 101). Therefore, the 80% unexplained variance in ethical behavior may in fact be explained by factors other than judgment. Rest et al. (1999) describe factors such as interpreting the situation, taking a moral course of action, and having the courage and character to overcome fatigue/fear to attain a moral goal as critical elements in carrying out an action.

Connecting virtue ethics theory and self-efficacy theory may provide a more holistic analysis of a nurse leaders' challenge when confronted with a moral dilemma. The character of the nurse leader as moral agent and taking a moral course of action link the two theories and tie into character-based leadership and ethical decision-making. As such, this study proposes that virtue ethics theory and self-efficacy theory provide a foundation for character-based leadership and ethical decision-making of nurse leaders encountering nurse-patient relationship boundary transgressions. The ethicality construct is illustrated in Figure 1.

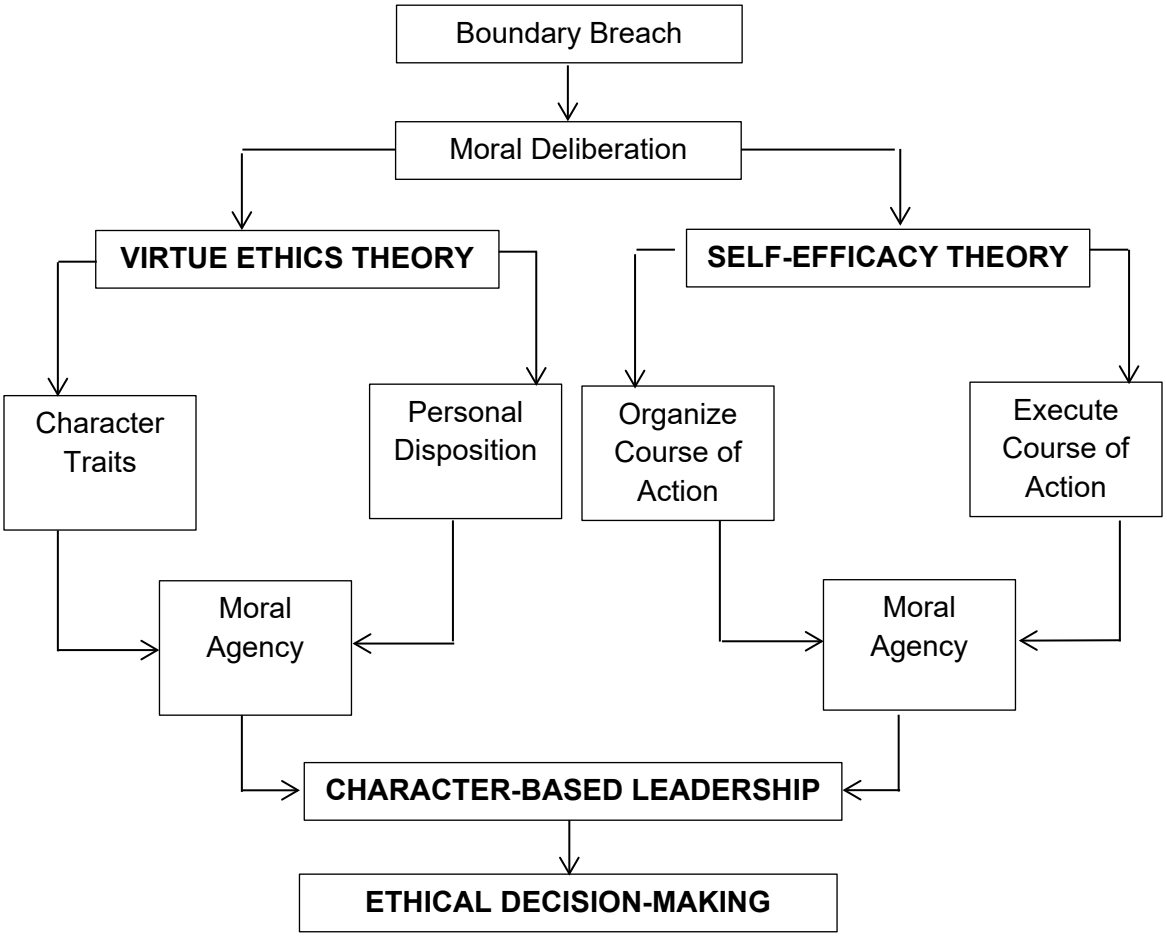

Figure 1. Visual illustration of the ethicality construct.

Professional boundaries construct. The nursing leader's role in ascertaining ethical professional boundaries among nurses and patients stems from the attributes of nursing as a profession. Professional nurse-patient relationship boundaries are predicated on the characteristics, responsibilities, and ethical obligations of the nursing profession. Gaining a clear understanding of the term profession and the role of a professional nurse is vital to nursing leader's engaging responsibly in managing ethical professional boundaries.

The term profession, as conceptualized by Bayles (2003), consists of three central features characteristic of occupations deemed a profession. Bayles, in congruence with multiple authors delineating 'what is a profession?' have singled out the following characteristics: (1) "a

rather extensive training is required to practice a profession," (2) "the training involves a significant intellectual component," and (3) "the trained ability provides an important service in society" (p. 56). Subscribing to the characteristics of a profession implies adherence to the profession's legal and ethical standards and therefore acceptance of the profession's mores governing practice.

This in turn sets the stage for a professional's conduct within the profession. According to Davis (2003), "following the rules" of the profession's standards and code of ethics is "acting as a responsible professional" (p. 63). As such, committing to a code of professional ethics, "the attempt to identify the parameters of discretionary judgment so that nurses act according to the ethical values of the profession" (Cameron, 1997, p. 142) binds the professional to a higher standard of due care. This standard, inherent in a professional's role, is described as "positional obligation," in that "filling a particular role carries with it obligations that that person would not otherwise have," such as fulfilling the duties that come with the positional obligation of accepting the role of a nurse leader (Welch, 2003, p. 79). One such obligation of nursing leaders is that of ensuring professional boundaries are heeded between nurses and patients. As such, this positional obligation aligns with the Code of Ethics for Nurses with Interpretive Statements (ANA, 2015a) for forming ethical leadership, in that nurse leaders undertaking an administrative role "have obligations to the recipients of nursing care … in assuming the responsibilities of a particular role … share responsibility for the care provided by those whom they supervise" (Butts & Rich, 2016, p. 423).

The relationship that exists between nurses and patients is such that professional boundaries are limits within professional relationships that allow for safe connections based on the needs of the individuals (Jacobson, 2002; Peterson, 1992). Professional boundaries can be

conceptualized as creating a therapeutic framework based upon fundamental components that establish a safe environment for a nurse and patient engaged in the healing process. The fundamental components derive from a therapeutic alliance between the nurse and patient in which the patient's dignity, independence, and best interests are promoted. Professional boundaries provide support for the key elements of a professional nurse-patient relationship: trust, compassion, mutual respect, empathy, and genuine caring (Baca, 2009, 2011; Benbow, 2013; Buhari, 2013).

Issues surrounding professional boundaries and boundary transgressions are of concern for the public and the profession. Nurses have the responsibility to establish a relationship that allows for a safe, therapeutic connection with their patients. Boundaries protect the space between a professional's power and the patient's vulnerability. The power of the nurse comes from professional position and access to private knowledge about the patient. Boundaries allow nurses to control this power differential and to provide for a safe connection, based on the patient's needs (Jones, Fitzpatrick, & Drake, 2008). As the nursing profession holds the coveted position of most trusted of the health care professions (Gallup, 2018), it is imperative to address the issue of boundaries and boundary transgressions to not only maintain this positive image but to primarily focus on mitigating potential patient harm and preserving a trusting therapeutic relationship with the patient. A visual model of the professional boundaries construct is illustrated in Figure 2.

Statement of the Problem

Professional boundary violations of nurse-patient relationships pose serious consequences to patients, nurses, health care organizations, and the nursing profession itself. Whether the

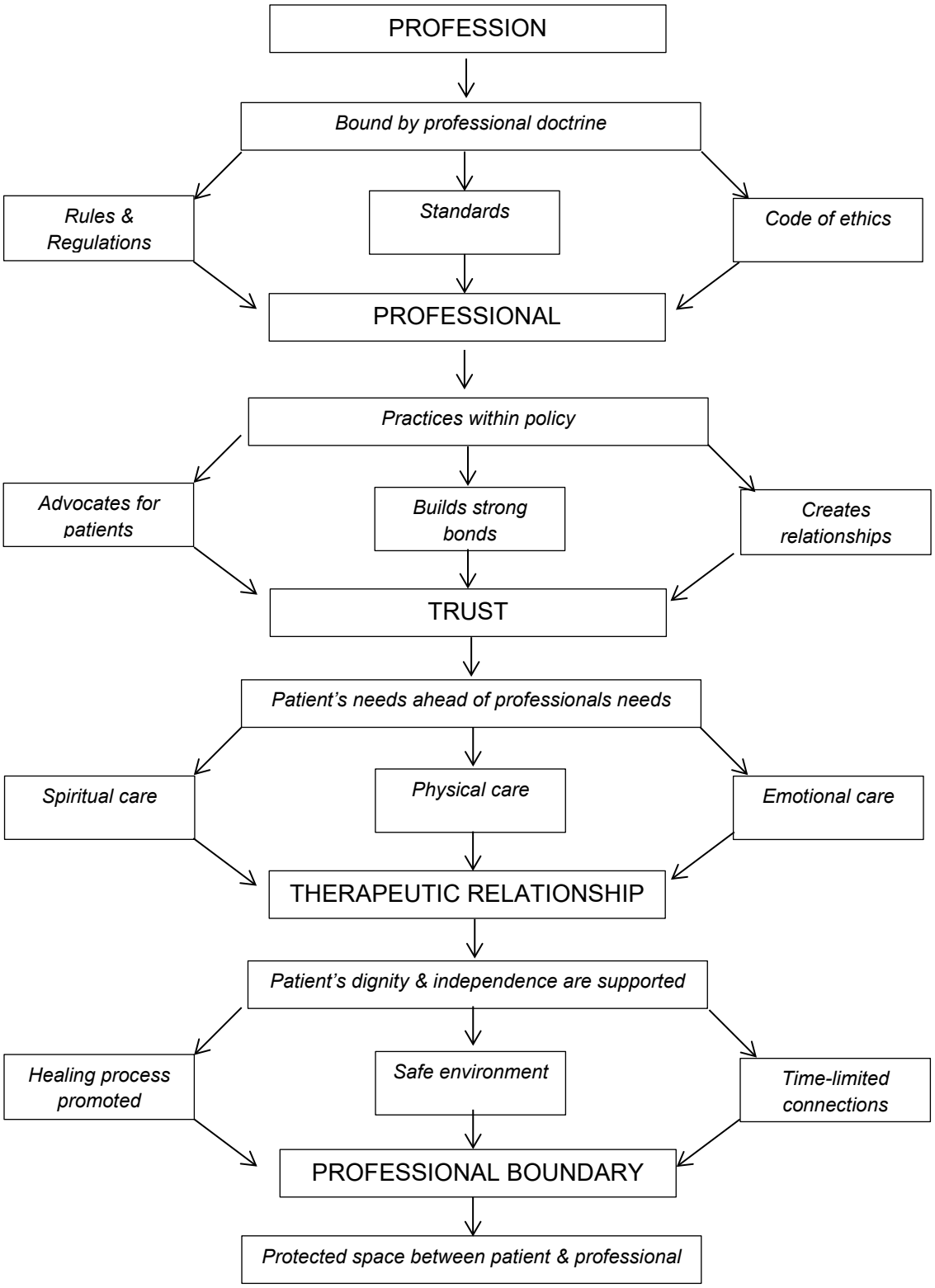

Figure 2. Graphic illustration of the professional boundaries construct.

boundary transgression is knowingly or unknowingly breached, nurses are held to the same level of accountability. Appreciating that professional boundary lines are invisible, and described as the "space between the patient's vulnerability and the nurse's power" it is the nurse's "responsibility for maintaining 'the space' in spite of who may be 'pushing' the boundary" (Hall, 2011, p. 210). As professionals, it is expected that nurses will be familiar with and conform to the standards of the NPA and Code of Ethics, and deliver patient care within the prescribed boundaries.

Although professional boundaries are a highly discussed topic in nursing literature, according to the NCSBN boundary breaches comprise a small percentage of disciplinary data obtained from state regulatory boards. The NCSBN found "approximately 0.24% of reported disciplinary cases involved sexual misconduct (boundaries)" (Fischer, Houchen, & Ferguson-Ramos, 2008, p. 317). Reviewing the data from a broader perspective, incorporating the categories of sexual misconduct, sex with a client, sexual abuse, sexual language or sexual boundaries, the NCSBN analyzed "10 years of Nursys® data and found "53,361 nurses were disciplined; of those, 636 or 0.57%" (NCSBN, 2009, p. 2) were from one of the boundary violation categories. According to the percentages, boundary violations related to sexual misconduct is not a common complaint. However, "38% to 52% of health care professionals (*N* = 3,650) report knowing of colleagues who have been sexually involved with patients" (Halter, Brown, & Stone, 2007, p. 7). Taking this information into consideration indicates a disparity in known and reported professional boundary violations versus known and not reported professional boundary violations. The implications of this variance have the potential to incur wide reaching negative outcomes. The potential negative outcomes—incurring patient harm,

losing public trust in nursing, and tolerating unethical nurse's ongoing access to vulnerable patients—are significant, and cause for deliberation and action.

Even though the percentage of reported cases is low, public interest remains high due to the devastating effect these cases have on both the patient involved and the nurse. The Council for Health Care Regulatory Excellence (2008) reports serious patient disorders and complaints as a result of boundary violations incurred by health care professionals. Resulting health care disorders can cause serious life-long harm, such as

> post-traumatic stress disorder and distress; major depressive disorder; suicidal tendencies and emotional distrust; high levels of dependency on the offending professional; confusion and dissociation; failure to access health services when needed; relationship problems; disruption to employment and earnings; and misuse of prescription (and other) drugs and alcohol (p. 3).

One potential explanation for under reporting boundary transgressions is found in an empirical review of the literature between 1970 and 2006, whereby health care professionals stated they "do not believe they were adequately educated on sexual boundaries with patients and that professional guidelines often lack clarity" (Halter et al., 2007, p. 21). Even though health care professionals' inappropriate behavior cannot be deterred by education alone, education and training are recognized as important in establishing clear sexual boundaries. These same studies pointed out that if "students were not taught about boundaries as part of the pre-licensure curriculum, it could not be assumed that they would receive any formal education on the subject later in their induction or in-service training" (Halter et al., 2007, p. 29).

As nurses are expected to abide by the rules, follow the ethics codes, and monitor their own behavior in maintaining professional nurse-patient relationships, "accurately assessing one's own boundaries can be difficult" (Peternelj-Taylor & Yonge, 2003, p. 63). In addition, clinical supervision put in place to work as a mentor and oversee nursing practice "is rarely formalized as

in other disciplines, and many nurses in practice today still lack adequate clinical supervision" (Peternelj-Taylor & Yonge, 2003, p. 63). Many nurses "feel uncertain that they have the skills needed to be effective managers and they lack confidence that the decision-making, interpersonal, and organizational skills they learned as staff nurses can translate to the management role" (Marquis & Huston, 2017, p. 276). Amplifying supervisory requirements for nurse managers includes integrating new graduate nurses into the staffing mix. Jones and West (2017) describe how many "begin working with little more than a few weeks of orientation, in contrast to most other professions, which require formal and often standardized internships or residencies" (p. 282). Moreover, organizational environments continue to grow in complexity and ambiguity, creating contexts that pose challenging moral dilemmas for nursing leaders. As such, nurses in managerial positions incur competing demands for their time, much of which is spent "critically examining issues, solving problems, and making decisions" (Jones & West, 2017, p. 3) regarding nursing practice, of which nurse-patient relationships are critical to therapeutic care.

The disparity between knowing and doing what is right, and the disparity in how organizational socialization affects ethical decision-making, requires further exploration to understand the level of knowledge and skills from which nurse leaders draw when presented with ethical dilemmas. In considering dilemmas in ethical decision-making, Hannah and Avolio (2010) believe the "concept of moral potency … a critical factor in developing leaders who have the conation to act on their moral judgments" (p. 291) is a construct that can partially explain this difference. Moral potency is a construct made up of three components, "moral ownership, moral efficacy, and moral courage" (p. 293), which are necessary elements, albeit not the only elements, essential to executing ethical actions. Respectively, these elements are defined as

"psychological resources instilled in leaders that it is their place to act, they can be successful in those actions, and they can overcome fears to persevere and see those actions through to resolution" (p. 293). In turn, these elements describe the thought processes incurred when thinking about moral dilemmas, making judgments, and generating actions in carrying out ethical decision-making. While ethical decision-making is a judgment call based on individual morality, there is a growing acknowledgment that the "scope and scale of malfeasance in organizations are also on the rise" (p. 291) creating indecisiveness in individualized thoughts and actions. Enhancing ethical maturity through moral development is critical in providing nursing leaders with the "psychological resources that bridge moral thought to moral action" (p. 292).

The emerging problem is that nursing leaders have a duty to report nurse-patient relationship boundary misconduct; however, data shows a large variance exists between known incidents and reported incidents of boundary violations. Studies have suggested this variance can be attributed to multiple factors, such as inadequate education, unclear professional guidelines, inability to monitor personal boundaries, inadequate supervision, organizational complexities, and immature moral maturity (Halter et al., 2007; Hannah & Avolio, 2010; Jones & West, 2017; Marquis & Huston, 2017; Peternelj-Taylor & Yonge, 2003). It is important to identify factors that predispose nursing leaders' ethical decision-making in determining and acting on boundary transgressions and align with methods of mitigating challenges preempting knowing and doing what is morally appropriate. The overarching aim of this study is the discerning of nursing leaders' moral agency, moral cognition, and level of preparedness in recognizing and handling nurse-patient relationship misconduct. The issues surrounding this problem are illustrated in Figure 3.

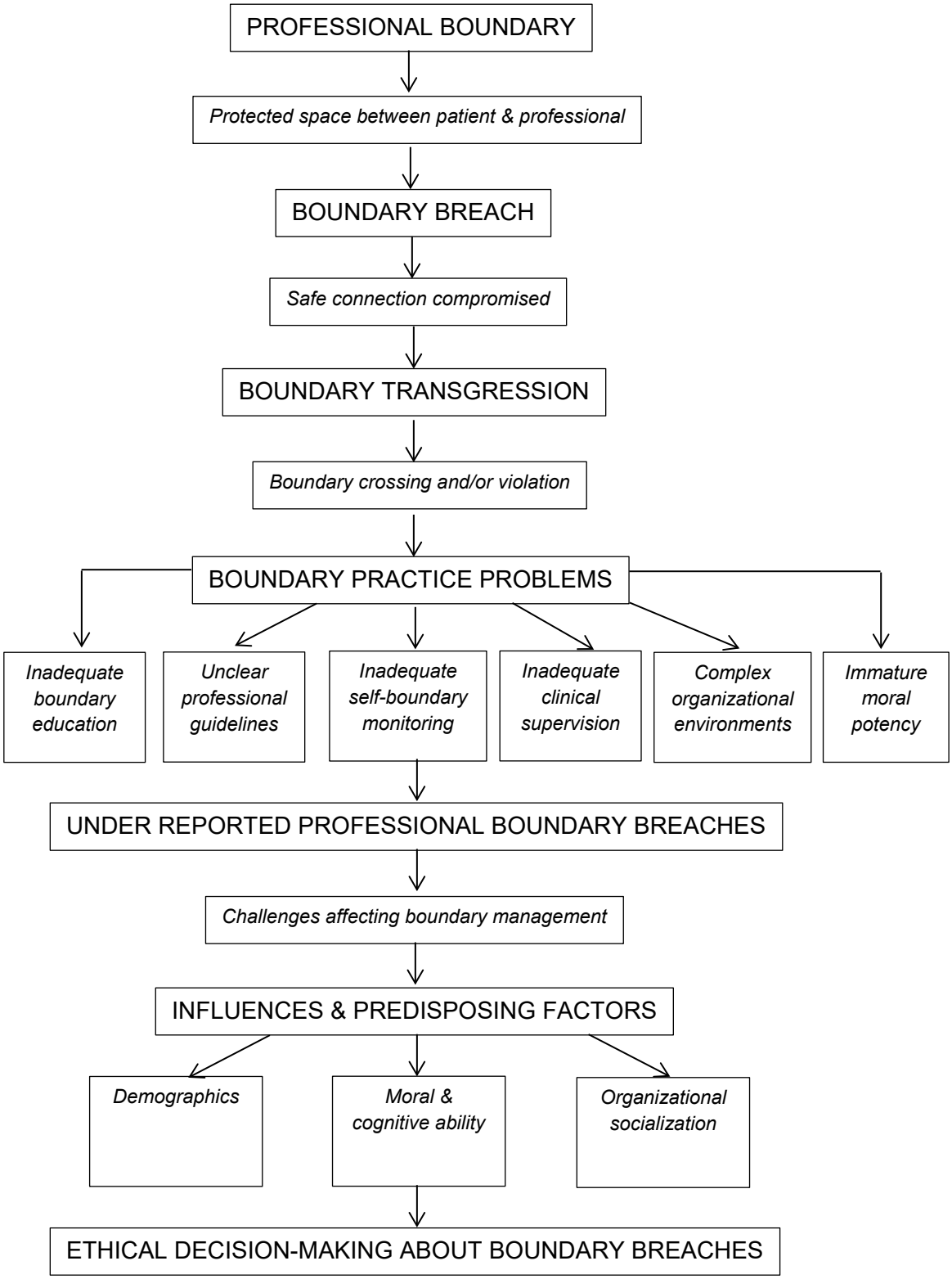

Figure 3. Flow chart illustrating the statement of the problem.

Gap in the Literature

As the problem statement highlights, the literature reveals a large variance between known incidents and reported incidents of nurse-patient relationship boundary violations. As well, the literature suggests multiple factors influence identifying and reporting boundaries. However, a review of the literature revealed that research studies related to professional nurse-patient relationship boundaries are limited in scope. The predominant source of nursing literature concerning nurse-patient professional boundaries and boundary transgressions stems from journal articles written about the NCSBN (2009) Nursys® data, the state BON rules, and the Nursing Code of Ethics and Interpretive Statements. Exhausting several databases, including CIHAHL, MEDLINE, Ebscohost, NCSBN, PsycLit and Social Care Online, revealed that literature addressing professional nurse-patient relationship boundary violations is scarce. Of the limited research studies found, the focus was on nurse-patient relationship boundary breaches within the specialty fields of mental health, community nursing, and case management. Research designs were descriptive and surveys structured, with findings describing respondent characteristics and categories of boundary transgressions.

As addressed in their problem statement, Halter and Stone (2007) searched the databases Medline, PsycLit, and Social Care Online for boundary related studies from 1970 to May 2006 and found over 86 studies specifically about professional boundaries in the field of health care. Most of the studies carried out were in the psychological therapies, with similar study results found in other areas of medicine and allied health professions. Of the 86 studies found, one study by Bachmann, et al. (2000) surveyed all nurses ($N = 714$) at two Swiss psychiatric hospitals to determine the frequency of nurse-patient sexual relationships with a 39% ($n = 279$) response rate, and found that 52% of the respondents reported knowing of colleagues having had such contact

with patients. Seventeen percent of male and 11% of the female nurses reported sexual relationships with patients. This study presented the frequency of nurse-patient sexual relationships and their prominent characteristics and the nurses' attitudes towards these contacts.

Another empirical review of the literature, conducted by Manfrin-Ledet, Porche, and Eymard (2015) searched the databases CINAHL, Medline, Ebscohost, and NCSBN in which over 40 publications from North America, Canada, United Kingdom, and Australia were reviewed. Of the 40 publications, only three research studies and one doctoral dissertation related to professional boundary violations in nursing related to nurse-patient relationships were found. Of the four, a study by Campbell, Yonge, and Austin (2005) and a doctoral dissertation by Steadman (2004) focused on the specialty field of mental health. Campbell et al. (2005) examined sexual boundary violations using a descriptive, structured mailed questionnaire of 923 active registered nurses in the mental health field. They found that those nurses who reported committing sexual behavior with patients were between 31 and 60 years of age, more likely to be male, single, and diploma level prepared. The study conducted by Campbell et al. (2005) was the first research study in Canada to explore professional nurse-patient boundary violations. In the dissertation study by Steadman (2004), using a comparative descriptive design, 138 advanced practice psychiatric nurses were surveyed by mail using the Exploitation Index. This study revealed advanced practice psychiatric registered nurses engage in low rates of self-reported boundary-crossing behaviors that would be considered detrimental. A third study conducted in New South Wales by Chiarella and Adrian (2014) reviewed disciplinary cases for nurse-patient boundary violations from 1999 to 2006. This study examined 29 disciplinary cases involving boundary violations, of which 58.6% were male registered nurses and 48.3% worked in the specialty area of mental health. A fourth study conducted by Jones et al. (2008) utilized a

comparative descriptive design using secondary data and found through chi-square analysis that nurses prepared at the associate degree level have a higher frequency of professional boundary violations in nurse-patient relationships than baccalaureate degree-prepared registered nurses. As shown, the studies were mainly descriptive in nature, delineating characteristics of nurses self-reporting or being reported for professional boundary violations.

Professional boundary violations have been researched thoroughly in other health professional disciplines to include medicine, mainly psychiatry, the field of psychology, and social work. Non-nursing health care disciplines have examined not only frequency and characteristics of professional boundary transgressions, but have examined influences and factors in an attempt to understand this phenomenon. Nursing has yet to expand its research to include potential predisposing influences and/or factors that may be associated with boundary violations.

To date, no research studies were found related to nursing leaders and nurse-patient boundary issues. Nor were any research studies found utilizing a research approach designed to further explain the phenomenon of boundary violations and nursing leaders' ethical management of nursing professionals involved in transgressions. In concurrence with Manfrin-Ledet et al. (2015), "additional nursing research is greatly needed in the area of professional boundaries" (p. 326). Therefore, given the paucity of research related to professional boundary transgressions in nursing, particularly in the context of nursing leader's ethical decision-making about nurse-patient relationship boundaries, this study is justified in that it aims to reduce the current gap in the literature.

Purpose of the Study

When nurses fail to "stay within the lines" of professional nurse-patient relationships, it is incumbent upon nursing leaders to intervene in reinstating professional boundaries and address

boundary transgressions. “Failure of a chief administrative nurse to follow standards and guidelines required by federal or state law or by facility policy in providing oversight of the nursing organization and nursing services for which the nurse is administratively responsible” is culpable as stipulated by the Texas Administrative Code (2018c), Unprofessional Conduct. Nursing leaders, particularly first-line nurse managers, “are regularly confronted with ethical dilemmas when making their daily administrative decisions that require choices of both a moral and ethical nature” (Nasae, Chaowalit, Suttharangsee, & Ray, 2008, p. 471); however, boundary breaches which occur outside of daily administrative decisions creates complex ethical dilemmas, and requires effective ethical decision-making.

In so doing, nursing leaders, when faced with their staff’s boundary transgressions, must make decisions when evaluating these types of situations and choosing among alternative actions in manners consistent with ethical principles. Perceiving and eliminating unethical options and selecting the best ethical alternative are key processes in making ethical decisions. Decision-making is a cognitive process that results in the selection of a belief or a course of action chosen from among several alternative possibilities (Marquis & Huston, 2017). Every decision-making process produces a final choice that may or may not prompt action.

As professional boundaries are intended to set limits and define safe, trusting connections between nurses and patients, boundary breaches have the potential to cause harm involving quality of care issues and patient care standards, conflict between organizational and professional philosophy and standards, and a reduction in professional autonomy by virtue of one’s actions. Therefore, investigating nursing leaders’ ethical decision-making about professional boundaries and nurse-patient relationships is critical, in that, the profession expects, and patients trust, that

nurses will act in their patients' best interests and nursing leaders will act in assuring that this trust is respected.

The purpose of this mixed methods sequential explanatory study was to ascertain nursing leaders' knowledge and skill in ethical decision-making when evaluating and managing professional nurse-patient relationship boundaries. It was also the purpose of this study to better understand nursing leaders' moral, cognitive, and organizational socialization factors influencing their ethical decision-making in evaluating and managing professional nurse-patient relationships. Utilizing scenario-based vignettes have been shown to provide a non-threatening approach to the study of sensitive topics in both quantitative and qualitative studies (Barter & Renold, 1999; Martin, 2006). Quantitatively, study participants will have an opportunity to complete an anonymous scenario-based vignette survey. Qualitatively, study participants will be provided an introduction to the topic by means of the scenario-based vignette survey. Generating a theory grounded in the views of the participants is an intended outcome of this study.

Research Question

The research question guiding this study is: What factors influence nursing leaders' ethical decision-making in their perceptions of and actions toward nurse-patient relationship transgressions? This study is intended to delineate relationships among nursing leaders' demographic characteristics and ethical decision-making. The focus of the research question and sub-questions (below) is to examine nursing leaders' characteristics and supervisory-level experience in addressing potential and/or actual staff violations of professional nurse-patient relationships, as well as their perceptions of and likelihood to act on staff members' unethical behaviors.

Sub Question 1. What are nurse leaders' opinions regarding the ethical behavior of a nurse as described in the nurse-patient relationship vignettes?

Sub Question 2. What action will be taken by the nurse leaders' in the vignettes involving staff members engaging in inappropriate nurse-patient relationships?

Sub Question 3. What moral, cognitive, and organizational socialization factors predispose nurse leaders' perceptions of and actions toward their evaluation and management of professional nurse-patient relationship boundaries?

Significance of the Study

The significance of this study has its roots in under reported professional nurse-patient relationship boundary transgressions. A study extracting factors predisposing nursing leaders' moral judgments in making ethical decisions related to boundary breaches in nurse-patient relationships is significant to a variety of stakeholders to include patients, staff nurses, nursing leaders, educators, nursing regulatory agencies, and researchers. Bringing to light the disparities in reported boundary violations and known or suspected breaches is an admonition to nursing leadership to question ethical judgment. In nursing, "we need to really think about our actions and how they may affect our patients" (Hall, 2011, p. 217). A clearer understanding of nursing leaders' opinions in recognizing and acting on nurse-patient boundary transgressions may reveal underlying challenges in ethical decision-making that can be utilized to change or adjust current practices.

Studies show professional boundaries are frequently discussed in mental health and counseling literature, however, "contemporary nursing literature addressing therapeutic boundaries is scarce; few in depth inquiries and critical analyses exist" (Holder & Schenthal, 2007, p. 26). Additionally, Holder and Schenthal (2007) only found two nursing surveys

showing evidence of boundary violations, both dated “but considered landmark studies from 1974 and 1990” (p. 26). As the NCSBN has taken a leading role in bringing the issue of boundary violations to the forefront of nursing, “even this work is almost a decade old” (Holder & Schenthal, 2007, p. 26). First, from a research and regulatory perspective, information derived from this study will add to the current body of literature by contributing updated information regarding boundary violations.

Policies written about boundary violation reporting are in effect for each state, and, mechanisms should be in place at each health care institution for reporting boundary violations. Reporting boundary violations is scant due to “a reluctance to report friends and coworkers” (Hanna & Suplee, 2012, p. 29), a commonly cited barrier to reporting. Second, presenting challenges nursing leaders identify in ethical decision-making regarding ‘knowing and doing what is right’ may be used by nursing leadership and educators to improve organizational staff development and nursing programs educational curricula.

> Nurse executives and nurse managers may find this data useful in providing focus to staff development activities. It may be that educating staff nurses about what conduct will likely result in board discipline and how to avoid that conduct not only can help reduce the individual nurse’s likelihood of experiencing discipline but also can improve patient care. (Kenward, 2008, p. 83)

Building awareness of legally mandated rules and regulations set by the NPA and Code of Ethics in regards to good professional character, unprofessional conduct, and grounds for disciplinary action can be utilized by educators to alert nurses to the hazards of overstepping professional boundaries.

Further exploration of nursing leaders’ decisions and actions in handling potential or actual nurse-patient boundary violations in association with moral agency, moral cognition, and personal characteristics may provide insight into factors affecting ethical decision-making and

appropriateness of actions. Nursing administrators, educators, and researchers may find the results informative in bridging the gap from thought to action. Third, developing and implementing educational programs designed to guide ethical decision-making in situations involving nurse-patient boundary breaches is a mechanism toward preparing nursing leaders to recognize and manage boundary transgressions. Fourth, equipping nursing leaders with an ethical decision-making skill set is a critical factor in developing leaders who have the volition to execute ethical actions. Fifth, information derived from this research may be used by nursing leaders, policy makers, and researchers in strategizing appropriate preventive and reporting measures.

This study aims at ascertaining boundary violation risk points by transparently discussing topics such as ethics, standards of practice, personal space, and therapeutic relationships, as well as explaining policies and procedures emphasizing professional boundary issues. In turn, the study findings can inform nursing administrators, educators, and researchers the necessity of clearly and objectively communicating the importance of ethical decision-making regarding nurse-patient relationship boundary breaches. Thus, presenting nurses with training through academia and workplace settings, imbedded in nursing curricula, orientations, and leadership courses, will contribute to the gap revealed by the findings.

Contribution to the Gap

As there is ongoing concern regarding professional boundaries in nurse-patient relationships and zero-tolerance policy towards nurses who engage in boundary transgressions with patients, nurses and nursing leaders share responsibility for managing these boundaries. However, nursing leaders have the burden of recognizing and acting according to a code of ethics in maintaining appropriate professional boundaries and reporting nurses engaged in

boundary indiscretions. This study is designed to enhance the current body of knowledge by expanding the scope and depth of research related to professional boundaries and nurse-patient relationships.

Based on the limited scope of research found in the literature and their narrow focus on the specialty fields of mental health, community, and case management, this study was conducted in an acute care facility providing a broader range of nursing specialties. This study is the first of its kind to attempt to understand the characteristics and perceptions of nursing leaders' ethical decision-making about professional boundaries and nurse-patient relationships. This study also establishes new ground in ascertaining contributing influences and/or factors predisposing nursing leaders' capacity to act when confronted with ethical dilemmas related to nurse-patient professional boundaries. Additionally, a theory grounded in the views of the participants was developed, thus providing a theoretical explanation of nursing leaders' ethical decision-making about professional boundaries and nurse-patient relationships.

Research Design

This study was a mixed methods sequential explanatory design in which two distinct interactive phases were conducted. The study began with the collection and analysis of quantitative data, followed by a subsequent collection and analysis of qualitative data. The quantitative phase "has the priority for addressing the study's questions" and the qualitative phase "is designed so that it follows from the results of the first, quantitative phase" (Creswell & Plano Clark, 2011, p. 71). The intent of utilizing this design for this study was "to use quantitative results about participants' characteristics to guide purposeful sampling for a qualitative phase" (Creswell & Plano Clark, 2011, p. 82). Quantitative data was collected and analyzed to identify significant characteristics and supervisory-level experience in addressing

potential and/or actual nurse-patient relationship transgressions. Qualitative interviews were conducted with nursing leaders who are experienced in supervising staff nurses to attempt to explain moral, cognitive, and organizational factors relevant to the quantitative results. As a final outcome of this study, qualitative findings were used to generate a theory grounded in the views of the participants. This grounded theory serves as a way to learn about ethical decision-making characteristics of nursing leaders representative of diverse health care specialties within a Level I military medical trauma center in South/Central Texas.

Quantitative phase. Nursing leader's characteristics and supervisory-level experience in addressing potential and/or actual nurse-patient relationship transgressions was collected through a researcher-designed vignette-style decision-making survey. The data collected by the researcher-designed vignette-style decision-making survey was obtained through a six question, six answer Likert scale and includes a separate participant demographics questionnaire. The survey was analyzed using the Statistical Package for the Social Sciences program (SPSS). The statistics selected for analysis as a result of the quantitative phase are descriptive statistics, whereby the demographic questionnaire was the source of data. Additionally, the inferential statistics selected for analysis are the bivariate Pearson's product-moment correlation coefficient (*r*), Paired samples *t*-test, and mixed between-within subjects ANOVA, whereby the demographics questionnaire, Vignette 1, and Vignette 2 were the sources of data. The bivariate Pearson's product-moment correlation was run to describe the relationships and determine the correlation among ethicality (virtue ethics and self-efficacy) in decision-making about professional boundaries from Vignette 1 and Vignette 2 and the variables from the demographic questionnaire. The paired samples *t*-test was run on the six pairs of answers from Vignette 1 Likert scale and Vignette 2 Likert scale in order to determine significant differences between

each of the two pairs of data; that is, changes in participant responses to ethical decision-making about professional boundaries. The mixed between-within subjects ANOVA was run utilizing data from the demographic questionnaire and compared the variances between Vignette 1 and Vignette 2 in order to determine change in the participant's answers between Vignette 1 and Vignette 2. The results were used to inform the qualitative research questions, sampling, and data collection methodology.

Qualitative phase. Nursing leader's moral, cognitive and organizational socialization factors predisposing perceptions of and actions in evaluating and managing professional nurse-patient relationship boundaries were collected through semi-structured, open-ended interview questions. The interview data was transcribed verbatim, coded categorically and chronologically, and reviewed repeatedly to search for key categories, themes, words or phrases. Data interpretation was used to further explain the quantitative results, and generate a theory grounded in the views of the participants.

Setting, population and sample.

Quantitative phase. A sample of nursing leaders from a hospital and/or ambulatory health care facility in South/Central Texas were selected through a convenience sample. Potential study participants were screened using the following inclusion/exclusion criteria:

1. Registered Nurse with a minimum of one year experience as a mid-level nurse leader in a hospital and/or ambulatory health care setting.
2. A minimum of one year experience as a mid-level nurse leader in a position overseeing one or more nurses.
3. Recruited from multiple inpatient and/or ambulatory care departments.

Qualitative phase. A sample of nursing leaders from a hospital and/or ambulatory health care facility in South/Central Texas were initially selected using purposeful convenient sampling followed by snowball sampling. Potential study participants were screened using the following inclusion/exclusion criteria:

1. Registered Nurse with a minimum of one year experience as a mid-level nurse leader in a hospital and/or ambulatory health care setting.
2. A minimum of one year experience as a mid-level nurse leader in a position overseeing one or more nurses.
3. Recruited from multiple inpatient and/or ambulatory care departments.

Limitations and Delimitations of the Study

The scope of this study may be limited by several characteristics that must be considered when defining the boundaries of this research. The limitations may affect the validity of my conclusions and generalizations.

Quantitative phase.

Limitations.

1. Finite resources limited sample size relative to the specific population included in this study.
2. Data results were based on the completion of a survey and offer limited insight into ethical decision-making by the participants.
3. Participant's may over- or under-estimate in ethical decision-making due to their state of mind at the time of the survey.
4. Conducting multiple comparisons statistical analyses increases the risk for Type I errors (rejecting the null hypothesis when it is actually true) if not controlled, increasing the risk

of finding a "significant result when in fact it could have occurred by chance" (Pallant, 2013, p. 217).

5. The novice experience of the researcher elicited some limitations with data collection and analyses.

Delimitations.

1. Securing permission from a Level I military medical trauma center in South/Central Texas to conduct a quantitative study within a specific facility.
2. The number of participants included in this phase of the study were limited to current mid-level nurse leaders from one Level I military medical trauma center in Central/South Texas.
3. The use of a convenience sampling approach restricted the ability to make inferences from the data results generalizable to any population.

Qualitative phase.

Limitations.

1. Finite resources limited the sample size relative to the specific population included in this study.
2. Ethical decision-making is a fluid process and may vary over time; this study explored this phenomenon at the time of the participant's interviews; therefore, it did not fully reveal associated factors from the sample.
3. Interviewees may be less forthcoming due to the sensitive nature of discussing personal opinions/experiences with ethical decision-making about professional boundary breaches.
4. The novice experience level of the researcher elicited some limitations with data collection and interpretations.

5. The principal investigator (PI) as the research tool may introduce bias into the data interpretation.

Delimitations.

1. Securing permission from a Level I military medical trauma center in South/Central Texas to conduct a qualitative study within a specific facility.
2. The number of participants included in this phase of the study were limited to current mid-level nurse leaders from one Level I military medical trauma center in Central/South Texas.
3. The use of initially acquiring a sample by purposeful sampling followed by snowball sampling restricted the ability to make inferences to any other population other than the participants listed in this study.

Definition of Terms

Mid-level nurse manager/leader. Directly oversees the standard of care and the standard of practice delivered by nursing staff assigned to the manager's specific span of control. "Examples of middle-level managers include nursing supervisors, nurse-managers, head nurses, and unit managers" (Marquis & Huston, 2017, p. 298).

Nurse executive/leader. Nurse executives set, oversee, and execute policy in accordance with standards of care and standards of practice as set forth in the NPA and Code of Ethics for health care organizations. "Current nomenclature for top-level nurse-managers varies … vice president of nursing or patient care services, nurse administrator, Director of Nursing (DON), chief nurse, assistant administrator of patient care services, or Chief Nurse Officer (CNO)" (Marquis & Huston, 2017, p. 298).

Nursing peer review. Is "the evaluation of nursing services, the qualifications of a nurse, the quality of patient care rendered by a nurse, the merits of a complaint concerning a nurse or nursing care, and a determination or recommendation regarding a complaint" (Texas BON, 2018, p. 53).

Quality of care. Is "the degree to which health services for individuals and populations increase the likelihood of desired health outcomes and are consistent with current professional knowledge" (Lorh, 1990).

Professional boundaries. "Are limits that protect the space between the professional's power and the client's vulnerability. Maintaining appropriate boundaries safeguards both the patient/client and the nurse by controlling or limiting this power differential. This boundary setting allows for a safe connection between the nurse and the patient based on the patient's needs" (Peterson, 1992, p. 182).

Power differentials. "Are the inequalities that exist between professionals and clients. Differentials exist in any professional situation in which the service provider has knowledge, experience, and authority that the client seeks and needs from the professional. In nursing, often the 'client' is exceptionally vulnerable by the nature of the illness or emergency for which he or she seeks services" (NCSBN, 2018a).

Therapeutic relationship. Is defined by the NCSBN as a continuum of professional behavior that spans from an extreme of under involvement to a "zone of helpfulness" to an extreme of over involvement (NCSBN, 2018a).

Breach. Is defined as an "act of breaking or failing to observe a law, agreement, or code of conduct." The word breach is synonymous with the word transgression (Breach, n.d.)

Transgression. Is defined as an "act that goes against a law, rule, or code of conduct; an offence." The word transgression is synonymous with the word breach (Transgression, n.d.).

Boundary breach and/or transgression. Is defined as an intentional or unintentional act that is not congruent with a code of conduct, rule, or law pertaining to professional boundaries. The terms boundary breach and/or boundary transgression are used interchangeably. An example might be a nurse paying special attention to a patient.

Boundary crossings. Are defined as "brief excursions across professional lines of behavior that may be inadvertent, thoughtless or even purposeful, while attempting to meet a special therapeutic need of the patient" and "should be evaluated for potential adverse patient consequences and implications." Boundary crossings generally produce no harmful long-term effects, but "repeated boundary crossings should be avoided" (NCSBN, 2018a).

Boundary violations. "Imply harm to the patient. They occur when therapeutic boundaries are crossed and are characterized by role reversal, secrecy, double binds, or the nurses' 'needs being met rather than the patients.' An example of a boundary violation might be an overtaxed nurse disclosing personal information or venting personal feelings to a patient" (Sheets, 2000, p. 28-33).

Sexual misconduct and exploitation. "Are extreme boundary violations and are now punishable as criminal offenses in 24 states. Though the obvious example of sexual misconduct is sexual contact with a patient against his/her will, many cases involve situations of two "consenting" adults, and in some instances even nurses who have subsequently married their patients. Nonsexual boundary violations usually relate to issues surrounding touch, dual roles, and self-disclosure" (Holder & Schenthal, 2007, p. 7).

Summary

The nursing professions standards, organizational factors, and personal characteristics may contribute to nursing leaders' ethical decision-making judgments. Nursing's code of ethics and practice standards prescribe nurse-patient relationship boundary limits for purposes of protecting patients from harm. Nursing leaders have a duty to oversee their staff's delivery of care and to act on situations deemed harmful to patients.

Numerous research studies regarding breaches in health care professionals' relationships with patients are concentrated in general practice medicine, psychological therapy, and social work. Additionally, boundary breach studies have delineated the long-term harm effects on patients and nurses involved in boundary transgressions. Nursing relationship transgressions with patients make up a small percentage of reported cases; however, boundary transgressions known but not reported are high. Most studies attribute under-reporting to unfamiliarity with codes of conduct, inadequate leadership training, organizational ambiguity, collegial familiarity, and immature moral maturity. In turn, these factors pose moral dilemmas for nursing leader's making ethical decisions about nurse-patient relationship boundary breaches.

Although studies have been done to determine the nature of boundary breaches and characteristics of those involved, scant research has been conducted on factors contributing to boundary misconduct. No nursing research has been found related to how boundary misconduct is managed by nursing leadership. Challenges remain for administrators, managers, and training providers to address professional boundary dilemmas (Evans, 2010; Fronek, et al, 2009). Therefore, a better understanding of nursing leaders' moral agency, moral cognition, and organizational factors influencing their ethical decision-making in evaluating and managing professional nurse-patient relationships is needed.

Chapter Two – Literature Review

The purpose of this mixed methods sequential explanatory study was to ascertain nursing leaders' knowledge and skill in ethical decision-making when evaluating and managing professional nurse-patient relationship boundaries by obtaining quantitative results from surveying 50 nursing leaders and then following up with a minimum of six purposefully selected nursing leaders to explain those results in more depth. The final outcome of this study was to better understand nursing leader's perceptions of moral, cognitive, and organizational factors influencing their ethical decision-making in evaluating and managing professional nurse-patient relationships, with the intent of generating a theory grounded in the views of the participants. Respondents' background information was collected and its examination was important to this study in correlating possible characteristics and factors contributing to significant relationships between nursing leaders' ethical decision-making and subsequent actions. This study was conducted with the intent of identifying factors contributing to the gap in knowing and doing what is right in situations involving unprofessional nurse-patient relationships.

The purpose of this literature review was to provide a foundation of knowledge related to character-based leadership, ethical decision-making, nurse-patient relationships, professional boundaries, and regulatory positions. This information supports the need for research about ethical decision-making and the challenges nursing leaders encounter when confronted with dilemmas surrounding ethics. This review also revealed current gaps in the literature surrounding ethical decision-making with regards to potential and actual violations of nurse-patient relationship boundaries. Critical examination of the current state of the literature with regard to nurse-patient relationship boundaries provides the up-to-date information guiding this research, clarifies the need to explore the experiences of nursing leaders' ethical decision-making style, and reveals the need for research in this area.

Leadership

Character-based leadership. Leaders, in a position of power ordained by an organization as the one with the knowledge, skill, and character possessing core values and integrity, which includes "personal traits of honesty, trustworthiness, and a moral or ethical orientation in one's actions" (Conger & Hollenbeck, 2010, p. 311), are essential elements in ethical decision-making. Leaders who have been judged to exhibit "character" are found to consistently display values associated with integrity (Conger & Hollenbeck, 2010; Sweeney & Fry, 2012). That being said, it raises the question, Is ethical decision-making solely dependent on the "character" of the leader?

According to the literature, character-based leadership is an emerging field with an array of definitions and constructs, ranging from a strict focus on the concept of integrity as the foundation of "character" (Grahek, Thompson, & Toliver, 2010; Kaiser & Hogan, 2010), to a diverse set of virtues with approximately 23 dimensions essential to "character" (Sosik & Cameron, 2010). Conger and Hollenbeck's (2010) review of the literature found that the majority of authors positioned integrity as core to the definition of "character." Sweeney and Fry's (2012) review of the literature reveals an individual's belief system about virtues influence their perceptions and judgments in moral and ethical issues, which in turn influence behavior. The concept of "character" carries a highly normative orientation with roots entwined in virtue ethics theory, which contends virtue ethics theory is specifically focused on individual moral character (Rowan & Zinaich, 2003). Utilizing virtue ethics theory as the foundation for character-based leadership may give rise to understanding what "character" traits predispose nursing leaders in making ethical decisions about nurse-patient relationship boundary breaches. However, simply

defining character-based leadership from a focus of individual character traits alone provides a narrow and unrealistic view, failing to recognize the reality of leaders and situational dynamics.

As leaders are complex humans with limitations, leading in complex organizations within a complex world, the reality is that situational dynamics in an organization impacts character and leadership. Leaders are expected to possess "character" conducive to knowing right from wrong, good from bad, and have the wherewithal to make ethical decisions. Hannah and Avolio (2010) described in their study that "character" is not only representative of the individual, but can also be representative of groups; such that each is influenced by the other and by the climate and culture of the organization. In essence, "ethics and integrity are relative or contextual" and ethical decisions are the result of complex phenomena resulting from a "dynamic set of characteristics of the individual that come to bear in different ways with different weights in different situations" (Conger & Hollenbeck, 2010, p. 312).

While morality is an essential characteristic of leaders knowing right from wrong, a value key in ethical decision-making, Hannah and Avolio (2010) point out a significant disconnect between knowing what is right and acting on that knowledge. According to the literature, recognizing an unethical behavior has not shown to be a strong predictor of ethical action (Bebeau, 2002; Blasi, 1980; Trevino & Youngblood, 1990). In fact, several researchers have tested and measured cognitive moral development by utilizing the *Defining Issues Test* and the *Leadership Virtues Questionnaire* and have found a large variance in actual ethical choices or behavior (Rest et al., 1999; Riggio, Zhu, Reina, & Maroosis, 2010). Hannah and Avolio (2010) pointed out that a leader's character is not only defined by his/her moral judgment, but also by his/her "motivation to act to address ethical dilemmas" (p. 292).

In addition to individual traits, situational context, and organizational influences, Barlow, Jordan, and Hendrix (2003) conducted a study in which early-, mid-, and mature-level manager's character was assessed using two different character assessment instruments. The two instruments used in their study were *The Character Assessment Rating Scale* and the *Behavioral Desirability Scale*, an instrument developed by William H. Hendrix in 2001. The study examined the differences in character across management levels and found that lessons learned from life experiences influenced a leader's character. The study suggested that through experience, training, mentoring, and education a leader's ability to morally know and feel develops with maturity.

The plethora of definitions of what constitutes character in leaders "shows that theory development on this concept still needs to mature" (Sweeney & Fry, 2012, p. 91). The processes that shape character, as well as, the factors that drive leaders to move from moral thought to moral action, are not fully understood nor well defined; however, most scholars contend that morality and ethics can be developed.

Ethical Decision-Making

Expectations in ethical decision-making. Nurse leaders frequently experience ethical issues related to their supervisory and managerial duties. The American Nurses Association Center for Ethics and Human Rights at the ANA Convention in 1994 reported that 79% of 934 nurses surveyed confronted ethical issues in practice daily (43%) or weekly (36%). Of these nurses, 50% identified incompetent, unethical or illegal practices of colleagues as one of the top four most frequent dilemmas. In 2004, the University of Virginia Center for Survey Research conducted a cross-sectional descriptive study in which 52% of 1000 nurses surveyed ranked unethical practices of health care professionals as one of the top five ethical issues creating most

stress (Ulrich et al., 2010). Musa, Harun-Or-Rashid, and Sakamoto (2011) conducted a cross-sectional survey of 417 nurse managers and found 95.2% experienced ethical issues and of these 47.2% experienced ethical issues on a weekly to daily basis. Of these nurse managers, staff management was reported as their top ethical issues encountered.

DeWolf Bosek and Stammer (2006) stated that "understanding nurse managers' role during ethical situations is contingent upon understanding the role and responsibilities associated with the profession" (p. 124). They assert the responsibility of assisting other nurses to understand their moral commitments is a key responsibility of nurse managers. As well, nurse managers have an ethical responsibility to lead by example when managing ethical situations, as well as to "take responsibility for promoting an ethical culture by acting as ethical role models" (Stenmark & Mumford, 2011, p. 942). It is incumbent upon the nurse manager to be competent in handling ethical issues and take the appropriate steps in responsibly dealing with moral dilemmas (Marquis & Huston, 2017). Marquis and Huston (2017) differentiate responsibilities of ethical decision-making between leadership roles and management functions. From a leadership role perspective, nurse leaders are expected to: be self-aware of their own values and basic beliefs; role model ethical decision-making in accordance with the Code of Ethics; communicate clearly expectations of ethical behavior; accept ambiguity, uncertainty, and negative outcomes; as well as be willing to take risks in ethical decision-making. From a management function perspective, nurse leaders are expected to utilize an ethical framework for decision-making, follow a systematic decision-making model, and take appropriate action in managing subordinates' unethical conduct. Expectations of nurse leaders' ethical decision-making stems from a moral obligation to ensure nurse-patient relationships are based on therapeutic relationships. It is expected that nurse managers will be competent in dealing with ethical issues.

Knowledge and skill related to ethical decision-making. Musa et al. (2011) conducted a qualitative, cross-sectional study to explore nurse managers' experience with ethical dilemmas and how they dealt with the issues. The participants, 417 out of 603, reported "feeling stressful [which] suggests that dealing with ethical issues is rather burdensome" (p. 5). The findings revealed that the top most stressful ethical issue was "working with unethical or incompetent colleagues" (p. 5). In handling ethical issues, nurse managers relied on their own skills, colleagues, or the code of ethics; however, only half of the nurse managers utilized the code of ethics for guidance. A criticism in referring to the code of ethics for guidance is that it "inadequately guides one's thoughts in formulating a viewpoint or judgment in dealing with ethical issues" (p.6).

Nursing managers are routinely confronted with ethical situations that require ethical decision-making from both a moral and ethical standpoint. Nasae et al. (2008) utilized the Critical Incident Technique to conduct a qualitative study investigating the ethics of dilemmas and decision-making by 53 nurse managers holding nursing administrative positions. The study explored ethical dilemmas that nurse managers face and their courses of action when making ethical decisions. The nurse managers surveyed reported that they experienced "ethical dilemmas regarding their obligation to manage and improve the quality of care for the benefit of patients vs. an obligation to the organization and colleagues" (p. 475). Ethical dilemmas that surfaced were related to interpersonal conflicts. Nurse Managers reported internal conflict when advocating for patients/subordinates versus maintaining relationships with the health care team, avoiding conflicts among colleagues, following organizational policy, and acting as a mediator. Findings from the study revealed nurse managers addressed ethical dilemmas by relying on guidance from higher authority, consulting with colleagues, following organizational regulations,

avoidance of conflict among colleagues, and by managing for quality care. As shown, nursing leader's knowledge and skill in making decisions regarding moral dilemmas are highly diverse, ranging from relying on own skills to utilizing a variety of sources to assist with the decision-making process. From a review of the literature, enhancing support for nurse managers,' professional development, and improving organizational approaches in dealing with ethical issues is needed. "Hence, in dealing with ethical dilemmas, it is difficult for nurse administrators to decide what is right or wrong or what ethical principles can be used to support their decisions" (Nasae et al., 2008, p. 477).

Factors related to ethical decision-making. As nurse leaders struggle with internal conflict over knowledge deficiencies and skill levels in handling ethical decision-making, studies have shown a myriad of factors affect ethical decision-making involving moral dilemmas. Stenmark and Mumford (2011) conducted an experimental study in which 238 participants were asked to assume the role of a mid-level manager in an organization and were presented with vignettes presenting different ethical problems and asking for solutions to each problem. The vignettes posed ambiguous ethical scenarios so that answers were not obvious and participants had to work with what they knew about the situation and the people involved in generating solutions. Approaching the study in this manner, rather than posing an egregious ethical violation, allowed for more diverse responses and were more representative of the ethical dilemmas faced by managers on a daily basis. The results indicated that a number of factors influence ethical decision-making, such as, perceptions of "trustworthiness" (p. 943) and "organizational citizenship behaviors" (p. 943). Situational variables, such as, "performance pressure" (p. 493), "interpersonal conflict" (p. 943-944), "threats to self-efficacy" (p. 944), and "moral autonomy" (p. 945) are significant in leaders' moral intensity, thereby impacting ethical

decision-making. This study demonstrated that situational factors may have complex effects on ethical decision-making.

Smith and Rogers (2000) conducted a survey of 126 female and 110 male participants utilizing four ethically ambiguous vignettes in order to capture gender and organizational socialization effects on ethical decision-making. Results revealed gender, as it relates to situational factors, plays a role in ethical decision-making. The authors found gender issues have received attention in relation to ethical decision-making; however, "there has been limited analysis of situational factors" (p. 73). In addition to the variables relating to gender and situational factors, another focus of interest is "whether there are differences in the responses of early-career professionals versus later-career professionals" (p. 74). Two theoretical frameworks, gender socialization theory and occupational socialization theory, were proposed as possible explanatory theories. Gender socialization theory proposes that "males and females tend to regard their work environments with different attitudes and expectations" and occupational socialization theory "concedes that differences may exist before employment" (pp. 75-76). However, with occupational socialization theory, the assumption is that "important, lasting socialization takes place in adulthood (i.e., through occupational training, organizational culture, and workplace rewards)" (p. 76). An analysis of the findings illustrated "males and females in the later stage of career development tend to give similar responses" (p. 81) to ethical decision-making dilemmas; whereas, males and females in earlier-career stages reflect "greater differences are noticed in the responses" (p. 81) to ethical decision-making dilemmas.

Franke, Crown, and Spake (1997) conducted a meta-analysis of research on gender differences in perceptions of ethical decision-making. Exploring the role gender plays in ethical decision-making, the researchers studied 66 samples totaling more than 20,000 respondents and

revealed on average higher ethical standards were found in women than men; however, ethical perceptions change with work experience for both genders. The researchers suggest it would be a misguided generalization to assert women are more ethical than men from this meta-analysis review, as a number of other possible influences were not available for review and this study addressed differences in ethical perceptions, not actual behaviors.

Lincoln and Holmes (2010) conducted a study in which 352 participants were presented with a two-part survey. Part one consisted of an adaptation of the Canadian Department of Defence's Ethics Survey focusing on philosophical approaches to ethical decision-making. Part two consisted of five scenarios varying in ethical intensity in which each scenario described a moral dilemma and a subsequent action or decision. The findings revealed recognizing a moral dilemma, evaluating potential choices of action and subsequent consequences, intention to act, and carrying out an action are "significantly associated with social consensus" (p. 61). In other words, a decision-maker's perception of his/her social group's belief about a particular situation, potential choices of action, and actions to be taken, will influence the process of ethical decision-making.

A variety of factors have been shown to influence leader's ethical decision-making when encountering moral dilemmas. Studies have revealed the process of ethical decision-making may be subject to external and internal influences from a variety of factors, some of which include situational variables, organizational socialization, individual characteristics, career development, and social consensus. As these factors have been shown to play a significant part in leaders' evaluation and management of moral dilemmas, having a better understanding of their influence may generate increased awareness giving nursing leaders additional knowledge and skill they can incorporate into their ethical decision-making style when facing moral dilemmas.

Gaps related to ethical decision-making. As organizations operate in more complex ambiguous contexts, organizations' leaders encounter challenging moral dilemmas; whereby, ethical performance by leaders is questioned. Moral potency, a new construct introduced by Hannah and Avolio (2010), captures the gap between knowing what is right and doing what is right. Recognizing challenging moral dilemmas, identifying limitations associated with ethics research, that is, how one behaves and actions taken following a judgment call, Hannah and Avolio proposed that "moral potency provides leaders with the psychological resources that bridge moral thought to moral action" (p. 292).

Focusing on the antecedents to ethical leadership behavior, Hannah and Avolio (2010) conducted a cross-sectional field study of 2,572 participants seeking to measure the moral potency construct. The three key factors of moral potency, moral ownership, "assuming responsibility to act" (p. 296); moral courage, "fortitude to face risk and overcome fears" (p. 296); and moral efficacy, "confidence to attain moral performance" (p. 297) were found to be predictive of the moral potency measure. The study found consistent evidence for the structure of the moral potency factors and found predictive validity of the moral potency measure. Specifically, an interaction between both moral courage and moral ownership were predictive of individuals confronting ethical transgressions of colleagues. Individuals who scored higher in both moral courage and moral ownership were more likely to step up and confront colleagues for unethical acts. Based on these findings, Hannah and Avolio believe the factors that make up the moral potency construct can be developed in leaders, thereby diminishing gaps associated with moral judgment. Considering that leaders serve as role models for others to emulate and establish the culture for their organization, it is critical that leaders possess the 'moral potency' to "step up and do what is right" (p. 307).

Ethics

Virtue ethics. Nursing is grounded in ethics, with morality emphasized in the profession. As nurses enter the profession, the assimilation of ethical reasoning and its application is core to the professional practice environment. For the nurse leader, having a clear understanding of how nurses acquire, assimilate, and actuate professional ethics is key in understanding how ethical challenges are experienced and resolved. Redman and Fry (2000) undertook a systematic analysis of five studies and found ethical conflict for the nurse was "not in knowing what should be done, but in the institutional constraints that made it nearly impossible to pursue the right course of action" (Andrews, 2004, p. 28).

As situations of moral difficulty are on the rise, nurse leaders are increasingly confronted with moral dilemmas requiring resolution through ethical decision-making. Arries (2005) contends that virtue ethics, which focuses on a person's character, "might provide a more holistic analysis of moral dilemmas in nursing and might facilitate more flexible and creative solutions when combined with other theories of moral decision-making" (p. 65). From a virtue ethics perspective, the moral character and disposition of the nurse leader as a moral agent determines the manner in which moral dilemmas are approached and ethical decision-making carried out.

Thus, relying on virtue ethics as a foundation for moral agency may prove beneficial to nurse leaders when encountering situations in which they are compelled to make ethical decisions about right from wrong. If used as a lone theory, however, it is unclear and questionable whether it provides a sufficient foundation for nurses encountering moral dilemmas. Varcoe et al. (2004) conducted an interpretive/constructivist study of 87 nurses' perspective of ethics in nursing practice. The findings showed that nurses perceived ethics as a way of being and a process of enactment; in other words, to be ethical one has to follow through in action.

Consistently, the nurses described ethical practice as relational and contextual. “Ultimately it was in the mesh of interdependence with the collective that they came to identify themselves and their actions as ethical (or not), and made their decisions about how they would or would not enact their moral agency” (p. 321).

Relational ethics. Relational ethics, a contemporary approach to ethics, presents a moral perspective that assists in expanding the understanding of nurses’ experiences with relationships in influencing moral choices (Bergum, 2004; MacDonald, 2006). Where ethics provides moral guidance on how we should live, relational ethics provides moral guidance on how we should live together. In nursing, how we should live together refers to the connection created between a patient and nurse that shape the moral space inhabited by both. This space is the zone in which professional interactions occur between a patient and nurse and is bounded within a therapeutic relationship. In sharing a therapeutic relationship, both the patient and the nurse maintains a safe place throughout their state of mutual vulnerability; that is, the space within the zone of helpfulness (Austin, 2007).

In defining relational ethics as it pertains to the nursing profession, a nurse philosopher, Gadow (1996, 1999) constructed a moral guide to nursing practice based on the assumptions that the nurse-patient relationship is the essence of nursing practice and that relationships between people are foundational to morality. Gadow (1996) conceptualized such a moral framework as a relational narrative, “the construction by patient and nurse of an interpretation that is their coauthored narrative describing the good they are seeking” (p. 8). The “good” being a safe place for both the nurse and patient to make sense of the situation (a patient’s particular circumstances), make the situation inhabitable, and find a path to attain a way forward in the face of the situation. “A relational narrative thus provides a morally habitable world where patient

and nurse can live" (Hess, 2003, p. 138). This space is attained through the construction of a coauthored relational narrative developed by patient and nurse generating a best fit for meaning and understanding the current situation. This morally habitable world is jointly created from the patient's understanding of his/her health condition in relation to a previously formed life story and the nurse's own self story based on both personal and professional meaning. The relational narrative is morally bound to the relationship in which both can be committed; yet, "does not transcend their relationship, its authority begins and ends with their authorship" (Gadow, 1999, p. 9).

Gadow's (1999) philosophy of nursing ethics is built on three layers, premodern, modern, and postmodern ethics, respectively corresponding to a triad of ethical layers, "subjective immersion (ethical immediacy), objective detachment (ethical universalism), and intersubjective engagement (relational narrative)" (p. 59), each layer connected within a coherent framework. The premodern layer, ethical immediacy, is not up for discourse; it is an understood 'good' that is based on predetermined value systems such as those established by religion, family, customs, or the ethos of a profession, thereby excluding reflection or criticality about the 'good'; the ethics originates outside an individual. In contrast, ethical universalism is a modern rationality in which principles are objectively applied to all situations and individuals. Individuals are respected equally and principles applied universally without thought given to differences in individual characteristics. Moving beyond subjective and objective certainty lies intersubjectivity, an existential or postmodern turn where the uniqueness of individuals is valued and responsiveness to the particular individual is embraced through engagement, or a relation between individuals. Through engagement, a nurse and patient together compose an ethical narrative where "patients can be helped to create emancipatory narratives, that is, to revise disabling into enabling views

that allow movement toward a self with possibilities" (Gadow, 1999, p. 65). The relational narrative provides the greatest engagement between nurse and patient in building a therapeutic relationship and thereby producing a 'good' path as developed and agreed upon by both participants in the relationship. As well, this level of nurse-patient engagement offers the greatest opportunity for over involvement in the relationship potentially extending outside the bounds of a therapeutic relationship.

To understand what it means to be a nurse leader in the complex world of nursing – a relationship-based profession – shaped by integrally connected relationships formed between nurses-patients-families, embedded in a complex health care system, requires an understanding of the point at which relationships are intricately interwoven, that is, at the point of care. As nursing is a relationship-based profession, a nurse-patient therapeutic relationship is attained through a nurse-patient co-constructed relational narrative that is morally habitable within a zone of helpfulness. Patient advocacy and bilateral trust engenders the relational narrative, with nurses finding themselves immersed in the circumstances of the patient-family particular situation.

As a leader, with the positional obligation of providing oversight of their staff, a nurse leader must be in tune with the relational narratives within their span of control. Developing and applying a relational consciousness highlights the interplay of a number of factors affecting the nurse and patient/family, enabling more informed decisions and more effective actions. Doane and Varcoe (2015) indicate that employing a relational consciousness extends your attention "to the relational interplay occurring at and between the intrapersonal, interpersonal, and contextual levels" (p. 4). Nursing leaders as moral agents, utilizing relational consciousness, pay attention to what is going on within people, among and between people, and around people and situations. "Specifically, relational consciousness is the action of being mindfully aware of the relational

complexities that are at play in a situation and intentionally and skillfully working in response to those relational complexities" (Doane & Varcoe, 2015, p. 5). Through the nurse leaders' individualist lens, evaluating and managing nurse-patient relationships are responded to from just the leaders' consideration; however, through a relational lens, the nurse leaders' response is seen as arising through the interplay between the nurse, patient/family, the situation, and the system. Approaching a nurse-patient relationship through a relational lens, a nurse leader "is seen as having the potential to inform both nursing action and ultimately the patient/family and system well-being" (Doane & Varcoe, 2015, p. 8).

From a leadership perspective, or the one expected to be in the know of what constitutes right and good, and morally held to action in making ethical decisions when faced with a nurse's over involvement in a nurse-patient relationship, nursing leaders as moral agents may look to ethical theory as a foundation for guidance. Having an understanding that nurses are frequently faced with making ethical decisions regarding what constitutes a 'good' path, professional codes of conduct, standards, and legally mandated administrative codes provide nurses with direction; however, these regulations may still prove deficient as nurses find themselves immersed in the particular circumstances and context of the patients' situation. Moreover, the application of ethical universalism is just as restrictive, in that it rationally applies principles across the board and does not take into consideration that nursing is a relationship-oriented profession in which the nurse-patient relationship is unique. However, the postmodern, relational narrative, developed through a nurse's engagement with a patient, is situational, contextual, and unique in that it is interdependent, and purports a co-constructed relationship; which in and of itself may prove beneficial to a nursing leader in understanding the nuances of a nurse-patient relationship, specifically when over involvement is in question.

Nurse-Patient Relationships

Professional relationships. Professional relationships are purposeful relationships based on individuals using their expert knowledge in meeting the needs of their patients. A professional relationship puts the patients' needs first. "Professional relationships occur within a continuum of under involvement to zone of helpfulness and to over involvement" (Buhari, 2013, p. 162). Figure 4 illustrates a continuum of professional behavior.

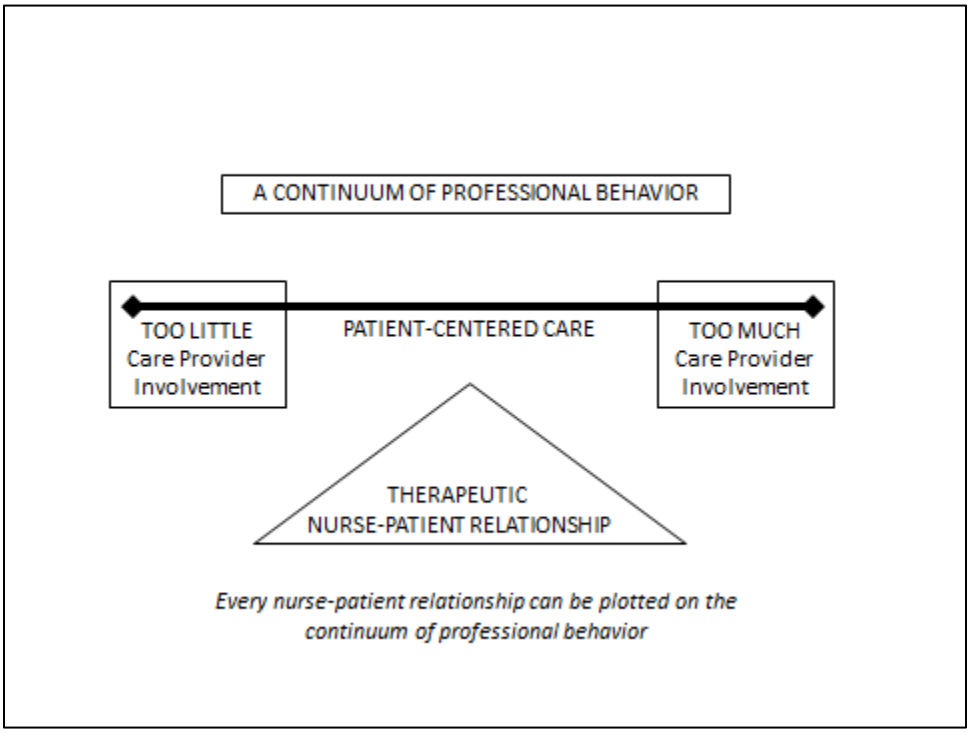

Figure 4. A continuum of professional behavior (NCSBN, 2018a, p. 5).

The continuum of professional behavior "provides a frame of reference to help nurses evaluate their professional interactions with patients" (Benbow, 2013, p. 31). At the center of the continuum is patient-centered care; this is the zone in which nurse-patient interactions occur within a therapeutic relationship. On the continuum to the right, the nurse is too involved with the patient, and this is the zone where boundary crossings and boundary violations occur. On the

continuum to the left, the nurse is under involved in the patient's care and this is the zone where patient neglect and distancing occurs.

The expectation of a professional relationship is one in which the nurse abstains from personal gain at the expense of the patient and stays focused on meeting the clinical needs of the patient. As there are no finite lines separating the zone of helpfulness from the ends of the continuum, and there is a gradual transition between patient-centered care and under or over involvement, a nurse must always ask the question; "Is my or my colleagues' interaction with the patient in the best interest of the patient?"

Therapeutic relationships. Therapeutic relationships, established within the zone of helpfulness, are based on a framework of health care specific to the patient. This framework, set up in collaboration with the patient, establishes a goal-directed plan of care incorporating treatment and expectations. The purpose of establishing a therapeutic relationship with the patient is multi-faceted; it provides a safe setting, establishes trust, makes it possible to evaluate deviations from the plan of care, facilitates communication, and limits interactions with the patient to those specific to meeting the patient's health needs. "The patient's health needs determine when the relationship begins and ends" (Wright, 2006, p. 52).

The key elements in a therapeutic relationship, trust, compassion, mutual respect, empathy, and genuine caring, are established and cultivated within the zone of helpfulness. Staying within the realm of a therapeutic relationship, which is confined within a professional relationship, is maintained by setting boundary limits of the nurse-patient relationship. On the continuum of professional behavior, boundary limits, which are non-discriminant and meld somewhere between therapeutic relationships and under or over involvement, lie within a gray area on either side of the zone of helpfulness.

Therapeutic relationships, built on humanness complete with all its fragilities, struggle with setting limits appropriate to the specific health care needs of the patient (Peternelj-Taylor, 2002). Collins (1989) observed, “Paradoxically, the very relationship that offers the promise of healing also exposes practitioners of all disciplines to the hazards of overstepping their professional bounds” (p. 153).

Professional Boundaries

Professional boundaries in nursing are a complex type of relationship that by virtue of the profession “allow for intimate entry into another person’s life experiences” (Remshardt, 2012, p. 5). Being given the privilege of entry into another person’s life is critical in developing a therapeutic connection with the patient. It is through a therapeutic connection that trust is built in a nurse-patient relationship; which, in turn, is supported by staying within professional boundaries.

The NCSBN (2018a) defines professional boundaries as “the spaces between the nurse’s power and the patient’s vulnerability” (p.4). The Texas Administrative Code defines professional boundaries as “the appropriate limits which should be established by the nurse in the nurse/client relationship due to the nurse’s power and the patient’s vulnerability” (Texas Administrative Code, 2018b). Both definitions allude to the power differential between the nurse and the patient, giving the nurse unbridled authorization to affect the well-being of the patient. If the power differential goes unchecked, the potential to overstep limits exists in nursing. “As each professional relationship develops, boundary setting is one area that requires nurses to develop proper self-awareness skills” (Moore, 2007, p. 39). Setting boundaries, a mainstay in supporting therapeutic integrity in a nurse-patient relationship, is one of the most important competencies a

nurse can acquire. These boundaries delineate the range of acceptable behavior permitted by both patients and nurses.

Professional boundaries, described as a framework in which well-defined restrictions sustain safe and effective nurse-patient interactions, are thought of as a line not to be crossed (Maes, 2003). However, as nurses live and work in a very complex world where boundaries are blurring and bleeding into each other, sometimes drawing the line while delivering compassionate care becomes blurred and makes adhering to a therapeutic, professional relationship much more difficult. Recognizing the issues of boundaries and heeding the warning signs of crossing them is a complex topic that must be examined carefully in order to balance the quest for maintaining therapeutic integrity within the parameters of professionalism and preserve the caring, compassionate human responses intrinsic to the nursing profession.

Boundary crossings. Crossing the line, an abstract, imprecise, nebulous location surrounding the zone of helpfulness, is defined in concrete language through multiple regulatory venues; however, in practice, it remains a subject difficult to address. The NCSBN (2018a) defines boundary crossings as "brief excursions across professional lines of behavior that may be inadvertent, thoughtless or even purposeful, while attempting to meet a special therapeutic need of the patient" (p. 4). Generally, crossing professional boundaries produces no harm, and depending on the context of the situation at the time, may be beneficial to the therapeutic relationship. However, it is paramount that a nurse use "careful judgment when intentionally crossing boundaries and should not cross them repeatedly" (Sheets, 2001, p. 38).

As stated in the literature, there are circumstances in which a nurse may intentionally cross the line to meet a specific therapeutic need of a patient. For example, sharing a personal health struggle that ended successfully in order to encourage and motivate a patient's fight for

survival and provide hope of recovering from an illness. Other examples include giving an inspirational gift signed by the nurses within the department, accepting a handmade necklace from a patient who would be offended if the gift was rejected, or sharing personal tips in managing diabetes during a patient teaching session; without which, the therapeutic relationship may suffer and patient overall well-being deteriorate (Buhari, 2013; Sheets, 2001; Wright, 2006). Even though there are times when crossing the line is considered appropriate to enhance the therapeutic relationship between the nurse and patient, it is advised to use caution in this practice, minimize repeated boundary crossings, and consult with colleagues or supervisors when not sure of what to do; and at all times, ask oneself "Is my action clearly based on the best interest of the patient in my care?" (Buhari, 2013; Peternelj-Taylor & Yonge, 2003).

Boundary violations. Determining whether a boundary violation has occurred is heavily dependent on the context of the situation, and/or whose needs are being met. Peternelj-Taylor and Yonge (2003), stress the importance of understanding what constitutes boundary crossings and the propensity for these supposedly compassionate acts to escalate into boundary violations—"transgressions that are clearly harmful or exploitive" to the patient (p. 57). Additionally, it is critical to nursing to understand the legal bounds of a professional relationship in terms of its fiduciary responsibility. That is, by the very nature of the therapeutic nurse-patient relationship and the power differential that exists in this relationship, it is expected that nurses will use their power responsibly to act in the patient's best interest toward achieving the treatment goal needs of the patient and not overstep and violate the trust and confidence placed in the nurse by the patient (Jorgenson, Hirsch, & Wahl, 1997).

The responsibilities of setting clear professional boundaries, staying within the framework of the therapeutic relationship, and abstaining from boundary violations are

exclusively the nurse's responsibility. As the NCSBN (2018a) defines boundary violations as a "result when there is confusion between the needs of the nurse and those of the patient" (p. 4), there are certain behaviors that signal a red flag, denoting potential boundary violations may exist. Nurse-patient relationships should be examined when there is excessive self-disclosure of personal problems or intimate life feelings, secretive behavior with the patient, a defensive posture when questioned about patient interactions, spending an inappropriate amount of time with the patient, soliciting gifts, and/or inappropriate communication such as being too familiar with the patient, suggests a potential non-therapeutic, social relationship indicative of a probable boundary violation (Benbow, 2013; Buhari, 2013; Sheets, 2001).

Professional sexual misconduct. Escalating unprofessional behavior of an even more serious failure of the nurse's responsibility for the well-being of the patient is sexual misconduct. Actions of this nature are egregious in that they are intentional, take advantage of the power differential in the relationship, are a violation of the patient's rights, and are potentially harmful to patients due to their vulnerability. Whether or not the patient consents to or initiates the sexual contact, the nurse's behavior violates the fiduciary responsibility to the patient and is a manipulation of a trusting relationship (Driscoll, 2004; Hanna & Suplee, 2012; Sheets, 2001). It is always the duty of the health care professional to set and maintain boundaries and to know when boundaries have been violated.

Professional sexual misconduct is defined by the NCSBN (2018a) as "an extreme form of boundary violation and includes any behavior that is seductive, sexually demeaning, harassing or reasonably interpreted as sexual by the patient" (p. 5). Some studies have suggested that there are particular health care personalities at a higher risk of committing sexual misconduct, just as some nursing specialties and environments are more conducive to boundary breaches. Respectively,

novice or young nurses, those with preexisting or underlying personal issues, such as substance abuse, situational stressors, insufficient supervision, are at a higher risk of professional sexual misconduct, and environments such as long-term care and rehabilitation, psychiatric-mental health, obstetrics-gynecology, and community-home health nursing (Baca, 2009; Buhari, 2013; Griffith & Tengnah, 2013; Hanna & Suplee, 2012; Peternelj-Taylor & Yonge, 2003).

In a review of the literature, the predominant research related to the study of professional boundaries has focused on "physician-patient and therapist-patient relationships, with little known about nurse-patient relationships, particularly in hospital settings" (Hanna & Suplee, 2012, p. 43). It behooves the profession of nursing to further explore professional boundaries in the nurse-patient relationship and the challenges associated with maintaining therapeutic integrity, recognizing misconduct, and acting ethically when professional boundaries have been breached.

Regulatory Positions – Legal Ramifications

American Nurses Association Code of Ethics. "A code of ethics is a fundamental document for any profession" (Lachman, 2009, p. 55). A code, developed by the profession, "provides a social contract with the society served, as well as ethical and legal guidance to all members of the profession" (p. 55). As progressively more complex roles and situations present themselves, the code delineates core values of the profession. The nursing profession's original code of ethics was developed by the ANA in 1950. Since its inception, the central significance of service to others has been consistent. Provision Two of the Nursing Code of Ethics states; "The nurse's primary commitment is to the patient, whether an individual, family, group, community, or population" (ANA, 2015a, p. 5). Within this provision, professional boundaries are specifically addressed defining the purpose of nurse-patient relationships. According to the ANA

(2015b), the relationship between the nurse and patient is not one of friendship but of "the promotion, protection, and restoration of health and the alleviation of pain and suffering" (p. 7).

Texas Board of Nursing. The Texas BON Rules and Regulations relating to Nurse Education, Licensure, and Practice, published October 2014, is based on statutory authority as provided for in Chapters 301, 303, and 304 of the Texas Occupations Code, to regulate the education and practice of nursing in the state. The rules and regulations are in place to protect and promote the welfare of the public by ensuring each licensed nurse is competent to practice safely. The Board undertakes a proactive leadership role in regulating nursing practice and education by promoting the highest standards of ethics, accountability, and responsibility expected of each licensed nurse.

The provisions within the Rules and Regulations are clearly set forth, providing guidance and support for decision-making at all levels of a licensed nurse. The provisions of Rule §213.27, last amended to be effective February 25, 2018 43 TexReg 863, defines good professional character as "behaviors indicating honesty, accountability, trustworthiness, reliability, and integrity" (Texas BON, 2019b, p. 21). Within this provision, it is clearly stipulated that a person who seeks to obtain or retain a license to practice nursing in the state of Texas will consistently display behavior whose actions are carried out in the best interest of the public. The rule specifically delineates the actions expected of an individual nurse to know right from wrong, think and act rationally, honor obligations, be accountable for one's behavior, and "recognize and honor the interpersonal boundaries appropriate to any therapeutic relationship or healthcare setting" (Texas BON, 2019b, p. 22).

In considering decisions related to interpersonal boundary breaches between a nurse and patient, the Texas BON (2019a) Rule §301.452(b)(10) includes a disciplinary matrix based on

the threat to public safety, the seriousness of the violation, and any aggravating or mitigating factors. The Disciplinary Matrix considers violations of unethical behavior such as personal relationships that overstep professional boundaries between a nurse and patient as a second tier offense, based on a first-through-third tier offense with the third tier level ranked as most severe. Additionally, repeated acts of unprofessional behavior and/or sexual or sexualized contact with a patient is categorized as a third tier offense and sanctions defined as Level I or Level II are stipulated in accordance with the severity of harm sustained by the patient.

In determining what constitutes ethical and unethical behavior and behaviors in question related to breaches in nurse-patient relationships, referring back to the Texas BON Rules and Regulations takes the guess work out of deciding what constitutes a breach in a nurse-patient relationship and what measures to take when the breach is substantiated.

Position Statement 15.29: Use of Social Media by Nurses. Social media sites, such as Facebook, Twitter, LinkedIn, YouTube, and blogs are recognized by the Texas BON as rapidly growing sites that can be valuable tools in health care, as long as used appropriately and without harm to patients. The Texas BON has adopted the guidelines and principles on the use of social media as set forth by the NCSBN in conjunction with the ANA.

Recognized as a positive media for networking, collegial exchange of knowledge, education, and research among nurses and between nurses and the public, it also has the potential, if used indiscriminately, to be a source that may contribute to the harm of a patient. In keeping with the NCSBN guidelines, it is the Texas BON (2012) position that

> nurses maintain professional boundaries in the use of electronic media. Like in-person relationships, the nurse has the obligation to establish, communicate and enforce professional boundaries with patients in the online environment. Use caution when having online social contact with patients or former patients. Online contact with patients or former patients blurs the distinction between a professional and personal relationship.

> The fact that a patient may initiate contact with the nurse does not permit the nurse to engage in a personal relationship with the patient. (p. 85)

Nurses must be aware of the potential consequences associated with indiscriminate use of social media. According to the NCSBN (2018b), "have been disciplined by boards, fired by employers, and criminally charged for the inappropriate or unprofessional use of social media" (p. 9). Maintaining professional boundaries, which extends to the use of social media, is an obligation expected of all nurses.

National Council of State Boards of Nursing. NCSBN (2009) published the booklet, *Practical Guidelines for Boards of Nursing on Sexual Misconduct Cases,* for the purpose of providing practical guidelines in making decisions about sexual misconduct cases that boards of nursing (BONs) may use as a resource or incorporate into their own rules and regulations. The booklet defines relevant terms, provides a detailed framework for deciding when and how to take action in sexual misconduct cases, and provides a *Sexual Misconduct Pathway* that serves as a quick reference when handling sexual misconduct cases.

The NCSBN, using language from BONs' laws and regulations, defines three different terms related to sexual misconduct; that is, sexual misconduct, sexual impropriety, and sexual violation. Respectively, each term describes a different level of inappropriate behavior involving sexual misconduct, to include physical and verbal behavior, suggestive comments, and/or physical contact.

A comprehensive framework for deciding when and how to take action when faced with a sexual misconduct case outlines considerations addressed through a series of questions that are illustrated in a *Sexual Misconduct Pathway*. The pathway is a user-friendly summary of major points to consider when evaluating sexual misconduct cases. The pathway is an algorithm that

provides step-by-step guidance for determining appropriate actions to be taken when faced with a sexual misconduct complaint.

In January 2009, the NCSBN conducted a survey in which all BONs were contacted for the purpose of determining the needs of BONs related to their work with sexual misconduct cases. Of all the BONs, only 26 boards responded to the survey. Of the 26 boards that responded, "46 percent were definitely satisfied with how their BON handles sexual misconduct cases; 50 percent were somewhat satisfied; and four percent (one BON) was not satisfied at all" (NCSBN, 2009, p. 48). The disparities among the boards responses alludes to potential mishandling of known sexual misconduct cases.

Additionally, the BONs were asked about their experiences with cybersex/communication technologies; and of the 26 BON respondents, seven BONs reported cases related to cybersex/communication technologies. These cases included inappropriate behaviors involving e-mail, electronically sent photos, and inappropriate behavior solicited through the internet. To take this a step further, "only two of the 26 BONs require sexual misconduct content in their nursing programs, though generally, it is assumed that this is discussed in ethics or other courses" (NCSBN, 2009, p. 50). Considering that only 26 boards out of 50 boards of nursing responded to the survey is cause for further examination.

Summary

The review of the literature provides a foundation of knowledge essential to understanding the major content areas of this study. The material presented in this section supports the need for research about ethical decision-making and the challenges nursing leaders encounter when confronting moral dilemmas. The information reveals current gaps in the

literature surrounding leader's ethical decision-making in evaluating and managing moral dilemmas.

Character-based leadership portrays leaders who embody characteristics grounded in virtues. Individual belief systems influence perceptions and judgments in moral and ethical issues, which in turn influence behavior. In addition to individual belief systems, organizational culture and groups have been shown to influence a leader's ethical decision-making when encountering moral dilemmas. Research has highlighted a gap between recognizing unethical behavior and taking ethical action. Gaining an understanding of what "character" traits predispose nursing leaders in knowing right from wrong and taking action will add to the body of knowledge and contribute to reducing the gap.

Nursing leaders report frequent encounters with moral dilemmas that require ethical decision-making. Research has shown that moral dilemmas related to incompetent, unethical or illegal practices of colleagues is one of the most common and most stressful moral dilemmas nurse leaders encounter. Nurse leaders are expected to be knowledgeable and skilled in ethical decision-making; however, research shows nurse leaders experience interpersonal conflicts between obligations to patients and obligations to colleagues and organizations. Many factors have been found to influence ethical decision-making, to include moral maturity, which encapsulates taking responsibility, overcoming fear, and confidence in taking action. In studying gaps related to leaders' interpersonal conflicts with ethical decision-making, researchers have found a number of factors influence ethical decision-making, to include but not limited to gender, situational and organizational factors, social consensus, experience, and moral maturity. As studies of factors have had limited analysis in nursing ethical decision-making, further

examination of factors influencing effects on ethical decision-making will add to the body of knowledge available for assimilation by nurse leaders.

Acquiring a deeper understanding of the role ethics plays in developing character and interdependent group formation provides a foundation for nurse leaders in making ethical decisions regarding professional boundary limitations. Studies have shown that leaders equipped with character traits based in virtue ethics approach moral dilemmas in a more holistic manner. Additionally, nurse leaders contend that being ethical requires judgment with follow-through, as well as, purports ethical decision-making is highly contextual and relational. In other words, nurse leaders' interdependence with groups forms an identity reflective of the groups, and therefore, a leader's moral agency is influenced by the group's identity. From this perspective, ethical decision-making is influenced through group interdependence, and relational ethics addresses the ethics of interdependent relationships. Relational ethics implies relationships are co-created through discourse in order to create morally habitable spaces that are therapeutic in nature and time limited. When this space and time is breached, nurse leaders are expected to evaluate and manage the situation. From a review of the literature, relational ethics theory centers on its description and relevance to nursing as a relationship-based profession. A research gap exists in studying nursing leader's moral dilemmas in ethical decision-making regarding nurse-patient relationship boundaries. Therefore, further examination in determining the effects of relational ethics as understood by nurse leaders in regards to nurse-patient relationships will add to the body of knowledge and provide nurse leaders with additional theory guidance for utilization in practice.

Nursing is a relationship-based profession in which a therapeutic relationship is built between a nurse and a patient. This professional relationship is a bond that is formed through

trust. Maintaining a therapeutic relationship requires setting boundary limits. The therapeutic relationship, or the 'zone of helpfulness,' is a safe and moral space established to meet the health care needs of the patient. As this is an invisible space, lines can become blurred and the potential to overstep limits exists. Maintaining professional boundaries, without exception, is the responsibility of the nurse. Boundary breaches, defined as boundary crossings, boundary violations, and sexual misconduct, respectively escalate in seriousness of offense. Limited research has shown that particular personalities and specific nursing specialties and environments are more prone to professional boundary breaches. As well, most research on professional boundary transgressions have focused on physicians, therapists, and social workers, with little research on nurse-patient boundary breaches. As this reflects a gap in nursing research, further examination of nursing leader's familiarity with professional nurse-patient relationships and their moral judgments in making ethical decisions about boundary transgressions will add to the body of knowledge and increase awareness of professional boundary setting.

Ethical and legal guidance on professional boundaries are defined by the American Nursing Association Code of Ethics, Texas BON Rules and Regulations, and the NCSBN. In reviewing the standards of the regulatory agencies, standards delineating expected behavior of both nurses and nursing leaders, as well as disciplinary actions set forth for substantiated professional boundary breaches, are well defined. From a research perspective, studies conducted on nurse-patient relationship boundary breaches are limited and dated. As well, studies conducted in determining satisfaction with Boards of Nursing handling of sexual misconduct cases reveals disparities among board responses and a low response rate. Delineating nursing leaders' interpretations of the regulating agencies standards for professional relationships and

their evaluation and management of boundary breaches will add to the body of knowledge and build awareness of the rules and regulations guiding nurse-patient relationships.

This chapter discussed a selection of major content areas associated with ethical decision-making in relation to knowledge, skill, and action upon encountering ethical dilemmas. Key findings were summarized and directed toward current gaps in the literature. Discontinuities across the different content areas imply that further research is warranted in the area of nursing leaders and the challenges they face in recognizing and acting upon ethical dilemmas; specifically, nurse-patient relationship boundaries.

Chapter Three – Research Methodology

This chapter presents the research design and methodology, as well as the setting, participants, data collection process, and data analysis procedures. A mixed methods explanatory sequential design for this study consisted of two phases. Phase one was conducted first with quantitative data collection and analysis followed by phase two wherein qualitative data collection and interpretation occurred (Creswell & Plano Clark, 2011).

The purpose of this mixed methods sequential explanatory study is to ascertain nursing leaders' knowledge and skill in ethical decision-making when evaluating and managing professional nurse-patient relationship boundaries. It is also the purpose of this study to better understand nursing leaders' perceptions of moral, cognitive, and organizational factors influencing their ethical decision-making in evaluating and managing professional nurse-patient relationships, with the intent of generating a theory grounded in the views of the participants as a final outcome of the study.

Research Question

The overarching mixed methods research question guiding this study is: What factors influence nursing leaders' ethical decision-making in their perceptions of and actions toward nurse-patient relationship transgressions? This study is intended to delineate relationships among nursing leaders' demographic characteristics and ethical decision-making. Nursing leaders' characteristics and supervisory-level experience in addressing potential and/or actual staff violations of professional nurse-patient relationships, as well as their perceptions of and likelihood to act on staff members' unethical behaviors, are the focus of the research question and sub-questions.

Quantitative phase. The following two sub-questions addressed the quantitative strand of this study. Two vignettes, describing a potential and/or actual nurse-patient relationship boundary transgression was given to each study participant. Each participant received a 6-point Likert scale anchored with the polar opposites *strongly agree* and *strongly disagree*. The 6-point Likert scale is composed of six statements invoking an ethical decision regarding the behaviors described in each scenario. Each respondent was asked to answer each statement based on his/her beliefs and feelings toward each scenario.

Sub Question 1. What are nurse leaders' opinions regarding the ethical behavior of a nurse as described in the nurse-patient relationship vignettes?

Sub Question 2. What action will be taken by the nurse leaders in the vignettes involving staff members engaging in inappropriate nurse-patient relationships?

Qualitative phase. The following sub-question addressed the qualitative strand of this study. Interviews were conducted by the PI and individual participants. The methods of acquisition included participant observations, written field notes, and audio recordings.

Sub Question 3. What moral, cognitive, and organizational socialization factors predispose nurse leaders' perceptions of and actions toward their evaluation and management of professional nurse-patient relationship boundaries?

During the interview process, the researcher used the following open-ended questions to guide the discussion; as well, used the results of the quantitative analysis to "define probing questions" (Curry & Nunez-Smith, 2015, p. 375):

1. Describe the education you received in school and/or work about the Nursing Code of Ethics and/or the Nurse Practice Act specifically related to professional boundaries?

2. If you received education about the Nursing Code of Ethics and/or Nurse Practice Act related to professional boundaries, how would you describe the function of the Nursing Code of Ethics and the Nurse Practice Act in preventing professional boundary transgressions?
3. In regards to nurse-patient relationship boundaries, how would you describe education received on the Nursing Code of Ethics and the Nurse Practice Act?
4. Based on your experience, describe the process staff nurses use in building a nurse-patient relationship?
5. Based on your experience, describe the process staff nurses use in advocating for patients?
6. What experiences have you encountered with nurse-patient relationship boundary breaches?
7. What types of nurse-patient relationship boundary breaches have you encountered?
8. What challenges have you experienced with nurse-patient relationship boundary breaches?
9. Describe how you made your decision in evaluating and managing nurse-patient relationship boundary breaches?
10. What impacted your decision-making regarding nurse-patient relationship boundary breaches?
11. What barriers have you encountered when evaluating and managing nurse-patient relationship boundary breaches?
12. What leadership approach/style do you follow in your daily practice?

The purpose of creating an interview protocol was to ensure that all participants were asked the same questions in an attempt to provide continuity to the study.

Research Design

This study used a mixed methods sequential explanatory research design. This design is considered appropriate because the quantitative measure may "not be wholly sufficient to address the research question" (Curry & Nunez-Smith, 2015, p. 47). The qualitative component was conducted to "generate further insights or clarification that may assist in explaining the quantitative findings" (Curry & Nunez-Smith, 2015, p. 47). "The quantitative side tells you what most people think about a certain question and then in the qualitative piece, you start to understand what that answer really meant to different people" (Curry & Nunez-Smith, 2015, p. 210). Whereas survey results provide an overall understanding of leaders' knowledge and actions related to ethical decision-making, participant interviews provide contextual and situational factors affecting ethical decision-making.

Characteristics of a mixed methods sequential explanatory research design occur in two distinct interactive phases. This research design was conducted in the following steps:

1. Quantitative data was collected and analyzed prior to the collection of qualitative data.
2. Qualitative data was subsequently collected and analyzed following an analysis of the quantitative data.
3. The results of the quantitative data influenced the format of the qualitative data collected.
4. The qualitative data results as interpreted by the researcher helped to explain the initial quantitative results (Creswell & Plano Clark, 2011, p. 71).

"The core assumption of this form of inquiry is that the combination of qualitative and quantitative approaches provides a more complete understanding of a research problem than either approach alone" (Creswell, 2014, p. 19).

As the first phase of this study begins quantitatively, this phase of the study is influenced from the perspective of postpositivism. The worldview of postpositivism "represents the thinking after positivism, challenging the traditional notion of the absolute truth of knowledge (Phillips & Burbules, 2000) and recognizing that we cannot be absolutely positive about our claims of knowledge when studying the behaviors and actions of humans" (Creswell & Creswell, 2018, p. 6). Postpositivist's assumptions represents the traditional form of research, such that it follows the scientific method and begins with theory, guides the development of a data collection instrument, measurable variables, and a relevant statistical analysis assessment, all of which is conducted in an objective manner.

Following phase one, the qualitative phase of the study shifts to a constructivist philosophical worldview. Constructivists, by means of an interactive link between the researcher and participants, seek to understand subjective meanings individuals develop about things as acquired through their experiences. It is in this form of inquiry that individual participants share their perspectives, understandings, and subjective views of the phenomena being studied. This in turn, leads researchers to "rely as much as possible on the participant's views of the situation being studied" and to "look for the complexity of views rather than narrowing meanings into few categories or ideas" (Creswell and Plano Clark, 2011, p. 8). In concluding this study, a theory grounded in the views of the participants emerged from the data. As this is a mixed methods explanatory sequential design, "grounded theory has much potential for making significant

contributions to its methodology" such that the "inductive, iterative process of grounded theory can complement moving between methods and mixing the results" (Charmaz, 2014, p. 324).

Re-inventing and energizing qualitative research at a time when it was losing ground to quantitative research, Glaser and Strauss in 1967 introduced grounded theory advocating for using a "general inductive research method" for developing new theories "from data acquired by a rigorous research method" (Mediani, 2017, p. 1) rather than "deducing testable hypotheses from existing theories" (Charmaz, 2014, p. 6), thus increasing analytical power, advancing theory development and legitimizing its status among researchers. Defining differences in focus, Strauss and Corbin (1990, 1998) vied for "additional technical procedures rather than emphasizing emergent theoretical categories and the comparative methods that distinguished earlier grounded theory strategies" (p. 11) consistent with Glaser's (1978) grounded theory method. Despite variations in focus, Glaser (1978), Strauss and Corbin's (1990) grounded theory methods employed "positivistic assumptions" (p. 12). Discontent with positivism, some scholars saw its approach as inflexible, mechanical, outdated and blurring respondent's narratives. Moving away from positivism toward constructivism, a number of scholars (see Bryant, 2002, 2003; Charmaz, 2000, 2002, 2006; Clark, 2003, 2005; Seale, 1999) adopted the "inductive, comparative, emergent, open-ended approach" (Charmaz, 2014, p. 12) including the "iterative logic" (Charmaz, 2014, p. 13) of its originators with the assumptions that "research reality arises within a situation and includes what researchers and participants bring to it and do with it" (Charmaz, 2014, p. 13). Charmaz's (2014) constructivist grounded theory acknowledges "subjectivity and the researcher's involvement in the construction and interpretation of data" aligning with "social constructivists who thus stress social contexts, interaction, sharing viewpoints, and interpretive understandings" (p. 14). Though grounded theory methodologies

have evolved with respect to differing conceptual and foundational assumptions, the basic framework of inductive logic, rigorous comparative analysis and theoretical analysis remains constant.

Utilizing an interpretive grounded theory research methodology, in alignment with Charmaz (2006) constructivist approach, fits with the design of this study and the overarching research question, "What factors influence nursing leaders' ethical decision-making in their perceptions of and actions toward nurse-patient relationship transgressions?" As Charmaz (2006) purports, "constructivists study *how*—and sometimes *why*—participants construct meanings and actions in specific situations," (Charmaz, 2006, p. 130) linking it to "*what* people do in specific situations" (Charmaz, 2014, p. 228) thus theorizing within the reality of participants situational context and researchers subjectivity.

Population, Sample, Participants

Quantitative phase. The quantitative phase of this research identified the target population as mid-level nurse leaders within a hospital and/or ambulatory health care facility in South/Central Texas. The target population ($N = 50$) of mid-level nurse leaders may represent active duty, retired, reserve, and nonmilitary registered nurses. A convenience sample, that is, "a nonprobability sample in which respondents are chosen based on their convenience and availability" (Creswell, 2014, p. 158) was drawn from all mid-level nurse leaders ($N = 50$) who worked at San Antonio Military Medical Center (SAMMC), Fort Sam Houston, Texas. SAMMC is a 425-bed Joint Commission-accredited military treatment facility and a Level I Trauma Center that is part of the larger Brooke Army Medical Center (BAMC). SAMMC has clinical, academic, research, and support facilities and provides health care to 1.1 million active duty, retired, and family member beneficiaries within its catchment area. It is the Army's largest

medical center and the only Level I Trauma Center in the U. S. Army. Moreover, it is the regional referral center for the Regional Health Command-Central (RHC-C) which covers 11 states and two territories. Part of its assigned war-time mission is to receive combat-injured soldiers from Iraq and Afghanistan, provide treatment and rehabilitation, and administratively process them back to active duty or through the medical retirement process. Currently, SAMMC houses 17 inpatient nursing care units and approximately 35 outpatient primary and specialty care clinics.

Eight additional nursing staff was asked to participate in validity testing of the instrument. Creswell and Plano Clark (2011) denote the purpose of validity testing is to ensure the quality of the data. Two methods of ensuring validity of the survey instrument are content and face validity. Content validity is defined as "how judges assess whether the items or questions are representative of possible items" (p. 210). Face validity "concerns the superficial appearance, or face value, of a measurement procedure" (Gravetter & Forzano, 2012, p. 78). Four subject matter experts who were not currently mid-level nurse leaders overseeing one or more nursing units, but experienced in that role and with a minimum of four years' experience providing mid-level nurse leader responsibilities in hospital and/or ambulatory health care facilities, were asked to review the instrument for content validity. Four nursing staff (RN, licensed vocational nurse [LVN], certified nursing assistant [CNA], medic) in non-mid-level nurse leader positions were asked to review the instrument for face validity. The eight nursing staff received a hard copy Study Information Sheet (see Appendix A for Study Information Sheet) informing them about the study, and an Information Sheet for Content and Face Validity (see Appendix B for Information Sheet for Content and Face Validity) attached to the anonymous Survey Instrument (see Appendix C for Survey Instrument). The Information Sheet

for Content and Face Validity provided instructions for completing their respective validity review and returning the survey to the PI. A disclaimer was placed in paragraph two of the Study Information Sheet and at the top of the Information Sheet for Content and Face Validity and the Survey Instrument, indicating the surveys are anonymous, that this is a research study, and that they may choose not to participate in the research without harm or negative consequence. All surveys were directed to be returned, sealed in their envelope, to a locked research box to ensure anonymity. There were two locked research boxes; one locked research box was located in the nursing morning report conference room and one locked research box was located at the entrance to Hospital Education, 2nd floor Consolidated Tower. The four nursing staff reviewing the instrument for content validity and the four nursing staff reviewing the instrument for face validity were not re-contacted for survey administration.

For the quantitative study, a convenience sample of all mid-level nurse managers (approximately $N = 50$) who worked at SAMMC or the outlying SAMMC primary care clinics were asked to participate. Announcements were made at several nursing morning report sessions to inform potential participants about the study. The quantitative study assessed preliminary descriptive data of demographic information, ethical decision-making practices and experience in this sample. Study participants were screened using the following inclusion/exclusion criteria:

1. Registered Nurse with a minimum of one year experience as a mid-level nurse leader in a hospital and/or ambulatory health care setting.
2. A minimum of one year experience as a mid-level nurse leader in a position overseeing one or more nurses.
3. Derived from multiple inpatient and/or ambulatory care departments.

Nursing staff for this quantitative phase received a hard copy Study Information Sheet attached to the anonymous Survey Instrument and handed out during nursing morning report to the Executive Nursing Leadership for delivery to mid-level nurse leaders. The Study Information Sheet informed them about the study and provided instructions for completing and returning the survey. All surveys were directed to be returned to a locked research box placed in the room where nursing morning report was conducted or a locked research box outside the entrance doors to Hospital Education, 2nd floor Consolidated Tower.

Qualitative phase. Qualitatively, the target population for this study was mid-level nursing leaders within a hospital and/or ambulatory health care facility in South/Central Texas. The target population of mid-level nurse leaders represented active duty, retired, reserve, or nonmilitary registered nurses. Merriam and Associates (2002) advocate selecting a sample for the purpose of generating the most information about the phenomena being studied (p. 20). As it is important to garner meaning of a phenomenon from the views of the participants, selecting a sample utilizing "purposeful sampling" (Patton, 1990) "which emphasizes sampling for information-rich cases" (Merriam & Associates, 2002, p. 166) provided depth to the study. This study design "often, though not always, uses a common sample drawn from the quantitative component" (Curry & Nunez-Smith, 2015, p. 16) permitting a sample that is site dependent, nor site averse. The issue of timing, that is, lag time between quantitative data collection, data analysis, and qualitative interviews, coupled with personnel turnover, precludes strict site dependence (Curry & Nunez-Smith, 2015, p. 216). The study began with purposeful convenient sampling and incorporated snowball sampling as an additional sampling approach, in order to identify participants selected for interviews (approximately N = 6-20). Snowball sampling involves using informants to identify interviewees useful to include in the study, such that,

insider knowledge maximizes strong, highly appropriate interviewees (Tashakkori & Teddli, 2003, p. 274). A minimum of six participants were interviewed, with additional participants interviewed until reaching "saturation point in terms of discovering new information" (Kumar, 2014, p. 246), or until reaching a maximum of 20 participants.

Interview selection began through colleague referrals, followed by introductions among the PI and potential study participant and an explanation of the research study by the PI to the potential interviewee in order to garner participant willingness for an interview. The criteria for screening study participants were based on the following inclusion/exclusion criteria:

1. Registered Nurse with a minimum of one year experience as a mid-level nurse leader in a hospital and/or ambulatory health care setting.
2. A minimum of one year experience as a mid-level nurse leader in a position overseeing one or more nurses.
3. Derived from multiple inpatient and/or ambulatory care departments.

Methods of acquisition included one-to-one, in-depth interviews utilizing an interview protocol producing a "guided conversation" (Yin, 2011, p. 139). With participant permission, digital recordings were utilized throughout the interview. During the interview process, the researcher used an open-ended questioning format to guide the discussion. An interview protocol, representing a "mental framework" serving as a "conversational guide" was developed as informed by the quantitative data analysis findings and used with each interview (Yin, 2011, p. 139). An interview protocol is one method of ensuring that all participants are asked the same questions in an attempt to provide continuity to the study. The individual interviews took place at a date, time, and interview location established with and for the convenience of the interviewee.

Protection of Human Subjects and Ethical Considerations

Source of data. Data for phase one, the quantitative section of this study, was obtained from a researcher designed vignette style Survey Instrument and Demographic Questionnaire. Questionnaires were in a paper format. Each survey was sequentially numbered to track the number of surveys distributed. There was no code or key linking the survey number to the participant. Participants received a Study Information Sheet containing information about the study and instructions for completing the survey. Completed surveys were stored in a locked cabinet. Only the PI had access to the data records. Immediately after data collection, the information was entered into an SPSS database in a secure computer. Electronic data records were password protected. Electronic databases and storage devices, back-up CDs, and surveys were maintained in a locked filing cabinet by the PI during and at the completion of the study.

As this study sought evaluation of the researcher designed vignette style Survey Instrument, the Information Sheets for Content and Face Validity, Survey Instruments, and Demographic Questionnaires completed by the eight nursing staff conducting validity testing were collected. Data dissemination, collection, and storage was controlled in the same manner as the Survey Instruments.

Data for phase two, the qualitative phase, was obtained through individual, face-to-face interviews carried out in a location convenient for the interviewee. The interview was digitally recorded, in agreement with the interviewee, and written field notes were taken during the course of the interview. The taped interviews and written field notes were maintained in a locked filing cabinet by the PI during and at the completion of the study. The digital recordings, written field notes, and interview transcriptions were coded by the PI so as to ensure anonymity of the

individual interviewees. Public display of the digital recordings, written field notes, and transcriptions were not displayed without written permission of the interviewee.

Benefits. There were no direct benefits for study participation; however, indirect benefits to study participants were the information gleaned from the data analysis. This study assisted the PI in development of an education intervention for nursing leaders to aide them with ethical decision-making dilemmas related to nurse-patient relationship boundaries.

Risks. There were no foreseeable risks associated with the quantitative phase of study. There was minimal risk for emotional distress due to the sensitive nature of this study to occur during the interviews and there was minimal risk for a breach of confidentiality associated with the qualitative phase of study. To diminish the minimal risk of a breach of confidentiality, no interviewee identification information was annotated on the audio recordings; instead, each recording was coded by number. There were no financial or commitment conflicts of interest associated with this study.

Safeguards. All human subjects were treated in accordance with the Institutional Review Board (IRB) guidelines and the PI did not begin data collection until receipt of an IRB research start letter (See Appendix G). Data collected during the quantitative phase did not contain any identifying information nor was it coded in any way to link it to a study participant. Data collected during the qualitative phase was collected through individual, face-to-face, audio recorded interviews. Individual interviewee audio recordings did not include participant names; instead, individual audio recordings were identified by number for purposes of "member checking using transcripts" (Hays & Singh, 2012, p. 260). The individual audio recordings were transcribed by the PI and all audio recordings were secured in a "locked file cabinet" (Hays & Singh, 2012, p. 317) within a locked office, and only accessible to the PI. All electronic data was

"password protected" and the data will be kept for "at least 5-7 years upon completion" (Hays & Singh, 2012, p. 317) of the study.

Quantitative phase. For phase one, the quantitative section of this study, a formal consent form was not submitted to San Antonio Military Medical Center IRB and the University of the Incarnate Word IRB for approval of the quantitative data collection Survey Instrument. As well, a formal consent form with request for signature was not provided to each participant in the quantitative phase of this study.

As this phase of the research was an exempt study, the utilization of a formal consent form was not required and was replaced with a disclaimer typed as a header on the Survey Instrument and all other survey forms utilized for this phase of study. The disclaimer text was directed by Brooke Army Medical Center, Department of Clinical Investigation, Office of the Institutional Review Board. BAMC, Department of Clinical Investigation, Office of the IRB made the determination due to no foreseeable risks associated with this phase of study and due to anonymity of study participants. The disclaimer consents each participant as follows:

> You are being asked to participate voluntarily in this study; by completing the questionnaire you are providing your permission to participate. If you choose to take part in this study, you may stop at any time during survey completion and you may skip any questions you do not wish to answer. You may choose not to participate without negative harm or consequence. The survey is anonymous, you will not be identified, please DO NOT type any identifiable information on the survey. This study has been reviewed and approved by the San Antonio Military Medical Center and the University of the Incarnate Word Institutional Review Boards.

The consent disclaimer was in accordance with the San Antonio Military Medical Center IRB exempt research protocol and the University of the Incarnate Word IRB exempt research protocol. It was typed as a header on each survey instrument as a means of protecting study participants' anonymity.

Qualitative phase. For phase two, the qualitative section of this study, a formal Subject Consent Form (see Appendix D for Subject Consent Form) was required for IRB approval by the University of the Incarnate Word, to protect the rights of the participating interviewees. Prior to an interview, the interviewee was provided an explanation of the research study by the PI. Additionally, the interviewee was given an opportunity to read the consent form, ask questions, and have their questions answered prior to agreeing to be a study participant and signing a Subject Consent form. The original Subject Consent Form is maintained with the PI in a locked file cabinet and a copy of the signed Subject Consent Form was provided to the interviewee. In addition, each interviewee received an Interview Study Information Sheet (see Appendix E, Interview Study Information Sheet) outlining the study purpose, why they were selected, how the study was to be conducted, how much time the interviews would take, risks, benefits, and how the information would be used. The participant received a copy of the Interview Study Information Sheet and the original signed by the participant is maintained in a secure locked file cabinet in accordance with research ethical protocols. Anonymity was stringently adhered to and pseudonyms used in the place of interviewee names. Financial inducement was not offered; however, participants may receive a copy of their interview transcript. Interviews took place at a date, time, and location convenient for the interviewee. Lastly, safeguards for human subjects followed research principles as outlined by the Collaborative Institutional Training Initiative (CITI), Human Research Curriculum Completion Report.

Research Instruments

Quantitative research instrument. The quantitative research study used a survey strategy to collect data. The utilization of the researcher-designed vignette-style survey instrument examined nurse leader's ethical decision-making when addressing potential and

actual violations of professional nurse-patient relationship boundaries by staff nurses. Secondarily, the survey collected demographic information of the participants to include gender, age, highest education level, years of experience as a registered nurse, supervisory level, supervisory experience, and a perceived observation of professional boundary crossings. The demographic data was utilized for correlational purposes.

In assessing nurse managers' ability to perceive potential or actual breaches in nurse-patient relationship boundaries, utilizing scenario-based vignettes is one method of collecting data. According to Barter and Renold (1999), vignettes are commonly used in social research for three main purposes: "to allow actions in context to be explored; to clarify people's judgments; and to provide a less personal and therefore less threatening way of exploring sensitive topics" (p. 1). In both quantitative and qualitative research, "vignettes enable participants to define the situation in their own terms" (p. 1). Martin (2006) describes vignettes as "brief stories or scenarios that describe hypothetical characters or situations to which a respondent is asked to react" (p. 2). As vignettes portray hypothetical situations, sensitive subjects are explored in a less threatening manner. In this manner, contextual influences on judgments can be examined. For this reason, two vignettes were created to illustrate actual and potential violations of appropriate nurse-patient professional relationship boundaries and were used in this study to examine nursing leaders' perceived sense of understanding and ability to appropriately respond to a potential or actual breach in nurse-patient relationship boundaries.

Vignette 1 and Vignette 2 Survey Instruments were developed by the PI of this study. The Flesch/Flesch-Kincaid readability tests were used to determine difficulty in readability. The Flesch Reading Ease test indicates the ease in reading a passage; whereas, the Flesch-Kincaid Grade Level test indicates the readability or grade level of the text (Kincaid, Fishburne, Rogers,

Chissom, 1975). Vignette 1 and Vignette 2 were tested for reading ease and grade level using the Flesch Reading Ease test and the Flesch-Kincaid Grade Level test. The Flesch Reading Ease test score for Vignette 1 was 50.737 and Vignette 2 was 58.992, which indicated the two scenarios can be easily understood by 13-15 year old students. The Flesch-Kincaid Grade Level test score for Vignette 1 was 13.536 and Vignette 2 was 9.946. The scores are interpreted as Vignette 1 generally requires 13.5 years of education to understand the scenario and Vignette 2 generally requires 9.9 years of education to understand the scenario. As the Vignette survey instruments were completed by nursing leaders with a minimum Associates degree college level education, Vignette 1 and Vignette 2 survey instruments were appropriate.

This study further evaluated the face and content validity of the researcher-designed vignette-style survey instrument. Content validity is the extent to which experts are aware of nuances in item and instrument construct that may be rare or elusive and potentially invisible to the layperson. Content validity evaluates sampling adequacy of the content being measured. A Content Validity Index Score (CVIS) sheet (see Appendix F for Content Validity Index Score) was completed by four subject matter experts who were not currently mid-level managers within the military treatment facility study site, but have experience in that role.

Face validity is the extent to which the instrument appears valid to the subjects who take it. Face validity requires that the measure appear relevant to the layperson. Face validity is essentially accomplished by having untrained persons review the survey for readability and clarity. Face validity was completed by nursing staff that were not mid-level nurse managers and were not working within the military treatment facility study site, but work in the nursing profession.

Qualitative research instrument. The data collection was conducted by one researcher, the PI, in order to delineate and ensure continuity of definitions and explanation of terms. An interview protocol was used to ensure all participants were asked the same questions in an attempt to provide continuity.

> Being the prime research instrument requires fieldworkers to be aware of the instrument's (i.e., your) potential biases and idiosyncrasies. These include conditions arising from your personal background, your motives for doing the research, and your categories or filters that might influence your understanding of field events and actions. (Yin, 2011, p. 123)

My interest in conducting this study originated from a previous position I held as an Advisor to a Nursing Peer Review Committee at a Level I Trauma Center located in the geographical region of South/Central Texas. It began as a concern for mid-level nurse managers who are in positions to be confronted by potential and actual violations of nurse-patient relationship boundaries. I had the opportunity to observe the struggles and challenges of the peer review committee members' deliberations relating to a potential professional nurse-patient relationship boundary breach. As I am the research instrument in the qualitative section of this study, disclosure of this personal role is one method toward ensuring research integrity, "meaning that you and your word(s) can be trusted as representing truthful positions and statements" (Yin, 2011, p. 41).

Data Collection Procedures

Quantitative phase.

Content and face validity. As a section of the quantitative study, eight nursing staff were asked to participate in validity testing of the instrument. Four subject matter experts who were not currently mid-level nurse managers at BAMC but have experience in that role and with a minimum of four years' experience providing mid-level supervisory responsibilities in a military

treatment facility were asked to review the instrument for content validity and four nursing staff (RN, LVN, CNA, medic), who were not in a supervisory position but working in the nursing profession, were provided the opportunity to review the instrument for face validity.

Experienced subject matter experts reviewing the instrument for content validity were asked to complete the CVIS sheet and to provide written comments on the Demographic Questionnaire and Survey Instrument as to whether they considered the ethical dilemmas in Vignette 1 and Vignette 2 to be actual or potential nurse-patient boundary transgressions, and whether the vignettes presented valid ethical dilemmas that could be experienced by a mid-level nurse manager. A disclaimer was placed at the top of the CVIS sheet indicating the surveys were anonymous, explaining that this is a research study, and that they may choose not to participate in the research without harm or negative consequence.

Nurses reviewing the instrument for face validity were asked to provide written comments on the Survey Instrument and Demographic Questionnaire in regards to the instrument's readability, understandability, and grammatical correctness. Those reviewing the Survey Instrument were asked the following questions:

1. Are there any grammatical or spelling errors on the instruments?
2. Are there any words or sentences that are unclear or misused?
3. Were the questions confusing or difficult to answer?
4. Were the font and size of the text easy to read?

The Information Sheet for Content and Face Validity provided instructions for completing their respective validity review and returning the survey to the PI. All surveys were directed to be returned, sealed in their envelope, to a locked research box to ensure anonymity. There were two locked research boxes; one locked research box was located in the nursing morning report

conference room and one locked research box was located at the entrance to Hospital Education, 2nd floor Consolidated Tower. The four nursing staff reviewing the instrument for content validity and the four nursing staff reviewing the instrument for face validity were not re-contacted for survey administration.

Survey instrument and demographic questionnaire. Because of the sensitive nature of querying nurse managers about ethical decision-making in the workplace and because of the small number of potential study participants, all questionnaires/surveys were anonymous. Participants were instructed that by completing the Survey Instruments and returning them to the study PI, they were providing their permission to participate in the study.

The quantitative data collection process to obtain the researcher-designed vignette-style Survey Instrument and Demographic Questionnaire follows:

1. Announcements were made at several nursing morning report sessions to inform the Executive Nursing Leadership about the study survey.
2. A hard copy Study Information Sheet attached to the anonymous Survey Instrument was enclosed in an envelope and labeled with return instructions.
3. Fifty envelopes, each with a copy of the Study Information Sheet and the Survey Instrument, were handed out during nursing morning report to the Executive Nursing Leadership for delivery to mid-level Nurse Leaders.
4. The Study Information Sheet informed the mid-level nurse leaders about the study and provided instructions for completing and returning the survey.
5. All surveys were directed to be returned, sealed in their envelope, to a locked research box to ensure anonymity. There were two locked research boxes; one locked research box was located in the nursing morning report conference room and one locked

research box was located at the entrance to Hospital Education, 2nd floor Consolidated Tower.

6. Two weeks after the initial distribution of surveys, follow-up announcements were made at several nursing morning report sessions reminding the Executive Nursing Leadership to encourage potential participants to complete and return the surveys per the instructions provided.

Qualitative phase.

Interviews. In constructing grounded theory, Charmaz (2006) purports gathering rich data that is detailed, focused, and full and "reveals participants' views, feelings, intentions, and actions as well as the contexts and structures of their lives" (p. 14). The intent of the one-to-one, in-depth interview was to collect information based on a set of open-ended questions that did not restrict interviewee's responses. Interviewees were consented immediately preceding the interview session by the PI. All interviews were conducted by the PI and the PI afforded the interviewee privacy during the interview session. In addition, each interviewee received an Interview Study Information Sheet, outlining the study purpose, why they were selected, how the study would be conducted, how much time the interviews would take, risks, benefits, safeguards, and how the information would be used. The participant received a copy of the Interview Study Information Sheet. Interviewees were instructed that they had the right to end the session at any point during the interview without fear of reprisal. Interviewees were informed that a copy of the interview transcript would be provided and requested to provide feedback. As well, interviewees were afforded the opportunity to delete, add, and/or change any statements articulated during the interview session. The qualitative data collection process to collect data from the interviewees follows:

1. The one-to-one, in-depth interviews were conducted by the researcher in 60 minute sessions with each participant.
2. The interviews were audio recorded without stopping and starting the audio recorder in order to diminish interruptions.
3. The interview sessions took place at a date, time, and location convenient for the interviewee.
4. The interviews were conducted utilizing a protocol.
5. The interviews were conducted in a conversational mode, with reflection conducted throughout the interviews in order to ascertain accuracy and clarity in understanding the meaning of the participants' statements.
6. Dialogue freedom and digressions with topic refocusing took place throughout the interviews. This interview style permits additional information from the interviewees that may not be communicated otherwise.
7. The interviewees were given opportunities throughout the interview to add information as they determined essential.
8. Following transcription, interviewees were afforded the opportunity to delete, add, and/or change any statements in the transcription.

Trustworthiness Criteria

Assuring for rigor in the qualitative section of this study is dependent on the strategies employed to ensure the ethical conduct of the research has been met. One manner in which to ensure study results can be trusted is by 'knowing' that the study was "conducted in a rigorous, systematic, and ethical manner" (Merriam & Associates, 2002, p. 24). Such a strategy to strengthen the internal validity of the study is through the use of triangulation. This process

involves using various data sources, such as a combination of interviews, observations, and documents as a means to corroborate and enhance the accuracy of the study (Yin, 2011). Strategies to strengthen the trustworthiness of this study utilized member checks, rich, thick descriptions and triangulation.

Member checks. A strategy for ensuring validity is through the use of member checking. Merriam and Associates (2002) states, "Here you ask the participants to comment on your interpretation of the data" (p. 26). An interview protocol was used as an interview question guide, with all participant interviews audio taped. Throughout the recorded interview, the PI summarized key points and annotated written field notes as necessary. This included clarification after each question and during participant key points. Thus, the participant was given an opportunity to respond verbally and confirm or offer correction to their statements throughout the interview. Additionally, each interviewee was afforded an opportunity to read his/her transcript and review for accuracy, offer corrections, and/or revise any statements.

Rich, thick descriptions. Another strategy to incorporate validity into this study included using rich, thick descriptions to convey the findings. When detailed descriptions of the interviewee's statements are provided, the "results become more realistic and richer" (Creswell, 2014, p. 202) and the description "moves the interpretation away from researcher-centric perspectives, portraying instead the people, events, and actions within their locally meaningful contexts" (Yin, 2011, p. 213). In this study, the researcher aimed to use the rich, thick descriptions to develop a broader theme(s) relevant to the nursing leader's ethical decision-making.

Triangulation. An additional method used to enhance the accuracy of this study was through the use of triangulation. Hays and Singh (2012) describes "using multiple theories—at

times across professional disciplines—to better conceptualize, describe, and explain a phenomenon" (p. 211). The method followed for this study incurred integrating theories throughout the qualitative inquiry, constructing a conceptual framework, and analyzing data concurrently with data collection.

Operational Definition

An operational definition assigns meaning to a concept for which the concept is limited to the study within which the concept is used. The operational definition is designed to remove ambiguity in communicating the exact meaning of a variable to its participants and readers (Kumar, 2014, p. 74). The operational definition that follows explains the variables related to the specific questions on the instrument in the quantitative phase of this study.

Ethicality. Defined as the state, quality, or manner of being ethical, involving or expressing moral approval or disapproval, and conforming to accepted standards of conduct (Ethicality, n.d.). Dimensions of the ethicality construct were measured utilizing a six-item Likert scale from Vignette 1 and a six-item Likert scale from Vignette 2. For the purpose of this study, the ethicality construct is supported through the concepts of the virtue ethics and the self-efficacy theories when constructing ethical decisions.

Data Analysis Procedures

The data analysis process for this sequential, explanatory mixed-methods research design is two-fold, occurring in two distinct phases. The first phase is a quantitative data analysis procedure and the second phase is a qualitative data analysis procedure. As quantitative and qualitative data analysis follow similar steps, that is, "preparing the data for analysis, exploring the data, analyzing the data, representing the analysis, interpreting the analysis, and validating the data and interpretations," (Creswell & Plano Clark, 2011, p. 204) the procedures associated

with each step differ. The steps evolve linearly in quantitative research and typically progress concurrently and iteratively in qualitative research.

Quantitative phase. Data was analyzed by the PI using descriptive statistics to "describe the characteristics of the sample," "check variables for violations of assumptions underlying the statistical techniques" and "address specific research questions" (Pallant, 2013, p. 55). The descriptive statistics included frequencies, percentages, means, and standard deviations. Additionally, data was analyzed by using inferential statistics to make "inferences about a data set," "find reliable differences or relationships" and "estimate population values for the reliable findings" (Tabachnick & Fidell, 2013, p. 8). The inferential statistics included the bivariate Pearson product-moment correlation coefficient, *r*, paired-samples *t*-tests, and mixed between-within subjects ANOVA. Data analysis was obtained by using the Statistical Package for the Social Sciences program (SPSS), version 23. Data analysis and interpretation followed a linear sequence of steps.

1. Number of surveys distributed, sample size, and percentages describing respondents and non-respondents were presented. The results were calculated and analyzed as follows:
    a. Surveys distributed sequentially numbered in order to determine number of non-returned surveys.
    b. Sample size reported as the number of returned surveys obtained subtracted from the total number of distributed surveys to an approximate population of $N = 50$.
    c. Using G*Power 3.1.9.software, *a priori* power calculations for bivariate Pearson product-moment correlations, paired-samples *t*-tests and mixed between-within subjects ANOVA's are provided.

i. Bivariate Pearson product-moment correlation coefficient, *r*: A power calculation for bivariate correlations with one-tailed test, alpha = .05, power = .80, and medium effect size (*r* = .40) indicated a minimum sample size of 37 is required.

ii. Paired-samples *t*-test: A power calculation of paired *t*-tests with two-tailed test, alpha = .05, power = .80 and medium effect size (*d* = .50) indicated a minimum sample size of 34.

iii. Mixed between-within subjects ANOVA: A power calculation of mixed between-within ANOVA with two tailed test, alpha = .05, power = .80, medium effect size (*f* = .25), 2 groups, and 2 measurements indicated a minimum sample size of 34.

iv. To accommodate potential missing responses, an initial sample size of 50 achieves sufficient statistical power for all inferential analyses.

d. Percentage of respondents calculated based on total number of possible participants and returned surveys.

2. Descriptive analysis of data obtained from the demographic survey results were presented. The results were calculated and analyzed as follows:
   a. Numbers and percentages of respondents in different sub-groups for categorical variables obtained from the demographic survey were calculated and analyzed.
   b. Means, medians, standard deviations, and frequencies for continuous variables obtained from the demographic survey were calculated and analyzed.
3. Relationships among variables obtained from the demographic survey results and the variables obtained from Vignette 1 and Vignette 2 Likert scales were presented.

Vignette 1 and Vignette 2 were created as six Likert questions designed to create an ethical decision-making Likert scale. According to Boone and Boone (2012), "Combined, the items are used to provide a quantitative measure of a character or personality trait" (p. 3). The six Likert scale questions were combined into a single composite score/variable during the data analysis process. "The composite score for Likert scales should be analyzed at the interval measurement scale" (p. 4). Allen and Seaman (2007) purport Likert scales can be analyzed effectively as interval scales when the "intervalness" (p. 65) is an attribute of the data and is combined to form an underlying characteristic or variable. In this study, the underlying characteristic is operationally defined as ethicality (Ethicality, n.d.). The results were calculated and analyzed as follows:

a. The bivariate Pearson product-moment correlation coefficient, *r*, was measured. It was used to describe the relationships and determine the correlation among ethicality (virtue ethics and self-efficacy) in decision-making about professional boundaries from Vignette 1 and Vignette 2 and the variables from the demographic questionnaire. The variables from the demographic questionnaire included the participant's age, years worked as a registered nurse, years worked as a mid-level nurse manager, and years worked in a military health care setting.

4. Differences between groups obtained from the results of Vignette 1 and Vignette 2 Likert scales were presented. The results were calculated and analyzed as follows:

   a. Paired-samples *t*-tests were calculated to determine whether there were statistically significant differences among the participants in terms of his/her responses between the two sets of data obtained from Vignette 1 Likert Scale and

Vignette 2 Likert scale. This test revealed if the mid-level nurse leaders differed on items between the two Vignettes.

b. Mixed between-within subjects ANOVA were calculated to compare differences among the participant's demographic characteristics and ethicality composite score/variable of Vignette 1 and ethicality composite score/variable of Vignette 2. The groups consisted of the same participants answering Vignette 1 Likert scale questions and answering Vignette 2 Likert scale questions. The factors consisted of demographic characteristics; such as, gender, observation of past inappropriate professional boundaries, education level, and current career status as a mid-level nurse manager.

5. Statistical results were presented in tables and figures with results obtained from the data analyses. Quantitative data results were analyzed for Sub-Question 1 and Sub-Question 2.

   a. Sub-Question 1. What are nurse leaders' opinions regarding the ethical behavior of a nurse as described in the nurse-patient relationship vignettes?

   b. Sub-Question 2. What action will be taken by the nurse leaders' in the vignettes involving staff members engaging in inappropriate nurse-patient relationships?

Sub-Question 1 and Sub-Question 2 are overarching questions that reflect a composite of the six ethical decision-making questions of Vignette 1 and six ethical decision-making questions of Vignette 2. Vignette 1 combined and Vignette 2 combined will be used to measure the ethicality of decision-making about professional boundaries. To answer the two sub-questions, statistical techniques selected for the analysis were based on the question's characteristics. The process and strategy of data analysis follows:

1. Is there a significant relationship between ethical decision-making and the characteristics of the participants surveyed? To answer this question, a bivariate Pearson product-moment coefficient correlation, *r* was calculated. The Pearson-*r* was used to describe the relationships and determine correlation among ethical decision-making and the participant's age, years worked as a registered nurse, years worked as a mid-level nurse manager, and years worked in a military health care setting.
2. Is there a significant change in participant's ethical decision-making between Vignette 1 and Vignette 2? To answer this question, a paired-samples *t*-test was calculated. The paired-samples t-test was used to determine whether there were statistically significant differences among the participant's ethical decision-making in terms of his/her responses between Vignette 1 and Vignette 2 (two different gradations of professional boundary breaches).
3. Is there a change in ethical decision-making between Vignette 1 and Vignette 2 based on characteristics of the participants? To answer this question, a mixed between-within subjects ANOVA was calculated. The mixed between-within subjects ANOVA was used to determine the impact of the participant's demographic characteristics, such as gender, observation of past inappropriate professional boundaries, education level, and current career status as a mid-level nurse manager on ethical decision-making about two different gradations of professional boundary breaches.
4. Data analysis was presented in the results chapter of this study.
5. Implications for practice or future research are presented in the discussion chapter of this study.

The Ethical Decision-Making Survey Instrument Vignette 1 and Vignette 2 variables are delineated in a codebook presented in Table 1.

The Demographic Questionnaire variables are described in a codebook displayed in Table 2.

Qualitative phase. Qualitative research, known for its abundance of raw data, is not bound to a rigid analytical sequence; however, managing, analyzing, and interpreting data utilizing a systematic methodology facilitates the analysis. Marshall and Rossman (2011) outlines an "analytic procedure that falls into seven phases: (1) organizing the data, (2) immersion in the data, (3) generating categories and themes, (4) coding the data, (5) offering interpretations through analytic memos, (6) searching for alternative understandings, and (7) writing the report or other format for presenting the study" (p. 209). Utilizing the seven phase process, as well as Yin's (2011) "five-phased cycle: (1) compiling, (2) disassembling, (3) reassembling (and arraying), (4) interpreting, and (5) concluding" (p. 177), afforded the PI a systematic process to perform data analysis utilizing Rossman's analytic procedure in parallel with Yin's cycle.

As data analysis is best performed concurrently with data collection, beginning this process at the time of the interviews enabled the PI to initiate a search for general, underlying themes. Conducting participant interviews were used to address sub question three. What moral, cognitive, and organizational socialization factors predispose nurse leaders' perceptions of and actions toward their evaluation and management of professional nurse-patient relationship boundaries? The participant interviews were transcribed verbatim and then reviewed by the PI for accuracy. Each transcript was read, analyzed, and initially color coded based on patterns. The process of analysis continued with assigning new labels, or "codes," to the patterned fragments.

Table 1

Vignette 1 and Vignette 2 Survey Instrument Variables Codebook

Variable ID	Label	Values	Data type (Measure)
Vig_1.1 & Vig_2.1	I believe the nurse's behavior toward the patient violated appropriate NPB	1 = strongly disagree 2 = moderately disagree 3 = mildly disagree 4 = mildly agree 5 = moderately agree 6 = strongly agree	Ordinal
Vig_1.2 & Vig_2.1	I believe the nurse's behavior toward the patient was unethical	1 = strongly disagree 2 = moderately disagree 3 = mildly disagree 4 = mildly agree 5 = moderately agree 6 = strongly agree	Ordinal
Vig_1.3 & Vig_2.3	As this nurse's mid-level NM, I feel comfortable speaking with the nurse about his/her behavior	1 = strongly disagree 2 = moderately disagree 3 = mildly disagree 4 = mildly agree 5 = moderately agree 6 = strongly agree	Ordinal
Vig_1.4 & Vig_2.4	As this nurse's mid-level NM, I do not feel it is my responsibility to speak to the nurse about his/her behavior	1 = strongly disagree 2 = moderately disagree 3 = mildly disagree 4 = mildly agree 5 = moderately agree 6 = strongly agree	Ordinal
Vig_1.5 & Vig_2.5	As a mid-level NM, I believe I have the knowledge to appropriately manage this situation	1 = strongly disagree 2 = moderately disagree 3 = mildly disagree 4 = mildly agree 5 = moderately agree 6 = strongly agree	Ordinal
Vig_1.6 & Vig_2.6	As a mid-level NM, I believe I have the skills to appropriately manage this situation	1 = strongly disagree 2 = moderately disagree 3 = mildly disagree 4 = mildly agree 5 = moderately agree 6 = strongly agree	Ordinal

Note. Missing data = 99; NM = Nurse Manager; NPB = Nurse-Patient Boundaries; Vig_1.1 = Vignette 1, item 1; Vig_2.1 = Vignette 2, item 1; Vignette items continue same pattern through item 6 of Vignette 1 and Vignette 2.

Table 2

Demographic Variables Codebook

Variable ID	Label	Values	Data type (Measure)
Age	Respondent's Age	in years	Scale
Gender	Respondent's Sex	1 = female 2 = male	Nominal
Exp_RN	Years Worked as RN	in years	Scale
Exp_Bound_Obs	Observed Perceived Boundary Crossings	0 = no 1 = yes	Nominal
Exp_NM	Years as Mid-Level Nurse Manager	in years	Scale
Exp_MTF	Years at Military Treatment Facility	in years	Scale
Education	Respondent's Highest Degree	1 = Associates 2 = Bachelors 3 = Masters 4 = PhD/DNP	Nominal
Status	Work Status	1 = GS Civilian/ No Prior AD 2 = GS Civilian/ With Prior AD/Reserve 3 = AD	Nominal

Note. Missing data = 99; RN = Registered Nurse; NM = Nurse Manager; MTF = Military Treatment Facility; PhD = Doctorate of Philosophy; DNP = Doctor of Nursing Practice; GS = General Schedule; Civilian; AD = Active Duty.

In developing a grounded theory, Charmaz (2006) maintains "coding is the pivotal link between collecting data and developing an emergent theory to explain these data" (p. 46). Utilizing Yin's (2011) steps of disassembling and reassembling data based on Hahn's (2008) Level 1 through Level 4 coding scheme, the researcher developed a five-column matrix taking illustrative

segments of participants' statements from the original transcripts and moving methodically from lowest to highest conceptual levels; that is, Level 1 through Level 4, respectively, enabled sorting coded items from different transcripts into similar and dissimilar groups. Again, Level 1 codes identify data that relate to each other and Level 2 codes categorize Level 1 coded data. Continuing to the next phase with this "formal coding process, the reassembling takes the form of bringing Level 1 and Level 2 codes onto an even higher conceptual plane, whereby themes or even theoretical concepts start to emerge and may be considered Level 3 and Level 4 codes" (Yin, 2011, p. 191). As coding is an emergent process in grounded theory, with consistent and active involvement in the process, new threads for analysis became apparent.

The second pivotal step in developing a grounded theory was through writing successive memos throughout the research process. Memo writing is an "intermediate step between data collection and writing drafts of papers" (Charmaz, 2006, p. 72). Memo writing encourages consistent data analysis which prompts connections and comparisons from coded material, thereby eliciting new ideas, insights, and thoughts. The memos were used to form the core of a grounded theory for this study.

In addition to coding and memo-writing, a third crucial step in generating a grounded theory was through theoretical sampling. A theoretical sampling strategy places emphases on incorporating a "systematic process in which you sample your population of inquiry," thus providing structure to the process and increasing the rigor of the study (Hays & Singh, 2012, p. 170). Systematically collecting data one step at a time allows for "movement back and forth between category and data," thus "raising the conceptual level of your categories and extending their reach" (Charmaz, 2006, p. 121). As a theory emerges, seeking additional data to elaborate and refine the categories develops from the data analysis process occurring in a purposeful

manner based on tightening the developing grounded theory. Analysis of participant data reveals patterns; and, the patterns, when compared to the research question, attempt to discover conceptual explanations. As such, completing one step at a time permits revisiting previously collected data and analyzing if "saturation" has occurred.

Interpretive theorizing further guided the data analysis. Balancing "thick descriptions" with insightful interpretations, anchored in the participant's accounts, maintained focus on the experiences and meanings articulated by the interviewees in this study. The researcher used the interviews in relation to various concepts and determined central themes consistent with the research question. In addition, the interpretations connected themes that emerged during the reassembling phase with relevant literature.

Summary

This study originated from the Advisor, Nursing Peer Review Committee, of concerns for mid-level nurse managers at a Level I Trauma Center located in the geographical region of South/Central Texas that are in positions to be confronted by potential and actual violations of nurse-patient relationship boundaries. Developing a valid vignette-style ethical decision-making instrument in order to accurately measure a baseline knowledge and skill level of a mid-level nurse manager's ability to recognize and intervene as necessary in accordance with the Texas BON professional conduct rules and the ANA code of ethics is one focus of this study. Secondarily, gathering mid-level nurse managers' data, resulting from a survey of the vignette-style ethical decision-making instrument, provided baseline information relevant to the thoughts and actions carried out by nursing leaders faced with potential nurse-patient boundary breaches. Third, a follow-up qualitative study incorporating interviews of mid-level nurse managers about their experiences with ethical decision-making regarding professional boundaries and nurse-

patient relationships added depth and meaning to the findings of the quantitative survey data results. Fourth, generating a grounded theory as interpreted from the mixed methods review of the survey results and the participant views was developed as a final outcome of this study. This grounded theory served as a way to learn about ethical decision-making characteristics of nursing leaders representative of diverse health care specialties throughout South/Central Texas. Fifth, the findings from the quantitative section in congruence with emerged themes delineated from the qualitative section of this study aided in the development of a future education program specific to the needs of the mid-level nurse managers in effecting ethical decision-making related to professional boundaries and nurse-patient relationships.

This section has been devoted to providing an overview of the research study design, site, and description of participants, processes, and procedures associated with protection of human subjects, instrumentation, data collection, risks, and benefits associated with this study.

Chapter Four – Quantitative Results

The purpose of this mixed methods sequential explanatory study was to ascertain nursing leaders' knowledge and skill in ethical decision-making when evaluating and managing professional nurse-patient relationship boundaries. It was also the purpose of this study to better understand nursing leaders' perceptions of moral, cognitive, and organizational factors influencing their ethical decision-making in evaluating and managing professional nurse-patient relationships, with the intent of generating a theory grounded in the views of the participants as a final outcome of the study.

As this was a mixed methods sequential explanatory design, this chapter addressed the quantitative phase, in which the data analysis and interpretation were presented using descriptive and inferential statistics. Descriptive statistics were reported on the participants' demographic characteristics and survey results about nurse leader's ethical decision-making when addressing professional nurse-patient relationship boundary transgressions by staff nurses. The inferential statistics addressed the research questions and provided significant information from which to draw conclusions and direct the focus of the qualitative phase of this study. The sequence of data analysis was as follows: return rate and data cleaning, reliability analysis, content and face validity, response to the instrument, demographic information of the participants, descriptive statistics, inference analysis, and summary.

Return Rate and Data Cleaning

A total of 50 surveys, including study introduction and survey instructions, were distributed to the Executive Nursing Leadership for delivery to mid-level Nurse Leaders within a Level I trauma military medical center in South/Central Texas. Forty-one respondents returned the surveys, for a return rate of 82% ($N = 50$). Four respondents did not complete all questions on

the demographic section of the survey instrument; however, the four respondents did complete the Ethical Decision-Making Survey Instrument, made-up of two (vignette one and vignette two) different gradations of nurse-patient professional boundary transgressions. Of the four incomplete demographic questionnaires, two respondents did not provide an answer to the questions on age and gender, a third respondent did not provide an answer to the questions on RN work experience and highest level of education, and the fourth respondent did not answer the question on age. Missing data for the continuous variables, age and RN work experience, accounted for approximately 7.3% and 2.4% respectively of the total data. Tabachnick and Fidell (2013) recommend "repeating your analyses using only complete cases" specifically "if the data set is small, the proportion of missing values high (greater than 5%), or data are missing in a nonrandom pattern" (pp. 63, 71).

As this data set is small and the missing data points for the variable age accounts for more than 5% of the total data set, the mean value of 50 years of age was substituted for each missing data point in order to check for normality with and without missing data points. Additionally, the mean value of 21 years of RN work experience was substituted for the missing data point in the variable RN work experience for the purpose of checking normality with and without missing data points. The analyses yielded similar results for the variables age and RN work experience, with and without replacing missing data points with mean value substitutions; therefore, missing values were not replaced.

The missing data from the categorical variables, gender and education level accounted for approximately 4.9% and 2.4% respectively. Replacement values were not substituted for the missing categorical variables. Since missing data items were relatively few in number, normality

was relatively unchanged for the continuous variables age and RN work experience, with and without mean substitutions, the missing data points were not replaced (see Table 3).

Table 3

Missing Data

Missing Item	Case Number	Scale	Value
Age	11	Continuous	Not Replaced
	27		Not Replaced
	30		Not Replaced
RN Work Experience	29	Continuous	Not Replaced
Gender	11	Categorical	Not Replaced
	27		Not Replaced
RN Education Level	29	Categorical	Not Replaced

Prior to conducting multivariate analyses, the variables age, RN work experience, years as a mid-level RN, years as a nurse manager, and years working in a military treatment facility were examined through various IBM SPSS programs for accuracy of data entry, missing values, and normality of the variables distributions. The variables, age, RN work experience, and years worked in a military treatment facility were checked for normality and met required assumptions. The variable, years worked as a nurse manager, revealed a slightly positive skew and was transformed using a square root and logarithm formula to determine which transformation better met normality assumptions. Based on the results, the variable, years worked as a nurse manager, will not be transformed, and will be retained for analysis.

Instrument Reliability

Reliability analysis. The instrument used in this study was a Likert-Scale survey composed of two scenario-based vignettes and a questionnaire for demographic data. The vignettes described two different scenarios of professional nurse-patient relationship boundary

transgressions. Each vignette consisted of six Likert-scaled questions asking mid-level nurse leaders about their ethical decision-making in judging boundary transgressions and their ability to manage the situations. The researcher used Cronbach alpha coefficients to establish the reliability of the survey instruments' internal consistency. The Cronbach alpha coefficients of vignette one and vignette two Likert-scale surveys were .53 and .79 respectively; however, as each vignette Likert-scale survey consisted of six items, it is "common to find quite low Cronbach values (e.g. .5)" (Pallant, 2013, p. 101) in scales with ten items or less. Based on the short scales per each vignette, it is more appropriate to report the mean inter-item correlation for vignette one and vignette two, reported as .16 and .46 respectively. According to Briggs and Cheek (1986), a range for the inter-item correlation of .2 to .4 is optimal. The Cronbach alpha and mean inter-item correlation of the 12 items that make-up the Ethical Decision-Making Survey instrument (vignette one and vignette two Likert-scale) were .71 and .21 respectively. As vignette one and vignette two were designed to measure the same underlying construct of ethical decision-making and the two vignettes were answered by the survey participants during one encounter, it was fitting to calculate and report a Cronbach alpha coefficient and mean inter-item correlation for vignette one and two's total 12 items. The Cronbach alpha coefficient of .71 met the minimum level for denoting instrument reliability as recommended by Nunnally (1978); just as the mean inter-item correlation of .21 falls within the optimal value range of .2 to .4 as recommended by Briggs and Cheek, 1986. Table 4 presents the reliability scores of the scale.

Instrument Validity

Content validity. Analyzing content validity of the survey instrument is important in that conclusions are drawn about the scale's quality in measuring the underlying construct that it is supposed to measure. According to Polit and Beck (2004), content validity is defined as "the

Table 4

The Reliability Scores of the Scale

Scale	Number of Items	Cronbach Alpha (α)	Mean Inter-item Correlation
Vignette One	6	.53	.16
Vignette Two	6	.79	.46
Vignette One and Two	12	.71	.21

degree to which an instrument has an appropriate sample of items for the construct being measured" (p. 423). Lynn (1986) recommends a minimum of three experts to rate each scale item in terms of relevance to the underlying construct. Additionally, Lynn recommends that with a panel of "five or fewer experts, all must agree on the content validity for their rating to be considered a reasonable representation of the universe of possible ratings" (p. 383). In this study, the item content validity index scale was designed as a 4-point scale with 1 = not relevant, 2 = unable to asses relevance without item revision, 3 = relevant but needs minor alteration, and 4 = very relevant.

Among nurse researchers, the content validity index has been the most widely reported measure of content validity computed. There are two types of index scores computed: item content validity index (I-CVI) and scale content validity index (S-CVI). Computation of I-CVI is generally straightforward; whereas, S-CVI can be computed by an averaging calculation method or a universal agreement calculation method. Polit and Beck (2006) found in their review of the literature that nurse researchers generally report a content validity index without specifying whether it is an I-CVI or an S-CVI and without stipulating the method of calculation. It is a recommendation of Polit and Beck (2006) that "scale developers be explicit about how their CVI

values were calculated so that potential users of the scale can draw informed conclusions about the scale's content validity, as a supplement to other empirical information about the scale's quality" (p. 496).

To assess the content validity of the Ethical Decision-Making Survey Instrument (vignette one and vignette two Likert-scale), four subject matter experts agreed to rate whether each item on the scale was relevant to the construct of measuring mid-level nurse leaders' ethical decision-making in evaluating boundary transgressions and their perceived ability to manage the situations.

Demographics. Demographic information was requested from the four subject matter experts who agreed to evaluate the content validity of the survey instrument. The subject matter experts had a minimum of four years' experience providing mid-level nurse leader responsibilities, but were not current mid-level managers. Of the four subject matter experts, two completed the demographic questionnaire providing a 50% response rate. The demographics of the content validity index evaluators are displayed in Table 5.

Content validity index score. The survey instruments, demographic questionnaires, and content validity index score sheets were delivered to four subject matter experts. Instructions for completing the content validity index score sheet and method for returning the completed score sheet and questionnaire to the researcher was provided as part of the packet containing the survey instrument, demographic questionnaire and score sheet. All four subject matter experts participated in scoring the content validity index sheet for a return rate of 100% and two of the respondents completed the demographic questionnaire for a return rate of 50%. ($N = 4$).

Table 5

Demographics of Content Validity Index Surveyors

Age	Gender	Years RN	Years Manager	Years MTF	Highest Level Education	Current Work Status	Observed Boundaries Crossed
57	Female	32	15	23	Bachelor Nursing	GS CIV No prior Military	Yes
Not completed							
		22		20	Master Nursing	Military Active	Yes
Not completed							

Note. $n = 2$. RN = Registered Nurse; MTF = Military Treatment Facility; GS = General Schedule; CIV = Civilian.

Content validity index score. The survey instruments, demographic questionnaires, and content validity index score sheets were delivered to four subject matter experts. Instructions for completing the content validity index score sheet and method for returning the completed score sheet and questionnaire to the researcher was provided as part of the packet containing the survey instrument, demographic questionnaire and score sheet. All four subject matter experts participated in scoring the content validity index sheet for a return rate of 100% and two of the respondents completed the demographic questionnaire for a return rate of 50%. ($N = 4$).

The four content experts were asked to rate each scale item in terms of its relevance to the underlying construct of a mid-level nurse leaders' ethical decision-making about professional nurse-patient relationships boundary breaches and perceived ability to manage the situations. The item ratings were scored on a 4-point scale so as to avoid an impartial and indecisive midpoint. Then, for each item, the I-CVI was computed as the number of experts provided a rating of either

3 or 4 divided by the total number of experts. The same computation process followed for ratings of 1 or 2. In this manner, the scale was dichotomized into relevant and non-relevant items.

In computing the I-CVI for the Ethical Decision-Making Survey Instrument (vignette one and two survey instrument), one subject matter expert rated item 'd' on vignette one and vignette two with a score of two, non-relevant. In reviewing the subject matter experts score sheet, no explanation of the non-relevant score was given; however, the item read as a negatively worded question. Since three of the four subject matter experts rated item 'd' on vignette one and vignette two as relevant, and there is research to substantiate using negatively worded items in surveys to avoid rater bias, item 'd' on vignette one and two was not changed. The computed scores of the four content validity index score sheets are reported as descriptive, narrative, and numerical data. Table 6 displays the item content validity index score (I-CVI) obtained for each item on the Ethical Decision-Making Survey Instrument (vignette one and vignette two survey instrument).

Table 6

Item Content Validity Index Scores (I-CVI)

	Not relevant	Unable to assess relevance without item revision	Relevant but needs minor alteration	Very relevant
Vignette 1a: I believe the nurse's behavior toward the patient violated appropriate nurse-patient boundaries.				1.00
Vignette 1b: I believe the nurse's behavior toward the patient was unethical.				1.00

(table continues)

	Not relevant	Unable to assess relevance without item revision	Relevant but needs minor alteration	Very relevant
Vignette 1c: As this nurse's mid-level manager I feel comfortable speaking with the nurse about his/her behavior.				1.00
Vignette 1d: As this nurse's mid-level manager, I do not feel it is my responsibility to speak to the nurse about his/her behavior.		.25		.75
Vignette 1e: As a mid-level nurse manager, I believe I have the knowledge to appropriately manage this situation.				1.00
Vignette 1f: As a mid-level nurse manager, I believe I have the skills to appropriately manager this situation				1.00
Vignette 2a: I believe the nurse's behavior toward the patient violated appropriate nurse-patient boundaries.				1.00
Vignette 2b: I believe the nurse's behavior toward the patient was unethical.				1.00
Vignette 2c: As this nurse's mid-level manager I feel comfortable speaking with the nurse about his/her behavior.				1.00

(table continues)

	Not relevant	Unable to assess relevance without item revision	Relevant but needs minor alteration	Very relevant
Vignette 2d: As this nurse's mid-level manager, I do not feel it is my responsibility to speak to the nurse about his/her behavior.		.25		.75
Vignette 2e: As a mid-level nurse manager, I believe I have the knowledge to appropriately manage this situation.				1.00
Vignette 2f: As a mid-level nurse manager, I believe I have the skills to appropriately manage this situation.				1.00

Note. $N = 4$. I-CVI = Item-level content validity index.

Three of the subject matter experts not only rated each item on the content validity index sheet, but additionally added written comments about the content relevance of the survey instrument. One participant wrote:

> I consider the ethical dilemmas to be both actual and potential situations. Any level nurse manager can be experiencing dealing with these ethical dilemmas, but I believe the vignettes present more valid ethical dilemmas that could be experienced for mid-level managers due to the population of the employees (age, level of maturity).

A second subject matter expert stated:

> Each vignette can present as actual situations when managing staff members. I do believe the vignettes present valid ethical dilemmas for nurse managers. I do feel that you may need to include 1) The definition of a mid-level nurse manager (i.e. HN, NCOIC, Section Supervisor?); 2) A review of vignette 1d and 2d – participants may get confused on how to mark not relevant vs relevant; 3) Wonder how many staff will truly be honest in their self-reporting; 4) Possibly under demographics, ask if received training on ethics in management to determine knowledge to handle situations.

A third subject matter expert commented: “I consider the ethical dilemmas as actual or potential situations and I believe the vignettes present valid ethical dilemmas that could be experienced for a mid-level nurse manager.” The comments written by the subject matter experts support the item’s relevance to the construct being surveyed.

In addition to reporting the item content validity index (I-CVI), the scale content validity index (S-CVI) was computed. Polit and Beck (2006) recommends computing and reporting both an I-CVI and S-CVI with a clear explanation of how the S-CVI was calculated. The S-CVI for the Ethical Decision-Making Survey Instrument (vignette one and two survey instrument) was calculated using the universal agreement calculation method (S-CVI/UA) and the averaging calculation method (S-CVI/Ave). An acceptable standard for the S-CVI/UA as per Davis (1992) and others have recommended a minimum of .80, whereas Waltz, et al. (2005) advises using .90 as the minimum standard for the S-CVI/Ave. Based on the computations for S-CVI/UA of 0.83 and S-CVI/Ave of 0.96, the content validity index scores are greater than the minimum acceptable standards for meeting content validity. As such, this scale was judged as having excellent content validity. Table 7 displays the item ratings by the subject matter experts and the S-CVI/UA and S-CVI/Ave scores obtained for this study’s survey instrument.

Table 7

Ratings on a 12-Item Scale by Four Experts: Items Rated 3 or 4 on a 4-Point Relevance Scale

Item	SME 1	SME 2	SME 3	SME 4	Number in Agreement	I-CVI
Vig 1a	X	X	X	X	4	1.00
Vig 2b	X	X	X	X	4	1.00
Vig 3c	X	X	X	X	4	1.00
Vig 4d	X	X	X	--	3	0.75
Vig 5e	X	X	X	X	4	1.00
Vig 6f	X	X	X	X	4	1.00
Vig 1a	X	X	X	X	4	1.00
Vig 2b	X	X	X	X	4	1.00
Vig 3c	X	X	X	X	4	1.00
Vig 4d	X	X	X	--	3	0.75
Vig 5e	X	X	X	X	4	1.00
Vig 6f	X	X	X	X	4	1.00
Proportion Relevant:	1.00	1.00	1.00	0.83	S-CVI/UA = 0.83 S-CVI/Ave = 0.96	Mean I-CVI = 0.96

Note. N = 4. Vig = Vignette; I-CVI = Item-level content validity index; S-CVI/UA = Scale-level content validity index, universal agreement calculation method; S-CVI/Ave = Scale-level content validity index, average proportion of items rated as 3 or 4 across the four subject matter experts.

Face validity. Analyzing face validity of the survey instrument was important in that it was a subjective assessment of whether the survey instrument appeared to be a valid measure for the construct of ethical decision-making by mid-level nursing leaders about professional nurse-patient relationship boundary transgressions and their perceived ability to manage the situation.

For this study, face validity was used to look at the overall commonsense assessment of the survey and the readability and understandability of the Ethical Decision-Making Survey Instrument (vignettes one and two), the 12-item Likert scale questions, and the demographic questionnaire. To evaluate the face validity of the survey instrument and demographic questionnaire, four non mid-level nurse leaders were asked to evaluate the face validity of the study instrument. Additionally, the four non-mid-level nurse leaders were asked to complete the demographic questionnaire.

Demographics. Demographic information was requested from the four non-mid-level nursing leaders (RN, LVN, CNA, medic), who agreed to assess the face validity of the survey instrument and demographic questionnaire. Of the four non-mid-level nurse leaders, two answered the demographic questionnaire, providing a 50% response rate ($N = 4$). The demographics of the face validity evaluators are displayed in Table 8.

Table 8

Demographics of Face Validity Surveyors

Age	Gender	Years RN	Years Manager	Years MTF	Highest Level Education	Current Work Status	Observed Boundaries Crossed
34	Male	N/A	5	14		Military Active	Yes
42	Female	5	0	16	Bachelors Nursing	Military Active	No
Not completed							
Not completed							

Note. $n = 2$. RN = Registered Nurse; MTF = Military Treatment Facility.

The survey instrument, demographic questionnaire, instructions for completing the face validity and method for returning the completed face validity evaluation to the researcher was

provided in a packet to the face validity surveyors. All four non-mid-level nurse leaders participated in evaluating the survey instrument and demographic questionnaire for a return rate of 100%. ($N = 4$)

The instructions for conducting the face validity evaluation directed the surveyors to provide written, descriptive responses about the instruments' readability, grammatical correctness, and understandability. The feedback received to the instruction sheet questions are reported in their entirety:

1. Are there any grammatical or spelling errors on the instrument?

The respondents found the instruments to be grammatically correct and found no spelling errors throughout the survey instrument.

2. Are there any words or sentences that are unclear or misused?

It was recommended that all military ranks be spelled out completely in order to avoid confusion and clearly articulate survey content. Additionally, eliminating the use of jargon would decrease misrepresentation of a word within a sentence creating an inaccurate understanding of the context of the vignette. For example, choose another word for "hitting" in the sentence "She obviously didn't miss how hard he was hitting on her." A survey participant may misunderstand the context of the sentence and interpret the word "hitting" as physically "beating a person". In this case, the word "hitting" refers to "flirting." A third recommendation was made to further clarify the context of a sentence by deleting the word "dependent" in the sentence "Ms. Peters, a 23-year old single dependent female" and change the descriptor "dependent" to "daughter of active duty parent."

3. Were the questions confusing or difficult to answer?

The first question of the Likert scale for vignettes one "a" and two "a" ask the survey participant to answer their level of agreement/disagreement with the statement, "I believe the nurse's behavior toward the patient violated appropriate nurse-patient boundaries." It was recommended that the statement be re-written to improve understanding. A face validity surveyor wrote, "I'm not sure if this question will give you a true picture of what the nurse really understands 'Appropriate nurse-patient boundaries' to mean or be. Maybe it should read, 'I believe the nurse's behavior towards the patient was inappropriate'? This wording relies too heavily on the nurse's perception instead of assessing her understanding of inappropriate nurse-patient boundaries."

4. Was the font and size of the text easy to read?

There were no recommendations to change font size; however, it was recommended to re-format the demographic questionnaire for ease of readability and enhance complete responses from survey participants. It was suggested that "ranges" be added to the questions asking age, years working as a registered nurse, years worked as a mid-level nurse manager, and years worked in a military health care setting. Additionally, the word "situations" in the question referring to managers observing nursing staff crossing appropriate nurse-patient relationship boundaries; re-write to reflect singular tense, "situation." A third recommendation was to add boxes preceding each level of education and preceding each work status. A fourth recommendation was to allow more than one level of education to be chosen. The last recommendation was to provide consistent instructions, such as, either put boxes in front of all "choice" answers or state to "circle one" with all questions that have multiple choices in their answers.

In reviewing the face validity evaluations and taking into consideration the content validity index scores, the survey instrument and demographic questionnaire were not edited. Based on the responses, 75% of the surveyors recommended no change to the survey instrument and demographic questionnaire.

Descriptive Statistics

Survey results.

Ethical decision-making survey instrument. The Ethical Decision-Making Survey Instrument is composed of two scenario-based vignettes, each vignette describing two different gradations of a nurse-patient professional boundary transgression. Vignette one describes a flirtatious situation between a nurse and patient; vignette two describes an intimate personal relationship between a nurse and patient. Both vignettes are composed of six items each, with each item scored on a 6-point Likert scale – 1 (strongly disagree), 2 (moderately disagree), 3 (mildly disagree), 4 (mildly agree), 5 (moderately agree), and 6 (strongly agree) – used to assess the participant's degree of ethical decision-making about nurse-patient professional boundary transgressions. In terms of understanding the participant's beliefs in deciding what constitutes nurse-patient professional boundary transgressions and self-assessment of their knowledge/skill in managing the situations, an item analysis was conducted. The mean score of 12 questions in the Ethical Decision-Making Survey Instrument was 5.54 (SD = .82).

In the mean comparison between each of the 12 questions, there were five questions higher than the mean (5.54) as follows: vignette one, item three (Vig 1.3) "As this nurse's mid-level manager, I feel comfortable speaking with the nurse about his/her behavior" (M = 5.63, SD = .80); vignette one, item four (Vig 1.4) "As this nurse's mid-level manager, I do not feel it is my responsibility to speak to the nurse about his/her behavior" (Reversed scored, M = 5.78, SD = .61); vignette two, item one (Vig 2.1) "I believe the nurse's behavior toward the patient

violated appropriate nurse-patient boundaries" (*M* = 5.93, *SD* = .47); vignette two, item two (Vig 2.2) "I believe the nurse's behavior toward the patient was unethical" (*M* = 5.93, *SD* = .35); and vignette two, item four, (Vig 2.4) "As this nurse's mid-level manager, I do not feel it is my responsibility to speak to the nurse about her behavior" (Reverse scored, *M* = 5.76, *SD* = .80).

The results further show that of the 12 items that make up the ethical decision-making scale, the two lowest mean scores were from vignette one, a scenario representative of a flirtatious relationship between a nurse and a patient. Vignette one, item 1 (Vig 1.1) "I believe the nurse's behavior toward the patient violated appropriate nurse-patient boundaries" (*M* = 5.27, *SD* = 1.25); and vignette 1, item 2 (Vig 1.2) "I believe the nurse's behavior toward the patient was unethical" (*M* = 4.83, *SD* = 1.30). Even though the two scenarios represent breaches in professional nurse-patient relationships, the mean scores show variations in ethical decision-making by the mid-level nurse managers between the two different gradations in the nurse-patient relationship scenarios. Table 9 presents the frequencies, percentages rating, and item analysis of each statement in the ethical decision-making survey instrument.

Table 9

Item Analysis of Ethical Decision-Making Vignettes 1and 2 Likert Scale

Question	1	2	3	4	5	6	M	SD
Vig 1.1	1	1	2	5	5	27	5.27	1.25
	2.4%	2.4%	4.9%	12.2%	12.2%	65.9%		
Vig 1.2	1	1	4	10	7	18	4.83	1.30
	2.4%	2.4%	9.8%	24.4%	17.1%	43.9%		
Vig 1.3	0	1	0	2	7	31	5.63	.80
		2.4%		4.9%	17.1%	75.6%		

(table continues)

Question	1	2	3	4	5	6	M	SD
Vig 1.4	0	0	1	1	4	35	5.78	.61
			2.4%	2.4%	9.8%	85.4%		
Vig 1.5	1	0	0	0	17	23	5.46	.87
	2.4%				41.5%	56.1%		
Vig 1.6	1	0	0	0	16	24	5.49	.87
	2.4%				39.0%	58.5%		
Vig 2.1	0	0	1	0	0	40	5.93	.47
			2.4%			97.6%		
Vig 2.2	0	0	0	1	1	39	5.93	.35
				2.4%	2.4%	95.1%		
Vig 2.3	1	0	1	2	8	29	5.51	1.00
	2.4%		2.4%	4.9%	19.5%	70.7%		
Vig 2.4	0	1	1	0	3	36	5.76	.80
		2.4%	2.4%		7.3%	87.8%		
Vig 2.5	2	0	0	2	12	25	5.46	.81
	4.9%			4.0%	29.3%	61.0%		
Vig 2.6	0	0	0	4	14	23	5.46	.67
				9.8%	34.1%	56.1%		
			The mean score of Vignettes 1 and 2 =				5.54	.82

Note. $N = 41$; Question descriptions can be found in Appendix A; Vig = Vignette; M = Mean; SD = Standard Deviation.

Demographic questionnaire. A demographic questionnaire was included in the packet with the survey instrument and study information sheet, in which instructions were provided

requesting participants to complete the questionnaire. In reporting demographic information from the surveys, frequencies and percentages of the categorical variables, gender, past observed nurse-patient professional boundary breaches, highest level of education, and career status were calculated. Of the 41 mid-level nurse leaders who completed the survey and demographic questionnaire, the participants in this study were predominately female (n = 28, 68.3%). Of note, the percentage of male RNs in this study accounted for 26.8%, which is three times higher than the national percentage of 9% of male nurses in the workforce (NCSBN, 2019). From an education stance, there were an equal number of mid-level nurse managers with bachelor's degrees (n = 18, 43.9%) as there were with master's degrees in nursing (n = 18, 43.9%). Additionally, there were an equal number of mid-level nurse managers with associate's degrees (n = 2, 4.9%) as there were with DNP/PhD degrees (n = 2, 4.9%). The mid-level nurse managers predominately reported having prior military experience or were currently active duty (n = 35, 85.4%) in comparison to those with no prior military work experience (n = 6, 14.6%). Interestingly, a large proportion of the mid-level nurse managers reported that they had observed past situations in which they believed nursing staff had crossed nurse-patient professional boundaries (n = 32, 78%). Table 10 presents the frequencies and percentages for the categorical variables from the demographic questionnaire.

Table 10

Frequency and Percentage Statistics for Variables from Demographic Questionnaire

Category	Number of Responses	Characteristics	Frequency	Percentage (%)
Gender	39	Male	11	26.8
		Female	28	68.3
Highest Level Education	40	Associate RN	2	4.9
		Bachelor RN	18	43.9
		Master RN	18	43.9
		PhD/DNP	2	4.9
Current Work Status	41	GS CIV No/Prior Mil	6	14.6
		GS CIV W/Prior Mil	18	43.9
		Active Duty Military	17	41.5
Observed Boundaries Crossed	41	No	9	22.0
		Yes	32	78.0

Note. RN = Registered Nurse; GS = General Schedule; CIV = Civilian.

In addition to the categorical variables, there were four continuous variables analyzed from the demographic questionnaire. The continuous variables analyzed included the mid-level nurse manager's age in years, years worked as an RN, years worked as a mid-level nurse manager, and years worked at a military treatment facility. Of the 41 mid-level nurse leaders who completed the demographic questionnaire, 38 respondents provided their age in years, calculating to a mean age of 49.6 and a standard deviation of 8.6 years. The mean age of the mid-level nurse manager in this study is in alignment with the mean age of 50 years for the nursing workforce in the United States (NCSBN, 2019). Of the 41 mid-level nurse managers that

answered the demographic questionnaire, 40 provided the number of years they had worked as an RN (M = 21.4, SD = 8.8). All 41 respondents provided information as to the number of years they had worked as a mid-level nurse manager and the number of years they had worked at a military treatment facility. The mean years worked as a mid-level nurse manager of 9.1 with a standard deviation of 6.2 depicts a relatively young managerial workforce in the health care facility. In analyzing the mean years worked in a military treatment facility of 18.2 with a standard deviation of 7.2, it appears to coincide with the high percentage of mid-level nurse managers who reported prior and/or current military work experience; however, it cannot be assumed that this is the mean number of years the participants in this study have been employed at this particular military treatment facility. There is significantly high turnover of personnel employed by military health care facilities for all nursing personnel, regardless of career work status. Table 11 presents the means, medians, standard deviations, and frequencies for the continuous variables from the demographic questionnaire.

Table 11

Mean, Median, Standard Deviation, and Frequency Statistics for Variables from Demographic Questionnaire

Category	Mean	Median	Standard Deviation	N
Age in Years	49.6	52.0	8.6	38
Years as RN	21.4	19.0	8.8	40
Years as Manager	9.1	7.0	6.2	41
Years Worked at MTF	18.2	18.0	7.2	41

Note. RN = Registered Nurse; MTF = Military Treatment Facility.

Inferential Statistics

Researchers use inferential statistical techniques to "test hypotheses about differences in populations on the basis of measurements made on samples of subjects" (Tabachnick & Fidell, 2013, p. 7). This study used a convenience sample of mid-level nurse leaders with a minimum of one year experience as mid-level nurse leaders in a position overseeing one or more nurses. The sample was derived from multiple inpatient and ambulatory care departments affiliated with a military treatment facility in South/Central Texas.

The researcher used inferential statistics to understand the differences among the mid-level nurse leaders' ethical decision-making responses in terms of nurse-patient professional boundaries. Additionally, demographic characteristics were investigated to determine any relationships, differences, or impacts these factors had in mid-level nurse leaders' ethical decision-making about nurse-patient professional boundaries.

All continuous variables were checked to determine if it could be assumed that their distributions of scores were taken from a normal population (Pallant, 2013). In this study, the dependent variable was numeric data gathered from a 12 item, 6-point Likert scale measuring ethical decision-making by mid-level nurse leaders about nurse-patient professional boundaries. In this study, the independent continuous variables—years worked at a military treatment facility, age, years worked as an RN, and years worked as a mid-level nurse leader—were numeric data gathered from a demographic questionnaire. The continuous independent variables were each tested to evaluate their respective skewness, kurtosis, and shape of their respective distribution of scores using a histogram, assessing for a symmetrical, bell-shaped curve. Additionally, each variable was tested to evaluate the Kolmogorov-Smirnov statistic and inspect the normal probability plots; Normal Q-Q plots, Detrended Normal Q-Q plots, and Boxplots. To

further evaluate normality, the continuous variables age and years worked as an RN were checked for normality with and without replacing missing values with their respective mean scores and evaluated for any significant changes. When checking normality of the distribution of scores for the continuous variables years worked as an RN and years worked as a mid-level nurse manager, their respective scores were transformed using a square root and logarithm formula, evaluated against the non-transformed results, with no significant change. Based on the evaluation of distribution of scores for each continuous variable, years worked at a military treatment facility did not violate the assumption of normality. The continuous variables age, years worked as an RN, and years worked as a mid-level nurse leader were reasonably normal and retained for analysis without replacing missing data and without variable transformations. All tests used a 95% confidence level to calculate an interval that estimates a population parameter. Unless noted otherwise, the *a priori* level of significance was $\alpha = .05$.

Results from the inferential statistical tests were analyzed and reported in tables with analyses explained. Additionally, the inferential statistics were used to direct focused interview questions during the qualitative phase of this study.

Addressing the research questions. The results of this quantitative study answered the following research questions:

Question 1. *Is there a significant relationship between ethical decision-making and the characteristics of the participants surveyed?* To answer this question, 48 bivariate Pearson product-moment correlation coefficients (r) were calculated to determine if there were any significant relationships between the 12 item ethical decision-making survey instrument and the four continuous variables in this study—participant's age, years of work experience as a

registered nurse, years of work experience as a mid-level nurse manager, and years worked in a military treatment facility. The results of the calculations are presented in Table 12.

To test the null hypothesis that there were no significant relationships among the four continuous variables, participant's age, years of work experience as a registered nurse, years of work experience as a mid-level nurse manager, and years worked in a military treatment facility with the 12 ethical decision-making items, 48 bivariate Pearson product-moment correlation coefficients (r) were calculated. The Pearson product-moment correlation coefficients (r) measured direction and strength of relationships among the variables. As the calculations show in Table 12, there were three correlations found at significant levels, all three with a positive direction and moderate strength. Table 12, Vig 2.3 results indicate a positive relationship with a moderate correlation between the two variables, mid-level nurse managers' feeling comfortable speaking with a nurse about his/her behavior regarding boundary transgressions and a higher number of years of work experience as an RN, $r = .32$, $n = 40$, $p < .05$. The second significant correlation, shown in Table 12, Vig 2.3, indicates a positive relationship with a moderate correlation between the two variables, mid-level nurse managers' feeling comfortable speaking with a nurse about his/her behavior regarding boundary transgressions and a higher number of years of work experience as a nurse manager, $r = .35$, $n = 41$, $p < .05$. Additionally, the coefficient of determination, calculated by squaring the Pearson correlation, r value and converting to a percentage of variance, is used to indicate shared variance between two variables (Pallant, 2013, p. 139). As shown in Table 12, Vig 2.3, the Pearson correlation $r = .32$, when squared, indicates a 10.24% shared variance, suggesting that the years of work experience as an RN helped to explain approximately 10% of the variance in the nurse manager's feeling comfortable speaking with a nurse about his/her behavior. It also shows in Table 12, Vig 2.3, the

Pearson correlation, $r = .35$, when squared, indicates a 12.25% shared variance, implying that, the years of work experience as a nurse manager helped to explain approximately 12% of the variance in the nurse manager's feeling comfortable speaking with a nurse about his/her behavior regarding boundary transgressions.

The third significant relationship, displayed in Table 12, Vig 2.5, indicates a positive relationship and a moderate correlation between a mid-level nurse manager believing he/she had the knowledge to appropriately manage boundary breach situations and a higher number of years of work experience as a nurse manager, $r = .43$, $n = 41$, $p < .01$. The coefficient of determination, calculated for Vig 2.5 Pearson correlation, $r = .43$, indicates an 18.49% shared variance, suggesting that the years of work experience as a nurse manager helped to explain approximately 19% of the variance in the nurse manager believing he/she had the knowledge to appropriately manage the boundary transgression situations.

In summary, the results showed that the null hypothesis was rejected in three of the 48 tests. There were three significant relationships indicating positive relationships with moderate correlations for Vignette Two, items Vig 2.3 and Vig 2.5. The greater the number of years of work experience as an RN and the greater the number of years of work experience as a nurse manager, the more comfortable a nurse manager felt speaking with a nurse about his/her behavior regarding nurse-patient professional boundary transgressions. Additionally, the greater number of years of work experience as a nurse manager, the more knowledge she/he believed she/he had to appropriately manage nurse-patient professional boundary transgressions. Table 12 displays the bivariate Pearson product-moment correlations between each ethical decision-making item and the variables age, years of work experience as an RN, years of work experience as a nurse manager, and years worked at a military treatment facility.

Table 12

Bivariate Pearson Product-Moment Correlations Showing Relationships among Ethical Decision-Making and the Variables Age, Years Worked as an RN, Years Worked as a Mid-Level NM, and Years Worked in a MTF

Measure	Age		Years – RN		Years – NM		Years – MTF	
	r	Sig	r	Sig	r	Sig	r	Sig
Vig 1.1	.01	.95	.06	.72	.30	.06	.08	.60
Vig 1.2	.03	.84	.22	.17	.31	.05	.03	.83
Vig 1.3	-.10	.57	.19	.23	.11	.52	.13	.42
Vig 1.4	.21	.22	-.11	.50	-.31	.05	-.28	.08
Vig 1.5	.13	.45	.10	.52	.18	.26	-.01	.97
Vig 1.6	.00	.98	.04	.81	.08	.60	-.14	.37
Vig 2.1	.17	.32	.10	.54	.21	.19	.18	.25
Vig 2.2	.09	.61	.10	.53	.26	.10	.25	.12
Vig 2.3	.25	.11	.32	.04*	.35	.03*	.21	.18
Vig 2.4	.25	.12	.08	.64	.28	.08	.12	.44
Vig 2.5	.21	.22	.21	.19	.43	.01**	.04	.78
Vig 2.6	.14	.41	.23	.16	.29	.07	-.01	.93

Note. Age $n = 38$, Years – RN $n = 40$, Years – NM $n = 41$, Years – MTF $n = 41$; *$p < .05$, **$p < .01$; RN = Registered Nurse; NM = Nurse Manager; MTF = Military Treatment Facility.

Question 2. *Is there a significant change in participant's ethical decision-making between vignette one and vignette two of the Ethical Decision-Making Survey Instrument?* To answer this question, six paired-samples *t*-tests were calculated. The paired-samples *t*-test was used to determine whether there were significant differences among the mid-level nurse manager's ethical decision-making in terms of his/her responses between vignette one and

vignette two. Vignette one describes a scenario involving a flirtatious encounter between a nurse and patient; whereas, vignette two describes a scenario involving a personal relationship between a nurse and patient.

The null hypothesis was tested to analyze the difference in the mean ethical decision-making scores for nurse managers on the two scenarios describing different gradations of nurse-patient boundary breaches. The null hypothesis was that there would be no significant difference in the mid-level nurse managers' ethical decision-making scores for vignettes one and two. To test this hypothesis, six paired-samples t-tests were conducted to evaluate whether there were differences in ethical decision-making among the same mid-level nurse managers' scores between vignette one and vignette two. Table 13 displays the six paired-samples *t*-test results for mid-level nurse managers' scoring of ethical decision-making about nurse-patient professional boundary breaches when facing two different boundary breach situations.

Table 13

Differences between Participants Scoring on Ethical Decision-Making between Two Different Gradations of Professional Boundary Breaches

Measure	M	SD	df	t	η2
Pair 1	-.66	1.06	40	-3.97**	0.28
Pair 2	-1.10	1.28	40	-5.49**	0.43
Pair 3	.12	.95	40	.82	
Pair 4	.02	1.01	40	.15	
Pair 5	.00	1.00	40	.00	
Pair 6	.02	1.01	40	.15	

Note. $N = 41$; η2 = eta squared; $^{**}p < .01$.

As Table 13 shows, there were two statistically significant differences in scores for Pair 1 and Pair 2; therefore, the null hypothesis was rejected for two of the six *t*-tests. There was a statistically significant increase in Pair 1 of the ethical decision-making survey scores from vignette one ($M = 5.27$, $SD = 1.25$) to vignette two ($M = 5.93$, $SD = .469$), $t(40) = -3.97$, $p < .001$ (two-tailed). The mean increase in the ethical decision-making survey scores was -.659 with a 95% confidence interval ranging from -.994 to -.323. The eta squared statistic (.28) indicated a large effect size, with a substantial difference in the ethical decision-making survey scores obtained from vignette one and vignette two.

There was also a statistically significant increase in Pair 2 of the ethical decision-making survey scores from vignette one ($M = 4.83$, $SD = 1.30$) to vignette two ($M = 5.93$, $SD = .346$), $t(40) = -5.49$, $t(40)$, $p < .001$ (two-tailed). The mean increase in the ethical decision-making survey scores was -1.098 with a 95% confidence interval ranging from -1.502 to -.693. The eta squared statistic (.43) indicated a large effect size, with a substantial difference in the ethical decision-making survey scores obtained from vignette one and vignette two.

Summarizing question two, both vignette one and vignette two describe nurse-patient professional boundary breach scenarios, vignette one portraying a flirtatious encounter and vignette two depicting a personal relationship. Based on the results, the mean scores calculated for Pairs 1 and 2 were significantly greater for vignette two than for vignette one, indicating there was a significant difference in the mid-level nurse managers' decisions about nurse-patient boundary violations and unethical behavior described in vignettes one and two. On the other hand, there was no significant difference calculated in Pair 3 through Pair 6, indicating the mid-level nurse manager's decisions about their knowledge and skill in managing the situations described in vignettes one and two were no different. Also, there was no significant difference in

how comfortable the nurse managers were in speaking with or believing it was their responsibility to talk with the nurse about his/her boundary transgression.

Question 3. *Is there a significant change in the participants' ethical decision-making between vignette one and vignette two based on characteristics of the participants?* To answer this question, a mixed between-within subjects ANOVA was calculated. The mixed between-within subjects ANOVA was used to determine the impact of the participant's demographic characteristics; gender, observation of past inappropriate professional boundaries, education level, and current career status as a mid-level nurse manager, on ethical decision-making about two different gradations of professional boundary breaches.

The null hypothesis was tested to analyze if any changes in ethical decision-making, as measured by six items between vignette one and vignette two, were based on the mid-level nurse managers' gender, observation of past boundary breaches, education level, and/or career status. The null hypothesis was that there would be no statistically significant differences in the main effects of the mid-level nurse managers' ethical decision-making scores for vignettes one and two or for the grouping variables tested; as well as, no interaction between vignettes one and two and the grouping variables. To test this hypothesis, 48 mixed between-within subjects ANOVAs were conducted to evaluate whether there were changes in ethical decision-making among the mid-level nurse managers' scores between vignette one and vignette two's different gradations of nurse-patient boundary breach scenarios; as well as, any changes due to gender, past observed boundary breaches, education level, and/or career status.

The means and standard deviations for the variables, gender, observed past boundary breaches, education level, and career status, were calculated for each item from vignettes one and two. An examination of the mean scores for gender, past observed boundary breaches, education

level, and career status, reported higher mean scores for item one and item two on vignette two. In other words, higher mean scores on all variables were shown for the item statements, “I believed the nurse’s behavior toward the patient violated appropriate nurse-patient professional boundaries” and “I believed the nurse’s behavior toward the patient was unethical” for vignette two, a scenario describing a personal relationship between a nurse and a patient.

Further examination of the mean scores for the variables, gender, past observed boundary breaches, education level, and career status, revealed mid-level nurse manager’s with a PhD/DNP were equally distributed on items three through six for vignettes one and two. However, this group of mid-level nurse managers accounted for a small percentage, 4.9% of the total sample. Upon further examination, the mean scores for the variables, gender, past observed boundary breaches, education level, and career status, did not reflect any obvious trends in mean scores on items three through six of vignettes one or two.

Table 14 displays the means and standard deviations for the variables, gender, observed past boundary breaches, education level, and career status, on ethical decision-making by mid-level nurse manager’s about nurse-patient professional boundaries.

Forty-eight mixed between-within subjects ANOVAs were conducted to assess the impact of the grouping variables, gender, past observed boundary breaches, education level, and career status on participant’s scores on ethical decision-making on two scenario-based vignettes describing two different nurse-patient relationship boundary breaches.

Table 14

Means and Standard Deviations for Gender, Observed Past Breaches, Education, and Career Status on Ethical Decision-Making about Nurse-Patient Boundaries

Item	Variable	Vignette 1		Item	Variable	Vignette 2	
		M	SD			M	SD
Vig_1.1	F	5.43	1.26	Vig_2.1	F	5.89	5.67
	M	4.91	1.22		M	6.00	.00
	Obs N	5.56	1.01		Obs N	6.00	.00
	Obs Y	5.19	1.31		Obs Y	5.91	.53
	Edu A	5.50	.71		Edu A	6.00	.00
	Edu B	5.44	1.29		Edu B	5.83	.71
	Edu M	5.28	1.10		Edu M	6.00	.00
	Edu PhD/DNP	4.00	2.83		Edu PhD/DNP	6.00	.00
	No AD	5.83	.41		No AD	6.00	.00
	Prior AD	5.56	.71		Prior AD	6.00	.00
	AD	4.76	1.68		AD	5.82	.73
Vig_1.2	F	5.04	1.26	Vig_2.2	F	5.93	.38
	M	4.45	1.44		M	5.91	.30
	Obs N	5.33	1.00		Obs N	6.00	.00
	Obs Y	4.69	1.36		Obs Y	5.91	.39

(table continues)

Item	Variable	Vignette 1		Item	Variable	Vignette 2	
		M	SD			M	SD
Vig_1.2	Edu A	5.50	.71	Vig_2.2	Edu A	6.00	.00
	Edu B	5.11	1.13		Edu B	5.83	.51
	Edu M	4.67	1.41		Edu M	6.00	.00
	Edu PhD/DNP	3.50	2.12		Edu PhD/DNP	6.00	.35
	No AD	5.50	.84		No AD	6.00	.00
	Prior AD	4.89	1.08		Prior AD	5.94	.24
	AD	4.53	1.59		AD	5.88	.49
Vig_1.3	F	5.61	.88	Vig_2.3	F	5.39	1.17
	M	5.64	.67		M	5.91	.30
	Obs N	5.67	.50		Obs N	5.56	.73
	Obs Y	5.63	.87		Obs Y	5.50	1.08
	Edu A	5.50	.71		Edu A	6.00	.00
	Edu B	5.50	1.04		Edu B	5.22	1.40
	Edu M	5.72	.58		Edu M	5.67	.49
	Edu PhD/DNP	6.00	.00		Edu PhD/DNP	6.00	.00
	No AD	5.17	1.60		No AD	5.17	2.04
	Prior AD	5.61	.70		Prior AD	5.56	.78
	AD	5.82	.39		AD	5.59	.71

(table continues)

Item	Variable	Vignette 1		Item	Variable	Vignette 2	
		M	SD			M	SD
Vig_R1.4	F	5.86	.45	Vig_R2.4	F	5.68	.95
	M	5.64	.92		M	6.00	.00
	Obs N	5.89	.33		Obs N	5.89	.33
	Obs Y	5.75	.67		Obs Y	5.72	.89
	Edu A	5.50	.71		Edu A	6.00	.00
	Edu B	5.78	.55		Edu B	5.50	1.15
	Edu M	5.78	.73		Edu M	5.94	.24
	Edu PhD/DNP	6.00	.00		Edu PhD/DNP	6.00	.00
	No AD	5.67	.52		No AD	5.83	.41
	Prior AD	5.61	.85		Prior AD	5.78	.73
	AD	6.00	.00		AD	5.71	.99
Vig_1.5	F	5.54	.51	Vig_2.5	F	5.39	.92
	M	5.18	1.47		M	5.64	.51
	Obs N	5.44	.53		Obs N	4.89	1.17
	Obs Y	5.47	.95		Obs Y	5.62	.61
	Edu A	5.50	.71		Edu A	6.00	.00
	Edu B	5.28	1.18		Edu B	5.22	.88
	Edu M	5.61	.50		Edu M	5.56	.78
	Edu PhD/DNP	6.00	.00		Edu PhD/DNP	6.00	.00

(table continues)

Item	Variable	Vignette 1		Item	Variable	Vignette 2	
		M	SD			M	SD
Vig_1.5	No AD	5.67	.52	Vig_2.5	No AD	6.00	.00
	Prior AD	5.61	.50		Prior AD	5.50	.62
	AD	5.24	1.20		AD	5.24	1.03
Vig_1.6	F	5.57	.50	Vig_2.6	F	5.36	.73
	M	5.18	1.47		M	5.73	.47
	Obs N	5.44	.53		Obs N	5.11	.78
	Obs Y	5.50	.95		Obs Y	5.56	.62
	Edu A	5.50	.71		Edu A	6.00	.00
	Edu B	5.33	1.19		Edu B	5.28	.75
	Edu M	5.61	.50		Edu M	5.50	.62
	Edu PhD/DNP	6.00	.00		Edu PhD/DNP	6.00	.00
	No AD	5.83	.41		No AD	5.83	.41
	Prior AD	5.56	.51		Prior AD	5.39	.61
	AD	5.29	1.21		AD	5.41	.80

Note. Variable – Gender, n = 39: F = female, M = Male; Variable – Observed past breaches, n = 41: N = No, Y = Yes; Variable – Education level, n = 40: A = Associate degree, B = Bachelor degree, M = Master degree, PhD/DNP = Doctorate degree; Variable – Career status, n = 41: No AD = Had no active duty military experience, Prior AD = Had prior active duty military experience, AD = Currently active duty military.

Analysis revealed that there was no significant interaction between gender and ethical decision-making for vignettes one and two, item one, Wilk's Lambda = .93, $F\ (1, 37)$ = 2.88, p = .10, partial eta squared = .07. There was a substantial main effect for ethical decision-making for

vignettes one and two, item one, Wilk's Lambda = .68, *F (1, 37)* = 17.73, $p < .001$, partial eta squared = .32, with both genders scoring higher on vignette two, item one. The main effect comparing ethical decision-making and gender was not significant for item one, *F (1, 37)* = .534, $p = .469$, partial eta squared = .014, suggesting no difference in the ethical decision-making scores based on gender for item one. Table 15 displays the results for gender and vignettes one and two, item one.

Table 15

Analyses of Variance Results for Gender and Vignettes 1.1 and 2.1 Questions for Ethical Decision-Making about Nurse-Patient Relationship Boundaries

Source	df	SS	MS	F	η2
		Between subjects			
Gender	1	.67	.67	.53	.01
Error	37	46.51	1.26		
		Within subjects			
EDM1	1	9.55	9.55	17.73***	.32
EDM1 x Gender	1	1.55	1.55	2.88	.07
Error (EDM1)	37	19.94	.54		

Note. η2 = effect size; ***$p < .001$.

Analysis revealed that there was no significant interaction between gender and ethical decision-making for vignettes one and two, item two, Wilk's Lambda = .96, *F (1, 37)* = 1.50, p = .23, partial eta squared = .04. There was a substantial main effect for ethical decision-making for vignettes one and two, item two, Wilk's Lambda = .59, *F (1, 37)* = 26.22, $p < .001$, partial eta squared = .42, with both genders scoring higher on vignette two, item two. The main effect comparing ethical decision-making and gender was not significant for item two, *F (1, 37)* = 1.40,

p = .245, partial eta squared = .036, suggesting no difference in the ethical decision-making scores based on gender for item two. Table 16 displays the results for gender and vignettes one and two, item two.

Table 16

Analyses of Variance Results for Gender and Vignettes 1.2 and 2.2 Questions for Ethical Decision-Making about Nurse-Patient Relationship Boundaries

Source	df	SS	MS	F	η2
		Between subjects			
Gender	1	1.43	1.43	1.40	.04
Error	37	37.76	1.02		
		Within subjects			
EDM2	1	21.76	21.76	26.22***	.42
EDM2 x Gender	1	1.25	1.25	1.50	.04
Error (EDM2)	37	30.70	.83		

Note. η2 = effect size; ***p < .001.

Analysis revealed that there was no significant interaction between past observations of boundary breaches and ethical decision-making for vignettes one and two, item one, Wilk's Lambda = .99, *F (1, 39)* = .46, p = .50, partial eta squared = .01. There was a substantial main effect for ethical decision-making for vignettes one and two, item one, Wilk's Lambda = .83, *F (1, 39)* = 8.29, p < .01, partial eta squared = .18, with significantly higher scores for the mid-level nurse managers who did and did not have a past observation of boundary breaches on vignette two, item one. The main effect comparing ethical decision-making and past observations of boundary breaches was not significant for item one, *F (1, 39)* = .615, p = .438, partial eta squared = .016, suggesting no difference in the ethical decision-making scores based on past

observations of boundary breaches for item one. Table 17 displays the results for past observations of boundary breaches and vignettes one and two, item one.

Table 17

Analyses of Variance Results for Past Observations of Perceived Boundary Crossings and Vignettes 1.1 and 2.1 Questions for Ethical Decision-Making about Nurse-Patient Relationship Boundaries

Source	df	SS	MS	F	η2
		Between subjects			
BB	1	.75	.75	.62	.02
Error	39	47.47	1.28		
		Within subjects			
EDM1	1	4.75	4.75	8.29**	.18
EDM1 x BB	1	.26	.26	.46	.01
Error (EDM1)	39	22.35	.57		

Note. η2 = effect size; ** $p < .01$.

Analysis revealed that there was no significant interaction between past observations of boundary breaches and ethical decision-making for vignettes one and two, item two, Wilk's Lambda = .97, $F\ (1, 39) = 1.32$, $p = .26$, partial eta squared = .03. There was a substantial main effect for ethical decision-making for vignettes one and two, item two, Wilk's Lambda = .72, $F\ (1, 39) = 15.34$, $p < .001$, partial eta squared = .28, with significantly higher scores for the mid-level nurse managers who did and did not have a past observation of boundary breaches on vignette two, item two. The main effect comparing ethical decision-making and past observations of boundary breaches was not significant for item two, $F\ (1, 39) = 1.98$, $p = .167$, partial eta squared = .048, suggesting no difference in the ethical decision-making scores based

on past observations of boundary breaches for item two. Table 18 displays the results for past observations of boundary breaches and vignettes one and two, item two.

Table 18

Analyses of Variance Results for Past Observations of Perceived Boundary Crossings and Vignettes 1.2 and 2.2 Questions for Ethical Decision-Making about Nurse-Patient Relationship Boundaries

Source	df	SS	MS	F	η2
		Between subjects			
BB	1	1.92	1.92	1.98	.05
Error	39	37.86	.97		
		Within subjects			
EDM2	1	12.49	12.49	15.34***	.28
EDM2 x BB	1	1.07	1.07	1.32	.03
Error (EDM2)	39	31.73	.81		

Note. η2 = effect size; ***$p < .001$.

Analysis revealed that there was no significant interaction between education and ethical decision-making for vignettes one and two, item one, Wilk's Lambda = .89, $F (3, 36) = 1.56$, $p = .22$, partial eta squared = .12. There was a substantial main effect for ethical decision-making for vignettes one and two, item one, Wilk's Lambda = .77, $F (1, 36) = 11.01$, $p < .01$, partial eta squared = .23,with significantly higher scores for the mid-level nurse managers with associates through doctoral degrees in nursing on vignette two, item one. The main effect comparing ethical decision-making and education was not significant for item one, $F (3, 36) = .426$, $p = .736$, partial eta squared = .034, suggesting no difference in the ethical decision-making scores based

on education for item one. Table 19 displays the results for education and vignettes one and two, item one.

Table 19

Analyses of Variance Results for Education and Vignettes 1.1 and 2.1 Questions for Ethical Decision-Making about Nurse-Patient Relationship Boundaries

Source	df	SS	MS	F	η2
		Between subjects			
Education	3	1.63	.54	.43	.03
Error	36	45.86	1.27		
		Within subjects			
EDM1	1	5.87	5.87	11.01**	.23
EDM1 x Education	3	2.49	.83	1.56	.12
Error (EDM1)	36	19.19	.53		

Note. η2 = effect size; **$p < .01$.

Analysis revealed that there was no significant interaction between education and ethical decision-making for vignettes one and two, item two, Wilk's Lambda = .87, $F (3, 36) = 1.73$, $p = .18$, partial eta squared = .13. There was a substantial main effect for ethical decision-making for vignettes one and two, item two, Wilk's Lambda = .71, $F (1, 36) = 14.63$, $p < .001$, partial eta squared = .29, with significantly higher scores for the mid-level nurse managers with associates through doctoral degrees in nursing on vignette two, item two. The main effect comparing ethical decision-making and education was not significant for item two, $F (3, 36) = .816$, $p = .493$, partial eta squared = .064, suggesting no difference in the ethical decision-making scores based on education for item two. Table 20 displays the results for education and vignettes one and two, item two.

Table 20

Analyses of Variance Results for Education and Vignettes 1.2 and 2.2 Questions for Ethical Decision-Making about Nurse-Patient Relationship Boundaries

Source	df	SS	MS	F	η2
		Between subjects			
Education	3	2.52	.84	.49	.06
Error	36	36.97	1.03		
		Within subjects			
EDM2	1	11.50	11.50	14.63***	.29
EDM2 x Education	3	4.08	1.36	1.73	.13
Error (EDM2)	36	28.31	.79		

Note. η2 = effect size; ***$p < .001$.

Analysis revealed that there was no significant interaction between career status and ethical decision-making for vignettes one and two, item one, Wilk's Lambda = .89, $F\ (2, 38) = 2.36$, $p = .11$, partial eta squared = .11. There was a substantial main effect for ethical decision-making for vignettes one and two, item one, Wilk's Lambda = .80, $F\ (1, 38) = 9.38$, $p < .01$, partial eta squared = .20, with significantly higher scores for the mid-level nurse managers with no military, prior military, and current military career status on vignette two, item one. The main effect comparing ethical decision-making and career status was not significant for item one, $F\ (2, 38) = 2.457$, $p = .099$, partial eta squared = .115, suggesting no difference in the ethical decision-making scores based on career status for item one. Table 21 displays the results for career status and vignettes one and two, item one.

Table 21

Analyses of Variance Results for Work Status and Vignettes 1.1 and 2.1 Questions for Ethical Decision-Making about Nurse-Patient Relationship Boundaries

Source	df	SS	MS	F	η2
		Between subjects			
Status	2	5.52	2.76	2.46	.12
Error	38	42.70	1.12		
		Within subjects			
EDM1	1	4.96	4.96	9.38**	.20
EDM1 x Status	2	2.50	1.25	2.36	.11
Error (EDM1)	38	20.11	.53		

Note. η2 = effect size; **$p < .01$.

Analysis revealed that there was no significant interaction between career status and ethical decision-making for vignettes one and two, item two, Wilk's Lambda = .95, $F\ (2, 38) = 1.00$, $p = .38$, partial eta squared = .05. There was a substantial main effect for ethical decision-making for vignettes one and two, item two, Wilk's Lambda = .67, $F\ (1, 38) = 18.35$, $p < .001$, partial eta squared = .33, with significantly higher scores for the mid-level nurse managers with no military, prior military, and current military career status on vignette two, item two. The main effect comparing ethical decision-making and career status was not significant for item two, $F\ (2, 38) = 1.395$, $p = .260$, partial eta squared = .068, suggesting no difference in the ethical decision-making scores based on career status for item two. Table 22 displays the results for career status and vignettes one and two, item two.

Table 22

Analyses of Variance Results for Work Status and Vignettes 1.2 and 2.2 Questions for Ethical Decision-Making about Nurse-Patient Relationship Boundaries

Source	df	SS	MS	F	η2
		Between subjects			
Status	2	2.72	1.36	1.40	.07
Error	38	37.06	.98		
		Within subjects			
EDM2	1	15.05	15.05	18.35***	.33
EDM2 x Status	2	1.64	.82	1.00	.05
Error (EDM2)	38	31.16	.82		

Note. η2 = effect size; ***$p < .001$.

In summary, 48 mixed between-within subjects ANOVAs were calculated to answer question three. Of the 48 mixed between-within subjects ANOVAs calculated, eight were found to have substantial main effects for ethical decision-making for vignettes one and two, items one and two. The other 40 mixed between-within subjects ANOVAs calculated for vignettes one and two, items three through six, were not found to have any significant findings and their results are displayed in Appendix G. In addition, 48 mean and standard deviations were calculated for the grouping variables gender, observed past perceived boundary breaches, education level, and career status, for vignettes one and two, items one through six.

The 48 mixed between-within subjects ANOVAs revealed that there were no significant interactions between the grouping variables gender, observed past perceived boundary breaches, education level, and career status, and the nurse manager's ethical decision-making in determining a violation of and the unethicality of a nurse-patient professional boundary breach.

Additionally, there were no significant interactions between the grouping variables tested and the manager's belief it was their responsibility to speak with the nurse about his/her behavior in both scenarios or their comfort in speaking with the nurse about his/her behavior. Nor, were there any significant interactions between the grouping variables tested and the mid-level nurse managers' belief in his/her knowledge and skill to manage both situations appropriately. However, the analyses showed there were substantial main effects for nurse manager's ethical decision-making in determining violations of nurse-patient professional boundary breaches and the unethicality of the behavior for vignettes one and two, items one and two, specifically showing vignette two with higher scores on items one and two than for vignette one.

Summary

This chapter provided descriptive and inferential data analyses obtained from the Ethical Decision-Making Survey Instrument and the Demographic Questionnaire. The Ethical Decision-Making Survey Instrument was developed to accurately measure mid-level nurse manager's baseline knowledge and skill levels in recognizing and intervening in professional nurse-patient boundary breaches. The Ethical Decision-Making Survey Instrument tested for reliability, scored a Cronbach alpha coefficient of .71, which met the minimum level for denoting instrument reliability as recommended by Nunnally (1978); just as the mean inter-item correlation of .21 fell within the optimal value range of .2 to .4 as recommended by Briggs and Cheek, 1986. Additionally, the Ethical Decision-Making Survey Instrument was tested for content and face validity. Based on the computations for S-CVI/UA of 0.83 and S-CVI/Ave of 0.96, the content validity index scores are greater than the minimum acceptable standards for meeting content validity. As such, this scale was judged as having excellent content validity. Face validity

resulted in 75% of the surveyors recommending no change to the survey instrument and demographic questionnaire.

Gathering mid-level nurse managers' data, obtained from the Ethical Decision-Making Survey Instrument, provided baseline information relevant to the thoughts and actions carried out by mid-level nursing leaders when faced with different gradations of nurse-patient professional boundary breaches. Prior to calculating descriptive and inferential statistics, a survey return rate of 82% was calculated and data cleaning was conducted, with the results included in this chapter.

Descriptive statistics were calculated for the Ethical Decision-Making Survey Instrument and the Demographic Questionnaire. Overall, the mean score of the Ethical Decision-Making Survey Instruments 12 items was 5.54 (SD = .82), with the mean comparison showing five items scoring higher than the overall survey instruments mean score. Of the five highest mean scores, two were from vignette one and three from vignette two; they were, Vig 1.3, Vig 1.4, Vig 2.1, Vig 2.2, and Vig 2.4. Of note, the two lowest mean scores were from vignette one, Vig 1.1 and Vig 1.2. Even though the two scenarios represent breaches in professional nurse-patient relationships, the mean scores show variations in ethical decision-making by the mid-level nurse managers between the two different gradations in the nurse-patient relationship scenarios.

To further analyze the data obtained from the Ethical Decision-Making Survey Instrument and the Demographic Questionnaire, inferential statistics were calculated to understand the differences among the mid-level nurse leaders' ethical decision-making responses in terms of nurse-patient professional boundaries. Additionally, demographic characteristics were investigated to determine any relationships, differences, or impacts these factors had in mid-level nurse leaders ethical decision-making about nurse-patient professional boundaries. Prior to calculating the inferential statistics, all continuous variables were checked to determine

if it could be assumed that their distributions of scores were taken from a normal population (Pallant, 2013). The results of the tests for normality are included in this chapter.

The inferential statistics calculated for this study were determined based on three research questions aimed at what factors influence nursing leaders' ethical decision-making in their perceptions of and actions toward nurse-patient relationship transgressions. The first research question asked if there were any significant relationships between ethical decision-making and the characteristics of the participants surveyed. To answer this question, 48 bivariate Pearson product-moment correlation coefficients (r) were calculated to determine if there were any significant relationships between the 12-item ethical decision-making survey instrument and the four continuous variables—participant's age, years of work experience as a registered nurse, years of work experience as a mid-level nurse manager, and years worked in a military treatment facility. The results showed there were three correlations found at significant levels, all three with positive direction and moderate strength, and all three from vignette two, items Vig 2.3 and Vig 2.5. Item Vig 2.3 resulted in two significant relationships: the greater the number of years of work experience as an RN and the greater the number of years of work experience as a nurse manager, the more comfortable a nurse manager felt speaking with a nurse about his/her behavior regarding nurse-patient professional boundary transgressions. Additionally, Vig 2.5 resulted in one significant relationship; the greater the number of years of work experience as a nurse manager, the more knowledge she/he believed she/he had to appropriately manage nurse-patient professional boundary transgressions.

The second research question asked if there was a significant change in participant's ethical decision-making between vignette one and vignette two of the Ethical Decision-Making Survey Instrument. Six paired-samples t-tests were calculated to determine whether there were

significant differences among the mid-level nurse manager's ethical decision-making in terms of his/her responses between vignette one and vignette two. Results showed that there were two statistically significant differences in scores for Pair 1 and Pair 2 of vignettes one and two; each pair with a statistically significant increase from vignette one to vignette two. Based on the results, the mean scores calculated for Pairs 1 and 2 were significantly greater for vignette two than for vignette one, indicating there was a significant difference in the mid-level nurse managers' decisions about nurse-patient boundary violations and unethical behavior described in vignettes one and two.

The third research question asked if there were significant changes in the participants' ethical decision-making between vignette one and vignette two based on characteristics of the participants. Forty-eight mixed between-within subjects ANOVAs were conducted to evaluate whether there were changes in ethical decision-making among the mid-level nurse managers' scores between vignette one and vignette two's different gradations of nurse-patient boundary breach scenarios; as well as any changes due to gender, past observed boundary breaches, education level, and/or career status.

Analysis revealed that there were no significant interactions between the grouping variables gender, past observed boundary breaches, education level, and/or career status and ethical decision-making for vignettes one and two, items one and two. However, the analyses showed substantial main effects for nurse manager's ethical decision-making in determining violations of nurse-patient professional boundary breaches and the unethicality of the behavior for vignettes one and two, items one and two; with higher scores on vignette two, items one and two than for vignette one. Additionally, the main effects comparing ethical decision-making and the grouping variables were not significant for vignettes one and two, items one and two,

suggesting no difference in the ethical decision-making scores based on the grouping variables. The ANOVAs calculated for vignettes one and two, items three though six, showed no significant findings, and their results are found in Appendix G.

Based on the results of the descriptive statistics and inferential test analyses, focused interview questions were developed to guide the qualitative phase of this study.

Chapter Five – Qualitative Results

The purpose of this mixed methods sequential explanatory study was to ascertain nursing leaders' knowledge and skill in ethical decision-making when evaluating and managing professional nurse-patient relationship boundaries. It was also the purpose of this study to better understand nursing leaders' perceptions of moral, cognitive, and organizational factors influencing their ethical decision-making in evaluating and managing professional nurse-patient relationships, with the intent of generating a theory modeled in the views of the participants as a final outcome of the study.

As this was a mixed methods sequential explanatory design, this chapter addresses the qualitative phase, in which the data analysis and interpretation are presented using thematic analysis. The process of thematic analysis was used to uncover factors perceived by each nurse leader as having influenced his/her ethical decision-making about professional nurse-patient relationship boundaries by staff nurses.

This chapter includes a description of the participants' demographic characteristics, a depiction of the interview process, and a delineation of common themes, sub-themes, and outliers. Categories reported by over half the participants warranted the development of both themes and sub-themes. An outlier is reported as a theme reflective of one or two participants and indicative of a significant finding. The sequence of data analysis was as follows: demographic information of the participants, thematic analysis categorized by overall themes, sub-themes, outliers, and a chapter summary.

Demographics

Demographic information was obtained from each interviewee per a participant-completed demographic questionnaire. The demographic questionnaire consisted of eight

questions, including each interviewee's age, gender, years worked as a RN, years worked as a mid-level nurse manager, years worked in a military treatment facility, highest education level, work status, and whether or not the interviewee witnessed a perceived nurse-patient professional boundary breach. As illustrated in Table 23, the demographic information for each interviewee was analyzed and reported as descriptive, narrative and numerical data.

The participants who were interviewed for the study ranged in age from 39 to 58 years with an average age of 48.4 years and a mode of 53 years. All participants were female and their years as an RN ranged from 16 to 31 years with an average of 23 years as an RN. The participants' experience working as a mid-level nurse manager ranged from 3 to 20 years; however, one participant did not provide an answer, but stated she/he did meet the one year screening criteria for participating in an interview. The participants' experience working in a military treatment facility ranged in years from 8 to 25; but, the same participant who did not answer the number of years working as a mid-level nurse manager also did not answer this question; however, the participant does have more than 1 year experience in the current military treatment facility. The group's current work status was representative of GS civilians with past military experience, GS civilians with no past military experience, and active duty military. The group consisted of two RNs with a Bachelor of Science degree in Nursing, five RNs with a Master of Science degree in Nursing, and one of the RNs with a Master of Science degree in Nursing is currently pursuing a Doctor of Philosophy degree in Nursing. Of the group, five mid-level nurse managers stated they had observed nurse-patient professional boundary breaches; two mid-level nurse managers stated they had not observed nurse-patient professional boundary breaches.

Table 23

Participant Demographics

Nurse Leader	Age	Gender	Years RN	Years Manager	Years MTF	Highest Level Education	Current Work Status	Observed Boundaries Crossed
NL 1 Jade	50	Female	27	20	25	BSN	GS CIV w/ Mil	Yes
NL 2 Kali	45	Female	23	15	22	MSN	GS CIV w/ Mil	Yes
NL 3 Allie	53	Female	16	3	8	BSN	GS CIV w/ No Mil	Yes
NL 4 Josie	41	Female	19	10	14	MSN	GS CIV w/ Mil	No
NL 5 Cora	58	Female	30	20	9	MSN	GS CIV w/ No Mil	Yes
NL 6 Mia	39	Female	16	No Ans	No Ans	MSN	Active Duty Military	No
NL 7 Sarah	53	Female	31	12-15	13	MSN PhD Prog	GS CIV w/ No Mil	Yes

Note. *n* = 7. RN = Registered Nurse; MTF = Military Treatment Facility; BSN = Bachelor of Science Degree in Nursing, MSN = Master of Science Degree in Nursing, PhD = Doctorate of Philosophy Degree; Prog = Program; GS = General Schedule; CIV = Civilian, Mil = Military; No Ans = No Answer.

Once demographic data was collected, a series of twelve open-ended questions was presented to each participant. The series of twelve questions and answers was digitally recorded during each participant interview. Throughout the recorded interviews, clarification was requested of the participant's responses as needed, as well as their concurrence with or corrections of interpretations of their responses to the questions. In addition to the audio recordings, field notes summarizing key points of their statements were annotated. Thus, the

interviewees were provided the opportunity to respond verbally and confirm or offer corrections to their statements throughout the interview. As illustrated in Table 24, the interview period for each participant ranged in time from 53 minutes to 60 minutes, with a total interview time equal to six hours and 48 minutes.

Table 24

Interview Time

Total Hours Spent in Interviews	Length of Time for Each Interview
6:48	53” – 60”

Each individual digitally recorded interview was transcribed verbatim into a Word document format by the PI. A total of 119 pages was transcribed with the individualized participant manuscripts ranging from 10 to 23 pages, as shown in Table 25.

Table 25

Transcript Chart

Total Pages	Transcript Page Range
119	10 – 23

Thematic Analysis

The essential themes discovered in this study emerged from an analysis of the data gathered from the participants’ responses to each of twelve interview questions. Reflection on essential themes was the central approach aimed at grasping the true essence of the participants’ experiences with evaluating and managing nurse-patient professional relationships.

Each interview was audio taped and transcribed verbatim into Word documents in order to facilitate the analysis process through a systematic methodology of organizing, analyzing, and interpreting the data. Upon completing each transcription, the transcript was read in conjunction

with listening to the audio recording to ensure accuracy. A typed copy of the transcript was sent to each interviewee for their review and feedback. In this manner, each interviewee was afforded an opportunity to read his/her transcript and review for accuracy, offer corrections, and/or revise any statements, to include additions, deletions, or any other changes they felt fully represented what they wanted to convey. Transcripts were edited in accordance with their feedback, and in turn updated transcripts were resent to the interviewees. Finalized transcripts were again reread for familiarization and preliminary exploration of the data.

Marshall and Rossman's (2011) seven-phased analytic procedure in parallel with Yin's (2011) five-phased cycle provided a framework for systematically working through the analytical processes of maintaining data organization, conducting data mining, data sorting, data interpretation and memo/report writing. Data analysis performed concurrently with data collection enabled initial searches for general underlying themes and the opportunity to reframe the interview questions, eliciting deeper discussions in relation to the experiences and perceptions being shared. Inciting deeper discussions led to the nursing leaders' conveying detailed descriptions of their experiences, thus the "results become more realistic and richer" (Creswell, 2014, p. 202).

As interviews continued, transcripts were read and reread, at which time patterns began to unfold. As patterns unfolded, each pattern was color coded within each transcript for the purpose of organizing conceptual and contextual patterns. As patterns unfolded, Yin's (2011) steps of "disassembling and reassembling data" created the need to assign labels, or "codes," to the patterned fragments (pp. 190-191).

Hahn's (2008) Level 1 through Level 4 coding scheme was the formal coding process utilized in sorting patterns. A five-column matrix was developed, taking segments of

participants' statements from their finalized transcripts and moving methodically from lowest to highest conceptual levels; that is, Level 1 through Level 4 respectively, enabling color coded items from each transcript to be sorted into similar and dissimilar groups. The Level 1 codes identified data that related to each other and the Level 2 codes categorized Level 1 coded data. Level 3 of the five-column coding matrix consisted of identified emerging themes; as well, notes were typed in the column if the emerging themes fit or did not fit with the literature. Level 4 consisted of emerging theoretical concepts, with notes typed in the column about new ideas, insights, and thoughts. According to Charmaz (2014) "coding is the pivotal link between collecting data and developing an emergent theory to explain these data" (p. 113). The organization of data within the five-column matrix was instrumental to using "constant comparative methods (Glaser & Strauss, 1967) to establish analytic distinctions – and thus make comparisons at each level of analytic work" (Charmaz, 2014, p. 132). The process of coding and the ongoing data comparison was beneficial in the process of constructing a grounded theory.

Throughout the Level 1 through Level 4 coding process, as new ideas, insights, and thoughts emerged from the data, "memo-writing" became a "pivotal intermediate 'step' allowing for the capture of 'comparisons and connections' giving rise to emerging themes and theoretical concepts" (Charmaz, 2014, pp. 162-164). The memos aided in revising and refining codes, categories, emerging themes and emerging theoretical concepts. Memo writing was instrumental in organizing thoughts and ideas related to the emerging themes.

In addition to coding and memo-writing, utilizing theoretical sampling by following a "strategic, specific, and systematic" (Charmaz, 2014, p. 199) strategy in "collecting pertinent data to elaborate and refine categories" (Charmaz, 2014, p. 192) was employed in developing the emerging theory. As categories were developing, theoretical sampling assisted in demonstrating

relationships and linkages among the categories, thus advancing the analysis. In order to determine associations among the developing categories, a diagram providing a visual representation of the categories and their relationships assisted with the analysis of the data. At this stage of the analysis, three main themes and nine sub-themes emerged; however, variation and overlap of data among the categories was evident; as well, the emerging themes and sub-themes remained immature.

In contemplating the coding, memo-writing, theoretical sampling, and initial themes and sub-themes, new questions emerged relevant to the initial coding, themes, sub-themes and developing theory. Up to this point in the process, coding did not focus on analyzing actions. According to Charmaz (2014), "adopting gerunds in coding and memo-writing…fosters theoretical sensitivity because these words nudge us out of static topics and into enacted processes" (p. 245). Changing the original focus from analyzing individual statements to emphasis on actions and processes of individual statements was a turning point in the analysis of the data and emerging themes, sub-themes and theory construction. Level 1 through Level 4 coding was revised in its entirety to utilize gerunds to delineate actions as relevant to the data. After employing gerunds, newly emerged themes and sub-themes developed, with clearly defined delineations.

Moving through the analysis process, Hahn's (2008) Level 1 through Level 4 coding scheme enabled coded items from segments of participants' statements to be sorted into similar and dissimilar groups, whereby four essential themes and ten sub-themes were identified as shown in Figure 5. These themes followed the research question, and are based on the participants' descriptions of their beliefs and experiences as related to their ethical decision-making about nurse-patient relationship boundary breaches. This study developed meaningful

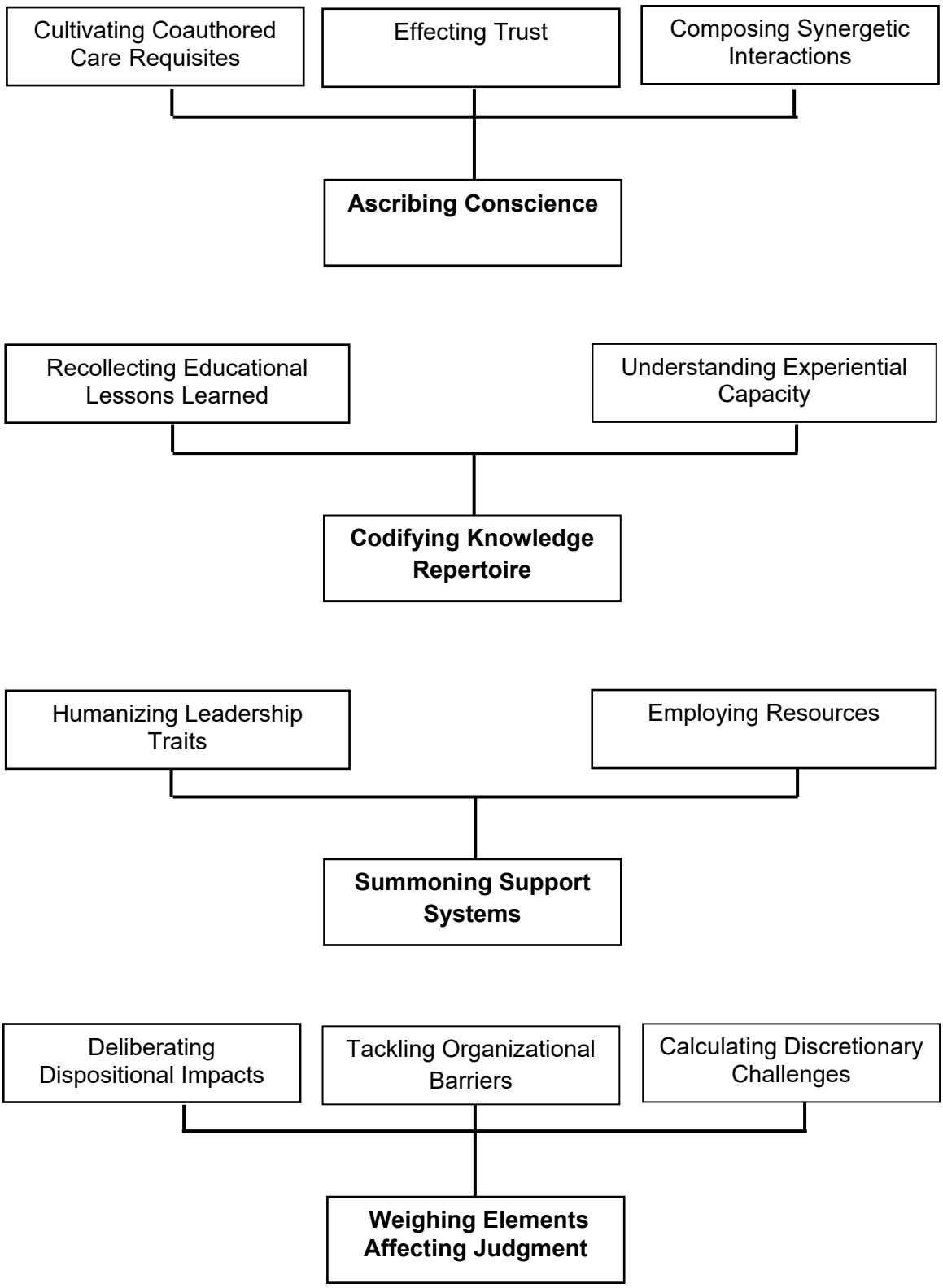

Figure 5. Thematic diagram.

themes based on the participant's moral, cognitive, and organizational factors predisposing their perceptions of and actions toward their evaluation and management of professional nurse-patient relationship boundaries.

This study revealed the following four essential thematic interpretations: Ascribing Conscience, Codifying Knowledge Repertoire, Summoning Support Systems and Weighing Elements Affecting Judgment. Each essential thematic interpretation was influenced through the discovery of sub-themes found through coding and categorizing data obtained from the participant's interviews. The three sub-themes listed as Cultivating Coauthored Care Requisites, Effecting Trust, and Composing Synergetic Interactions influenced the essential theme of Ascribing Conscience. The two sub-themes listed as Understanding Experiential Capacity and Recollecting Educational Lessons Learned influenced the essential theme of Codifying Knowledge Repertoire. The two sub-themes identified as Humanizing Leadership Traits and Employing Resources influenced the essential theme of Summoning Support Systems. The three sub-themes listed as Deliberating Dispositional Impacts, Tackling Organizational Barriers and Calculating Discretionary Challenges influenced the essential theme of Weighing Elements Affecting Judgment.

The researcher supported the thematic statements through narrative interpretation and direct participant quotes. Any quotation that appears in this study is derived from participants' interviews and is transcribed exactly as it appears in the transcript. There has been no attempt to correct grammar or alter syntax. This researcher determined that altering the sentence structure of participant quotations would alter the essence of true meaning.

Findings

This study discovered an abundance of data based on interviews, recordings, field notes, and observations. The qualitative data was analyzed by the researcher and four essential themes and ten sub-themes emerged. The following section is the researcher's interpretation of those findings. Each segment offers a description of the essential theme and sub-themes based on the participant's views, participant excerpts with researcher interpretations and exact quotations.

Essential theme: Ascribing conscience. The nursing leaders described the role that they perceive moral, cognitive, and organizational factors play in influencing their ethical decision-making about professional nurse-patient relationships. As open-ended questions were posed throughout the interviews, the leaders shared feelings, beliefs, and opinions personifying factors influencing ethical decision-making in evaluating and managing professional nurse-patient relationships. As a professional nurse, accepting the role of a nursing leader carries positional obligations that one would not normally have if not in the leadership role, such as ensuring professional boundaries are heeded between nurses and patients for which the leader has oversight. Within the context of morality, cultivating coauthored care requisites, effecting trust and composing synergetic interactions are the crux to bonding with patients and families. The element of bonding allows a rapport that encourages patients and families to share needed health information with the nurse so ongoing care needs can be met. As nursing is a relationship-based profession, the way in which nursing leaders forge relational bonds with patients and families gave measure to the way in which nursing leaders judged their staff's therapeutic versus non-therapeutic relationships forged between patients and families. The nursing leaders described relying on their own conscience as the yardstick by which they measure staff nurses' approach to advocating, building trust, and forming relationships with patients and families. In this realm, the

nurse leaders ascribed conscience as influencing perceptions of and actions toward determining nurse-patient therapeutic relationships versus nurse-patient relationship transgressions. Nursing leaders making ethical decisions involving moral dilemmas such as determining nurse-patient therapeutic versus non-therapeutic relationships was found to be a gap in research. Grasping the manner by which staff nurses incur relational activities with patients, as seen through the lens of nursing leaders, proved beneficial to understanding factors influencing decision-making about professional boundary breaches. The nurse leaders did not offer any particular sources or references for their perceptions; instead, their personal feelings, beliefs and opinions were the basis for their responses. The three sub-themes, cultivating coauthored care requisites, effecting trust, and composing synergetic interactions shaped the essential theme ascribing conscience when assessing behaviors constituting nurse-patient therapeutic relationships versus nurse-patient relationship transgressions.

Sub-theme: Cultivating coauthored care requisites. The nursing leaders consistently described patient advocacy as seeking to provide patients with what they want and/or need in relation to their perceived health care needs. Advocacy is looking out for the patient and assisting the patient with making the best possible health care decisions based on their situation. Cora, one of the nurses interviewed, conjectured that "you need that nurse to advocate for you [patient] and to explain to you and listen to you," such that advocacy is a mainstay of a nurse's role. Placing the patient at the center of care, partaking in a dialogue with the patient to ascertain their needs, and bolstering support for the plan of care mutually set between the patient and health care personnel is nursing advocacy. Assisting the patient through the health care system, within the zone of helpfulness, mitigates over-involvement. Kali saw patient advocacy as steering the patient through a complicated course within an area constrained between invisible lines

separating under or over involvement and a zone of helpfulness; "…we help the patient navigate the complexity and without building too intimate of a relationship."

Guiding the patient through their health care plan strengthens the bond formed between the nurse and patient. Josie believed that advocacy is when "the nurse uses everything they have to be able to make them comfortable. It's really going a step further in order to make sure the patients are safe in everything they do." Allie expressed similar thoughts, with the addition of describing advocacy as a process: "if the patient needed something or anything where the patient needed advocacy, you would go up the chain and explain the reason for the need until you felt you got what you needed for the patient."

As advocating takes an assertive stance by nurses in meeting the patient's needs, care must be taken in not over-stepping boundaries. Ensuring the patient is actively involved in their plan of care is essential to the patient taking ownership of their health care journey. Balancing advocacy, while at the same time encouraging the patient's active participation in their care, was, as Jade stated, by accepting the patient's stated needs and assisting them to meet those needs. "You have to figure out how you can advocate for the patient, without over-stepping the boundary taking over…the way you advocate is by helping them through that process."

What may initially be considered over- or under advocating may in fact be reflective of the patient's situation and/or need and may not be outside the range of a therapeutic relationship. Josie perceived more often than not that staff nurses over-advocate for patients in an attempt to ensure patient satisfaction. She did not see over-advocating in terms of overstepping nurse-patient professional boundaries. "I think in my experience, I've seen nurses kind of over-advocate for patients. You know, I've always thought that it came from a good place." A similar perception is shared by Mia, although, she believed one's "value system" plays into whether

advocacy is within the boundaries of a therapeutic relationship or considered outside the therapeutic boundary. Mia believed care in judging a nurse's role as over-advocating for a patient may be "a little bit opinionated" and that "it's a fine rope when you over-advocate because sometimes you give the appearance" of over-advocating, but in fact, "doing the right thing by your patient."

The process of advocating has various dimensions, depending upon the health care setting and patient condition. For instance, advocating for a patient in the OR requires a nurse to assume the role of speaking for the patient since the patient cannot participate in their care. Jade perceived this as "being a passive advocate," as the nurse becomes the patient's spokesperson; "you're the patient advocate, so there again, professional boundaries."

In the intensive care setting, Cora perceived nurses as strong advocates, and again, at times, as the spokesperson for the patient due to their incapacity. "They're pretty good at standing up for what the patient has told them that they want to happen. They're pretty good at elevating that stated wish to the family and to the physician." Whether being a strong patient advocate is perceived as over-advocating, is dependent on staying within the therapeutic nurse-patient relationship. Cora perceived therapeutic advocacy was based on the nurse knowing and understanding the patient's wishes, and standing up for the patient even when the patient's desires counter other health care providers or the patient's family and/or guardian. Per Cora's perspective, "You're the therapeutic person in this relationship and your responsibility is to advocate for the patient… and sometimes you have to align yourself that this is what the patient is saying and respect that."

Patient advocating is seen as a crucial nursing role in meeting the needs of a patient; but when the patient is unable to speak for him- or herself, family and/or guardians become the

spokespersons for the patient. The nurse leaders consistently described the importance of the nurse gaining the trust of the family, developing a healthy bond with the family, and the need to include family when advocating for a patient who is not able to assist with planning their own care. In so doing, the potential for a nurse to over-advocate for a patient through a family member may incur blurring of boundary lines. This, in turn, has the potential to destabilize a therapeutic nurse-patient relationship.

Sarah, a nurse leader overseeing staff nurses, experienced a situation in a critical care unit where overstepping therapeutic boundaries occurred with a patient's family member. "I have seen it where maybe they breached it with the family. Way too close. I was manager then, and I took the nurse off from caring for the patient." This situation ended well; however, many times nurses find themselves at extreme opposite ends of the patient and family/guardian's wishes. This in itself creates ambivalence, and sets up the nurse for under- and over-advocating throughout the course of the patient's health care needs:

> Sometimes, on the same day on the same patient. They just want their wishes honored. And so then you maybe have a nurse who is on the extreme one end or the other. And so the patient's in the middle.

Maintaining a balance when advocating for a patient is walking a fine line where nurses' personal values are foundational in determining what is and is not within the bounds of a therapeutic nurse-patient relationship. Staying within the nurse-patient therapeutic relationship and not blurring boundary lines is incumbent upon the nurse. Therefore, Kali believed nurse leaders have a duty to educate nurses on the process of providing therapeutic patient advocacy. "You want to teach nurses how to help their patients through difficult health care decisions and kind of advocate for them; vote for the underdog, but without crossing the boundaries of becoming too familiar."

Sub-theme: Effecting trust. The nurse leaders consistently described trust as a derivative of values essential to a nurse establishing a rapport with a patient. The value in establishing an open and safe line of nurse-patient communication was considered the crux of forming a bond essential to developing and maintaining a professional nurse-patient therapeutic relationship. In turn, a professional nurse-patient therapeutic relationship is embedded within a framework that allows for a nurse to advocate for a patient without over- and under-involvement by the nurse.

Earning "trust," perceived as a predisposing factor to establishing a therapeutic nurse-patient relationship, was best framed by Josie as, "You want them to trust you, you want them to open up, but at the same time you want them to respect that boundary. And so it's delicate." It's delicate from the sense that nursing, a relationship-based profession in which trust fosters open dialogue, requires boundary setting due to the familiarity of the relationship. Diverse nursing roles present differing levels of intimacy, calling for a trusting relationship developed and maintained through "delicate" communication in which boundary setting is established. Kali presented an insight into the varying levels of familiarity of nurse-patient relationships, such that "Depending on the role, when you're at the bedside, obviously a pretty intimate relationship with patients; whereby, if you are a nurse case manager, a little bit less intimate, you don't have that physical contact." No matter what the role, Kali spoke to the fact that nurses "still have [to] develop a level of trust, a level of … how to communicate with your patient."

Through trust, open dialogue ensues from communication, forming relationships between nurses and patients. Trust was consistently touted as a critical element in building nurse-patient relationships. The predominate method of achieving a trusting nurse-patient relationship was described by the nurse leaders as occurring through open dialogue with patients. Allie believed that the first step in garnering patient trust, "starts with getting [a patient] report, and people start

forming their impressions of the patient at that point. And then, they will introduce themselves and meet the patient and you know, just chatting back and forth with the patient." Jade's description mirrored Allie's process of garnering trust through communication, but she emphasized putting the patient first as essential in establishing a trusting relationship. A nurse will "build the relationship and that trust by either just talking to them and making them the center, the focus of it," which then strengthens trust, allowing the patient to share their values, fears, and desires, enabling the nurse to better understand the patient's needs. Cora described the value of earning a patient's trust, whereby the patient feels safe in sharing personal information so the nurse knows how to meet the patient's needs. "I expect to ... answer your questions, provide information for you, to help you get to feeling better, moving better, talking better, whatever your problem is. And your job is to tell me whatever you need to do that." This, in turn, allows the nurse to support the patient throughout their continuum of care, enhancing the delivery of care.

At times, the patient's family or guardian is the initial point of contact and earning trust begins with them. In many cases, the patient's family or guardian is the advocate for the patient and getting to know the patient is developed through the patient's family or guardian. For instance, Mia's experience in working with nurses in trauma settings observed the dynamics of nurses earning trust through families and/or guardians due to the patient's inability to advocate for themselves, such that "the first step is just building the trust and rapport with the patient and the family." Working in critical care is similar to working in trauma settings, where the patient may initially be unconscious and again the family and/or guardian is the spokesperson for the patient. Sarah similarly perceived trust began with the family/guardian. "I think a lot of the staff

nurses, because working in the critical care most of our patients are unconscious, that the relationship starts with the family."

Just as trust is an essential quality in developing relationships with patients, trust is essential in setting boundary limits that are foundational to establishing therapeutic relationships with patients. Allie equated trust to boundary setting in therapeutic relationships, such that "you're supposed to have the trusting relationship which implies ethical boundaries." Even though it is perceived that trusting relationships infer ethical boundaries, it is still incumbent upon nurses to ensure boundary limits are set and maintained in nurse-patient relationships.

All interviewed nurse leaders subscribed to the importance of trust initially established through clear communications allowing for open dialogue with patients. Effective communication, whereby nurses provide clear explanations pre-procedures, were perceived as not only establishing trusting relationships but sustaining trust with patients. Based on Josie's experience as both a staff nurse providing direct patient care and from a supervisory role with oversight of staff nurses, "the top thing would just be making sure that you communicate effectively, the things that you're going to do before you do it, so that you can establish a sense of trust between the nurse and the patient."

Where developing trust is the crux in forming healthy therapeutic nurse-patient relationships, breaking a patient's trust presents daunting challenges to nurses. Kali described two experiences where re-building trust necessitated an active process of reinstating confidence with the patient that their care would be provided in a manner that was in their best interest. The perception of this type of situation was described as difficult. "The challenge is that when you violate patient's privacy or maybe their trust, you end up having to rebuild a relationship where patients can then again trust you to care, trust you to provide a service." Additionally, putting

self needs ahead of patient needs defeats the cultivation of trust in a nurse-patient relationship and is difficult to regenerate once it has been broken. Kali described a situation whereby trust was broken by a nurse who over-stepped nurse-patient professional boundaries:

> On a very personal level, because I felt like she could of trusted me with that information, we could have helped her. But then on a peer level, I was angry that she jeopardized our patient care and our trust with such an unethical, unethical action. But either way, both equally unethical behaviors, both obviously breaking the law and also breaking trust of patients.

In a separate situation, where staff's under-involvement in the delivery of patient/family care occurred, "I went home having the families feel like they didn't trust us." In order to rebuild trust with the patient and family, "I developed a focus group … we ended up having a tremendous amount of coaching and training on how to build trust." It was a lengthy and complicated process, expending considerable time and effort on the part of Kali and her staff. "So, although it wasn't unethical, it became related to ethics because they didn't trust us."

Both over- and under-involvement by staff nurses present opportunities for breaking a patient's, a family's, and/or a guardian's trust. Compromising trust creates a domino effect whereby therapeutic nurse-patient relationships are endangered. In turn, the ability to forge bonds is hindered, and is a potential precursor to nurse-patient relationship boundary breaches. Therefore, guarding earned trust is critical to developing and sustaining therapeutic nurse-patient relationships.

The value of trust was consistently perceived by the nurse leaders as antecedent to building therapeutic nurse-patient relationships, as well as subsequent to sustaining trustworthiness thorough effective communication, open discourse, and ongoing pre-procedure explanations with patients, their families and guardians. Maintaining therapeutic nurse-patient

relationships within a framework of boundary limits was consistently perceived as balancing between over- and under-involvement with the patient, family, and/or guardian.

Sub-theme: Composing synergetic interactions. Repeatedly, the nurse leaders described trust established through open dialogue as the fundamental building block for developing therapeutic nurse-patient relationships. Relationship building, developed through mutual trust and effective communication, is a critical step in building therapeutic nurse-patient relationships. Therapeutic relationships put the patient at the center of care with the nurse's focus on meeting the clinical needs of the patient.

Understanding the process nursing leaders follow in building therapeutic nurse-patient relationships is beneficial in gaining insight into their predisposed views of how nurse-patient relationships are built. In building nurse-patient relationships, Jade strived to get to know the person and discover how they felt about "their care, their disease process…how they deal with it, how it interferes with their normal day-to-day… I build the relationship and that trust by talking to them, making them the center, the focus of it." Jade's perception of the process staff nurses use in building relationships with patients is similar to the method in which they develop personal relationships, such that a nurse's personality drives the manner in which nurse-patient relationships are formed. "I would think that they're pulling off their personal relationships, how they interact with people that are close to them that they aren't caring for; and, that's how they build their relationship with their patients." This perception of how a nurse builds a relationship with a patient is of importance as it is believed to be shaped through a personal construct rather than through a therapeutic construct.

As the goal in building professional nurse-patient relationships is to place the patient at the center of care, establishing and maintaining therapeutic relationships are intricate balancing

acts. This was well articulated by Kali who stated, “Oftentimes we may have to, we kind of help the person, help the patient navigate the complexity and without building too intimate of a relationship.” Framing the relationship within a zone of helpfulness centers the relationship around the patient’s needs and mitigates under- and over-involvement by the nurse in caring for the patient.

Building a trusting nurse-patient relationship has been touted to occur through open dialogue. Josie believed the key to therapeutic relationships through open dialogue was based on dutiful, patient-focused communication, “just make sure that whatever things are communicated are kind of in a respectful manner.” Communicating and delivering care-based interventions foster “trust” and sustain therapeutic relationships; in how nurses “say what they’re doing and do it, and if the patient needs anything … intervene and get them the things that they need so that they can continue to foster that trusting relationship between the nurse and the patient.”

In addition to trust, respectful communication, and open dialogue, Josie addressed “appropriate attire” as an approach to impart professionalism when building nurse-patient relationships. “I think a huge part of this probably has to do with their attire. Just making sure they are dressed appropriately, to kind of start things off on more of a professional manner.” Josie perceived setting a professional tone from first introductions with appropriate attire expresses patient-centric therapeutic relationships rather than personal relationships. Appropriate attire is perceived as an additional method of developing and maintaining professional nurse-patient relationships and maintaining the lines that separate personal relationships and professional relationships.

In establishing trust with the patient in building therapeutic relationships, the nurse leaders also identified the patient’s family as a primary contact in the development of therapeutic

nurse-patient relationships; specifically, in situations in which the patient is temporarily or permanently unable to participate in their own care. In situations in which the nurse is unable to communicate with the patient directly, the dialogue begins with the patient's family and the process of establishing 'trust' with the family in order to build a nurse-patient relationship is the same. Mia, whose leadership is in a trauma setting, believed relationship building was collaboratively forged between the nurse and the patient and their family. "Building that trusting relationship, meaning they're doing everything they can to help the patient. And the patient feels comfortable telling the nurse whatever is going on with them at that point in time and the family feels comfortable." Further developing a trusting relationship by being "able to articulate you know the needs of the patient and what they are there for" supported an environment whereby "they can disclose everything we need to know so we can effectively treat the patient."

Depending on the patient's condition, family may hold a greater or same weight as the patient in building therapeutic nurse-patient relationships. Allie believed building a therapeutic nurse-patient relationship began prior to meeting the patient: "I think it actually starts with getting [a patient] report and people start forming their impressions of the patient at that point." In consensus with the preceding nurse leaders, initial introductions, "chatting back and forth with the patient…then interacting with the family, I think that's mostly how they build the relationship." Allie also addressed the topic of time, such that nurse-patient relationships vary in developmental stages from the amount of time spent with a patient, such that, "the longer amount of time they spend with the patient, meaning if it's on the floor and they have the patient several days in a row, or if you're in an ER situation, where it's a couple of hours."

Sarah, a nurse leader in a critical care setting, perceives families may be the primary source of relationship building since "most of our patients are unconscious." In many instances,

the nurse bonds with the family prior to the patient and "they find some kind of common bond … so when the patient's no longer unconscious, they can say, you know this is nurse Susie, she's been taking care of you." Situationally, a nurse-family relationship is developed prior to a nurse-patient relationship. "So it's kind of like you're the cheerleader for the family and the cheerleader for the patient and that's kind of how I see those relationships started."

The process of forming a "verbal contract with the patient the minute you walk into the room" was described as a method Cora was taught in her basic nursing education program for establishing nurse-patient relationships. Forming a verbal contract with a patient was described as a process geared toward developing and sustaining nurse-patient relationships within a therapeutic zone of helpfulness. "You form a verbal contract and you establish a relationship that I'm here to be in charge of your care for the shift, maybe for your stay." The relationship is forged through a nurse-patient mutually agreed upon plan of care. Cora's expectations of the manner in which nurses should build nurse-patient relationships was forged from her basic nursing education program. "I expect the nurse to introduce herself… set the goals for the day; here's what we need to accomplish today, how do you want to do it? We need to get out of bed…get in the shower … whatever it is."

However, from Cora's perspective, she did not observe staff nurses building therapeutic relationships with patients through verbal contracts. In fact, in the trauma setting, "it's not that organized, it's very fractionated, and I don't see that happening as much." Relationship building in the trauma setting was deemed as fractionated "mostly because these people have absolutely no relationship socioeconomically or structurally or culturally with the patients they take care of." As it was perceived that the nurse's relationships with the trauma patients are fragmented and that there was no identification with the patients, potential nurse-patient boundary breaches

were perceived as less likely to occur. “I don’t think on a day-to-day basis there’s any discussion about boundaries where I work currently. So, there’s no way they’re going to see these people again. The trauma population and the military population, they just aren’t crossing paths.”

A therapeutic relationship incurred between a nurse and a patient exists within a zone of helpfulness on a continuum of care, and is generally a safe and moral space which minimizes over- or under-involvement with the patient. This, is turn, limits interactions with the patient to those specific to meeting the patient’s health needs. Based on the nurse leader’s statements, their individualized approach to building nurse-patient relationships pre-disposes their perceptions of the manner whereby staff nurses build and maintain nurse-patient relationships. The nurse leader’s predisposed views determine what is perceived as under- or over-involvement with patients and/or families/guardians; which, in turn, determines action or inaction in boundary breach occurrences. This suggests that a personal value system is a predisposing factor in their ethical decision-making when evaluating and managing nurse-patient relationship boundary breaches. Expectations of a nurse leader’s ethical decision-making stems from a moral obligation to ensure nurse-patient relationships are based on therapeutic relationships; however, personal values predispose the determination of whether the staff nurse’s relationship with a patient is viewed as a personal relationship versus a therapeutic relationship.

Essential theme: Codifying knowledge repertoire. The nursing leaders clearly articulated the bearing education and experience play in their perceptions of and actions toward ethical decision-making when evaluating and managing professional nurse-patient relationships. The nursing leaders were forthcoming in the amount and type of education they remembered receiving in their nursing school programs and work settings related to the Nurse Practice Act and the Nursing Code of Ethics, specifically pertaining to behavioral standards. Education geared

toward behavioral rules, regulations, and standards as written in the Nurse Practice Act and the Nursing Code of Ethics was remembered as none-to-scant instruction received in undergraduate nursing school programs. Use of the term “boundaries” in respect to maintaining professional nurse-patient therapeutic relationships was limited. However, the nurse leaders did speak to receiving instructions on treating patients “respectfully,” which was interpreted as treating patients professionally, therapeutically, and maintaining a “distance” in the nurse-patient relationship. When caught in the throes of confronting professional nurse-patient relationship boundary breaches, the nursing leaders openly shared their thoughts about the lack of functionality of the Nurse Practice Act and the Nursing Code of Ethics in providing guidance for addressing inappropriate boundary behaviors. Discussion ensued that the Nurse Practice Act and the Nursing Code of Ethics are rarely referenced due to a lack of knowing the rules, regulations, and standards content. Predominately, the nursing leaders spoke to not availing themselves of reviewing the standards, difficulty with reading and interpreting the standards, vagueness and difficulty with navigating the references’ websites. Work setting regulations, policies, and training encroach and take precedence as the references routinely sought and utilized for initially addressing any type of behavioral boundary improprieties. Overwhelmingly, the nurse leaders spoke to employing personal ethics codes and values to make up for the lack of “knowing” and “using” the Nurse Practice Act and the Nursing Code of Ethics when evaluating and managing nurse-patient relationships. From an experiential capacity, the nursing leaders candidly discussed the role experience contributed to their decision-making about nurse-patient relationships. Overwhelmingly, the nurse leaders reflected on the impact their levels of experience, in terms of years and positional obligations, have had in influencing their perceptions of boundary breaches. The nursing leaders describing lessons learned through experiences acquired in both civilian and

military health care settings strengthened their ethical decision-making about nurse-patient relationships. With experience, the nursing leaders expanded their views of what constitutes nurse-patient relationship boundary breaches to extend outside the scope of an over-involved personal relationship between a nurse and patient. The nursing leaders included activities such as violating a patient's privacy by leaving medical records laying open, talking about patients with non-authorized people, talking about patients in non-secured areas, sharing patients' information on social media, siphoning patients' pain medications; as well as activities of under-involvement such as neglecting patients' care needs. The two sub-themes, recollecting educational lessons learned and understanding experiential capacity shaped the essential theme codifying knowledge repertoire when assessing behaviors constituting nurse-patient therapeutic relationships versus nurse-patient relationship transgressions.

Sub-theme: Recollecting educational lessons learned. The nursing leaders offered reflections on training they received within their nursing school programs on the Nurse Practice Act and the Nursing Code of Ethics as related to nurse-patient relationship boundaries. The nurse leaders primarily remembered receiving little education on the Nurse Practice Act specifically related to discussions about the standards that address nurse-patient relationship boundaries. The nurse leaders did acknowledge that a greater emphasis was placed on ethics training in their nursing school programs, predominately in their graduate nursing programs, related to nurse-patient relationships. Training was not specifically related to "boundary and boundary limits"; however, the nurse leaders were trained on ethical and appropriate behaviors with patients. Allie specifically discussed receiving limited education in her undergraduate nursing program about professional boundaries. "The only education I remember [was] in my master's, a policy and

ethics class a year ago; which was divided up… probably two-thirds policy and one-third ethics. Even in my BSN, I don't recall anything about any of this."

Mia spoke to limited education received in school on the topic of preventing nurse-patient relationship boundary breaches; however, emphasis about acceptable nurse-patient relationships was taught. "We took an Ethics class…even during my master's, I do not recall that (preventing boundary transgressions) being a topic… definitely not a mandatory class. In nursing school we were taught about nurse-patient relationships and what's acceptable and what's not."

Jade reiterated receiving limited education about the Nurse Practice Act and the Nursing Code of Ethics, but emphasis was placed on treating patients with respect and dignity. "I don't really remember discussing in school the Nursing Code of Ethics and the Nurse Practice Act. The thing I remember the most is that you treat patients with respect and dignity, preserve their dignity and do no harm."

Cora did not address receiving education in her nursing program regarding the standards of the Nurse Practice Act; however, she was taught to treat patients with respect and establish boundaries early, and not to cross those boundaries. Cora spoke to receiving "boundary" education in both undergraduate and graduate nursing school programs. "We had a one-hour course, it was pretty much worked into almost every course about treat your patients with respect, establish boundaries early, do not cross those boundaries." Cora described "boundary" education she received in nursing school as "encoded differently." "There was not a lot of discussion about boundaries"; however, there was education related to professional conduct. Specifically,

> don't date your patients, don't flirt with your patients, don't have a sexual connotation to anything you're saying with your patients. Try to maintain distance…beware that the line shifts with every statement you make, the line shifts a little bit.

As formal education about boundaries was perceived as "encoded differently," maintaining a professional distance with patients was described as based on personal interpretations:

> So boundaries were a much looser term I think. And most of my boundaries are my own interpretation I guess. Most of the things I've had to enforce, I've had to think you know where's the line. What should the prudent nurse do? So no, basically there was not a lot of discussion about boundaries.

Sarah did not receive education on the standards of the Nurse Practice Act related to nurse-patient relationship boundaries; however, she described the ethics class received in her undergraduate nursing school program: "We had like a whole one day on ethics and code of behavior because it was a Catholic school. And so that was actually the only time I ever have had training." Josie's education consisted of "an ethics class for my MSN," in which the focus was on "therapeutic communication between the nurse and patient"; basically, instruction on "where they kind of teach you how to talk with people in a professional way." Similarly, Kali addressed receiving ethics training in school. "We did have code of ethics training in school I recall, in a formal setting. We had to learn how to interact with patients and other staff members."

Training received in various work settings was predominately described by the nurse leaders as general ethics training; though, not necessarily focused on the Nursing Code of Ethics, but largely delivering the same message; that is, how to interact with patients and maintain professionalism. Kali specifically addressed receiving ethics training in the military work setting. "And again, there was formal education [ethics] in my undergrad, orientation within the military, and of course, through nursing leadership courses." Though not specifically related to maintaining professional boundaries with patients, the training did allude to professional interactions with patients, "not violating privacy," and/or "not breaking the law."

Mia's on-the-job "classes have truly pertained to just military ethics or ethics in general, not necessarily the Nursing Code of Ethics or the Nurse Practice Act." As well, she did not recall

any requirement for annual refresher training specific to nurse-patient professional boundaries. Similarly, Sarah's experience with receiving any ethics training in the military setting was limited. Sarah described emphasis placed on ethics training in the military setting only after an ethical event occurs. "Just working with the Department of Defense, some classes that would borderline into the ethics a little bit. It's usually after an event has happened that they start bringing something up. But I don't think it's a good, thorough ethics." Josie recalled, specifically in new employee orientation, ethics training delivered in a general format, but not related to professional relationship boundary compliance. "Typically in your orientation there was always some sort of …talk about ethical issues. Most of the things they focus on were …just trying to be in compliance. I think some of that was glossed over a little bit." From Josie's perspective, ethics was a topic covered in new employee orientation, but with limited focus on professional relationships.

Promoting public protection, each state has developed a BON. This BON has stipulated rules and regulations through their individualized Nurse Practice Acts. The Texas BON NPA delineates rules that speak to standards in guiding professional nurse-patient relationships. It was the perception of most of the nurse leaders that the Nurse Practice Act is difficult to access and navigate. Cora's position was such that she stated, "I find the Texas Nurse Practice Act very difficult to get a good answer from when you're actually reading it yourself."

Navigating the Nurse Practice Act and the Code of Ethics is difficult and vague; however, the Nurse Practice Act and Nursing Code of Ethics do contain rules of conduct for nurse-patient relationships. Jade stated, "But when you're on the website, it's very hard to get to; its set-up very funny. We don't really keep it in front of us. And we don't revert back." Josie recalled studying the Nurse Practice Act in her graduate nursing program and the "wording

seemed very vague" regarding "where the line in the sand would be drawn for crossing the line as far as professional nurse-to-patient boundaries."

Perceiving the Nurse Practice Act supported the nursing profession, Kali believed it "definitely gives us a straw man to be able to say no … it's against the Nurse Practice Act." In describing the function of the Nurse Practice Act in preventing nurse-patient relationship boundary breaches, Josie found that it did contain rules of conduct for nurses' behavior related to maintaining professional nurse-patient relationship boundaries. Josie's impression was that she "felt like it sort of came at it from more of a disciplinary … like what the legal ramifications would be for any major transgressions like sexual assault or contact or negligence or anything like that; or, just inappropriate contact in any way." Josie perceived the standards provided guidance such that, "if you go beyond this boundary then you break the law. You could end up having to face disciplinary action for it."

Mia's stance on the function of the Nurse Practice Act and the Code of Ethics in providing guidance on nurse-patient relationship boundaries was clear. "I think the Practice, the Code of Ethics, I think it's clear what we should and should not do, but I don't think that's something that's reiterated following class or undergraduate studies in Nursing." As a requirement for maintaining nursing licensure, Kali had to complete refresher training on the Nurse Practice Act. Her perception was that refresher training "reminds us of obviously our ethical obligations, to do what's right, to cause no harm with our care, to be compassionate." Similar to Kali, Mia discussed the Texas BON requirement for refresher training on the Nurse Practice Act and the Nursing Code of Ethics for nursing licensure renewal. Mia believed the refresher requirement was necessary because she thought that "a lot of times nurses know but everybody's different, we have different values, we were raised differently." Therefore, the

standards for maintaining professional nurse-patient relationships "have to be put in black and white." Allie perceived the Nurse Practice Act's function of providing guidance for maintaining professional boundaries as "it seems rather vague and it's implied …that's basically what I know." Cora's perception regarding the function of the Nurse Practice Act's guidance about professional boundaries was similar to Allie's; however, she described the Nursing Code of Ethics as having "a little bit more on boundaries. And that you know you can be, I think they say under involved and over involved, and you're supposed to stay in the middle. But, that's still your own barometer." Jade described relying on "my personal strengths…how I was raised" as the measures by which she evaluated professional relationships. In place of not knowing and utilizing the Nursing Code of Ethics or the Nurse Practice Act, Jade applied her personal values of "morally and ethically what was right in treating people" as the standard by which she evaluated and managed nurse-patient relationships. Jade did not believe the Nurse Practice Act or the Nursing Code of Ethics was well known or utilized as a resource when faced with boundary dilemmas. "To have the actual exact practice standard, I think we have to live by that, but I don't think we do that. I mean I know I don't." Educating ourselves on the Nurse Practice Act in order to protect patients and nurses is in the best interest of all. "I really need to be smarter on the code of ethics. I mean I think it's something we as professionals probably need to really look at and know it. And I don't think we do."

The evolution of professional nursing educational offerings and the complexities of work settings, innovations, and patient populations experienced by nurses, were described as instrumental to requiring more open discussions about nurse-patient relationship boundaries. Josie expounded on discussing professional nurse-patient relationship boundaries in open conversations. "I've been in nursing for 20 years…and this isn't a topic I've given a lot of

thought to. I think it's a good conversation…a necessary one because I think we're only going to get in more complicated territory."

Consistently, the issue was raised by the nurse leaders that more education and a better understanding of the Nurse Practice Act and the Nursing Code of Ethics, as directed toward maintaining professional nurse-patient relationships and preventing boundary transgressions, were needed. Jade spoke to educating nurses about nurse-patient relationship boundaries through comparison accounts of real events related to the Nurse Practice Act. "I think that… if it's brought up more in our day-to-day work…and say look this relates to, the Nurse Practice Act, section…that's going to help us to prevent any boundary questions."

Nurse-patient relationship boundary breaches were described as occurring in various ways. Josie raised the issue of social media as an avenue for potential nurse-patient relationship transgressions. Josie believed "we should pay extra attention to this [social media]." Josie expressed concern with limited education on the topic, and, did not know if the subject was taught during nursing orientations in work settings. "It's possible that nurses in their nursing orientation now, they get a little bit more of this then when I did when I was a nurse. But as a Nurse Practitioner I don't really get a lot of that in any of my orientation."

Overall, nursing leaders described their perceptions of the education they received in their nursing school programs and through their work settings on professional nurse-patient relationship boundaries as limited. They shared their perceptions regarding the amount of training received, the functional role this training provided them in relation to nurse-patient relationship boundaries, the general need for more open conversations about nurse-patient relationship boundaries, and to place a stronger emphasis on education about this topic in both nursing school programs and work settings.

Sub-theme: Understanding experiential capacity. The nursing leaders spoke to experiences influencing their perceptions of and actions toward evaluating and managing professional nurse-patient relationship boundary breaches. Study participants primarily identified maturation as a growth process in their nursing careers based on an increase in the years of professional nursing and an increase in the years of experience as a nurse leader. Jade shared her thoughts on how she conducted ethical decision-making as she moved through the levels of proficiency over time. As a novice nurse, "I think when I was a young nurse it was difficult because you … feel like you're drinking from the fire hose. So, you don't know if you're really practicing according to a Nurse Practice Act." Through maturation in personal growth and professional development "I realize, hey, this is wrong or this is right in relation to being a patient advocate." Jade's ethical decision-making stemmed from her personal value system and experience more so than from her education, "so I don't know if I really relate that much to my training per se." Linking maturation to one's personal value system was described as influential to a nurse leader's perception of nurse-patient relationship boundary breaches and its effect on "how you look at those boundary breaches."

Maturation, in terms of age and experience in nursing, was perceived as influential in the nurse leader's perceptions of nurse-patient relationship boundary breaches. For instance, Jade described her early years in nursing and her response to observed nurse-patient relationship boundary breaches. "I think back and maybe I should have said something. But I think it has to do again with age, how comfortable you are with being a nurse, and how comfortable you are with confrontation." Jade again described personal values as a key factor in evaluating and managing nurse-patient relationship boundaries, as well as determining whether she considered a nurse-patient relationship a boundary breach. "I think back and maybe I should have said

something. But I think it has to do again with age, how comfortable you are with being a nurse, and how comfortable you are with confrontation." Throughout the interviews, the nurse leaders consistently described their personal value system as an influence in their decision-making regarding ethical situations, such as nurse-patient relationship boundary transgressions. Kali stated, "If I had a situation, I could rely back on my own personal ethics." Personal value systems and personal ethics were referred to as foundational for making decisions, in lieu of or in concert with age and experience.

Additionally, positional obligations influenced the nurse leaders' perceptions of nurse-patient relationship transgressions. Different nursing role experiences played a part in grooming nursing leaders' perceptions and actions in evaluating and managing boundary breaches. Sarah shared a prior work experience in which a mandatory training contributed to her personal belief system when evaluating and managing nurse-patient relationship boundaries. She spoke to utilizing this training experience as a steadfast go-by: "I was actually a prison nurse for a while. And that's where I got my hard line ethics. It does not waver. And that was actually mandatory training, just working in a prison."

In addition to positional obligations, specific expectations related to the work environment, such as being a past or present member of the military, requires specific training that is in concert with maintaining professional boundary limits. For instance, two of the nurse leaders, Kali, retired active military service and Mia, current active duty, shared their common experience with the "no fraternization" rule common to all military services and its relation to professional boundary setting. Kali and Mia spoke to their belief that the military "no fraternization with colleagues rule" in turn bore the same weight in professional nurse-patient relationships and boundary limit enforcement. Kali stated, "And then there's obvious things in

the military, we don't fraternize with our staff, but we also don't fraternize with our patients to disrupt that boundary of health care decision-making, so that it remains private and clear." In concert with Kali's belief, Mia expounded on the same military reference of 'non-fraternization with colleagues' as a basis for preserving therapeutic nurse-patient relationships. Mia spoke to the impact of her military experience, "I mean just by being in the military, not necessarily reading the Nursing Code of Ethics, because we have such strict limitations…such that…nurse-patient relationships are expected to remain professional based on the military fraternization rule."

Based on work experience, Josie and Cora brought attention to the issue of relationship boundary limits being "pushed" by the behavior of patients toward nurses. The nurse leaders stated that this behavior on the part of patients is perceived to happen more often than the opposite behaviors and creates stress for nurses. In many instances the nurse is caught off-guard and is at a loss of how to respond and deflect the unwanted attention by the patient. For instance, Cora stated, "So I've had more of that; patients trying to get over involved; or, could I [patient] call you [nurse], you know later and ask you about this." The role of a nurse influences perceptions of nurse-patient relationships, responses to them and interventions. Nurse-patient relationship boundary lines are at times pushed by patients, with the potential of creating conflict for nurses, and potential for blurred/breached boundaries.

Josie raised the same issue as Cora; over the course of her various experiences, she has encountered patients pushing boundary lines. Josie discussed redirecting patients' behaviors when boundary limits were being pushed with nurses. "Even if we maintain our professionalism, I can think of times where patients have behaved inappropriately and I've had to think about how to deflect or redirect or what to do." Josie described utilizing work related experiences and

educational resources to raise awareness. “That’s a big conversation to have because you don’t hear about that as much either. I think when you’re being prepared (in a nursing role/position), sort of (being mentored) on-the-job training (on deflecting patients attempts at boundary crossing).”

Various work experiences, along with maturation, were described as key factors in influencing interpretations of nurse-patient relationship boundary breaches. The nurse leaders spoke to their beliefs and experiences with managing nurse-patient boundary transgressions. Kali spoke to nurse leaders’ “different experiences” that support them when working with staff nurses who must deal with “different ethics” based on “different types of environments.” Kali discussed receiving formal training through the military that bolstered her comfort and ability to manage staff nurses through professional nurse-patient relationships. “As a nurse leader you know, coaching, coaching people through experiences. And that comes certainly with time, experience, and also your role.”

Cora described the dilemma nursing leaders experience in making decisions in evaluating and managing nurse-patient relationship boundary breaches, and stated it was “somewhat loosely based on the job description. If the job description covered me at all and our HR policies, which depending on where I was working had better and worse guidelines.” As previously described, standards, policies, guidelines are lacking in availability, somewhat vague, and/or not well known/ understood by the nurse leaders:

> In disciplinary relationships, when I was the supervisor, I have actually looked things up in the Practice Act to counsel staff members. You know, you have violated the Nurse Practice Act by A, B, or C here, and put it into written counseling. I find the Texas Nurse Practice Act very difficult to get a good answer from when you’re actually reading it yourself.

As an overall consensus, the nurse leaders drew from their personal values, which may or may not direct ethical decision-making about boundary breaches. As well, it created unsafe situations for nurses, patients, and organizations, depending on the nurse leader's evaluation of whether a nurse-patient relationship was perceived as a boundary breach and what, if any, action was taken:

> But, again it came back to my gut. This is outside your scope or outside what's ethical. Rarely was it outside what I thought was legal. That was the easy one. But, it came down to again, what would the prudent practitioner here do in this situation, so. But this was not right. On some level, I can tell, this was not right.

Again, maturation and positional obligations provided the nurse leaders with the foundation they needed for managing nurse-patient relationship transgressions. Overall, they felt these key factors gave them the knowledge and skill to effectively evaluate and manage nurse-patient relationship boundary breaches.

Essential theme: Summoning support systems. Leadership style and leadership engagement of self and the organization were espoused as playing a role in the nursing leaders' ethical decision-making about nurse-patient relationship transgressions. Overwhelmingly, the nursing leaders described their consistent leadership style employed throughout their careers as "leading by example." They believe it was necessary to be actively engaged, supportive, available, and approachable, and to role model the behaviors and activities expected of a professional. Depending on the leadership position held, varying leadership styles were explained as essential depending on the environment in which the nursing leader was immersed, the situation that necessitated a different style, and/or supervising novice versus seasoned nursing staff. Democratic leadership styles were touted as engendering good working relationships among leadership and staff, encouraging staff engagement and participation in resolving issues and changing processes as needed. Authoritative leadership styles were

described as the “go-to” approach when leading staff nurses in complex environments, particularly young novice nurses, advocating for patient care, and enforcing safety policies, such as conduct rules and regulations. The nursing leaders relied heavily upon their leadership methods as a primary resource when evaluating and managing nurse-patient relationships. The nurse leaders also spoke to congruently employing alternative resources considered effective in resolving ethical dilemmas such as nurse-patient relationship boundary breaches, along with discussing resources considered ineffective and the reasons. Resources effectively utilized were documents geared toward protecting patient safety, such as the nursing profession’s and the hospital organization’s rules, regulations, standards, and policies. In addition to the use of regulatory documents, personnel were sought for assistance in resolving nurse-patient relationship breaches. Personnel consulted were executive leadership, health care resolutions specialists, sexual assault nurse consultants, ethics committees, chaplains, and colleagues. The two sub-themes, humanizing leadership traits and employing resources, influenced the essential theme summoning support systems when assessing behaviors constituting nurse-patient therapeutic relationships versus nurse-patient relationship transgressions.

Sub-theme: Humanizing leadership traits. The nursing leaders reflected on how their leadership styles affected their decision-making when evaluating and managing professional nurse-patient relationships. When describing comfort and skill in supervising staff nurses, assessing and confronting boundary breaches were highlighted through experiences shared. Active leadership engagement, Jade’s steadfast style, was considered essential to maintaining oversight and leading staff nurses: “I think you have to lead from the front. And that’s really where you see the rubber meets the road if people are doing the right thing.” Due to maturation and experience, Jade’s leadership style has evolved over the course of time, leading to self

confidence in managing ethical dilemmas. “At this time in my life I would absolutely feel comfortable approaching the staff about a boundary breach. I don’t have any problem saying anything anymore. I used to have a little more of a filter.” Depending on the seriousness of the nurse-patient relationship boundary transgression, Jade felt comfortable confronting staff nurses who cross boundary lines, correcting behavior, and coaching staff nurses in appropriate professional behavior. Jade believed if the situation is such that the boundary breach can be resolved, correcting a nurse’s behavior and teaching the nurse about boundary limit setting may yield an advocate for modeling professional nurse-patient relationships. “If it’s not so egregious … you would want to correct it. Correct, teach them, I think sometimes that makes the best advocate for that patient, because now they know that’s not so appropriate.”

Leadership style is described as varying depending on the role obligation, the work setting, and the level of experience of the staff nurses being supervised. An authoritative leadership style was consistently utilized when supervising novice staff nurses and when alternative courses of action were unacceptable. Consistently, the nurse leaders described “being available” and “being approachable” as mechanisms for ensuring staff nurses abide by the organization’s policies and do not cross professional nurse-patient relationship boundaries. Kali described utilizing various leadership styles, but spoke to using an authoritarian style when supervising young staff nurses and incorporating ongoing coaching and mentoring. “I’ve had to employ different types of leadership style when I was in a role of supervisor…clearly an authoritative…this is how the military works… but, really it was a tremendous amount of coaching and mentoring.” Making a point of being available for staff, providing oversight and assistance as needed was seen as positively impacting staff providing on-the-job teaching. “Being available, coming in on different shifts, working the night shift, going to the same

training and really making myself available and approachable, but yet firm, to teach them that we have policies and procedures." Active leadership engagement with staff nurses to emulate behavior and actions desired was described by Kali as her predominate leadership style. "Leading by example is my consistent approach to leadership, leadership challenges, and coaching nurses either senior or junior to me. Do what you say you're going to do, do what is right, and others will definitely follow that same path."

Allie also described utilizing a "lead by example" leadership style as a means of doing "all I can to get you going in the right direction." As Allie oversaw "Charge Nurses a hundred times a day," her approach in working with them is "best if we're on the same team." Allie perpetuated her style through teaching, coaching and "try and give them reasons why they should" follow a particular course of action; however, switching to an authoritative leadership style would occur if a situation warrants a more direct approach to resolving issues.

In a subsequent interview, Sarah also spoke to the importance of conveying to staff nurses a commitment to "being approachable"; but also to impart to staff a "non-judgmental" character trait, which in turn exudes an open, non-threatening work environment. Presenting an approachable, non-judgmental demeanor allows staff to feel comfortable when confronted by the leader for clarification of questionable professional behavior. "So the situation where you've dealt with a couple of staff who were getting close to that boundary breach, or maybe they had already breached the boundary, they were comfortable when you pulled them aside." Leading without morally judging, "regardless of any choices they had in their life" allowed for greater engagement and leadership oversight. "There was one that upset her … then a couple of months later we talked about it again. She said, 'I didn't realize what was happening.' So yeah, she still knew that she could talk to me about anything."

Leading by example and role modeling were consistently described as methods of showing staff nurses' methods of emulating appropriate professional nurse-patient relationship behaviors. Setting an example for the staff nurses was consistently described as one way of demonstrating therapeutic relationships with patients. Mia's leadership style was a reflection of her personal values and her military bearing. "I definitely have the approach and most of us in uniform should, as I would not ask anything of my employees that I am not doing myself. So I have the style where I'm definitely setting an example for them." Mia believed in setting an example for staff nurses as a method of teaching, but more importantly, as a method of setting expectations of the staff nurses. "And I expect them to do the right thing by their patient, peers, and everyone else on a daily basis just as I do by them. So, I definitely say I lead by example. That is my goal every day."

Again, leading by example, touted as active leadership engagement with staff nurses to emulate behavior and actions desired, was described by Josie as her primary leadership style. "I try to lead by example … meaning the example I send, to be consistent, make swift, concise decisions … admit when I'm not sure of an answer, so everybody knows that's okay; but, at the same time find the best answer." Emulating respect for one another and setting similar expectations for staff was a standard Josie set for all in her department. "I think treating the people that I work for with respect…kind of expecting that to come back…but not tolerating disrespect. And that goes between workers and with patients ... that's the environment I've tried [to] foster with the nurses." Josie has described this style of leadership as effective in her department such that conflicts among staff are limited and negative issues with nurse-patient relationships are nonexistent. Josie described the importance of leading by example and treating each other with respect as valuable to the team. "If there's something that doesn't go well, we

address it right then, you talk about it, and we all move on; and that all parts of the treatment team are valuable. I think that it makes everybody happier."

In a supervisory role, Cora described herself as actively engaged with her staff nurses, predominately leading with a democratic style, as well as utilizing an authoritative style as needed based on the situation. "Supervisory role, mostly democratic; but, I mean I could pull it together and say now this is what you're going to do." Collaboration with staff through a democratic form of leadership was implemented by seeking staff input and ideas. Gaining staff "buy-in" was paramount in resolving issues and bringing about change. "Tell me your ideas, and sometimes they had good ideas…you could throw one out there and they'd run with that and you'd go 'Yes!' Because, if you don't get 'buy in' you're just going nowhere." Cora also spoke to her most common leadership style; that is, leading by example. Perpetuating behaviors to be emulated was the approach Cora used to inspire nursing staff's actions. "Now in my role I purely lead by example. I don't counsel people, rarely. I don't have to, I'm much more like, 'Look, watch, we can do this.' So, whatever that kind of leadership is. Lead by example, I hope."

Sarah, in concert with the other nurse leaders, described her leadership style as leading by example. Sarah espoused walking-the-talk; such that, staff nurses will want to follow her actions. "I believe in leading by example. I'm not going to ask anybody to do anything that I wouldn't do myself." Sarah described her leadership style, that is, leading by example, as ensuring the staff knows that she is there for them and will do "whatever needs to be done to get it (any situation) taken care of."

Consistently leading by example was espoused as the most common form of leadership style among the nurse leaders who participated in this study. This style portrayed active

leadership engagement with staff nurses, consistently reinforced "what I say I will do is what I do," which is a critical element in establishing trust between the nursing leaders and their staff.

Overall, the nurse leaders spoke to leading by example, role modeling, and when necessary, utilizing an authoritative style. Predominately, the nurse leaders believed the first line in preventing nurse-patient relationship boundary breaches is through role modeling and coaching. However, if a boundary breach was confirmed and the situation was not evaluated as egregious in nature, the overall consensus was to resolve the situation in the least disruptive manner to the nurse, staff and patient, and teach the nurse about professional relationships, and setting and maintaining professional boundaries.

Sub-theme: Employing resources. The nurse leaders shared their viewpoints regarding organizational resources they felt were available to them when evaluating and managing professional nurse-patient relationship boundary breaches. Study participants primarily described policies or personnel as the resources most considered for their use in determining what constitutes a nurse-patient relationship breach and the appropriate action for intervention. Kali stated that the state BON where she is licensed as a nurse periodically requires refresher training on the Nurse Practice Act rules and regulations for a nurse license renewal. "To maintain nursing licensure from New Hampshire, occasionally we have that refresher training … they'll have us review … go back and sign off that I have the Nurse Practice Act." She described the refresher training as a mechanism for reminding nurses that the Nurse Practice Act provides guidelines for evaluating unethical behavior. "I think that what that does is remind us that there are resources and lines of communication when we observe unethical behavior, whether that may be abuse of a patient, drugs, and alcohol by staff members." Kali perceived the Nurse Practice Act standards related to inappropriate conduct of a nurse as a supportive resource when making decisions about

potential nurse-patient relationship boundary breaches. “You’re reminded that there is an outlet to help you kind of stop that situation.”

Kali questioned herself as to whether she had encountered a professional nurse-patient relationship boundary transgression, such as a nurse dating a patient. “I was thinking, have I ever known someone to date a patient? That would be completely unethical. I don’t know, I don’t think so. I don’t remember it.” As a nurse leader however, Kali had encountered situations where patients’ privacy had been breached. She described the military health care setting having clear pathway processes for managing patient privacy breaches. “Clearly there’s a pathway when you have a privacy act breach. And we basically have to halt that information and make notification. And that’s very clear in the military on how to manage that.”

In addition to the Nurse Practice Act, the Nursing Code of Ethics and the military’s ethics, the military’s rules and policies were considered beneficial resources available to nurse leaders when evaluating and managing nurse-patient relationship boundary breaches. Mia described the process she would follow if confronted with a perceived professional nurse-patient relationship boundary breach. “Once a situation is brought to me, I would use my available resources to research exactly where this breach may fall.” Mia addressed available resources she would find beneficial if confronted with potential unethical nursing behaviors related to professional nurse-patient relationship boundary breaches. She described confidence in referencing both the nursing profession’s and military standards as supportive resources. “The Code of Ethics or the Practice Act …even within our organization, we have our own set of ethics, rules, policies that govern a lot of this stuff. So, I would use my resources to determine where does this fall.”

Seeking assistance from personnel was consistently mentioned as an available resource to confer with prior to either making decisions about a nurse-patient relationship breach or before carrying out any interventions with a staff nurse found to be crossing the lines of professional nurse-patient relationship boundaries. Personnel such as patient care advocates, employees of health care facilities whose role it is to intervene on behalf of patients, or administrators, typically holding executive level leadership positions, are considered resource options that have been described as potential resources for obtaining appropriate guidance in evaluating and managing nurse-patient relationship boundary breaches. Josie listed specific personnel she would seek advice from if she had a concern with a nurse-patient relationship boundary breach. "For breaches…I would have gone to either an administrator or manager for that unit…in certain hospital systems they have patient care advocates….so I might of gone and spoke with a patient care advocate."

Chaplains were another resource requisitioned for their skill in evaluating and managing personnel issues. Chaplains hold unique positions in health care facilities as they are privileged to protect confidentiality and are exempt from disclosure of information. Chaplains are generally perceived as non-threatening liaisons, clear communicators, and neutral mediators. Sarah described two instances in which she called upon a chaplain to evaluate a potential nurse-patient relationship boundary breach and assist with interventions in resolving the transgression. "If I'm not making progress with subtle hints with administration, then I actually call the chaplain. And I think they pick up on it…I've called them twice. So they (chaplain) would go ahead and just talk and (de-escalate the situation)."

Additionally, Mia described personnel resources that are readily available in the trauma setting. "We definitely have plenty of resources that we can use to advocate for our patients' best

wishes." She described conferring with a Healthcare Resolutions Officer; as well as with the Chaplain Services when confidential and neutral judgments are needed to advocate for a patient's well-being. "We have a Healthcare Resolutions Officer… she's neutral… nothing you tell her is reportable…other than the normal stuff you have to report… she listens to the nurse's side and the patient's side… and we have the Chaplain Services."

Ethics committees, ethics councils, and legal counsel were identified as additional resources considered viable options in assisting with ethical decision-making. Ethics committees generally consist of multi-disciplinary health care clinicians who have the role of reviewing situations from a neutral position and providing guidance based on evidence. Kali stated, "there is always an ethics committee in your organization to help support ethical decisions, or ethical clinical decisions." Ethics committees can be trusted to support ethical decisions based on objective data. It was further delineated by Kali that ethics boards are available within military health care facilities. Kali referred to the ethics committee as a "fair and balanced decision-making board." Additionally, Mia acknowledged an ethics council within the organization as a resource available to provide guidance with ethical decisions regarding nurse-patient relationship boundary breaches. "We have to have an ethics council practice; so yes, I do, I feel that I have the resources, I have ample support here." Mia stated that she has involved legal counsel in situations that require that proper determinations were made and appropriate interventions were carried out within a legal frame of reference. "We'll involve JAG if it gets down to it. We've involved JAG (Judge Advocate General) before; just to help us walk through that process. To make sure everything is okay. We'll use all our resources to make sure we're making the right decision."

Peer colleagues or peer directors were another resource Cora often approached in order to talk through a perceived nurse-patient relationship boundary breach and in seeking confirmation prior to carrying out any intervention with the staff nurse who crossed the line. Peer feedback was generally utilized in concert with the organization's policy guidelines regarding professional behavior and after considering if the staff nurse behavior was in line with the actions of a prudent practitioner.

> I actually went as far as talking to colleagues before I would counsel someone; because I was like, "Am I out of line here," HR is sometimes a good advisor, but sometimes not as far as what's out of the boundaries of nursing care. So, it was more often I was talking to peer directors or whatever. Because we all know nobody wants to be sued, nobody wants to do something illegal.

Based on experience within civilian and military health care facilities, Sarah's perception of available resources within the organizations varied. "In the civilian hospitals yeah, the prison definitely, the military hospital, no." Sarah described a lack of support and push back from leadership when informed of perceived nurse-patient relationship boundary transgressions. "When you've had to mention it, they're like, there's no way, I've known them for years. Well, you may have known them for years, but this is happening. Then they think it's because you don't like that nurse." Sarah believed there was no support from leadership when she approached them with a nurse-patient relationship boundary breach. "No, it has nothing to do with liking, I actually like them very much; but, they're crossing the lines here. And so, there isn't that backup." Due to the lack of response received from leadership, in lieu of leadership support alternative resources were sought. "So, I've learned how to go around it a different way."

Additionally, The Sexual Assault Response Coordinator was not contacted by Sarah as an expert resource in assisting with nurse-patient relationship boundaries due to the perception of inappropriate management of events. "You can go to her if you think boundaries are crossed. But

that person's general reaction is to overreact and blow everything out of proportion, so I don't go there. I don't need somebody coming in and start hounding them." Sarah's primary concern in handling nurse-patient relationship boundary breaches was the well-being of the patient, their family and the nurse. Sarah's primary focus was resolution without reprisal. "It needs to be handled tactfully and gracefully for that patient, as well as for the staff and the family members, to not feel threatened, if you know the staff are getting too involved. I can get around it here."

Nursing leaders presented descriptions about available resources that were often utilized to assist with ethical decision-making about professional nurse-patient relationship boundary transgressions they encountered in their collegial and supervisory roles. Additionally, resources considered as barriers or non-supportive were also discussed; as well as ways of getting around the barriers that were found to be helpful. Resources in the form of policy, standards, rules and regulations; as well as resources in the form of personnel, both nursing and non-nursing, were expounded upon as support mechanisms in evaluating and managing nurse-patient relationship boundary breaches.

Essential theme: Weighing elements affecting judgment. The nursing leaders addressed various impacts that they perceived influenced decision-making when evaluating and managing nurse-patient relationships. Being entrenched in a complex organization, the nursing leaders' accountings of experiences delineated situational dynamics they felt impacted decisions made about nurse-patient relationship boundary breaches. Sharing stories expressing maturation in nursing and nursing leadership experience was also described as influencing perceptions of and actions toward nurse-patient relationship boundary breaches. Impacting decisions made in identifying and acting on nurse-patient relationship boundary breaches, included factors described as personal views, interpretations of circumstances surrounding breaches, and

organizational culture. Organizational culture, as defined by Ravasi and Schultz (2006), is "a set of shared mental assumptions that guide interpretation and action in organizations by defining appropriate behavior for various situations" (p. 437). In turn, organizational culture affects the way people interact with each other, with customers, and how much employees identify with an organization; therefore, impacting the identification of and actions toward boundary breaches. Additionally, the nursing leaders described organizational barriers encountered when evaluating and managing nurse-patient relationship boundary breaches. A barrier, that which "obstructs or impedes progress" (Barriers, n.d.), was described in terms of adding additional complexity to resolving already difficult ethical dilemmas. Barriers encountered were described as factors relating to organizational processes and leadership, organizational/ department socialization issues, lack of or inappropriate resources, and lack of or inappropriate staff engagement. The nursing leaders, in calculating challenges experienced in evaluating and managing professional nurse-patient relationship boundary breaches, touted discretion as an influencing force in determining and carrying out actions for resolving boundary breach situations. Discretion, "the freedom to decide what should be done in a particular situation, meaning a choice, option, preference, disposition, or volition" exemplified the nursing leaders' actions when judging, reasoning, and intervening in boundary breaches (Breach, n.d.). In conjunction with discretion, the nursing leaders described their willingness or obligation in accounting for their actions and that of the organizations in evaluating and managing boundary breaches. Multiple factors, as described by the nursing leaders, spoke volumes about the responsibility of weighing elements affecting judgment, such that the impacts, barriers, and challenges incurred were considered when making decisions affecting the outcome of nurse-patient relationship boundary breaches. Therefore, three sub-themes emerged from the nursing leaders' responses; that is, deliberating

dispositional impacts, tackling organizational barriers, and calculating discretionary challenges; all three influenced the essential theme, weighing elements affecting judgment.

Sub-theme: Deliberating dispositional impacts. The nursing leaders addressed various impacts they perceived as affecting their decision-making when evaluating and managing nurse-patient relationship boundary breaches. Jade, throughout her interview, spoke to situations not perceived as nurse-patient relationship boundary breaches at the time of the events; but, upon reflection, described realizing that "personal view' impacted the dispositions of the events as non-breaches, "probably just personal view and that I didn't feel that it was truly a breach." Jade expressed hesitancy about her ability to evaluate and manage boundary breaches during her early years in nursing, predominately all related to personal growth factors:

> I think what impacts decision-making, is not only your ethical point of view, but also your age, your comfort level, your skill level, your ability to communicate with your fellow co-workers, and your ability to communicate with your patients. That would impact, definitely impact your decision-making on how you look at those boundary breaches.

Allie described her lack of action in addressing nurse-patient relationship boundary breaches as being impacted by the organization's culture, specifically the unit she was working in at the time. Deciding not to intervene in perceived nurse-patient relationship boundary breaches was impacted by the unit's culture of acquiescing to inappropriate behaviors, "you know, it was accepted … you knew it and everybody knew." Allie described the unit culture as that of a "herd mentality." Coming to terms with the realization that nurse-patient relationship boundary breaches were ignored, status quo was unchallenged, and "cover-ups" were deep seated in the unit impacted Allie's decision to not report the ongoing breaches:

> And it was just how it was and when you're kind of the newer one, I mean I wasn't that young in my career, but I was…new in that unit and…so you're just like "oh, this is how this goes here?"

Josie described that making a decision to take action and intervene in nurse-patient relationship boundary breaches was impacted by knowing what personnel within the organization possessed the knowledge and skill to manage boundary breaches and knowing their positional structure. “I really listened up to make sure that I knew if there was ever a situation where I needed to advocate for a patient I knew who to talk to.” Paying close attention to knowing the right people to pull in for guidance in resolving nurse-patient relationship boundary breaches, such as following the organizations chain-of-command, impacted Josie’s dispositions of boundary breaches. “I think that it also just comes from working in many different units and just sort of understanding the chain-of-command.”

Nurses breaching professional boundaries were identified by Cora as impacting her decisions when evaluating and managing nurse-patient relationship boundary breaches. Cora recounted the resignation of a nurse counseled for nurse-patient boundary breaches as impacting further escalation of actions levied against the nurse. Describing the nurse’s resignation following counseling due to boundary breaches eliminated further decisions regarding resolving inappropriate behavior. “One nurse resigned … but it wasn’t a one-plus-one equation. She had other reasons she was thinking about resigning so it wasn’t just that.” Cora perceived that the resignation of the nurse she counseled for breaching nurse-patient relationship boundaries was interpreted as relinquishing taking further action against the nurse. Additionally, Cora described encountering daily boundary issues between nurses and patients in the behavioral health unit as impacting her decision-making in resolving boundary breaches. Seeking support from the organization’s leadership was described as one approach to resolving the situation. “I brought some ongoing problems to light and dumped them on somebody else’s plate when they took over. I don’t think there was any great long-term gains made from any of my decisions, that’s for

sure." Conducting staff meetings to discuss boundary setting between nurses and patients was also described as impacting decision-making regarding nurse-patient relationships.

> We had one staff meeting where that was the topic, of boundaries. It wasn't any one thing that had happened in our unit, it wasn't like a debriefing. But we talked about it kind of in general… To try to get a consensus is impossible.

Mia described following the organization's chain-of-command as impacting her decision-making about evaluating and managing nurse-patient relationship boundary breaches. She touted the organization's ample and supportive resources; and therefore, believed her decision-making was impacted by the organization's resources. "I would seek information from my Section Chief. I would go all the way up to the DCCS (Deputy Commander Clinical Services) if I needed to, before I actually get deep into an investigation or anything." Seeking "all available resources" to make the right decisions impacted Mia's evaluating and managing nurse-patient relationship boundary breaches:

> Once a situation is brought to me, I would use my available resources to research exactly where this breach may fall or escalate to the Code of Ethics or the Practice Act and even within our own organization, I would say it may not be called a Nurse Code of Ethics, but again in this organization we have our own set of ethics, rules, policies that govern a lot of this stuff also. So, I would just use my resources to determine where does this fall?

Mia perceived her organizational resources as supportive, therefore impacting Mia's decision-making about nurse-patient relationship boundary breaches. "We have to have an ethics council practice, so yes, I do. I feel that I have the resources, I have ample support here."

Sarah expressed being impacted in her decision-making about nurse-patient relationship boundary breaches by her belief that staff nurses' "principles, their values, morals, and ethics" influenced their level of involvement in nurse-patient relationships. Sarah spoke to experiences with staff nurses who "weren't brought up with them… weren't ever taught what yours are … or developed your own personal identity," exhibited conflict with nurse-patient relationships due to

the concept that in nursing "you're supposed to be the kind, caring, wonderful person that everybody thinks you are and that you sometimes don't think ethically that you should have these thoughts." Sarah's perception was that "it's all about balance" when evaluating and managing nurse-patient professional boundaries. Sarah's view on "balance" not only referred to her belief regarding staff nurses balancing a therapeutic relationship with their patients, but also her interventions with the staff. This was evident from her statement, "I'll help you with anything, but you won't run over me and that's kind of what I think, and so they don't have that as a defense."

Sarah described how her "strong values and ethics and personal beliefs" impacted her approach to evaluating and managing nurse-patient relationships. "And so you let those personal beliefs guide you in how you care for your patients and how you care for you staff and how you perceive the relationship that's going on between staff and patients." Sarah's ethics drove her actions so as not to "let something slide" and "do everything I could to try and help."

The nursing leaders described various factors impacting ethical decision-making about nurse-patient relationship boundary breaches. The impacts experienced were described in terms of personal views, socialization effects, and organizational culture. As described, deliberating dispositional impacts ran the gamut, to include personal value systems, age, comfort and skill in handling ethical dilemmas, ability to communicate across the spectrum of staff to leadership, higher authority support versus non-support, and organizational/unit cultures' acceptance/ tolerance of inappropriate nurse-patient relationship behaviors.

Sub-theme: Tackling organizational barriers. The nursing leaders addressed various barriers they perceived affected their decision-making when evaluating and managing nurse-patient relationship boundary breaches. Jade reflected on her own educational experiences and

those of other nurses regarding relationship boundary breaches and the role of the Nurse Practice Act in defining a boundary breach. She described her educational foundation as a barrier in understanding nurse-patient relationship boundary breaches. She questioned "what really identifies as a breach of practice?" Jade stated that "Maybe I didn't know a lot of time, which is not always an excuse, but it's an honest one. I didn't know it was a breach." Jade perceived the lack of understanding professional boundary breaches and the guidance set forth in the Nurse Practice Act on professional relationship boundaries stemming from the "foundational" curriculum taught in two-year and/or diploma nursing programs. "Remember, a lot of times we were two year prepared or diploma prepared and I don't think that they really touched a lot upon that."

Allie described succumbing to the "norm" of co-workers' threats of retaliation creating barriers to intervening in nurse-patient relationship boundary breaches. "There just were certain people that really could make your life miserable." Capitulating to staying on the "good side" of "influential" co-workers caused barriers in carrying out actions aimed at resolving nurse-patient relationship boundary breaches. "You just knew they were the people to stay on the good side of … going against what the norm was, would have been; I've seen them with people."

Experiencing situations where inappropriate nurse-patient relationship behaviors were accepted as the "norm," "covered up" and "not addressed by leadership" were described by Allie as predisposing factors influential in her handling the situation. The fear of retribution was disconcerting and generated doubt in making decisions about nurse-patient relationship boundary breaches. Allie described leadership's lack of concern and knowing nothing would change as a barrier to reporting nurse-patient relationship boundary breaches. "But it was a barrier and nobody cared at that point, none of the leadership … you could say stuff and nothing changed."

Allie portrayed co-workers pressuring peers to conform to the unit culture as analogous to "peer pressure in middle school." Dreading peer pressure, fear of retaliation and non-leadership engagement in managing nurse-patient relationship boundary breaches incentivized Allie's transfer out of a unit. "That was actually part of my decision to leave the ER (emergency room). Now things have changed, there's new leadership and they've kind of cleaned house a little bit. It's good for everybody."

Fear of being accused of inappropriate behavior with patients by co-workers was also described as a predisposing factor affecting Josie's evaluation and management of nurse-patient relationship boundary breaches. Josie described her concern as "maybe I've done something that someone else thinks is inappropriate also" and therefore, this fear clouds nurse leaders' "thinking" and interventions. Josie cited actions pretending nurse-patient relationship boundary breaches do not occur and not holding nurses responsible for their behaviors in order to avoid conflict in the workplace as barriers.

> I think barriers are that we try to pretend like … I guess we don't really want to have conflict in the work place. I think we're a little resistant to making people take responsibility for their actions in that realm. Unlike saying your behavior is inappropriate.

Fearing "to point fingers" at a peer due to fear of being accused of the same inappropriate behavior is a barrier to managing nurse-patient relationship boundary breaches. Fear of being on the receiving end of the same accusations levied against peers thwarts managing nurse-patient relationship boundary breaches and was described as a barrier.

> Typically we're pretty easy to do this when it's nurse against nurse, but I think we're a little less apt to do it when it's nurse versus patient. Mainly because I think nurses oftentimes are afraid to point fingers in that situation for fear that maybe I've done something that someone else thinks is inappropriate also.

The apprehension of making a determination about what type of behavior constitutes a nurse-patient relationship boundary breach was identified as one factor predisposing nurse

leaders to confront potential boundary transgressions. For instance, Josie asked the question, "Like what is appropriate behavior and what's not?" Determining what is and is not appropriate behavior was voiced as a concern in making ethical decisions about potential nurse-patient relationship boundary breaches by all the nurse leaders interviewed. Fearing retaliation thwarts interventions for resolving inappropriate behaviors. "Just for fear of maybe it will come back to bite them. I think that's a barrier that so often affects nurses' thinking. I think it is kind of a shame, but it is very real."

Cora expressed the belief that "everybody has their own boundaries" and this is therefore perceived as a barrier when evaluating and managing nurse-patient relationship transgressions. Among the staff nurses in a long-term behavioral health care setting, "to try to get a consensus is impossible" in sustaining professional rather than personal nurse-patient relationships. Reviewing with staff good professional character and unprofessional conduct rules as set forth in the Nurse Practice Act was an ongoing conversation.

> Frequently you'd say, you can't do that, and they'd go, "well why? Why can't we have these people in or why can't we go to their house?" And then you're stuck with, I don't have a really good answer to that why, except it crosses the boundaries of professionalism. Your doctor doesn't go out drinking with you, this is a different relationship.

Cora described supervising staff nurses unfamiliar with the concepts of therapeutic versus personal nurse-patient relationships, and abiding by professional boundaries as barriers to evaluating and managing boundary breaches. Conducting staff meetings as a forum to discuss therapeutic nurse-patient relationships versus nurse-patient relationship boundary breaches took place in order to raise staff understanding, foster discussion and promote sustainable therapeutic relationships. Cora stated the meeting's focus was about "boundaries" whereas, "we talked about it kind of in general." Even though the meeting was held as a "staff meeting," it was conducted

"informally" and "no rules set down in stone." The point of the meeting was to bring about open discussion about "why" staff cannot participate in personal relationships with patients because "it crosses the boundaries of professionalism."

Cora described organizational leadership "pushing customer service" as a barrier to evaluating and managing nurse-patient relationship boundary breaches. In the behavioral health unit, where boundary limit setting was an ongoing issue, nursing personnel interpreted the organization's directive of providing customer service liberally. Cora voiced concern to organizational leadership, but was met with resistance and a reiteration of the expectation to provide customer service. Leadership's stance was, "We have to take care of these patients…they don't have any place else to go. So, the nurses were pushed frequently from that side to extend their boundaries." Cora described the directive as sending a conflicting message between direct supervision and organizational leadership. Cora continually spoke to setting boundary limits and organizational leadership spoke to extending boundary limits "in the name of customer service." Without clear "customer service" criteria from organizational leadership, the behavioral health nurses teetered on- and breached nurse-patient relationship boundary lines "almost on a daily basis."

Mia described encountering lack of staff willingness to come forward with information about nurse-patient relationship boundary breaches as a barrier to evaluating and managing breaches. Without knowledge of a nurse-patient relationship transgression, inappropriate behavior goes unchecked. "The barrier with that and anything else is individuals' willing to come forward who may have information or some type of intel about what actually happened." Relying on the organization's robust system for disciplinary action was a barrier encountered for nurse-patient relationship boundary breaches. "Another barrier will be just our robust system and

how we go through any type of disciplinary action for military and/or GS (General Schedule) employees." Carrying out an investigation and identifying factors contributing to a nurse-patient relationship boundary breach were perceived as barriers. "I would say that would honestly be the biggest barrier, is just the process of getting down to the bottom line of what happened and what can we do to prevent this from happening again."

Sarah, expressing socialization issues such as the buddy system preventing further action from taking place, described this as a barrier in evaluating and managing nurse-patient relationship boundary breaches. "I found in this place barriers. I think more of the barrier though is the socialization part, maybe 70%, organization 30%. But, yeah, I think its more socialization." The fear of making a false claim about a perceived nurse-patient relationship boundary breach was described as a predisposing factor in delaying the nurse leaders' evaluation and management of a boundary breach. Sarah described a situation whereby she "let go" a staff nurse due to a nurse-patient relationship transgression and was approached by the terminated nurse's co-workers who then voiced their concerns, but were afraid of making an incorrect accusation. "After we got rid of that employee, the staff was talking and like, 'why did you not talk to us about this? I thought it was just me.' And they didn't want to say anything in case they were wrong."

The nursing leaders openly expressed a variety of barriers affecting their ethical decision-making when evaluating and managing nurse-patient relationship boundary breaches. Barriers such as scant nursing education related to professional boundaries, fear of retaliation, accusations of similar inappropriate behavior from colleagues, lack of leadership engagement or push-back, avoiding conflict in the workplace, the organizations disciplinary process, lack of available resources, and lack of staff willing to come forward with information about nurse-patient

relationship boundary breaches equate to predisposing factors affecting the nursing leaders actions. The nursing leaders shared the ambivalence they wrestled with in taking action to resolve nurse-patient relationship boundary breaches due to the effects of the predisposing factors.

Sub-theme: Calculating discretionary challenges. The nursing leaders addressed multiple challenges in utilizing discretion and assuming accountability in determining and acting on boundary breaches. These challenges were perceived as affecting ethical decision-making when evaluating and managing nurse-patient relationship boundary breaches. The experiences shared predominately fell into three categories relating to challenges in utilizing discretion and assuming accountability. The nursing leaders' determinations of a boundary breach and follow-up actions ranged from "did not see it as a breach and therefore no action needed" (thought we were doing "good" at the time), "did see it as a breach and no action taken" (it was accepted and we were afraid of repercussions), and "did see it as a breach and action taken to resolve the breach" (took actions to resolve the issue).

Sharing her experiences, Jade, utilizing discretion and assuming accountability when evaluating and managing nurse-patient relationship boundary breaches, shared experiences of events depicting the first category, "did not see it as a breach and therefore no action needed" at the time the events transpired. Jade described three different nurse-patient relationships that occurred in an oncology department, a staff female nurse dating a male patient, offering a patient's sister a place to stay, and two nurses occasionally spending time outside of the hospital fishing with a patient's spouse. At the time in Jade's career, these three nurse-patient relationships were not viewed as crossing the line. "I guess I really never looked at them in the terms of a breach." From the standpoint of accounting for one's actions, there was no recognized

obligation to intervene as the staff nurses were not seen as breaching any professional boundaries. “I didn’t feel that it was a breach, I felt like you were still doing good.” On the contrary, the three different nurse-patient relationship boundary breaches were viewed as helpful and comforting to the patients and families. “A code of ethics, you know, it’s how you interpret them, right?”

In further detail, Jade shared an experience she encountered in an Interventional Radiology health care setting, where patients “come in for frequent treatments” and many of the patients were accompanied by family. The nursing staff became “very close to all the families, because you get to know them, you see them every week.” Jade described an experience where two of her male nurses “befriended” a female patient who was diagnosed with cancer and was receiving weekly treatments for an extended period of time. “I know they spent time with her husband and the family … who were in the same boat that she was, they weren’t medical professionals … (they) would go fishing and it was an outlet for him, which then helped and assisted her.” Jade perceived nurse-patient relationships extenuating holistically, that is, inclusive of patient and family. “It’s hard when you are a nurse, we look at the whole patient…the whole person, the family, you get involved, and that’s good and bad. Sometimes it’s too much, and that’s when I think we cross the boundary.”

Jade reflected on her belief of “her staff nurses” interactions with the patient’s family outside of the health care setting. At the time of the encounter, the nurse-patient/family relationships were not perceived as professional boundary transgressions, but were perceived as compassionate and helpful to the relief of stress incurred by the patient and her family. It’s “difficult because you are a part of their lives and we have good days, bad days, just like they do. And we get sad about their illness, because we get close and so it’s hard, there’s that fine line.”

Long term patient care creates bonds between the nurses and patients, along with the patient's family. Rationalizing family relationships as non-boundary breaches is common in long term health care settings. Jade shared her perception about her own and her staff's nurse-patient/family relationship, "the thing with my staff and me getting close to the family, overstepping outside of the hospital, I guess the way I dealt with it, is I didn't feel that it was a breach, so basically just business as usual."

Personal values, as well as the nature of the nursing profession, a relationship-based, holistically focused profession are geared toward caring for all aspects of the patient and the patient's significant others. Maturation in professional and leadership skills furthers a reflection of the event in terms of evaluating prior experiences of nurse-patient relationships through a seasoned lens. "You think, well, how does that breach the code of ethics? But it does in a way in that you're becoming a little more involved, and maybe you can't think clearly sometimes, so it might be very difficult."

Long term patient care presents the presumption of feeling like family such that nurse-patient relationships are not always perceived as boundary transgressions. Jade shared an experience where she opened up her house as a place to stay for the sister of a long-term patient, a soldier, "19 years old and had leukemia." Jade stated, "I befriended his sister and it was difficult for her … she was from out-of-state and she ran out of money." At the time, Jade felt "like you can't walk away … cause we had very few Fisher houses at that time, it's not like now." Delivering holistic care for the patient and family was based on personal values and the sense of being part of a "military" community which created a sentiment of family. "It breaches a boundary, because you're no longer just my patient, you're family, you're my family friend or 'framly' whatever you want to call it." At the time, Jade did not consider aiding the patient's

sister with a place to stay as crossing a professional nurse-patient relationship breach. Jade considered the aid she provided to the patient's sister as appropriate and helpful to both the patient and the sister. "But I think it offers a whole, I think it's more complete that way and while it's probably ethically not the most sound way to be, you probably have to figure out ways where you can still stay connected but not be so involved." Jade shared her experience and her thought process about providing the sister with a place to stay while her brother was in the health care facility. Justifying "benefit to patient as helpful" circumvented evaluating a boundary crossing as a breach in a therapeutic nurse-patient relationship:

> Giving somebody a home that has no money that wants to be by their sick brother to me is in my mind not a breach. But is it? You look at the code of ethics, it really is. I mean it really does cross the boundary. Now is it so totally egregious? Well, now we're kind of, do we justify things? People that do bad things justify why they do bad things. And so you want to be that person who thinks you're doing good, it's not good. It could get very ugly very quickly. It could be just a bad situation all the way around thinking about it now. So, sometimes you're not as objective is the word I was looking for.

Jade stated that she relied on her "personal view" as to whether she felt a nurse-patient relationship was a breach of professional boundaries. In "thinking about the nurse ethics, the Code of Ethics, the Nurse Practice Act," Jade reflected on past nurse-patient relationships whereby at the time of the events, her personal value system supported the breaches as helpful and comforting to the patients and their families. Through experience and maturation, Jade's embraced personal value system appreciated the past relationships as it "really kind of is a breach, not kind of, it is a breach of, of that."

Jade also shared an experience of a professional nurse-patient relationship boundary breach that led to a marriage between a nurse and a patient:

> One of the nurses, she fell in love with her patient … they stayed together for quite some time…. from what I understand, they stayed connected. He got out, he was discharged, medically discharged, and she got out of the military.

At the time the transgression occurred, Jade did not perceive the event as inappropriate and did not confront the nurse who breached the boundary. No intervention ensued.

> I don't think any of us thought about it, it was right after the Gulf War, we were working a lot of hours, 60 hours a week sometimes, so none of us thought of it as wrong. Although, really, it's not so great.

Illustrating boundary breach events depicting "did see it as a breach and no action taken," two of the nursing leaders shared an account of a breach and their response to the breach. Allie, working in a collegial capacity, observed on more than one occasion a male nurse continually "pushing the boundaries" with a specific type of female patient.

> There was one guy (male nurse), very friendly, well not like sexually inappropriate, but inappropriate friendly to a certain type of woman. It's like his little spiny senses went up whenever one came in the ER, just chatting, sitting at the bedside … ignoring his own patients.

Allie described the work environment and the demeanor of the nurses within the ER and their behaviors at the time that allowed the behavior to continue. Fear of collegial reprisal and lack of leadership engagement prevented Allie from speaking up and reporting the non-therapeutic behavior. Due to the ongoing work culture, Allie transferred to another position within the hospital.

Cora, in her early years of nursing, recounted a boundary breach where no follow-up intervention took place. Cora described a nurse-patient relationship in which a female nurse providing direct care for a hospitalized male patient continued to maintain a relationship after his discharge, and eventually married the patient.

> This elderly patient came in with a huge heart attack … was extremely wealthy … and was actively looking for somebody to take care of him in the last couple of years of his life. He would jokingly say ... to every nurse who came through, "Are you available?" And Sonja said, "I am, are you serious?" And so she asked for his assignment every night and took care of him … and seriously continued to see him and married him in the end.

Even though the event was recognized as a nurse-patient relationship boundary breach, at the time, the event was rationalized as a consensual relationship and no harm was perceived as an outcome.

> I was like, okay, this is wrong somehow. But I didn't do anything about it. He wanted, she wanted somebody, whatever. But I thought, "Wow, that's just wrong on a lot of levels." It happened and she got out of nursing.

Boundary breach events identified as "did see it as a breach and action taken to resolve the breach," were shared by two of the nursing leaders. Nuances of familiarity between nurses and patients in long-term behavioral health care settings were perceived as challenging in evaluating and managing nurse-patient relationship boundaries. The habitual return of the same patients, patients continually "pushing the boundaries," or nurses "too intimate" with patients, created ongoing challenges for the nurse leader. Cora described the challenges associated with the long-term behavioral health care setting in relation to evaluating and managing nurse-patient relationship boundaries. She described her actions taken and perceived challenges in sustaining therapeutic nurse-patient relationships.

In long-term health care, professional nurse-patient relationships extend over periods of months, perhaps even years, and have the capacity of creating an environment where boundary limits are blurred due to the familiarity of the patients and families with the nurses. Per Cora, an occurrence of blurred boundaries occurred in an inpatient psychiatric unit where "patients tended to be recurring admissions" and the nurses cared for the patients on a long term basis. "The nurses got to know the patients very well, over years … knew all of their intimate problems. And so the boundaries bordered at the best of times because the patients thought the nurses were their friends." In the psychiatric unit, one nurse routinely asked to be assigned as the caregiver for a specific behavioral health patient who was admitted to the unit on a regular basis. "She, to my

knowledge anyway, took care of him every time he was admitted." Additionally, the nurse-patient relationship extended outside of the health care facility and culminated in the nurse befriending the patient. "It came to my attention … that she saw him outside the facility. I questioned her about this because … he was in at least seven or eight admissions a year." Cora confronted the staff nurse on more than one occasion, suspended the nurse from work, and elevated the situation to hospital leadership. "She denied it, so I had nothing to back it up. I said, 'I'm advising you, do not see this person outside of this facility because you've a contractual relationship with him on a repeat basis, basically a long-term relationship'." In this situation, the first intervention of "advisement" did not deter the nurse-patient boundary breach. The patient was re-admitted in the psychiatric unit and the nurse provided his care and "allowed him (hair stylist) to bring his tools in to the unit … several shears and razors … to do several of the patients' hair … a gross violation of what could be a weapon in the hands of possibly anybody on the unit." Following this second nurse-patient boundary breach, a second intervention ensued. "I actually suspended her for that violation … we talked about it, she saw the error of her ways and just abjectly apologized, she realized … she was his nurse and she was supposed to help him deal with (his) issues." Following this second boundary breach, Cora discovered this same patient "was the stylist for her daughter's wedding party … at her house." This nurse-patient relationship breached professional boundaries and Cora described this situation as "out-of-control. I really had great confusion about what to do; I even took that to my boss. She wound up resigning luckily, because we didn't have to deal with it." Cora identified the nurse-patient relationship as a boundary breach and intervened on two separate occasions. She felt she received inadequate support and guidance from hospital leadership. "Yeah, that was part of a phenomenal classic, you don't know your boundaries kind of thing."

Throughout the interviews, the nurse leaders described validating nurse-patient relationship boundary breaches as challenging. Sarah utilized co-workers' behaviors and accounts to substantiate her judgment in determining a nurse-patient boundary breach. "I think the challenge is trying to see is it really a breach or are they just being supportive … you never want to make that mistake, because then you look like a cold person." Evaluating and deciding if a nurse-patient relationship has overstepped the bounds of a therapeutic relationship is not an exact science, it is a complex dilemma. "I'm not for sure sometimes if I maybe have missed a few. That maybe they were violating that relationship." Making a judgment call that a professional nurse-patient relationship boundary has been violated requires objectivity and verification. In some situations, the nurse's co-workers are the first to become aware of a potential boundary crossing and may or may not feel empowered to report their suspicion to a nurse leader. "I watch and when co-workers start looking at things funny you're like, 'Okay they're seeing it too.' Then all of a sudden everybody is watching Susie over here because they think, 'She's trying to hook up'."

Sarah shared another experience about a potential professional nurse-patient relationship boundary crossing that was thwarted before it violated a boundary. A nurse became aware of being watched by Sarah and corrected her own behavior in the nurse-patient relationship. "Sometimes they say there's not a problem but you know that there probably is and you just watch it and they know they're being watched. And they seem to kind of make things right again." Sarah assessed the nurse-patient relationship boundary as being overstepped by the nurse and intervened in the situation by approaching the staff nurse with what she perceived as happening. "I said, 'When did you realize that?' She said, 'I didn't realize it until after you told me and after I cooled off. I went back and I looked, I was just falling right into the middle of a

trap'." This incident occurred with a patient "who had been here so long and she had bonded with him." The incident was resolved prior to a boundary breach occurring, "there was never any incident." The professional nurse-patient relationship was re-established as a therapeutic relationship and did not incur any negative outcomes for the patient, nurse, or health care facility. "I haven't regretted I had to do it, because it did work out for the best."

Sarah described how professional nurse-patient relationships are in many situations developed through or in concert with a patient's spouse/significant other and/or extended family. Building a relationship with the patient's family adds additional opportunities for boundary transgressions to ensue. Sarah encountered a staff nurse caring for a patient encroaching upon a boundary breach with the spouse of a dying patient. "The patient's wife was not going to live and she (nurse) was looking for a new boyfriend. It was brought to my attention … I watched and I'm like, 'oh yeah, okay'." Sarah confronted the nurse and helped her "come up with an excuse to leave the patient." This approach resolved the situation from escalating to a nurse-patient relationship boundary breach.

The nursing leaders also spoke to multiple personnel systems such as the chain of command, human resources and union rules and regulations, embedded within a complex military organization, which were perceived as challenges in evaluating and managing nurse-patient relationship boundary breaches. Mia described the challenges of working in a large bureaucratic organization where "we have a very robust system here and that we have to go through all the appropriate channels" if a boundary breach is discovered. Mia described the "tedious process in going through any type of investigation of any type of nurse-patient breach" and therefore "opt to get some expert opinion" prior to acting on nurse-patient relationship boundary breaches.

Kali described taking the approach “to halt the situation” first, and then to determine “if there was some sort of policy to mitigate the breach” to “try to figure out what could be rectified at that time … re-direct” and “pulling in appropriate resources, whether that’s like the Chief of the Medical Staff or the Chief of the Nursing Staff” to confer with prior to taking any action. In congruence with Mia, Kali described feeling “very confident in my own ability to be able to kind of re-direct in the short term and then to process in the longer time” by seeking expertise prior to intervening in resolving any nurse-patient relationship boundary breaches.

The nurse leaders articulated challenges in determining what behaviors constitute professional nurse-patient relationship boundary transgressions, expressing varying judgments. Boundary breaches were classified as sharing patient private information with non-approved entities, which in turn diminishes trust earned with a patient. Kali recounted various experiences of situations she perceived as nurse-patient relationship boundary breaches. Some of these she perceived to “violate HIPPA violations with personal information on social media, communicating in the hallway and leaving health records out and about.” Breaching patients’ personal information is in violation of privacy information acts and can lead to professional and legal ramifications for nurses. These types of breaches were perceived by Kali as important to “halt that behavior” and utilize the situation “to teach, where they don’t realize that leaving a stack of medical records on the desk is a breach, and that violates patient boundaries. The patient should be able to trust us with their information.”

Determining what constitutes professional nurse-patient relationship boundary breaches at times is conflicting and challenging in terms of what actions to take, especially if the patient was a prior patient and is no longer in a health care facility. Patients who are no longer in the direct care of a nurse, and who form friendships, are not always viewed as a nurse-patient

relationship boundary breach by the nurse, particularly if no discussion of health care transpires. Josie relayed a conversation she had with a colleague about a patient to whom she and the colleague provided direct care, who was discharged from the health care system, and who was befriended by a colleague of Josie's. Josie's colleague stated, "I have a patient that is a friend of mine … the patient comes now just to check in whenever she is here for an appointment just to give updates on how she's doing." The discussion that followed between Josie and her colleague was geared toward the avoidance of crossing professional nurse-patient relationship boundaries. From the gist of the conversation, it gave the impression that the colleague considered how to pursue a friendship with the patient without breaching professional boundaries. "I was not friends with her while she was on my treatment team; it was after I finished being on her treatment team that we became friends and we maybe talked outside of work and things like that." The ensuing conversation highlighted the colleague's personal views on where she perceived the lines were drawn between maintaining professional boundaries versus breaching professional boundaries. "She felt very strongly about that … if she (patient) asked me (colleague) what were my labs or something like that…I would just tell her where she could go to get it. She's like, 'I was very cautious about that whole scenario'." Determining whether a friendship between a nurse and former patient was ethically appropriate and not in violation of professional nurse-patient relationship boundaries was based on personal judgment; that is, where the nurse determined boundary lines were drawn.

Josie shared experiences where she had been recognized and approached by prior patients outside of the health care facility seeking consultations. "I always laughed and said my follow-up visits were at the mall when I worked the ER because people would see me in the mall." Josie described this dilemma as difficult and stated that she was not sure how to deal with the

situation. Josie felt obligated to interact with the patients and respond to their health care questions. “I would run into folks and they would come up and be like, ‘hey you fixed my finger.’ I would … look at it and ask them if they’ve had any problems … it’s like it became my follow-up visit.” Josie perceived this as over stepping a professional nurse-patient relationship boundary and questioned the ethicality of the situation. “I always felt like I was being contacted more maybe by my patients than vice versa and to continue that relationship you know.”

Sharing patient confidential information on social media was not only perceived as a venue for nurses to breach nurse-patient relationship boundaries, but was also described as an avenue through which nurses have been contacted by patients requesting to “friend” them on Facebook. In these situations, it remained the responsibility of the nurse to uphold professional nurse-patient relationship boundaries and prevent inappropriate associations with patients outside of the health care setting. Josie shared an experience in which a former patient from three years prior “recognized me at this car place and struck up a conversation and told me how she was doing. She was like, ‘yeah, I’ll Facebook friend you and show you what I’m doing’ and I was like great.” The patient had been “through a trauma” in which Josie “spent a lot of time with her.” Josie “considered her request” and “at the time just didn’t really think that it was an issue.” Josie shared her reasoning about “friending” the patient on Facebook. The former patient was “going to just let you see their progress and all the great things they’re doing because she healed up so well … because she’s so proud of herself, and you were there at this very traumatic moment in their life.” Josie clearly described her thought process at the time of the encounter and her current thought process about Facebook “friending” the former patient.

> I guess I could see now days where those lines, I mean it has to be a little bit more clear. I mean with social media those things that you think are kind of harmless …you could easily gloss it over in your mind thinking that it’s not, that it’s no big deal, but it could

> end up being a big deal. Like now with social media things like that, I guess, can happen more often.

Mia described a boundary breach in which a patient's personal health care information was breached by a nurse sharing a patient's health care information with a non-approved individual. "There was a breach in disclosing health care information about a patient outside of the family … to someone who did not need to know that information, nor did they have the right to know that information." The event was recognized as a nurse-patient relationship boundary breach and action was taken to resolve the situation. "I had to speak with the nurse about it. It didn't necessarily happen on my watch, but I fell into it, the final decision or the ruling."

The challenges described by the nursing leaders are instrumental in understanding the ethical dilemmas associated with evaluating and managing nurse-patient relationship boundary breaches. Within the challenges described, an array of diverse moral, cognitive, and organizational factors were acknowledged predisposing the nursing leaders' perceptions of and actions toward their evaluation and management of professional nurse-patient relationship boundaries.

Summary

This chapter provided descriptive data obtained from the Demographic Questionnaires of each participant, time spent in the interviews, and page lengths of each transcription. A thematic analysis was also conducted of the responses to each of twelve interview questions obtained from the participants. In turn, four essential themes and ten sub-themes were discovered from the analysis, described throughout the chapter in a narrative format with author interpretations and direct participant quotes.

Demographic characteristics were investigated to determine any relationships, differences, or impacts these factors had in the mid-level nurse leaders' ethical decision-making

about nurse-patient professional boundaries. Sharing experiences that spanned their individual careers, maturation, experience as a registered nurse, and time spent in leadership positions were identified as influencing factors that led to an increased comfort level and knowledge base in their recognition and management of nurses' behavior regarding nurse-patient relationship boundary transgressions. It was also discovered that education on the Nurse Practice Act rules and the Nursing Code of Ethics standards about nurse-patient professional boundaries was described as occurring more often in their advanced nursing programs, primarily through Ethics and Policy courses, as opposed to undergraduate nursing programs. Additionally, those nurse leaders with military experience described receiving general ethics and leadership training in accordance with positional obligations, and therefore described utilizing all aspects of education to draw from in making decisions about nurse-patient relationship boundaries. Five out of seven of the nurse leaders described observing nurse-patient relationship boundary transgressions at least once in their nursing careers, although not all observed nurse-patient relationship boundary breaches were recognized or acted upon at the time the boundary breach occurred. Nurse-patient relationship boundary breaches were described by the nurse leaders as ranging in scale from low to high levels of egregiousness as well as ethicality. The nurse leaders' perceptions and descriptions of nurse-patient relationship boundary transgressions varied in scope, such as breaches in patient confidentiality, sharing a patient's private information, and overstepping professional relationships with patients and/or their family members.

The four primary themes uncovered were identified as Ascribing Conscience, Codifying Knowledge Repertoire, Summoning Support Systems, and Weighing Elements Affecting Judgment. Each primary thematic interpretation was informed by sub-themes. Ascribing Conscience was influenced by the three sub-themes identified as Cultivating Coauthored Care

Requisites, Effecting Trust, and Composing Synergetic Interactions. Codifying Knowledge Repertoire was influenced by the two sub-themes identified as Understanding Experiential Capacity and Recollecting Educational Lessons Learned. Summoning Support Systems was influenced by the two sub-themes identified as Humanizing Leadership Traits and Employing Resources. Weighing Elements Affecting Judgment was influenced by the three sub-themes identified as Deliberating Dispositional Impacts, Tackling Organizational Barriers and Calculating Discretionary Challenges. The participants described multiple moral, cognitive, and organizational factors within each sub-theme as having influenced their ethical decision-making in evaluating and managing professional nurse-patient relationships.

In Ascribing Conscience, the nurse leaders defined their personal value system as foundational and non-negotiable. Personal values were described as the bedrock of knowing and understanding the roles patient advocacy, trust, and relationship building have on professional nurse-patient therapeutic relationships. Recognizing personal values as core principles, the nurse leaders confirmed that values decisively played a role in their ethical decision-making about nurse-patient relationships. Making a decision as to whether a nurse-patient relationship was perceived as crossing a professional boundary was vetted through the lens of the nurse leader's personal value system. A nurse leader's value system was espoused as a primary predisposing factor influencing their perception of and actions toward nurse-patient relationship transgressions.

In Codifying Knowledge Repertoire, the nurse leaders described education and experience as influential in evaluating and managing nurse-patient relationship boundary breaches. Education received in nursing school programs on the function of the Nurse Practice Act and the Nursing Code of Ethics in providing guidance to nurse leaders when confronted with

potential professional boundary transgressions was perceived as limited. General ethics and leadership training received in work settings was perceived as having a greater impact in their decision-making process in recognizing and acting on nurse-patient relationship boundary transgressions. The nurse leaders spoke to the effect experience, in number of years and positional obligations, played in influencing their perceptions of nurse-patient relationship boundaries. Increased years of experience, as both a registered nurse and as a nurse leader, was perceived as a factor in contributing to their comfort with and knowledge in appropriately recognizing and acting on nurse-patient relationship boundary transgressions. Utilizing discretion in evaluating and managing nurse-patient relationship boundary transgressions was described by the nurse leaders as dependent on a variety of factors. In situations where boundary transgressions were not perceived as breaches, the nurse leaders utilized justification and rationalization as predisposing factors contributing to non-breach summations of the relationships. Additionally, nurse leaders described various nurse-patient relationships in which they determined professional boundaries were breached; however, interventions were not acted upon. Factors described as attributing to non-interventions were identified as fear of co-worker reprisal, inadequate leadership engagement, inadequate leadership support, and organizational cultures entrenched in denial of inappropriate behaviors by nurses. Familiarity was also described as a factor in long-term care settings contributing to nurse-patient relationship boundary breaches that required nurse leaders' ongoing interventions in mitigating boundary transgressions.

In Summoning Support Systems*,* the nurse leaders described the influence their leadership style and the use of resources affected perceptions of and actions toward professional nurse-patient relationship transgressions. Leadership style was espoused as a predisposing factor

in the nurse leaders' ethical decision-making about nurse-patient relationship transgressions. Active leadership engagement and leading by example were consistently described as beneficial in assessing nurse-patient relationship boundary breaches on an ongoing basis. Being "available" and "approachable" were regarded as factors in assuring staff nurses abide by the organization's policies and do not cross professional nurse-patient relationship boundaries. An approachable, non-judgmental demeanor affords a non-threatening environment, which in turn, allows staff to feel comfortable when confronted by the leader for clarification of questionable professional behavior. Resources, primarily described as policies and personnel, were described as available for use in evaluating and managing nurse-patient relationship boundary breaches. The nurse leaders described organizational leadership, chaplains, legal counsel, and patient advocates as supportive personnel available to confer with in evaluating and managing nurse-patient relationship boundary breaches. Organizational policies were often referred to as helpful in seeking written guidance for evaluating and managing nurse-patient relationship breaches. Described as a hindrance, organizational "buddy systems" were perceived as creating organizational environments entrenched in denial, thereby producing organizational "work-arounds."

In Weighing Elements Affecting Judgment, the nurse leaders spoke to deliberating impacts, tackling barriers and calculating challenges they encountered with respect to utilizing discretion and assuming accountability in evaluating and managing nurse-patient relationship boundaries. Accepting responsibility for utilizing discretion and assuming accountability for one's actions when evaluating and managing nurse-patient relationship boundary transgressions fell into three predominate categories. The nursing leaders illustrated the categories through shared stories of their experiences in dealing with nurse-patient relationship boundary breaches.

The experiences ranged in scope as follows: boundary crossings not seen as transgressions and therefore no actions taken (thought we were "doing good" at the time), boundary crossings recognized as breaches, but no actions taken (it was accepted and we were afraid of repercussions), and boundary transgressions identified and interventions taken (took actions to resolve the issue). Factors identified by the nurse leaders as influencing their ethical decision-making in evaluating and managing professional nurse-patient relationships were described as individually defined boundaries, fear of being accused of inappropriate behavior with patients by co-workers, a complex organization with multiple personnel layers, nursing personnel unwilling to come forward and report observed boundary breaches, and fear of making a false claim about a perceived boundary breach.

Throughout this chapter, the nurse leaders candidly shared their diverse experiences with evaluating and managing nurse-patient relationship boundary breaches. They highlighted an array of moral, cognitive and organizational factors perceived as influencing their interpretation of and motivation to act in addressing professional boundary transgressions. The emergence of the themes and sub-themes discussed in this chapter underscores the complexity of the nurse leader's ethical decision-making essential to executing ethical actions when confronted with the ethical dilemma of a nurse-patient relationship boundary breach.

Chapter six culminates with a discussion of integrated quantitative and qualitative findings, connection to theory, and implications and recommendations for future research. A constructed theory generated from the results of the integrated findings is narratively and visually modeled in the chapter. The findings address the overarching research question: What factors influence nursing leaders' ethical decision-making in their perceptions of and actions toward nurse-patient relationship transgressions?

Chapter Six – Discussion, Implications and Recommendations

In this final chapter I will provide a discussion of the integration of quantitative and qualitative findings, connection to theory, literature related to findings, the emergence of a grounded theory, implications, a reflection on the process and study, limitations of the study, and recommendations for future research. I conducted this study using a mixed methods sequential explanatory design, divided into two distinct phases. Quantitative data was collected and analyzed in phase one followed by qualitative inquiry and interpretative techniques undertaken in phase two. As this methodology captures the qualities of both designs and yields greater insights than either method independently, it was chosen for the purpose of enhancing the "breadth and depth of understanding and corroboration" of the data findings (Curry & Nunez-Smith, 2015, p. 4). The overarching research question that guided this study was: What factors influence nursing leaders' ethical decision-making in their perceptions of and actions toward nurse-patient relationship transgressions?

The purpose of this study was to ascertain nursing leaders' knowledge and skill, with an overarching aim of better understanding their perceptions of moral, cognitive, and organizational factors influencing their ethical decision-making when evaluating and managing nurse-patient relationships. Constructing a theory grounded in the views of the participants was generated as a final outcome of this study. According to Curry and Nunez-Smith (2015), studies aimed at understanding underlying beliefs, values, and motivations of individual behaviors benefit from a mixed methods design "such that the design and findings of one component are central to the other" (p. 7).

Capitalizing on the strengths of each methodology, sub-questions addressing each phase of the study guided the method of inquiry and analysis, such that statistical techniques selected

for the analysis were based on the question's characteristics. The quantitative phase of this study addressed the following two sub-questions.

Sub Question 1. What are nurse leaders' opinions regarding the ethical behavior of a nurse as described in the nurse-patient relationship vignettes?

Sub Question 2. What action will be taken by the nurse leaders' in the vignettes involving staff members engaging in inappropriate nurse-patient relationships?

Data was collected by means of two vignettes that were given to each study participant, of which each described a potential and/or actual nurse-patient relationship boundary transgression. Each participant received a 6-point Likert scale anchored with the polar opposites *strongly agree* and *strongly disagree*. The 6-point Likert scale was composed of six statements invoking an ethical decision regarding the behaviors described in each scenario. Each respondent was asked to answer each statement based on his/her beliefs and feelings toward each scenario. Additionally, each participant completed a demographic questionnaire composed of eight questions.

To address the qualitative phase of this study, the following sub-question directed this section of the study.

Sub Question 3. What moral, cognitive, and organizational socialization factors predispose nurse leaders' perceptions of and actions toward their evaluation and management of professional nurse-patient relationship boundaries?

I developed a series of 12 open-ended questions to guide each interview. Each participant transparently shared her experiences and perceptions related to the overarching aim of this study. Additionally, the interviewed nursing leaders completed a demographic questionnaire composed of the same eight questions used in the quantitative phase of study. The methods of data

acquisition included participant observations, written field notes, audio recordings, and demographics.

This study delineated relationships among nursing leaders' demographic characteristics and ethical decision-making about professional boundaries and nurse-patient relationships. In addition, nursing leaders' beliefs about boundary transgressions and unethical behavior, as well as their comfort and skill in evaluating and managing boundary breaches, were uncovered. Sharing experiences, the nursing leaders described factors they perceived as influencing their deliberation of and motivation to act on nurse-patient relationship boundary breaches.

Integration of the quantitative and qualitative study findings are presented in the following section. The integration of results is represented in the format in which the quantitative and qualitative findings are "arrayed one after the other, in parallel fashion" (Creswell, 2015, p. 84). In this approach, I will first discuss the quantitative results followed by the qualitative results and then indicate how the qualitative findings provide more depth and context relevant to the quantitative results.

Discussion

Given the serious consequences of boundary violations in terms of harm to patients, nurses, and organizations, it is important to determine characteristics associated with and underscore factors predisposing nursing leaders' ethical decision-making skills to manage such quandaries. As this study is a mixed methods sequential explanatory design, a number of notable findings revealed during the quantitative analysis phase were further developed through personal narratives disclosed during the qualitative phase. Through interviews, the nurse leaders divulged a plethora of predisposing factors influencing their ethical decision-making about nurse-patient relationship boundaries. Employing a "narrative, contiguous" approach, the following section

presents the integration of data results by connecting the quantitative and qualitative findings, providing a more comprehensive and enriching set of insights (Curry & Nunez-Smith, 2015, p. 248).

Ethical decision-making about professional boundaries and nurse-patient relationships.

Quantitative phase. In the quantitative phase of this study, an Ethical Decision-Making Survey Instrument was utilized to ascertain nursing leaders' self-assessment about their beliefs and actions about different gradations of nurse-patient boundary transgressions. The instrument consisted of two vignettes, each representing a boundary breach in professional nurse-patient relationships, such that vignette one described a flirtatious relationship and vignette two described a personal relationship between a nurse and a patient. Each vignette, through a six question, 6-point Likert scale questionnaire, surveyed the nurse leader's ethical decision-making when evaluating and managing boundary breaches. Based on the results of the item analysis it was found that the nursing leader's degree of ethical decision-making about nurse-patient boundary breaches varied between the two different gradations in the nurse-patient relationship scenarios. In a mean comparison between each of the 12 questions, the two lowest mean scores revealed a belief by the nurse leaders that nurses' flirtatious behaviors toward patients did not violate, nor were they perceived as unethical professional conduct. On the other hand, two of the five highest mean scores revealed a belief by the nurse leaders that personal relationships with patients were perceived as unethical behaviors and considered violations of professional boundaries. Additionally, the third highest mean score revealed that nurse leaders felt comfortable speaking with nurses about their flirtatious behavior towards patients. The remaining two highest mean scores revealed that nurse leaders did not feel it was their

responsibility to speak to nurses about flirtatious behaviors or personal relationships between a nurse and a patient. Based on the fact that both scenarios represent boundary breaches in professional nurse-patient relationships, the mean scores show variations in ethical decision-making by the nursing leaders between the two different gradations in the nurse-patient relationship scenarios. The results merited further inquiry in order to better understand the variance in ethical decision-making about nurse-patient relationship boundary transgressions.

Qualitative phase. Interviews obtained from the nurse leaders during the qualitative phase of this study provided depth and context related to ethical decision-making about professional boundaries and nurse-patient relationships. The nursing leaders' decisions about what constituted nurse-patient relationship boundary breaches and those perceived as unethical are ascribed to the nurse leaders' moral voice of conscience, such that personal values are the determining factor in ethical decision-making and emerged as a central theme of all interviewees. Nursing leader's decisions in managing nurse-patient relationship boundary breaches are anchored in their personal value system. Overseeing staff nurse's advocacy and relationship building with patients, nurse leaders benchmark staff nurses' interactions with patients and families as gauged against their personal beliefs. Relying on their own conscience as the standard by which they appraise staff nurses' advocacy and relationship building with patients is applied when weighing therapeutic relationships versus boundary breaches. This common thread is reverberated throughout their narratives mirroring similar statements, thus defining their process of ethical decision-making about professional boundaries and nurse-patient relationships.

Connecting/integrating findings. Personal values create context in which nurse-patient relationship boundary breaches are deliberated and egregiousness determined. In alignment with the findings of the item analysis, the nurse leaders do not readily deem flirtatious type behaviors

by nurses toward patients as professional boundary breaches or consider these type of behaviors unethical, but the behaviors were generally determined inappropriate. On the other hand, nurses engaging in personal relationships with patients are perceived as violations of professional boundaries and unequivocally unethical, though boundary violations and unethical behaviors were not always realized at the time the events occurred. Feeling comfortable in speaking with staff nurses about flirtatious behaviors and/or personal relationships with patients, the nurse leaders spoke to a plethora of factors influencing their decisions of whether or not to address boundary transgressions with nurses. Positional obligation committed the nurse leaders to accept responsibility in advocating for professional nurse-patient relationships; however, they did not believe it was their responsibility to speak to staff nurses about any types of professional boundary breaches without seeking appropriate assistance. Working in a military organization where chain-of-command is the line of authority/responsibility and personnel actions are governed by regulations entrenched in a bureaucratic organization, overwhelmingly, the nurse leaders sought higher levels of leadership and/or subject matter experts for guidance in carrying out interventions necessary in resolving any type of nurse-patient relationship boundary breaches.

Individual values attributed to virtues derived from one's upbringing were described as influencing perceptions of and actions toward nurse-patient relationships. As such, personal values provide a framework for evaluating and managing professional boundaries. Determining what is and is not a boundary breach, as well as determining what actions to take in resolving a boundary breach, is aligned with one's personal values. The nurse leader's value systems lead to questioning the ethicality of relationships, questioning interventions in mitigating boundary breaches and questioning methods of carrying out actions in resolving boundary transgressions.

Mitigating negative effects of professional boundary transgressions are seen as requiring a tactful and non-threatening approach in addressing the patient, family and nurse while also focusing on rebuilding a trusting relationship.

Summarizing findings. Reflecting on the findings from the thematic analysis, factors such as the nurse leader's personal upbringing, strengths, boundaries, and ethics defines their primary moral guide in deliberating ethical decision-making about professional boundaries and nurse-patient relationships, thus attributing to variances in ethical decision-making about nurse-patient relationship boundary transgressions. Ascribing conscience, the nurse leader's personal value systems, influence their perceptions about the process nurses engage in when building relationships, advocating for patients, and building patient trust, thus introducing bias into their interpretations of nurse-patient relationship boundary violations and unethical behaviors due to benchmarking nurse-patient relational activities against their own. The nurse leader's personal value system morally factors into the nurse leader's ethical decision-making about what is and is not deemed boundary violations and unethical behaviors, thus connecting to and further illuminating the findings of the item analysis offering possible explanations for the variances in ethical decision-making about nurse-patient relationships and boundary transgressions.

Relationships between nurse leaders' characteristics and ethical decision-making about boundary breaches.

Quantitative phase. Relationships between ethical decision-making and the characteristics of the nursing leaders surveyed were statistically analyzed by conducting 48 bivariate Pearson product-moment correlation coefficients. The tests were run to determine if there were any significant relationships between the 12 item Ethical Decision-Making Survey Instrument and the nursing leader's age, years of work experience as a registered nurse, years of

work experience as a nurse manager, and years of work in a military treatment facility. The findings revealed three significantly positive relationships with moderate correlations, of which all three were from vignette 2, the scenario depicting a personal nurse-patient relationship boundary breach. The first and second significant moderate correlations with positive relationships indicates that the greater the number of years of work experience as a registered nurse and the greater the number of years of work experience as a nurse manager, the greater comfort the nurse leader felt in speaking to a nurse about a personal relationship boundary breach with a patient. Additionally, the third significantly positive relationship with moderate correlation indicates that the greater the number of years of work experience as a nurse manager, the more knowledge the nurse leader believed she/he had to appropriately manage a personal nurse-patient relationship boundary breach.

Qualitative phase. Through thematic analysis of the interviews collected during the qualitative phase of this study, codifying a repertoire of knowledge evolved with maturation, such that maturation played a key role in the nurse leaders' ethical decision-making about professional boundaries and nurse-patient relationships. The nurse leaders revealed maturation in the realms of experience as a registered nurse and experience as a nurse leader led to changing perceptions of and actions toward nurse-patient relationship boundary breaches. As maturity ensued and experience was gained in both nursing and in management, the nurse leader's personal assessments of comfort and knowledge in speaking to and appropriately managing a personal nurse-patient relationship boundary breach increased. Overwhelmingly, reflections shared over the course of their careers presented sometimes stark differences in how ethical decision-making about nurse-patient relationship boundary breaches were perceived and acted upon early in their nursing careers as opposed to their current nursing careers. Stories were

shared whereby nurse leaders in their novice years did not perceive nurse-patient relationship boundary breaches as transgressions but, on the contrary, in some situations believed the relationships to be helpful to patients and/or the families. Maturation in experience as an RN and nurse leader rendered perceptive changes about once-held views.

Connecting/integrating findings. Various nursing and leadership experiences accrued over time lent to an enhanced knowledge base in which the nurse leaders were more inclined to pick up on subtle boundary breaches as well as the more blatant transgressions. Even though the Pearson product-moment correlation coefficients did not determine any significant relationship between the Survey Instrument and the nurse managers' years of work in a military treatment facility, the nurse leaders' narratives highlighted military work experience as advancing their knowledge repertoires influencing ethical decision-making when evaluating and managing nurse-patient relationship boundaries. Crediting the military's formal ethics and leadership training courses with content pertaining to maintaining professional interactions with patients, it is also purported as contributing to a value system that drives actions aimed at identifying and resolving nurse-patient relationship boundary breaches. Specific to military service, non-fraternization rules with colleagues are carried over into health care, asserting an ethical standard of non-fraternizing with patients, such that nurse-patient relationships are expected to remain professional. The rule was credited as supporting personal morals considered foundational for making decisions about boundary violations and unethical behavior. Diverse nursing experiences garnered in military health care facilities were described as continuously compounding breadth and depth of comfort, knowledge, and skills to draw from when evaluating and managing boundary breaches.

Summarizing findings. Maturation in nursing experience as an RN and nurse leader was described as strengthening self-efficacy, such that nurse-patient relationship boundary breaches were identified and acted on. As such, the nurse leaders not only described nurse-patient relationship boundary breaches occurring as flirtatious and intimate relationships, but they also described situations such as diverting patients narcotics, leaving patients medical records lying open for anyone to see, sharing patient information on social media, talking in public areas about patients, contacting patients once discharged, and/or contacting patients family members outside of the health care facility as nurse-patient relationship boundary transgressions. Considering the findings of the thematic analysis, the nurse leaders' descriptions of codifying knowledge through experiential and educational experiences gained over time connects to and further explains findings from the Pearson product-moment correlation coefficients. As such, maturation in experience and position builds comfort and wisdom, fortifying the nurse leader's ability to ethically manage boundary violations and unethical behaviors.

Variances among nurse leaders' ethical decision-making about differing gradations of boundary breaches.

Quantitative phase. To determine whether there were significant differences among the nursing leader's ethical decision-making about two different gradations of nurse-patient relationship boundary breach scenarios, six paired-samples *t*-tests were run. Results show two statistically significant differences in the scores of two pairs of items between vignette one and vignette two of the Ethical Decision-Making Survey Instrument. Findings reveal that the mean scores for Pair 1 and Pair 2 were significantly greater for vignette two than for vignette one. The results indicate there was a significant difference in the nurse manager's ethical decision-making about nurse-patient relationship boundary violations and unethical behaviors regarding a nurse's

behavior in a personal relationship with a patient than that of a nurse's flirtatious behavior with a patient. Considering these results, qualitative inquiries about nurse leader's ethical decision-making about professional boundaries and nurse-patient relationships are important to further explain the variability in nursing leaders' perceptions of boundary violations and unethical conduct.

Qualitative phase. During the qualitative phase of this study, thematic analysis of the interviews discerned multiple elements affecting judgment about professional boundaries and nurse-patient relationships. The nurse leaders shared experiences of discretionary challenges they perceived as influencing their ethical decision-making about boundary violations and unethical behaviors. Analyses of their narratives revealed insights into the variances associated with acknowledging boundary breaches and with decisions regarding non-actions or actions carried out in resolving unethical behaviors. The nurse leaders not only further explained the quantitative findings, but provided context elucidating factors influencing their decision-making, in turn highlighting a greater understanding of the complexities associated with evaluating and managing boundary breaches.

Connecting/integrating findings. In several of the nurse leaders' narratives, they described witnessing staff nurses extending their relationships with their patients and/or patient's families outside the limits of a professional therapeutic relationship to that of a personal relationship. The narratives reflected variances among the nurse leader's identification of and actions toward the nurse-patient relationship boundary transgressions. In some situations, contextual factors perceived as compassionate, helpful expressions of care for the patients and families preempted the perceptions of boundary violations and unethical behaviors. In others, circumstances surrounding personal nurse-patient relationship boundary breaches were

rationalized as consensual relationships and perceived as no harm to the patients, thus weighing into their decisions that no obligation for interventions were believed necessary. In still others, personal nurse-patient relationships were perceived as boundary violations and unethical behaviors and were confirmed by means of objectively verifying over involvement through observation and confrontation; however, circumstances surrounding the transgressions yielded varying actions toward resolutions.

Summarizing findings. The various elements affecting judgment in determining boundary violations and unethical behaviors indicative of nurse-patient relationships revealed the variability in perceptions and the complexities associated with evaluating and managing professional boundary transgressions. Taking into account the reality that nursing is a relationship-based profession, the nursing leaders used discretion when weighing circumstances surrounding nurse-patient relationships. Calculating contextual and circumstantial factors such as holistic versus non-holistic, compassionate versus non-compassionate, beneficial versus non-beneficial, and intrusive versus non-intrusive relationships weighed heavily in determining what behaviors constitute boundary violations and unethical behaviors. Confirming relationship boundary breaches by means of objectively verifying over involvement through observation and confrontation reflected the challenges associated with ethical decision-making. As such, weighing elements affecting judgment speaks to the necessity of calculating discretionary challenges influencing nurse leaders' ethical decision-making, thus connecting to and providing additional insights into the findings of the six paired-samples *t*-tests, presenting possible reasons for the variances in nurse-managers views about nurse-patient relationships considered boundary violations and unethical behaviors.

Impact of nurse leaders' characteristics on ethical decision-making about differing gradations of boundary breaches.

Quantitative phase. Forty-eight mixed between-within subjects ANOVAs were statistically analyzed to determine the impact of the nursing leaders' characteristics—gender, observation of past inappropriate professional boundaries, education level, and current career status as a mid-level nurse manager—on ethical decision-making about two different gradations of professional boundary breaches. The findings revealed that there were no significant interactions between the manager's characteristics and the manager's ethical decision-making in determining a violation of and the unethicality of a nurse-patient professional boundary breach in the two scenarios. Additionally, there were no significant interactions between the manager's characteristics and the manager's (a) belief it was their responsibility to speak with the nurse about his/her behavior, (b) comfort in speaking with the nurse about his/her behavior, and (c) belief in his/her knowledge and skill to manage the situations appropriately in both vignettes. However, the analyses showed a significant difference in the nurse manager's ethical decision-making, revealing that professional boundary violations and unethical behaviors scored higher for nurses engaged in personal relationships with patients than nurses engaged in flirtatious relationships with patients. As both scenarios were nurse-patient relationship boundary transgressions, qualitative inquiries addressing the variabilities in nursing leaders' perceptions of boundary violations and unethical behaviors is paramount to further explain nurse leader's ethical decision-making about professional boundaries and nurse-patient relationships.

Qualitative phase. Thematic analysis of the nurse leaders' narratives obtained during the qualitative phase of this study highlighted past and present experiences with deliberating dispositional impacts and organizational barriers affecting ethical decision-making about nurse-

patient relationships and professional boundaries. By summoning support systems, the nurse leaders employed resources in weighing factors when assessing nurse-patient relationship boundary violations and unethical behaviors. Transparently portraying nuances associated with decoding these ethical dilemmas shed light on the perplexity of the decision-making process in acknowledging and resolving professional boundary violations and unethical behaviors.

Connecting/integrating findings. Identifying factors affecting judgment, the nurse leaders articulated the impact of their personal views when deliberating boundary transgressions and unethical behaviors such that decisions made acquiesce to their age, comfort and skill levels in managing ethical dilemmas, and perceived ability to communicate effectively with patients, staff, peers, and leadership. In turn, levels of experience, education and navigating situational dynamics of ethical dilemmas impacts decisions made about boundary violations and actions taken. Additionally, the nurse leaders concede holistically building nurse-patient relationships with the intent of establishing trust and strengthening advocacy generates familiarity, a factor viewed both positively and negatively. From a positive perspective, familiarity enhances the bond between nurses and patients, allowing patients to share needed information essential to their care. From a negative perspective, familiarity has the potential of over-extending relationships, thus potentiating blurring and/or crossing of professional boundaries. Thus vacillating with “where’s the line” in determining nurse-patient relationship boundary transgressions and unethical behaviors and determining what actions to take in resolving boundary breaches is due in part to deliberating the multiple factors impacting judgment.

Factors impacting judgment were also highlighted as barriers such that they were viewed as detrimental and contributing to delaying or preventing the nurse leaders from acknowledging and/or intervening in nurse-patient relationship boundary violations and unethical behaviors.

Barriers experienced impacting judgment included scant nursing education related to professional boundaries, fear of retaliation, accusations from colleagues of similar inappropriate behaviors with patients, lack of leadership engagement or push-back, avoiding conflict in the workplace, the organizations disciplinary process, lack of available resources, and lack of staff willing to come forward with information about nurse-patient relationship boundary breaches. Of the barriers listed, scant nursing education related to professional boundaries counters the ANOVA finding of no significant interactions found between the manager's characteristic and education level, and the manager's ethical decision-making in acknowledging and managing nurse-patient relationship boundary breaches. The nurse leaders believed that scant education about boundary limits impacted recognition and actions toward mitigating boundary transgressions. The multiple barriers impacted nursing leaders determining where therapeutic nurse-patient relationship lines end and where nurse-patient relationship boundary breaches and unethical behaviors begin.

Concerned with misjudging nurse-patient therapeutic relationships, as well as knowing nurse-patient relationship boundary breaches can be deleterious to all embroiled in the situation, the nurse leaders sought resources when deliberating and weighing factors affecting their judgment in evaluating and managing nurse-patient relationship boundary breaches and unethical behaviors. Summoning support systems included seeking guidance from organizational policies, standards, rules and regulations; as well as seeking reassurances from both nursing and non-nursing personnel, by consulting with colleagues, leadership and/or subject matter experts. Exercising prudence, the nurse leaders were deliberate in summoning support systems with negotiating moral, cognitive and organizational factors impacting ethical decision-making about nurse-patient relationship boundary breaches and unethical behaviors.

Summarizing findings. The nursing leaders expressed ethically determining boundary lines, identifying boundary breaches, and carrying out interventions aimed at resolving boundary violations and unethical behaviors as monolithic conundrums. Recognizing nursing as a holistic profession, based on a philosophy of "living and being that is grounded in caring, relationship, and interconnectedness" (Klebanoff, 2013, p. 1), healing the whole person without becoming over-involved straddles a fine line between therapeutic and non-therapeutic boundaries. As the nurse leaders experienced nurses overextending relationships with patients, deciphering between behaviors indicative of therapeutic relationships versus non-therapeutic relationships impacted deliberating "Where's the line?" Acknowledging that professional boundary lines are invisible, the nursing leaders' attempts at deciphering boundary violations and unethical behaviors were predicated on balancing their personal views with circumstantial and organizational factors impacting ethical decision-making and asking one's self, "What would a reasonably prudent nurse do?" Thus, revealing dispositional impacts and organizational barriers influencing nurse leaders' ethical decision-making in determining boundary violations and unethical behaviors spurred summoning support systems by employing resources to assist with deliberating and weighing the elements affecting judgment. In turn, the findings from the thematic analysis connects to and provides additional insights into the findings of the mixed between-within subjects ANOVAs, presenting possible reasons for the variances in nurse-managers views about nurse-patient relationships considered boundary violations and unethical behaviors.

Connection to Theory

As this study is about nursing leaders' ethical decision-making about professional boundaries and nurse-patient relationships, virtue ethics, self-efficacy, and relational ethics theories informed this study from its onset. For the quantitative component, phase one, the

survey was developed to measure the dimensions of the ethicality construct, which was supported through the concept of the virtue ethics and self-efficacy theories. In phase two, the qualitative component, the results of the surveys were followed up and further explained by nurse leaders sharing their perceptions of and actions toward nurse-patient relationship boundary breaches. During this component, the nursing leaders described moral, cognitive, and organizational factors they perceived as influencing their moral deliberation and impulse to act on nurse-patient relationship boundary breaches. Expanding the understanding of nurse-patient relationships, that is, a morally bound co-constructed connection between a patient and a nurse, relational ethics theory supports nursing leaders' experiences with moral choices regarding nurse-patient relationship boundary breaches. As a final outcome of this study, an ethical decision-making model grounded in the views of the participants was constructed, interpreted from the mixed methods review of the survey results and the participant views. The ethical decision-making model is narratively explained and figuratively illustrated later is this chapter.

Virtue ethics theory.

Quantitative phase. As nurse leaders' face ethical dilemmas, such as encountering professional boundary breaches by staff nurses, virtue ethics helps moral agents behave morally by "acting according to right reason" (Devettere, 2016, p. xx). Of the participants surveyed in the quantitative phase of this study, 66% strongly believed a flirtatious encounter between a nurse and patient violated professional boundaries and 44% strongly believed the encounter was unethical; whereas, 98% strongly believed an intimate personal relationship between a nurse and patient violated professional boundaries and 95% strongly believed the encounter was unethical. The variances in findings informed the need for more in depth probing of nursing leaders' perceived moral and intellectual virtues and their influence on moral judgment.

Qualitative phase. Findings derived from the qualitative phase of study realized a better understanding of the moral and intellectual virtues predisposing nursing leaders' ethical decision-making about professional boundary breaches and unethical behavior. Consistently, the nurse leaders expressed that decision-making about professional boundary breaches was impacted by their strong values, ethics, and personal beliefs. They expressed the belief that everybody is different and thus have different values; therefore ethical decision-making about professional boundary breaches is impacted differently based on one's personal value system. Additionally, discussions revealed that the standard by which they evaluate and manage nurse-patient relationships was based on what they consider was morally and ethically right. The nurse leaders also described ethical decision-making about professional boundary breaches as being impacted by the belief that staff nurses' principles, values, morals, and ethics influence their level of involvement in nurse-patient relationships. Recognizing personal values as core principles, the nurse leaders confirmed that their values decisively played a role in their ethical decision-making about nurse-patient relationships. Their beliefs are in congruence with Arries (2005), who contends that virtue ethics, which focuses on a person's character, "might provide a more holistic analysis of moral dilemmas in nursing and might facilitate more flexible and creative solutions when combined with other theories of moral decision-making" (p. 65). From a virtue ethics perspective, the moral character and disposition of the nurse leader as a moral agent determines the manner in which moral dilemmas are approached and ethical decision-making carried out.

Self-efficacy theory.

Quantitative phase. Nurse leaders encountering nurse-patient relationship boundary breaches intervene as reflective of Bandura's self-efficacy theory (Bandura, 1997). The nurse

leaders' decisions on courses of actions and their capability for carrying through on those actions in resolving breaches were partly based on judgment of one's knowledge and skills, as well as one's belief in their capability of confronting and overcoming the uncertainties associated with their decisions. Of the participants surveyed in the quantitative phase of this study, findings revealed the greater the number of years of work experience as an RN, the greater comfort the nurse leaders felt in speaking to a nurse about a personal relationship breach with a patient. As well, the greater the number of years of work experience as a nurse manager, the greater comfort they felt in speaking to a nurse about a personal relationship breach with a patient. It was also found that the greater the number of years of work experience as a nurse manager, the more knowledge the nurse leaders believed they had to appropriately manage a nurse-patient relationship boundary breach. The findings informed the need for more in depth probing of nursing leaders' perceived sense of self-efficacy in carrying through on courses of actions geared toward managing nurse-patient relationship boundary breaches.

Qualitative phase. During the qualitative phase of this study, the nurse leaders conveyed their sense of self-efficacy when managing nurse-patient relationship boundary breaches by transparently describing their personal experiences. In consensus with the quantitative findings, the nurse leaders spoke to maturation in personal and professional growth as influencing their actions in managing boundary breaches. As such, nurse leaders described responding to nurse-patient relationship boundary breaches observed during their early years as being encumbered due to inexperience, inadequate skill, and no experience with confrontation. Thus, no actions were taken in mitigating boundary breaches. On the other hand, maturation and experience bolstered the nurse leaders' self-confidence, in turn creating a higher sense of self-efficacy and comfort approaching staff about boundary breaches. In line with nursing and management

experience, the nursing leaders with military service spoke to military experience as intensifying their sense of self-efficacy such that they felt comfort in their ability to manage nurses through professional nurse-patient relationship boundary breaches. From a self-efficacy perspective, maturation in terms of personal and professional growth enhanced their sense of comfort and skill, enabling the nurse leaders as moral agents to carry out courses of actions for managing nurse-patient relationship boundary breaches.

Connecting/integrating virtue ethics and self-efficacy theory with findings. Linking the theories of virtue ethics and self-efficacy provides a foundation for nursing leaders' character-based leadership and ethical decision-making when encountering nurse-patient relationship boundary breaches. As virtue ethics theory portends character traits and personal dispositions are the crux of moral judgment and self-efficacy theory portends belief in one's capabilities are the crux of organizing and executing a course of action, the two theories converged give credence to nursing leaders' moral agency in making ethical decisions about nurse-patient relationship boundary breaches. As realized from this study, nurse leaders' core values predisposed their interpretation of and actions toward nurse-patient relationship boundary breaches. As well, this study brought to light a number of factors that influenced interpretations of and actions toward nurse-patient relationship boundary breaches.

First and foremost, in determining if behaviors are perceived as ethical or unethical and whether a nurse-patient relationship is breached, the surveyed nurse leaders answered the questions for each vignette based on their personal beliefs, just as the interviewed nurse leaders answered the questions benchmarked against their personal core values. The nurse leaders as moral agents exuding character-based leadership ethically determine nurse-patient relationship boundary violations and unethical behaviors from a position of personal values. As character-

based leadership consistently positions “integrity” as a “common denominator across the articles” defining “character” (Conger & Hollenbeck, 2010; Thompson & Riggio, 2010, p. 214), the interviewed nurse leaders routinely described their “character” as grounded in “integrity” and their foundation for ethical decision-making. Consistently, the nurse leaders described “integrity” as the standard by which they assessed and managed nurse-patient relationship boundaries.

Secondarily, organizing a course of action and carrying through on interventions to resolve nurse-patient relationship boundary breaches are again based on the nurse leaders’ personal belief of one’s capability. Realizing character-based leadership implies moral thought is shaped by “character,” or the integrity of an individual, Hannah and Avolio (2010) assert “character” is also representative of groups; such that, each is influenced by the other and by the climate and culture of the organization. A group’s “character” may vary across contexts, influencing a leader’s “level of confidence in their ability to perform those ethical behaviors across various contexts”; that is, generate “moral efficacy across contexts” in taking actions to resolve boundary breaches (p. 297). Emerging from the nurse leaders’ narratives, an array of moral, cognitive, and organizational factors described as influencing ethical decision-making about nurse-patient relationship boundary violations and unethical behaviors impacted courses of actions. Factors ranged across a spectrum from that of inhibiting to supporting the nurse leaders’ belief of one’s capability to perform in a given situation. The nurse leaders described factors inclusive of people, policies and processes that influenced motivation in taking moral actions. Personnel factors such as peers, colleagues and leadership were perceived as both supportive and/or inhibitive depending on the context of the situation. From an inhibitive perspective, group character described as having “herd mentalities,” accusative behaviors, or retributive natures instilled fear, thus impacting moral judgment, hindering interventions aimed at resolving

boundary violations and unethical behaviors. On the other hand, from a supportive perspective, group character described as objective provided verification of nurse-patient relationship boundary breaches, thus validating the nurse leader's perceptions, hence providing the impetus to proceed from moral judgment to moral action aimed at mitigating nurse-patient relationship boundary violations and unethical behaviors.

Summarizing theory connections with findings. From a nursing leadership perspective, connecting virtue ethics and self-efficacy theory offers clarity in understanding the impacts, barriers and challenges nursing leaders face as moral agents in carrying out moral courses of action when making ethical decisions about nurse-patient relationship boundary breaches. Virtue ethics theory and self-efficacy theory provide nurse leaders with a foundation supporting character-based leadership and ethical decision-making. Converged, the two theories arm the nurse leader with the psychological resources that bridge moral thought to moral action. As realized from this study, factors attributed to the "character" of the nurse leader's and those attributed to the "character" of groups have been identified, contributing to the body of knowledge and potentially reducing the gap between recognizing and taking actions in mitigating these behaviors.

Relational ethics theory.

Quantitative phase. Nurse leaders, by position, are expected to be aware of the relational narratives co-constructed between nurses and patients within their span of control. As such, determining nurse-patient relationship boundary breaches in congruence with relational ethics theory reflects the complexity of "knowing" at what point intricately interwoven relationships overextend professional bounds. Of the participants surveyed in the quantitative phase of this study, findings consistently revealed the belief by the nurse leaders that personal relationships

between nurses and patients score higher than flirtatious relationships between nurses and patients when determining behaviors considered boundary violations and unethical behaviors. The two highest mean scores resulting from the item analysis reflected these findings; in addition, the mean scores from the paired-samples *t*-tests and the main effects resulting from the mixed between-within subjects ANOVAs reflected similar results. The variances in findings informed the need for additional depth of understanding the role relational ethics plays in influencing ethical decision-making when deliberating the line separating therapeutic from non-therapeutic nurse-patient relationships.

Qualitative phase. Narratives shared during the qualitative phase of this study embodied the nurse leaders' relational consciousness in terms of how they viewed nurse-patient relationships and professional boundaries. Being mindfully aware of the relational complexities at play in nurse-patient relationships, the nurse leaders repeatedly described an invisible line between what is and is not within the bounds of a therapeutic nurse-patient relationship. The nurse leaders perceived nurses forming nurse-patient relationships by building trust and rapport whereby the patient felt comfortable talking to the nurse about their health concerns. Immersed in a patient's health care dynamics, nurses employed advocacy to assist patients navigate difficult health care decisions. This type of "encounter brings into focus a particular kind of relation that connects strangers together in meaningful and even intimate ways" (Storch et al. 2004, p. 497). In building relationships with patients, the nurse leaders purported that nurses learned to advocate for patients without over-stepping therapeutic boundaries by placing patients at the center of care and cultivating co-constructed care requisites, thus forming therapeutic bonds with patients.

Connecting/integrating relational ethics with findings. To further explain the findings from the quantitative phase, the nurse leaders' narratives revealed maturation through experience in nursing and nursing leadership enhanced relational consciousness when deliberating nurse-patient relationship boundary violations and unethical behaviors. Increasing comfort, skill, and knowledge was shown as influencing nurse leaders moving past an individualist lens to embracing a relational lens when managing professional boundary breaches such that moral, cognitive and organizational factors were considered within the relational interplay occurring at and between intrapersonal, interpersonal and contextual levels. The nurse leaders, when employing relational consciousness, directed attention toward "relational transactions" occurring within and among nurse-patient relationships; thus decisions acknowledging boundary breaches and actions taken in resolving boundary breaches were objectively made.

Summarizing theory connections with findings. As nurses engaged in garnering trust and advocating for patients, fundamental elements of relational discourse utilized in building nurse-patient relationships, nurse leaders admitted ambivalence abounds when deciphering what behaviors constitute over-advocating to the extent of breaching boundaries. The nurse leaders believed that care in judging a nurse's role as over-advocating and over-stepping boundaries bears the responsibility of controlling opinion, thus employing verification when determining therapeutic versus non-therapeutic boundaries. Nurse leaders have a duty to attend to the quality of nurse-patient relationships within their charge, thus determining at what point over-advocating breached a nurse-patient therapeutic relationship and required attention to the relational space co-constructed between nurses and patients. By knowing and understanding the elements nurses utilized in building relationships and utilizing a relational consciousness when evaluating nurse-patient relationships, ethical decision-making was facilitated by intentionally and skillfully

responding to the relational complexities and relational transactions occurring within and among nurses and patients.

Literature Related to Findings

The literature review about nursing leaders managing professional nurse-patient relationship boundaries brought to light a limited scope of research related to this topic. Research geared toward nursing leaders ethical decision-making when evaluating and managing nurse-patient relationship boundary transgressions was negligible. This study narrowed the gap by adding significant findings garnered from nursing leaders expressed through survey results and given voice through shared perceptions and experiences. This study, a mixed methods sequential explanatory design, is the first to give nursing leaders' an opportunity to convey their views in assessing and acting on professional boundaries and nurse-patient relationships.

Leadership.

Character-based leadership.

Literature findings. According to the literature, character-based leadership is an emerging field with an array of definitions and frameworks describing constructs or attributes of 'character" in leadership. Conger and Hollenbeck (2010) found similarities among the authors in the Special Issue on "Defining and Measuring Character in Leadership" (Thompson & Riggio, 2010) that focuses on "integrity, which includes personal traits of honesty, trustworthiness, and a moral or ethical orientation in one's actions" among leaders considered to possess "character" (Conger & Hollenbeck, 2010, p. 311).

Connecting/integrating study findings. In concurrence with Conger and Hollenbeck (2010), the nursing leaders overwhelmingly spoke to "trustworthiness" and an "ethical orientation to one's actions" as personifying the character attributes guiding their ethical

decision-making. Findings from this study detailed leadership's stance of consistently manifesting "leading by example" where this style of leadership imparted "do what you say you're going to do, [and] do what is right," thus modeling behaviors of "character" such that "integrity" formed the basis for all actions and attributes worthy of being emulated.

Literature findings. Sweeney and Fry's (2012) review of the literature reveals leaders' belief system "about virtues and values influence their perceptions and judgments in moral and ethical issues" and, in turn, influencing behavior. Their review further reveals leaders whose beliefs and values are fundamental to their self-identities and display a greater internal drive to "close the gap between intentions and actions" (p. 90).

Connecting/integrating study findings. In concurrence with Sweeney and Fry (2012), the nurse leaders repeatedly embraced a "strong value system" and proclaimed "virtues" as fundamental to defining their self-identity, thus influencing their ethical decision-making. In turn, relying on steadfast virtues and values provided the impetus of "doing what's right" in acknowledging and taking actions in resolving nurse-patient relationship boundary breaches.

Literature findings. Barlow et al.'s (2003) study found that, as leaders matured, lessons learned from life experiences, training, mentoring, and education influenced their character, enhancing their "abilities to morally know and feel throughout their career" pointing to an "anecdotal proof of moral action" (p. 578).

Connecting/integrating study findings. In concurrence with Barlow, Jordan, and Hendrix (2003), the findings from the 48 bivariate Pearson product-moment correlation coefficients confirmed maturation in experiences as an RN and as a nurse (a) significantly influenced ethical decision-making about personal nurse-patient relationship boundary violations and unethical behaviors, (b) revealed increased comfort a nurse manager felt speaking with a nurse about

his/her behavior regarding a personal nurse-patient relationship boundary violation and unethical behavior, and (c) revealed the more knowledge she/he believed she/he had to appropriately manage a personal nurse-patient relationship boundary violation and unethical behavior.

Additionally, the interviewed nurse leaders substantiated the findings resulting from the surveys, such that maturation as an RN and nurse leader positively impacted decision-making and increased "comfort level" and "skill level" in managing nurse-patient relationship boundary breaches. With experience, the nurse leaders' belief in their ability to handle nurse-patient relationship boundary breaches increased as described in their narratives, reflecting differences in their actions from that of a novice to present status as a nurse leader.

These findings are further supported through Patricia Benner's novice-to-expert model, such that "nurses develop skills and understanding … over time through a sound educational base as well as a multitude of experiences" (Marquis & Huston, 2017, p. 267). The theory purports that nurses progress through multiple stages, from novice to advanced beginner, to competent, to proficient, and finally to expert. Conceptually stated, "the new nurse moves from reliance on past abstract principles to the use of past concrete experience as paradigms and changes his or her perception of situations to whole parts rather than separate pieces" (p. 268).

Ethical decision-making.

Knowledge related to ethical decision-making.

Literature findings. According to the literature, Musa et al. (2011) found that nurse managers relied on their own skills, colleagues, or the code of ethics for handling ethical issues. Musa et al. also found that only half of the nurse managers utilized the code of ethics for guidance, citing a criticism that it "inadequately guides one's thoughts in formulating a viewpoint or judgment in dealing with ethical issues" (p. 6).

Connecting/integrating study findings. In concurrence with Musa et al. (2011) the interviewed nurse leaders consistently described relying on their own personal "value system" for handling nurse-patient relationship boundary breaches and unethical behaviors. The nurse leaders' reliance on their personal values is their go-to source for ethical decision-making when encountering nurse-patient relationship boundary breaches. Additionally, the interviewed nurse leaders never referenced using the Nursing Code of Ethics as their guide for determining nurses' behaviors not in alignment with the Code of Ethics conduct rules. Even though the Nursing Code of Ethics is recognized as including "some information on boundaries," the nurse leaders referred to the Code of Ethics as less than adequate for guiding ethical decisions primarily due to a "lack of familiarity with the code." The nurse leaders also do not believe the "Nursing Code of Ethics is well known" or utilized as a resource when deliberating nurse-patient relationship boundary breaches or unethical behaviors. Thus, formulating views or judgments when facing ethical conduct dilemmas leaves ethical decision-making to the nurse leaders' interpretations, rather than reliance on the profession's ethics code.

Literature findings. Nasae et al. (2008) found nursing leaders experience in handling ethical dilemmas difficult in deciding "what is right or wrong or what ethical principles can be used to support their decisions" (p. 477). Their study revealed nurse leaders relied on guidance from higher authority, consulting with colleagues, following organizational regulations, and avoiding conflict among colleagues in addressing ethical dilemmas.

Connecting/integrating study findings. In concurrence with Nasae et al. (2008), the nurse leaders described "knowing" there are supportive organizational resources available for guidance in identifying and managing nurse-patient relationship boundary breaches. Seeking both organizational policies and personnel within the organization possessing the knowledge and skill

to manage boundary breaches is deemed as supportive in carrying through in actions aimed at resolving nurse-patient relationship boundary violations and unethical behaviors. Consulting with "colleagues or peer directors" was a resource frequently sought for assistance in confirming decisions prior to carrying out interventions with staff nurses who crossed the line.

Factors related to ethical decision-making.

Literature findings. Stenmark and Mumford (2011) found a number of situational factors influence ethical decision-making involving moral dilemmas. Their results suggested that "leaders who have a low level of autonomy and whose self-efficacy has been threatened, may be more likely to use the authority of their superiors as an excuse to make poor ethical decisions" (p. 947).

Connecting/integrating study findings. In concurrence with Stenmark and Mumford's (2011) study, the nurse leaders described unit cultures fostering a "herd mentality" and/or "buddy systems," as well as departmental and/or organizational leadership perceived as inept, negatively impacts decision-making, thus affecting self-efficacy. The nurse leaders feeling threatened by a perceived social consensus and by lack of leadership support negatively impacts self-efficacy. Lacking a belief in one's capability of successfully taking actions in mitigating the boundary breach stifles action, thus leading to low or no interventions.

Literature findings. Smith and Rogers (2000) illustrated "males and females in the later stage of career development tend to give similar responses" (p. 81) to ethical decision-making dilemmas; whereas, with males and females in earlier-career stages "greater differences are noticed in the responses" (p. 81) to ethical decision-making dilemmas. Of note, Franke et al. (1997) revealed findings resulting from a meta-analysis review on gender differences suggesting it would be a misguided generalization to assert women are more ethical than men, as a number

of other possible influences were not available for review and their study addressed differences in ethical perceptions, not actual behaviors.

Connecting/integrating study findings. In contrast to Smith and Rogers (2000) study, mixed between-within subjects ANOVAs were run during the quantitative phase of this study to determine the impact of the nursing leaders' gender on ethical decision-making about the two different gradations of professional boundary breaches (flirtatious versus personal relationship). The findings revealed that there were no significant interactions between gender and the nurse managers' ethical decision-making in determining a violation of and the unethicality of a nurse-patient professional boundary breach. Additionally, there were no significant interactions between gender and the managers' belief it was their responsibility to speak with the nurse about his/her behavior or their comfort in speaking with the nurse about his/her behavior in both vignettes. Nor were there any significant interactions between gender and the mid-level nurse managers' belief in their knowledge and skill to manage both scenario situations appropriately. During the qualitative phase of this study, the nurse leaders interviewed consisted of all female participants and therefore no further explanations regarding gender differences impacting ethical decision-making about ethical dilemmas can be made of the quantitative findings.

Literature findings. Lincoln and Holmes (2010) found decision-making about moral dilemmas are "significantly associated with social consensus" such that a decision-maker's perception of his/her social group's belief about a particular situation, potential choices of action, and actions to be taken, will influence the process of ethical decision-making (p. 61).

Connecting/integrating study findings. In concurrence with Lincoln and Holmes' (2010) findings, relying on co-workers reporting/substantiating nurses suspected of overstepping professional boundary lines is perceived as a barrier impacting decision-making when evaluating

and managing boundary violations and unethical behaviors. Staff nurses' fear of being ostracized, retaliated upon, and/or retributions from their social group delays or prevents nurses from coming forward with information pertaining to perceived boundary breaches and negatively impacts nurse leaders' decisions in identifying and managing nurse-patient relationship boundary breaches. Additionally, the nurse leader's described fear of being accused of the same inappropriate behavior levied against a co-worker as clouding their 'thinking' and was seen as a barrier, thus impacting their ethical decision-making in taking actions aimed at resolving boundary violations and unethical behaviors.

Gaps related to ethical decision-making.

Literature findings. Hannah and Avolio (2010) found, among organizational leaders encountering challenging moral dilemmas, that a gap exists between knowing what is right and doing what is right. They introduced the construct of "moral potency," which portends three factors, i.e., moral ownership, courage, and efficacy, and "provides leaders with the psychological resources that bridge moral thought to moral action" (p. 292). They found that leaders with moral ownership "assuming responsibility to act" (p. 296), moral courage "fortitude to face risk and overcome fears" (p. 296), and moral efficacy "confidence to attain moral performance" (p. 297) predictive of leaders likely to step up and confront colleagues' ethical transgressions and take actions in resolving ethical dilemmas.

Connecting/integrating study findings. In concurrence with Hannah and Avolio (2010), findings from the item analysis revealing that nurse leaders felt comfortable speaking with nurses about their flirtatious behaviors toward patients, as well as the findings from the bivariate Pearson product-moment coefficient correlations revealing increased years of work experience as an RN and nurse manager increase comfort and knowledge in managing personal nurse-patient

relationship boundary breaches, exemplifies moral potency. Providing further depth to the surveyed findings, the interviewed nurse leaders that exemplified moral potency described relying on their values, increased experience, and policy/personnel resources as supporting their comfort and knowledge, thus overcoming perceived challenges and barriers impacting ethical decision-making, further fostering their belief of successfully confronting and following through with actions in resolving nurse-patient relationship boundary violations and unethical behaviors.

Nurse-patient relationships.

Professional nurse-patient relationships.

Literature findings. Professional relationships establish a protected space between a professional's power and a client's vulnerability, such that the professional puts the patient's needs first. According to Buhari (2013) "professional relationships occur within a continuum of under involvement to zone of helpfulness and to over involvement" (p. 162). Benbow (2013) further defines the continuum of professional behavior, stating that it "provides a frame of reference to help nurses evaluate their professional interactions with patients" (p. 31). Marquis and Huston (2017), takes this a step further describing that nurse managers, by virtue of their leadership role, have a responsibility to "foster nurse-patient relationships that are respectful, caring, and honest" (p. 110) and to "create a climate in their organizations in which ethical behavior is the norm" (p. 558).

Connecting/integrating study findings. In concurrence with Buhari (2013), Benbow (2013) and Marquis and Huston (2017), the nurse leaders consistently described "trust" and "respect" as essential elements in establishing and maintaining professional nurse-patient relationships. Additionally, the nurse leaders spoke to nurses building trusting nurse-patient relationships as occurring through open dialogue. In contrast to the literature findings, one of the

nurse leaders addressed “appropriate attire” as “starting things off on more of a professional manner,” thus imparting professionalism when building professional nurse-patient relationships.

Therapeutic relationships.

Literature findings. Collins (1989), in describing practitioner-patient therapeutic relationships, stated, “Paradoxically, the very relationship that offers the promise of healing also exposes practitioners of all disciplines to the hazards of overstepping their professional bounds” (p. 153). Peternelj-Taylor (2002), in line with Collins (1989), states that therapeutic relationships built on humanness complete with all its fragilities struggle with setting limits appropriate to the specific health care needs of the patient.

Connecting/integrating study findings. In concurrence with Collins (1989) and Peternelj-Taylor (2002), one of the interviewed nurse leaders described staff nurses building relationships with patients similarly to the approach they used in developing personal relationships. As such, this approach presumes a nurse’s personality drives the manner in which nurse-patient relationships are formed. This perception is significant as it infers nurses build relationships with patients through a personal construct rather than through a therapeutic construct. The nurse leaders describe avoidance of over-stepping professional bounds, thus establishing and maintaining therapeutic relationships, is an intricate balancing act. Overwhelmingly, the nurse leaders spoke to centering patients within the zone of helpfulness mitigates over-involvement, potentially resulting in boundary violations and unethical behaviors.

Literature findings. According to Wright (2006), “The patient’s health needs determine when the relationship begins and ends” (p. 52). As such, establishing a therapeutic relationship provides a safe setting, facilitates communication, and limits interactions with the patient to those specific to meeting the patient’s health needs.

Connecting/integrating study findings. In concurrence with Wright (2006), the nurse leaders described establishing and maintaining therapeutic relationships occurring when nurses focus their attention on placing the patient at the center of care. One of the nurse leaders described the process of forming a "verbal contract with the patient the minute you walk into the room." The verbal contract is aimed at developing and maintaining nurse-patient relationships within the therapeutic zone of helpfulness. Additionally, half of the nurse leaders purported that families may hold as great or greater weight as the patient when building therapeutic nurse-patient relationships. Situationally, families may be the primary source of relationship building depending on the condition of the patient, thus establishing and maintaining a therapeutic nurse-family relationship was necessary to the well-being of the patient.

Professional boundaries.

Boundary crossings.

Literature findings. The NCSBN (2018a) defines boundary crossings as "brief excursions across professional lines of behavior that may be inadvertent, thoughtless or even purposeful, while attempting to meet a special therapeutic need of the patient" (p. 3). Crossing professional boundaries may at times depend on the context of the situation, be considered beneficial to a therapeutic relationship, and produce no harm. However, according to Sheets (2001), it is paramount that nurses use "careful judgment when intentionally crossing boundaries and should not cross them repeatedly" (p. 38). Minimizing repeated boundary crossings and consulting with colleagues or supervisors when unsure of what to do is advised. One should always ask oneself the question, "Is my action clearly based on the best interest of the patient in my care?" (Buhari, 2013; Peternelj-Taylor & Yonge, 2003).

Connecting/integrating study findings. In concurrence with Buhari (2013), Peternelj-Taylor and Yonge (2003) and Sheets (2001), the nurse leaders described conflicting decision-making on whether or not befriending patients post-discharge "loosely" crosses the boundaries of professional nurse-patient relationships. Determining where the line is drawn constituting boundary crossings was considered at times challenging for the nurse leaders to assess and address. The nurse leaders described conferring with colleagues and/or supervisors routinely when deliberating boundary crossings and for setting arbitrary boundary lines defining behaviors/actions that cross over to boundary violations. One such behavior/action was accessing and disclosing the "friend's" personal health information, i.e., labs, and providing the results to the friend, thereby violating professional boundaries.

Boundary violations.

Literature findings. As the NCSBN (2014) defines boundary violations as a "result when there is confusion between the needs of the nurse and those of the patient" (p. 3), there are certain behaviors that signal a red flag denoting that potential boundary violations may exist. Peternelj-Taylor and Yonge (2003) stress the importance of understanding what constitutes boundary crossings and the propensity for these supposedly compassionate acts to escalate into boundary violations—"transgressions that are clearly harmful or exploitive" to the patient (p. 57). Nurse-patient relationships should be examined when there is excessive self-disclosure of personal problems or intimate life feelings, secretive behavior with the patient, a defensive posture when questioned about patient interactions, spending an inappropriate amount of time with the patient, soliciting gifts, and/or inappropriate communication such as being too familiar with the patient, suggesting a potential non-therapeutic, social relationship indicative of a probable boundary violation (Benbow, 2013; Buhari, 2013; Sheets, 2001).

Connecting/integrating study findings. In concurrence with Benbow (2013), Buhari, (2013), Peternelj-Taylor and Yonge (2003), and Sheets (2001), the nurse leaders described encountering nurse-patient relationships with blurred boundary lines, indicative of boundary violations. The nurse leaders routinely asked the question "What really identifies as a breach of practice?" expressly confirming the dilemma of acknowledging and resolving boundary violations and unethical behaviors. The nurse leaders consistently described health care settings promoting familiarity between nurses and patients, such as in behavioral health and long-term care settings, as areas prone to blurred boundary lines. Health settings, where "patients tend to be recurring admissions" and/or patients "come in for frequent treatments," were described as fostering familiarity, since "nurses got to know patients very well" were described as high risk environments, thus creating opportunity for nurse-patient relationship boundary violations and unethical behaviors.

Specific to the military, the nurse leaders described that having a sense of being part of a military community generated relationships where "you're no longer just my patient, you're family." Relational bonds formed not only with the patients, but with the patient's families, thus engendered nursing staff becoming "close to all the families." These nurse-patient relationships were perceived as "more complete that way;" in turn, potentiating blurred boundary lines. Thus, familiarity, perceived as blurring nurse-patient relationship boundary lines, was described as clouding the nursing leaders' decisions in confirming boundary violations and unethical behaviors.

Professional sexual misconduct.

Literature findings. Professional sexual misconduct is defined by the NCSBN (2018a) as "an extreme form of boundary violation and includes any behavior that is seductive, sexually

demeaning, harassing or reasonably interpreted as sexual by the patient" (p. 3). Whether or not patients consent to or initiate sexual contact, the nurse's behavior violates the fiduciary responsibility to the patient and is a manipulation of a trusting relationship (Sheets, 2001). Additionally, long-term care settings and situational stressors are shown to incur higher risks of sexual misconduct; however, it is always the duty of the health care professional to set and maintain boundaries and to know when boundaries have been violated (Baca, 2009; Buhari, 2013; Driscoll, 2004; Griffith and Tengnah, 2013; Hanna & Suplee, 2012; Peternelj-Taylor & Yonge, 2003).

Connecting/integrating study findings. In concurrence with Buhari (2013), Baca (2009), Driscoll (2004), Griffith and Tengnah (2013), Hanna & Suplee (2012) and Peternelj-Taylor and Yonge (2003), findings resulting from the item analysis revealed that the two highest mean scores for nurse leaders believing personal nurse-patient relationships were perceived as boundary violations and unethical behaviors, whereas the two lowest mean scores reflected flirtatious nurse-patient relationships deemed boundary violations and unethical behaviors. Additionally, findings from the mixed between-within subjects ANOVAs revealed significant main effects for nurse leaders' belief that personal nurse-patient relationships were boundary violations and unethical behaviors.

Providing further explanations and substantiating the quantitative findings, the nurse leaders described encounters reflecting boundary violations and unethical behaviors indicative of nurses engaging in intimate relationships with patients. The nurse leaders described experiencing nurse-patient relationship boundary violations and unethical behaviors occurring within intensive care units, a behavioral health care unit, and a long-term procedural care setting, all environments conducive to facilitating familiarity between the nurses and patients. Additionally,

multiple situational stressors were described as influencing personal nurse-patient relationship boundary violations, such as closeness between the nurses and the patients/families, feeling compassion for the patients/families, and considering patients/families as part of the nursing family. The nurse leaders described their perceptions of the boundary breaches ranging from "did not consider the nurse-patient relationship a boundary breach," thus no actions warranted, to "did see the relationship as a boundary breach," but no actions taken, to that of "did see the relationship as a boundary breach," and actions were taken to resolve the boundary violation.

Regulatory positions – legal ramifications.

***American Nurses Association Code of Ethics*.**

Literature findings. Provision Two of the Nursing Code of Ethics states, "The nurse's primary commitment is to the patient, whether an individual, family, or community" (ANA, 2015a, p. 5). Within this provision, professional boundaries are specifically addressed, defining the purpose of nurse-patient relationships. According to the ANA (2015a), the relationship between the nurse and patient is not one of friendship but of "alleviating suffering, and protecting, promoting, and restoring the health of patients" (p. 7). The ANA Code of Ethics "is nonnegotiable and … each nurse has an obligation to uphold and adhere to the code of ethics" (ANA, 2015a, p. vii).

Connecting/integrating study findings. Overall, the nurse leader's recalled receiving limited ethics training specifically related to "preventing boundary transgressions" during their nursing programs; however, they did recall receiving training "in nursing school … about nurse-patient relationships and what's acceptable and what's not." Ethics training received in their work setting was described as general ethics, largely delivering the same message as the ANA Code of Ethics but with limited focus on professional relationships.

The nurse leaders currently serving in the military and those with prior military service highlighted on-the-job training pertaining to "just military ethics or ethics in general, not necessarily the nursing code of ethics" as advancing their knowledge about professional relationships. They described the military's "no fraternization" rule as carrying over into their nursing practice, thus providing a framework and guide for setting professional boundaries.

Texas Board of Nursing.

Literature findings. Promoting public protection, the Texas BON stipulates rules and regulations guiding nursing practice, education, and disciplinary actions as delineated through the Nurse Practice Act and Texas Administrative Code. The Texas BON, through the Nurse Practice Act and Texas Administrative Code, specifies good professional character, unprofessional conduct, and grounds for disciplinary actions.

Connecting/integrating study findings. It was the perception of most of the nurse leaders that the Nurse Practice Act and Texas Administrative Code was difficult to access and navigate; however, the nurse leaders did describe the Nurse Practice Act rules of conduct as providing a frame of reference for taking actions in mitigating nurse-patient relationship boundary breaches. The standards were seen as providing guidance in managing nurse-patient relationship boundary breaches, but of the nurse leaders interviewed only one described referring to the Nurse Practice Act's standards as a reference for framing a counseling session. Overall, the nurse leaders did not routinely refer to the Nurse Practice Act for guidance or utilize it as a resource or reference its specific standards when counseling or dispersing disciplinary actions regarding nurse-patient relationship boundary violations or unethical behavior. Nurse leaders said they turned to the organizations regulations, policies, rules, and standards as references.

Position Statement 15.29. Use of Social Media by Nurses.

Literature findings. Nurses must be aware of the potential consequences associated with indiscriminate use of social media. According to the NCSBN (2018b), "nurses have been disciplined by boards, fired by employers, and criminally charged for the inappropriate or unprofessional use of social media" (p. 70). Maintaining professional boundaries, which extends to the use of social media, is an obligation expected of all nurses.

Connecting/integrating study findings. Sharing experiences, the nurse leaders described social media as a venue easily accessible and an enabler for breaching nurse-patient relationship boundary breaches. Raising concern with the availability and use of social media, it was believed that "we should pay extra attention to this." Divulging patient personal information on social media "violates patient boundaries" and was described as one mechanism of breaching nurse-patient relationships requiring actions to "halt that behavior." Social media was viewed as posing challenging ethical dilemmas in maintaining professional boundaries and creating ethical dilemmas for nurses. Overall, the nurse leaders expressed concern with limited education on the topic of social media and posed teaching the safe use of social media during nursing orientations in school and work settings.

National Council of State Boards of Nursing.

Literature findings. The NCSBN (2014), in alliance with state boards of nursing, collaborate in providing regulatory guidance for public health, safety and welfare. As a collective regulating body, the NCSBN sets the standard of nursing care, which is codified by law and implemented through education, licensure, practice, and discipline. Guiding and governing nursing care through regulatory decision-making for public protection is the responsibility of the boards to ensure care does not give rise to harm. As the NCSBN (2018a) defines boundary

violations as a "result when there is confusion between the needs of the nurse and those of the patient" (p. 3), there are certain behaviors that signal a red flag denoting that potential boundary violations may exist.

Connecting/integrating study findings. In concert with the NCSBN (2018a) boundary violation definition, the nurse leaders shared multiple situations depicting nurses confusing their needs with those of the patient and signaling red flags denoting boundary violations. The nurse leaders shared experiences whereby nurses' behaviors signaled red flags indicating nurse-patient relationship boundary breaches, such as a nurse who "took care of him [patient] every time he was admitted" and a nurse who would "spend a lot of time … chatting, sitting at the bedside really pushing the boundaries [with a patient]." Multiple stories delineating behaviors signaling red flags were illustrated throughout the nurse leaders' experiences with evaluating and managing nurse-patient relationship boundary breaches.

Grounded Theory

This study, a mixed methods sequential explanatory design, ascertains nursing leaders' knowledge and skill in ethical decision-making when evaluating and managing professional nurse-patient relationship boundary transgressions, and further garners nursing leaders' perceptions of moral, cognitive, and organizational factors influencing ethical decision-making when evaluating and managing boundary transgressions. Generating a grounded theory, as interpreted from the mixed methods analyses of the survey results and the participant interviews, finalizes the outcome of this study. According to Johnson, McGowan and Turner (2010), "grounded theory fits mixed methods research particularly well," (p. 65) with the caveat, that the quantitative and qualitative phases of the research study encompass the methods and principles of each technique. As such, a grounded theory emerging from a mixed methods study, "can

connect theory generation with theory testing, integrate theory and practice, and join interpretive understanding of experience with generalizations and explanations" (p. 65).

The emergence of this theory, grounded in the data, represents the nurse leaders' underlying beliefs, views, values, and motivations affecting their ethical decision-making about nurse-patient relationship boundary breaches and unethical behaviors. According to Charmaz (2014), "theories offer accounts for what happens, how it ensues, and may aim to account for why it happened" (p. 228). Accounting for what ethical decisions nurse leaders make when evaluating and managing nurse-patient relationship boundary transgressions, the nurse leaders perceive moral, cognitive, and organizational factors specific to the encountered situations as influencing elements affecting their decisions. Delineating how nurse leaders make ethical decisions addressing nurse-patient relationship boundary transgressions, the nurse leaders give voice through the survey analyses and narratives by expressing the relationship and impact their characteristics bear in this process. In turn, discovering why nurse leaders ethically make decisions to take or not take actions to resolve nurse-patient relationship boundary breaches and unethical behaviors, is explained by understanding the link between the nurse leaders' characteristics and perceived factors influencing bridging moral thought to moral action.

Appreciating transparent introspection, personal core values are the nurse leaders' primary predisposing factor influencing ethical decision-making when qualifying nurse-patient relationships as boundary breaches. Personal beliefs and personal ethics, steeped in the nurse leaders' value system, overtly characterizes the foundation relied upon when processing ethical decisions about nurse-patient relationship boundary breaches. Seeing the nurse leaders insights into their own identifying characteristics and the impact they have in the oversight of those they supervise adds depth to the initial survey findings.

Affirming values support nurse leaders' ethical decision-making, the survey analyses reveal significant findings reflecting nurse leaders' beliefs about nurses' behaviors they determine breach professional boundaries and are unethical. In determining nurses' behaviors perceived as boundary violations and unethical, the analyses reveal higher scores resulting for nurses engaging in personal relationships with patients and lower scores resulting for nurses engaging in flirtatious behaviors with patients. The nurse leaders' personal values shape how they make ethical decisions; however, without context there are no explanations for the variances in scores reflecting the nurse leaders' ethical decision-making choices.

Offering context, the nursing leaders' narratives further explain why personal value systems factor into ethical decision-making when deliberating nurse-patient relationship boundary violations and unethical behaviors. Appreciating nursing is a relations-based profession, the nurse leaders identify values as moral guides influencing nurses' activities of advocating, building trust, and forming bonds with patients. It is through advocacy, trust, and bonding that nurses build nurse-patient relationships, where patients feel free to share private health information so that their care needs can be met. Placing patient's needs at the center of care establishes a relationship that allows for a safe connection created between a nurse and patient that shapes the moral space occupied by both. This safe space allows for professional interactions between patients and nurses and is bounded within therapeutic relationships. The therapeutic relationship, built through advocacy, trust, and bonding, is attained through a coauthored relational narrative developed between patients and nurses and lies within a zone of helpfulness. Co-constructing a relational narrative through advocacy, trust, and bonding provides the greatest engagement between nurses and patients as well as the greatest opportunity for over involvement in the relationship. Thus, the relational narrative is morally bound to the therapeutic

relationship yet does not transcend the relationship. Nurse leaders, providing oversight of their staff by virtue of positional obligation, duly carry an expectation of ensuring that professional boundaries are heeded between nurses and patients. Formulating ethical decisions when judging nurse-patient relationships, the nurse leaders' personal value system is the benchmark applied when evaluating staff nurses' approaches to advocating, building trust and bonding with patients. Within the context of the relational framework, nurse leaders' core value systems aid in determining whether or not staff nurses' interactions with patients are too involved, nurses seek personal gains over patient gains, and relationships extend outside the zone of helpfulness to a zone of over involvement. As moral agents, nurse leaders' core value systems fundamentally support their judgment and actions in ways consistent with what they believe is right or wrong behaviors of nurses in nurse-patient relationships. The nurse leaders, when evaluating and managing nurse-patient relationship boundary breaches and unethical behaviors, being morally accountable and responsible, as well as possessing a strong sense of self and capable of taking actions to resolve boundary violations and unethical behaviors, denotes nurse leaders' moral agency.

Recognizing that the profession of nursing is unique, in that nurses' relationships with patients are built through co-constructed relational narratives and nursing care is holistic in nature, nurses' engagements with patients are interdependent and contextual. In turn, nurse leaders' evaluation and management of nurse-patient relationship boundary breaches are in fact judged through the lens of their core value systems, their beliefs, their understanding of how nurses build nurse-patient relationships, the context in which relationships are formed, and the circumstances surrounding nurse-patient relationship boundary breaches. As seen through data analyses, the nurse leaders' characteristics play a significant role in their affirmation of and

actions taken in resolving nurse-patient relationship boundary breaches and unethical behavior. Significant findings revealing the greater the number of years of work experience as a registered nurse and as a nurse manger, the greater comfort the nurse leader feels in speaking to a nurse about a personal relationship boundary breach with a patient. Additionally, findings revealing the greater the number of years of work experience as a nurse manager, the more knowledge the nurse leader believes she/he has to appropriately manage a personal nurse-patient relationship boundary breach. The nurse leaders' narratives legitimize the findings, revealing maturation in terms of years and experience accrued as a registered nurse and as a nurse leader significantly increases their self-efficacy. As such, the nurse leaders' described feeling greater comfort and having more knowledge in confronting and taking actions in managing and resolving boundary beaches in which nurses engage in personal relationships with patients. From a leadership perspective, the nurse leaders' personal core values, grounded in integrity, factors significantly in shaping their leadership traits and further explains why nurse leaders espouse their leadership style as a predisposing factor in shaping moral agency. Believing it necessary to role model actions and behaviors expected of a professional, and to be actively engaged, available, approachable and supportive of their staff nurses reflects the nurse leaders' primary leadership style of leading by example, thus conveying character-based leadership. As such, the nurse leaders' actively role model actions and behaviors in order to set expectations for staff to emulate. Additionally, the nurse leaders maintain active engagement with their staff so as to maintain on-going staff oversight. This, in turn, promotes being readily available, permitting ongoing coaching, and being approachable, implying a non-judgmental demeanor signifying a just culture, thus promoting trust. Embracing their character traits, which in turn mirrored their core values, predisposed their moral judgment, directly influencing ethical decisions. Linking

characteristics to predisposing factors influences bridging moral thought to moral action. Maturation fosters moral maturity, thus positively generating confidence in taking actions as appropriate in resolving nurse-patient relationship boundary breaches and unethical behaviors.

Channeling moral thought to moral action in carrying out interventions aimed at mitigating boundary violations and unethical behaviors behests nurse leaders' strength of conviction when confronting perceived moral, cognitive and organizational factors circumstantial to managing breaches. Nurse leaders as moral agents making moral judgments bank on core values in guiding ethical decisions delineating right and wrong. They draw upon experiential maturation in strengthening comfort and knowledge and employ lessons learned from leadership ethics training in managing boundary breaches. Following through with interventions aimed at resolving nurse-patient relationship boundary breaches and unethical behaviors beckons self-reflection of one's efficacy in overcoming predisposing factors presenting challenges, creating barriers, and impacting nurse leaders ethically executing actions. Uncovering why nurse leaders ethically make decisions in which variances between morally intending to act and morally executing acts to resolve nurse-patient relationship boundary breaches occurs is further explained by understanding the extent to which predisposing factors are perceived as inhibiting or supporting nurse leaders' moral agency. Predisposing factors inhibiting moral agency comprise context dependent beliefs compelling nurse leaders to non-action. Experiences with nurse-patient relationship boundary breaches in work environments where fear of co-worker reprisals, fear of making false claims, co-worker buddy systems, non-leadership engagement and non-leadership support represents departmental and/or organizational culture inhibits actions. This is compounded by difficult/vague Nurse Practice Act rules and limited boundary education which dissuades confidence, thus inviting non-performance.

Conversely, predisposing factors supporting moral agency fortifies beliefs in capability driving nurse leaders to action. Employing resources, inclusive of organizational policies and processes, as well as personnel such as engaged and supportive executive leadership, chaplains, legal counsel, health care resolutions specialists, sexual assault nurse consultants, and ethics committees and colleagues reinforces one's motivation to take moral action and promotes confidence, thus inviting performance. Believing one has the ability to perform a moral task/action and feeling confident that available resources will sustain accomplishing taking actions enhances moral agency and follow-through in resolving nurse-patient relationship boundary breaches and unethical behaviors.

Considering that nurse leaders, by virtue of their position, have an obligation to mitigate nurse-patient relationship boundary violations and unethical behaviors, having the conation to act on moral judgment is relative to individual characteristics, situational context and organizational influences. Leadership ethics and efficacy grounded in core values, strengthened by experiential maturation and refined through lessons learned, is tested by predisposing factors entailing life experiences, ability to interpret risk, ability to identify benefits, and motivation to change behaviors. Exercising moral agency through self-reflection individualizes the capacity of holistically constructing ethical decisions subject to internal and external predisposing moral, cognitive and organizational factors. Closing the gap between knowing and doing what is right in making ethical decisions to resolve nurse-patient relationship boundary breaches and unethical behaviors is partially explained by this grounded theory, with arguments and evidence to justify the theory. Figure 6 presents a visual illustration of the ethical decision-making model as constructed from the data.

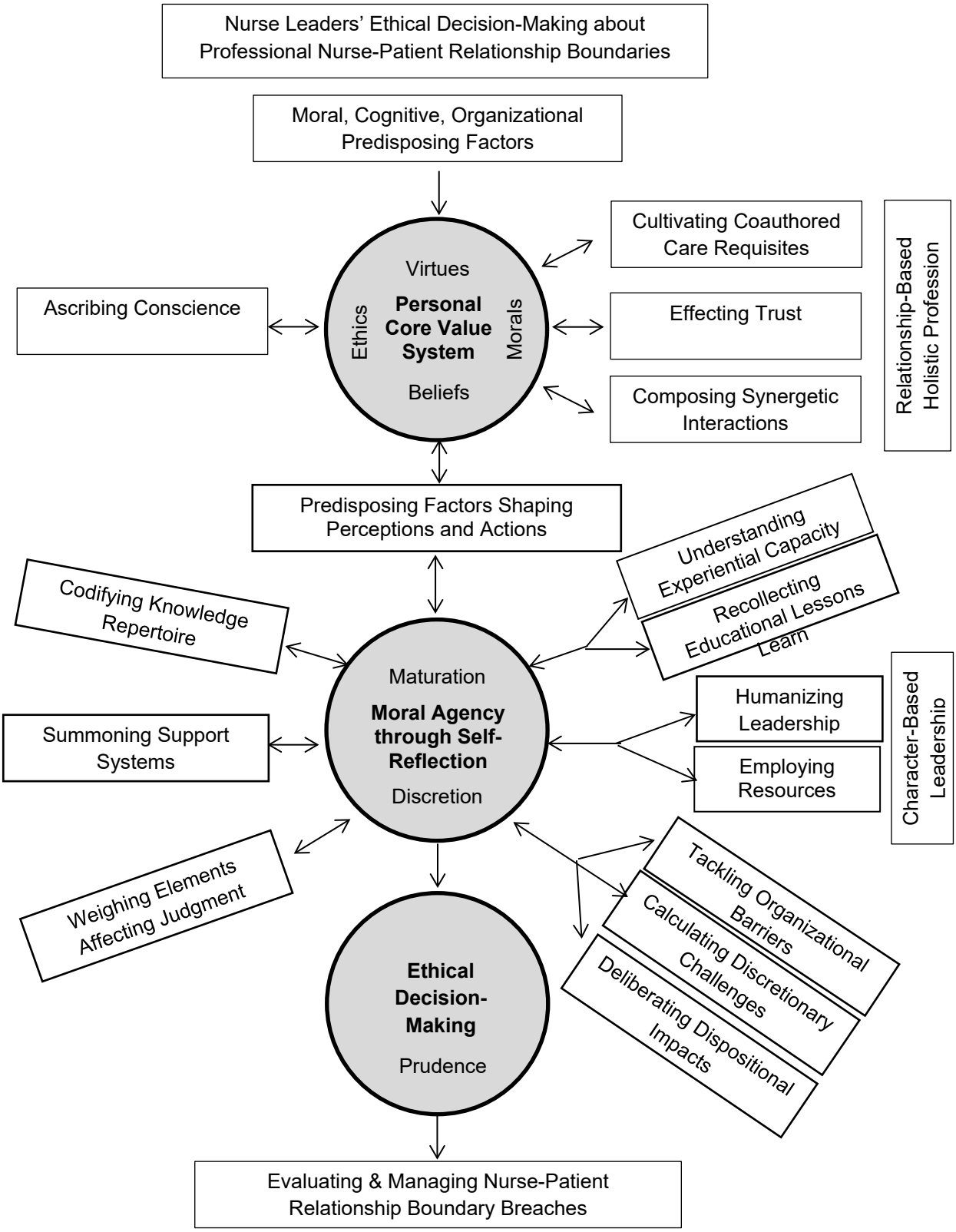

Figure 6. Visual depiction illustrating the ethical decision-making model.

Implications

This study shows the relationships among perceived moral, cognitive, and organizational predisposing factors and their impact on nurse leaders' ethical decision-making when evaluating and managing professional nurse-patient relationship boundary breaches. Based on the findings of this study, there are three main implications for nurse leaders' ethical decision-making in recognizing and resolving nurse-patient relationship boundary breaches—moral cognition, self-reflection, and moral agency. I recommend the development and implementation of an education program specific to promoting a skill set aimed at improving nurse leaders' knowledge and comfort in ethical decision-making specific to recognizing and acknowledging nurse-patient relationship boundary breaches and the volition to organize and execute ethical actions resolving boundary breaches.

Moral cognition.

Six-step process of ethical decision-making.

Ethical decision-making typically requires thoughtful reflection and logical judgment while encountering a situation fraught with partial facts, strong reactions and uncertainty. Providing a framework for working through the myriad of emotion, cognition, resolution, and action toward decision-making allows a more organized way of taking the situation apart while confronting predisposing factors affecting the process. Doherty and Purtilo (2016) introduce a six-step process of analyzing ethical dilemmas using an approach arriving at a "caring response" (p. 108). (See Table 26)

Table 26

Six-Step Process of Analyzing Ethical Dilemmas

Step	Process
One	Get the story straight—Gather relevant information
Two	Identify the type of ethical problem
Three	Use ethics theories or approaches to analyze the problem
Four	Explore the practical alternatives
Five	Complete the action
Six	Evaluate the process and outcome

"Step One: Get the story straight—Gather relevant information" (Doherty & Purtilo, 2016, p. 108). Gathering as much relevant information as possible contributes to getting the facts straight. Fact finding is a measure essential to ethical decision-making in that it has the potential to safeguard against starting off on a false course from the outset. Knowing the facts versus making assumptions is necessary in making a prudent and cognizant decision.

"Step Two: Identify the type of ethical problem" (Doherty & Purtilo, 2016, p. 111). As a nurse leader with a moral responsibility to uphold professional standards, surmising a perceived boundary breach incurs an ethical dilemma. Take measures to assess personal emotional responses, character traits, and guiding principles to draw upon to navigate the dilemma and organize an effective plan aimed at resolution.

"Step Three: Use ethics theories or approaches to analyze the problem" (Doherty & Purtilo, 2016, p. 113). Decide on the ethics approach that will best get at the heart of the problem identified in step two. Keeping relevant details at the center of deliberations is crucial to eventually making an ethical decision in keeping with professional ethics. For nurse leaders who

are morally accountable to take actions in resolving nurse-patient relationship boundary breaches, drawing on ethical theories, such as virtue ethics and self-efficacy, and/or focusing on principles, duties, rights and/or consequences, aids in guiding decision-making. Utilizing theories as the foundation for ethical reasoning supports action, thus resolution of boundary breaches.

"Step Four: Explore the practical alternatives" (Doherty & Purtilo, 2016, p. 115). Decide what should be done and how it best can be done (explore the widest range of options possible). Conferring with colleagues generates alternative strategies and options available in resolving boundary breaches thus enhancing ethical decision-making enabling knowing and doing the right thing. Doing the right thing requires taking action.

"Step Five: Complete the action" (Doherty & Purtilo, 2016, p. 116). Call upon your strength of will and moral courage to act. Action requires courage and strength of conviction as well as moving past risks or backlashes. Relying on an ethical purpose and basing actions on an ethical decision supported by sound reasoning and courage motivates follow-through with carrying out action.

"Step Six: Evaluate the process and outcome" (Doherty & Purtilo, 2016, p. 117). Reflect on your experience to better prepare yourself for future situations. Following resolution, reflecting on the ethical decision-making process presents an opportunity to critically think about the process and determine lessons learned from the experience.

Self-reflection.

Character.

Ethical decision-making dictates employing moral character reflecting professional ethics. Through self-reflection nurse leaders assess their characters in respect to perceived predisposing factors impacting their feelings and behaviors, in turn shaping their motives and

final actions. Sweeney and Fry (2012) contend that "the more central leaders' core values and beliefs are to their self-identities, the greater the moral awareness and the more complex the moral reasoning are, which then result in more consistent self-determined moral and ethical action" (p. 92). Guidance presented in the form of cultivating moral character of an individual has the potential to transform ethical decisions, and potentially transform inter-professional and institutional professional morality. "Most authors argue that morality and ethics can be developed. They outline various interventions that organizations can undertake to reward, reinforce, and develop character in their cadres of leaders" (Conger & Hollenbeck, 2010, p. 314).

A holistic character development model based on the West Point Leader Development System (United States Military Academy, 2010) shown in figure 7 facilitates a greater understanding of the concept, the processes that shape character and focus character developmental strategies.

Interpreting the character development model begins with understanding that individuals view the world and make sense of experiences based on personal values and beliefs. Educating nurse leaders by role modeling and mentoring different perspectives when facing ethical dilemmas teaches them how to critically think, frame the issue, and make moral and ethical decisions increasing self-efficacy. Leaders who intentionally seek out development experiences that will broaden their perspectives and actively engage in a continuous development of their character enhance their sense of agency. Through regular reflection and introspection leaders gain an appreciation of how their key values and beliefs influence their daily behavior, experiences, and mindfulness, thus enhancing self-awareness. Reflecting on the ability of controlling emotions, thoughts, and behaviors and utilizing self-directed influence in making changes as needed to achieve desired outcomes involves self-regulation. Drawing from internal

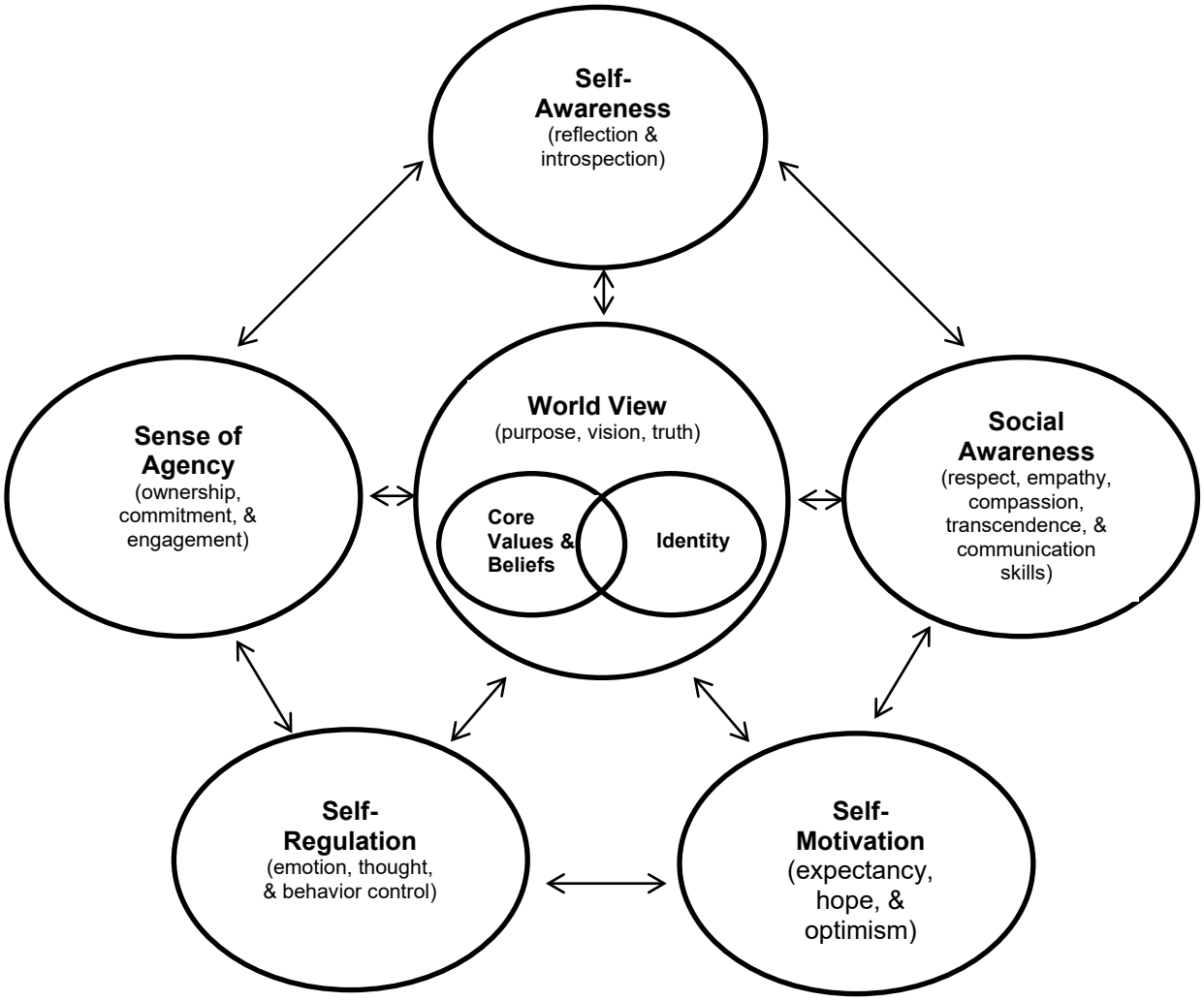

Figure 7. Character development model (Sweeney, Hannah, & Snider, 2007, p. 64).

sources such as optimism to influence moral and ethical behavior tends to promote self-motivation. Social awareness involves positive connections with others and plays an important role in teaching character development. Role models "modeling moral and ethical behavior provide individuals with a source of social support to help them handle the adversities associated with making tough moral choices and making meaning out of their experiences" (Sweeney & Fry, 2012, p. 97).

Moral maturity.

Moral ownership.

Ethical decision-making entails taking appropriate responsibility, stepping up, and taking action as needed. Moral ownership equates to leaders feeling a sense of responsibility over the ethicality of their own actions, their staff's actions, and their organization's actions. Leaders self-identifying with justifications for moral actions display moral ownership. Hannah and Avolio (2010) lay out methods of developing moral ownership in leaders. Utilizing debriefing techniques and discussing examples of ethical incidents, such as real cases of nurse-patient relationship boundary breaches, demonstrates how leaders can and should act, thus maximizing transfer of learning and reinforcing appropriate action. Utilizing mentor emphasis, discussion, and/or simulations, teaching what is defined as acceptable and unacceptable behavior, coaching nurse leaders through moral dilemmas and resolution plans, and role modeling leadership expectations aids in building moral ownership.

Moral courage.

Ethical decision-making necessitates overcoming fear and standing up for core values and ethical obligations. Doherty and Purtilo (2016) contend that righting a wrong relies on personal integrity, which in turn requires moral courage, and moral courage is the "capacity to overcome fear and standup for core values and ethical obligations" (p.134). Moral courage is context specific and requires nurse leaders to know the situation, control emotions, and rationally manage the fear and risk associated with the situation thus enabling ethical principles to be put into action. Hannah and Avolio (2010) identify multiple methods of developing moral courage in leaders, thus enhancing ethical decision-making and action follow-through. Leaders serving as role models can be powerful influencers in the development of their staff. Senior organizational

leaders encouraged to display moral courage create organizational conditions promoting moral courage in followers, while also reinforcing an organizational culture supportive of moral courage and moral actions. Designing training programs to develop moral courage consist of teaching nurse leaders specific behavior routines to use when facing perceived fears. Creating scripts to guide nurse leaders' ethical decision-making and actions specific to managing nurse-patient relationship boundary breaches may prove helpful in developing moral courage. Utilizing role playing and/or simulation training, whereby nurse leaders are provided with nurse-patient relationship boundary breach scenarios to include imposed challenges and are directed to make ethical decisions and role play confronting and taking action toward resolution, is another means of developing moral courage.

Moral efficacy.

Ethical decision-making requires the confidence to address the specific ethical issue or the subtleties of the context in which the issue is entrenched. Hannah and Avolio (2010) define moral efficacy as "one's belief (confidence) in his or her capabilities to organize and mobilize the motivation, cognitive resources, means, and courses of action needed to attain moral performance, within a given moral domain, while persisting in the face of moral adversity" (p. 297). Bandura (1997) established four methods of developing a strong sense of self-efficacy, mastery experiences, vicarious learning, social persuasion, and emotional and physiological reactions. In other words, respectively defined, past successes strengthen the belief that future success is possible, watching other people perform the behavior strengthens self-efficacy, telling people they can be successful adds to a sense of efficacy, and feeling energized in the face of stressful or challenging situations helps performance, thus adding to a sense of self-efficacy (Krapp, 2015). Hannah and Avolio (2010) expand on Bandura's methods of developing self-

efficacy in leaders by adding external factors that enhance moral efficacy. Providing and articulating "organizational support, means, and systems that provide leaders with external sources of confidence to take moral action" increases nurse leaders' moral efficacy (p. 303). Having nurse leaders analyze real nurse-patient relationship boundary breach vignettes/scenarios and express how they would respond to the events has the potential to enhance moral efficacy by providing the leaders with progressively more difficult or intense ethical mastery or vicarious experiences. Through reflection and debriefing, experienced coach leaders examine the nurse leader's strategies used in addressing the vignettes/scenarios, discuss responses with the nurse leaders, and provide strategies that can be successfully applied or modified if similar boundary breach situations are encountered in the future. Additionally, training nurse leaders in a range of experiences through simulation aids nurse leaders in building scripts that can be used to interpret and guide actions in future boundary breach events, thus enhancing their level of moral efficacy, since they will have developed potential response repertoires.

Moral agency.

Ethical decision-making about moral dilemmas compels moral agency; that said, moral agency "implies that people are responsible for and have the capacity to direct their beliefs and actions" (Butts & Rich, 2016, p. 248). Nurse leaders confronting nurse-patient relationship boundary breaches require decisional capacity in forming reasonable conclusions or resolutions and require the conation to act on their ethical decisions. Leading with character and commanding moral ownership, moral courage, and moral efficacy enhances nurse leaders' moral agency.

Doherty and Purtilo (2016) contend that moral agency is a learned action and identified strategies for developing moral agency, thus leading to success as a moral agent. One of the first

steps in developing nurse leaders' moral agency is to "find a mentor" and partner with the mentor who demonstrates or models moral agency when confronting ethical dilemmas, thus serving to help nurse leaders' "confidence grow" and "experience deepen" (p. 146). Second, "practice moral courage" through simulation trainings and/or in congruence with a mentor when confronting real ethical dilemmas. Following training or upon resolution of a real ethical issue, reflecting on "professional and cultural competence," "applying ethical reasoning," "practicing self-care," and considering "professional goals, learning, and growth" (p. 146) are learning strategies. A third strategy to enhancing moral agency is to be "prudent when reporting wrongdoing" by "engaging in thoughtful reflection before going forward" and to "honor the confidentiality of everyone involved" (p. 146). In congruence with this strategy, know the organization's policies and procedures designed for reporting ethical issues regarding nurse-patient relationship boundary breaches and utilize these channels as a resource for ethical deliberations. It is incumbent upon nurse leaders to be familiar with the organization's policies and processes and to review them often. When confronting ethical dilemmas such as boundary breaches, seek experienced leaders, mentors, and personnel representatives for sources of information and support. Fourth, "remember your code and ethics resources" (p. 147) as frameworks for evaluating and managing nurse-patient relationship boundary breaches. Consider referring to either nursing or military "professional codes of ethics" and as necessary, consult with "ethics committees" in attaining guidance with handling nurse-patient relationship boundary breaches (p. 147). Last, "create and participate in a reflection group" or reflect with a mentor or trusted colleague by sharing concerns about ethical decisions made and the impact on self-care; that is, health, safety, integrity, character, competence, and personal and professional growth. Engaging with mentors or colleagues provides an opportunity to reflect on personal values and

consider how and when personal values may present moral distress or impact ethical decision-making. Gaining the insight of others when faced with, or looking back on, difficult ethical decisions aids with "ensuring self-care," promoting a "well-working professional environment" and bringing a "collective wisdom" to bear in developing nurse leaders' moral agency (p. 147).

In summary, I argue that recruiting experienced senior leaders to role model, mentor, and coach nurse leaders in developing ethical decision-making, character, and moral ownership, courage, and confidence, offers a transfer of learning, promoting a greater sense of self-assurance in confronting and taking actions on nurse-patient relationship boundary breaches. Developing nursing leaders' beliefs in their capability of making moral judgments and taking actions to successfully manage nurse-patient relationship boundary breaches may in turn support moral agency when facing varying ethical dilemmas.

Reflecting on the Research Process and Study

Reflecting on the research process.

Utilizing a mixed methodology culminating in a grounded theory as the process for conducting this research study demonstrates two distinct quantitative and qualitative methods and integration of findings culminating in a grounded theory, thus producing a finished product where the sum is greater than the parts. The overarching research question, "What factors influence nursing leaders' ethical decision-making in their perceptions of and actions toward nurse-patient relationship transgressions?" sets the stage in determining methodology, informing the research sub-questions, and meeting the intent of the study. As such, the research process progresses through multiple stages respective to each phase and order of the mixed methods sequential explanatory design.

Reflecting analytically, conducting each phase of research with methodological rigor, findings resulting from statistically and iteratively analyzing data gained from the surveys and narratives respectively, reveals that nurse leaders perceive moral, cognitive, and organizational factors influence their decisions and actions around nurse-patient relationship boundary breaches. The study design, an appropriate choice for uncovering answers to the overarching research question, began by offering a voluntary anonymous survey, giving nurse leaders an opportunity to convey what ethical decisions they make respective to their beliefs, knowledge, comfort, and skill when evaluating and managing nurse-patient relationship boundary breaches. Seeking a more complete story, resulting from the interviews, gave the nurse leaders a platform to clearly articulate their lived experiences on how making ethical decisions about nurse-patient relationship boundary breaches develop and why taking actions in resolving nurse-patient relationship boundary breaches vary.

Moving through the analytical process, descriptive and inferential data analyses findings derived from the Ethical Decision-Making Survey Instrument and the Demographic Questionnaire reveal relationships and differences among the nurse leaders' characteristics and ethicality in decision-making about nurse-patient relationships and boundary breaches, thus providing baseline information, but also generating additional questions. Seeking to further explain the survey results, thematically analyzing the nurse leaders' narratives by systematically working through the analytical process of uncovering patterns and categories while employing a continuous comparative analysis enhanced facilitating emerging themes, thus revealing situational and contextual factors affect ethicality. The analytical process of coding and the ongoing data comparison continually sparked new ideas, insights and thoughts, giving rise to emerging themes, theoretical concepts, and theory construction. Congruently integrating the

significant findings with the patterned relationships inspired the conceptualization of a grounded theory reflecting the views of the nurse leaders.

Reflecting on the research study.

Enlightening the audience by contributing a grounded theory reflective of the beliefs, characteristics and perceptions of nurse leaders' ethical decision-making about professional boundaries and nurse-patient relationships, as revealed through the survey and narrative analyses, enriches a body of knowledge relevant to nursing and organizational leadership, nurse educators, and researchers. Finding the current literature review about nurse-patient relationship boundary breaches limited in scope and narrow in focus, this study adds depth and breadth and reduces the current literature gap. As the literature review findings focus on nurses within mental health, case management and community nursing, this study expands its scope to include a level 1 trauma military hospital encompassing all inpatient and outpatient specialty fields. Additionally, the literature review research findings are predominately descriptive studies, delineating nurses characteristics involved in boundary transgressions with patients and frequency of boundary breaches, whereas this study's focus is a mixed methods approach with a focus on nurse leaders' ethical decision-making process when evaluating and managing nursing professionals involved in boundary transgressions with patients, perceived predisposing factors affecting their decision-making process, and their conation to act in resolving boundary breach events.

Critically reflecting, this study explicitly expresses a more thorough insight with explanatory clarifications of the phenomena of nurse leaders' moral deliberations and motivation to act when facing ethical dilemmas, specifically those of nurses overstepping professional boundaries with patients. Gaining knowledge by obtaining a baseline from the findings of the

survey analyses and garnering further explanations through thematic analyses provide a plethora of information relative to acknowledging and resolving this ethical dilemma. Culminating in a grounded theory, this study acknowledges the complexity nurse leaders incur in making ethical decisions about nurse-patient relationships and professional boundaries, showing the interactional effects predisposing personal, organizational, and environmental factors affect bridging moral thought to moral action. The variances in outcomes are morally, contextually and perceptively dependent.

Realizing the implications of nurse leaders' non-actions in recognizing and resolving nurse-patient relationship boundary breaches, taking the information gleamed from this study and channeling the findings into a didactic and interactive educational offering is one aspect in addressing the complexity associated with this ethical dilemma and serves in closing the knowledge gap identified in the literature review. Aiming to enhance the nurse leaders' knowledge and comfort in evaluating and managing nurse-patient relationship boundary breaches entails acquiring a skill set offsetting moral, cognitive, and organizational predisposing factors inhibiting bridging moral thought to moral action. On the upside, the content delineated in the educational program is relevant and adaptable to varying ethical dilemma situations, having the potential to transform nursing leadership's ethical decision-making practices.

Recommendations for Future Research

This study shows several significant moral, cognitive, and organizational factors influencing nurse leaders' ethical decision-making in their perceptions of and actions toward nurse-patient relationship transgressions. Additionally, the study shows nurse leaders bridge moral thought to moral action in response to their perception of supportive or inhibitive

predisposing factors in acknowledging and resolving nurse-patient relationship boundary breaches. As a result of the study findings, I recommend the following areas for future research.

Considering this study is the first of its kind to assess nurse leaders' ethical decision-making about nurse-patient relationships and professional boundaries, future research may benefit from conducting a similar study by extending the scope of study to include additional military health care facilities of varying branches of service. Additionally, expanding the range by conducting a similar study within civilian health care facilities may prove beneficial in identifying similarities or differences in results. This study also offered an initial validation of a measure of ethicality, the Ethical Decision-Making Survey Instrument, presenting a first test of its psychometric properties and validity. Revealing sound psychometric properties, further testing of this instrument by extending work on this preliminary measure to a broader array of health care organizations is warranted. As this study reveals significant variances in nurse leaders' ethical decision-making between two scenarios showing different forms of nurse-patient relationships boundary breaches, the outcomes of future studies may serve to support or refute the findings of this study.

As this study measures relationships among variables obtained from the demographic questionnaire and the survey instrument, the results show that increasing "years worked as a registered nurse" and increasing "years worked as a mid-level nurse manager" shows positively influencing ethical decision-making in recognizing and taking actions in resolving boundary breaches. This finding, supported by the responses of the nurse leaders' narratives, also confirms findings in the literature. However, the remaining demographic characteristics did not show any significant findings either positively or negative influencing nurse leaders' ethical decision-making when evaluating and managing nurse-patient relationship boundary breaches. According

to the literature, studies confirm gender, age, and education levels have been shown to influence ethical decision-making about nurse-patient relationships and boundary breaches. Based on the findings of this study, consider enlarging the sample size and conducting a similar study utilizing the same demographics and the same inferential statistics. Additionally, to control for an increased risk of making Type I errors, consider applying an adjustment to the alpha level for multiple comparison tests in future study replications.

The findings from both phases of study demonstrate the nurse leaders' beliefs in their comfort, knowledge, and skill in evaluating and managing nurse-patient relationship boundary breaches varies. The variances are a result of the impact the nurse leaders perceive predisposing factors—that is, value systems, characteristics, and situational/contextual factors—are seen as supportive or inhibitive in successfully bridging moral thought to moral action. Based on these findings, future studies should further examine the predisposing factors identified in this study in relation to their influences on nurse leaders' ethical decision-making. Additionally, examining different combinations may be useful in explaining the impact nurse leaders perceive as affecting ethical decision-making. According to the literature, examining predisposing factors on nurse leaders' ethical decision-making has largely been neglected. As such, expanding the study to predisposing factors' influence in nurse leaders' ethical decision-making may provide a better understanding of the process leaders follow in making ethical decisions.

As this study shows, the nurse leaders' lived experiences illustrate the effect predisposing factors play in whether or not ethical decision-making in acknowledging nurse-patient relationship boundary breaches results in actions taken to resolve boundary breaches. Facing inhibitive predisposing factors affects the nurse leaders' belief in their capability of successfully confronting and intervening in resolving boundary breaches. According to the literature, Hannah

and Avolio (2010) define the "moral potency construct" as enhancing leaders' moral maturity (p. 291). The three factors, moral ownership, moral courage, and moral efficacy are found to be predictive of the moral potency measure. Based on the findings of this study, realizing moral ownership, courage, and efficacy differ in strength among the nurse leaders in terms of their self-identity, thus reflects the variances in bridging moral thought to moral action in confronting and intervening in resolving nurse-patient relationship boundary breaches. Therefore, future research should seek to test levels of moral potency in nursing leaders by recruiting leaders to participate in completing the moral potency scales, such as the Moral Potency Questionnaire "12-item measure, available at http://www.mindgarden.com" (p. 298). The scale contains four items measuring moral courage, three items measuring moral ownership, and five items measuring moral efficacy, thus capturing specific aspects of self-identity with lower levels of strength and being more inclined to be negatively impacted by the influences of moral, cognitive, and organizational factors.

Additionally, findings from this study bring to light situations whereby professional boundary limits are being pushed by the behavior of patients toward nurses. The nurse leaders' state that this behavior on the part of patients is seen as happening more often than the opposite behavior. The result of this type of nurse-patient relationship boundary breach creates stress for nurses through lack of knowing how to respond to patients, difficulty with deflecting unwanted attention of the patient, conflict in the workplace with the patient, and potential for blurred/breached boundaries. Whether the boundary limits are over-stepped by a nurse or a patient, the positional obligations for nurse leaders remains the same in evaluating and managing nurse-patient relationship boundary breaches. Thus, further research to explore nurse leaders'

ethical decision-making in their perceptions of and actions toward nurse-patient relationship transgressions, whereby patients over-step professional boundaries, is recommended.

This study also highlights multiple types of nurse-patient relationship boundary breaches that pose serious ethical decision-making dilemmas for nurse leaders. Some of the nurse-patient relationship boundary breaches that nurse leaders describe as ethical dilemmas include violating a patient's privacy by leaving medical records laying open, talking about patients with non-authorized people, talking about patients in non-secured areas, sharing patients' information on social media, siphoning patients' pain medications, as well as activities of under-involvement such as neglecting patients' care needs. In terms of making ethical decisions in their perceptions of and actions toward these types of nurse-patient relationship transgressions, the nurse leaders describe moral, cognitive, and organizational predisposing factors as affecting bridging moral thought to moral action. As a result of the findings, consider expanding the ethical dilemma vignettes to include the ethical dilemmas as described by the nurse leaders and utilize a similar methodology as followed in this study.

Summary

In this chapter I provide a discussion section integrating the study findings obtained from the descriptive and inferential analyses conducted during the quantitative phase and from the thematic analyses interpreted during the qualitative phase. Based on the findings, four discussion sections emerged. The first section integrates the findings of the ethical decision-making survey instrument item analysis and the essential theme, ascribing conscience, thus highlighting nurse leaders' ethical decision-making about professional boundaries and nurse-patient relationships. The item analysis reveals variations in ethical decision-making by the nursing leaders. A belief by the nurse leaders that personal relationships with patients are considered unethical behaviors

and violations of professional boundaries resulted in a higher mean score than a belief by the nurse leaders that nurses' flirtatious behaviors toward patients are considered unethical behaviors and violations of professional boundaries. With further inquiry, the nurse leaders provide depth and context as explained through their lived experiences. The nurse leaders' ethical decisions in evaluating and managing nurse-patient relationship boundary breaches are anchored in their personal value system. In turn, the nurse leaders measure nurses' behaviors toward patients benchmarked against their personal beliefs, thus conjuring an egregiousness ruler based on their own interpretation of boundaries. Therefore, the nurse leaders do not readily deem nurses' flirtatious type behaviors toward patients as boundary breaches or unethical, but the behaviors are generally deemed inappropriate. On the other hand, the nurse leaders do believe that nurses engaging in personal/intimate relationships with patients are violations of professional boundaries and unequivocally unethical. Seeing the ethical decision-making process about nurse-patient relationships and professional boundaries through the lens of the nurse leaders adds clarity in understanding the variances in nurse leaders' decisions about nurse-patient relationship boundary violations and unethical behaviors.

The second section assimilates the findings from the 48 bivariate Pearson product-moment correlation coefficients and the essential theme, codifying knowledge repertoire, whereby relationships between the nurse leaders' characteristics and ethical decision-making affect evaluating and managing nurse-patient relationship boundary breaches and unethical behaviors. The findings from the 48 bivariate Pearson product-moment correlation coefficients show that the greater the number of years of work experience as a registered nurse and the greater the number of years of work experience as a nurse manager, the greater comfort the nurse leader feels in speaking to a nurse about a personal relationship boundary breach with a patient.

Additionally, the greater the number of years of work experience as a nurse manager, the more knowledge the nurse leader believes she/he has in appropriately managing a personal nurse-patient relationship boundary breach. Similarly, the nurse leaders describe maturation in experience as a registered nurse and as a nurse manager increased their comfort, knowledge, and skill in evaluating and managing nurse-patient relationship boundary breaches and unethical behaviors. Maturation in terms of age and career experience strengthens self-efficacy, factoring into their decisions to take action in resolving nurse-patient relationship boundary breaches.

In the third section, the findings from the six-paired-samples t-tests are integrated with the findings from the essential theme, weighing elements affecting judgment, such that variances among nurse leaders' ethical decision-making about differing gradations of boundary breaches incur. Findings from the six-paired-samples t-tests reveal significantly greater mean scores for nurse managers' ethical decision-making about nurse-patient relationship boundary violations and unethical behavior regarding a nurse's behavior in a personal relationship with a patient than that of a nurse's flirtatious behavior with a patient. The nurse leaders' narratives also reveal variances in ethical decision-making based on perceiving multiple challenges resulting in nursing leaders utilizing discretion in determining and acting on boundary violations and unethical behavior. Decisions in acknowledging and resolving nurse-patient personal/intimate relationship boundary breaches and unethical behaviors are influenced by nurse leaders' perceptions of moral, cognitive and organizational factors. The nurse leaders' personal values, level of maturation, and moral, cognitive, and organizational factors weigh into their decisions prior to intervening in resolving boundary violations and unethical behaviors. Thus, using discretion when weighing circumstances surrounding nurse-patient relationships reveals the variability in

perceptions of and the complexities associated with managing professional boundary transgressions and unethical behavior.

The fourth section integrates the findings of the 48 mixed between-within subjects ANOVAs and the essential theme, summoning support systems, thus highlighting a significant difference in the nurse managers' ethical decision-making in determining violations of nurse-patient professional boundary breaches and unethical behavior. Even though the 48 mixed between-within subjects ANOVAs did not determine any impact of the nurse leaders' characteristics on ethical decision-making about boundary breaches, the tests did find a significant difference in determining boundary violations and unethical behaviors. Specifically, personal/intimate relationships between nurses and patients scored higher than nurses' flirtatious behaviors with patients. Through the narratives, the nurse leaders highlight dispositional impacts affecting their decision-making when evaluating and managing nurse-patient relationship boundary breaches, thus resulting in the nurse leaders summoning support in determining and acting on boundary violations and unethical behaviors. Again, the impact of personal beliefs influencing dispositioning nurse-patient relationship boundary violations and unethical behaviors implores prudence in their decision-making process when ascertaining what behaviors are appropriate and where's the line. Vacillating with conflicting views when determining the line impacts summoning support prior to carrying out any interventions so as to not misjudge nurse-patient relationships. Thus, the nurse leaders employ prudence by summoning personnel support with helping in weighing moral, cognitive and organizational factors impacting ethical decision-making in taking actions toward resolving boundary violations and unethical behaviors.

This chapter presents a connection to theory, such that virtue ethics, self-efficacy, and relational ethics theories provide a frame of reference for nurse leaders' ethical decision-making

processes about nurse-patient relationships and professional boundaries. From the findings of the descriptive and inferential analyses and the shared experiences from the nurse leaders' narratives, knowing right from wrong and having the motivation to bridge moral thought to moral actions is reflective of the theoretical concepts informing this study. The theories provide a foundation for the nurse leaders' character-based leadership and ethical decision-making when encountering nurse-patient relationship boundary breaches and unethical behaviors.

Within this chapter, descriptive, inferential, and thematic findings related to the literature review specifically describes concurrences or non-concurrences with the topics addressed in this study. Interjecting test results and narrative examples in congruence or non-congruence with the findings from the literature provides a thorough review and further explains the results of this study. Discovering the variances found between the study findings and the findings presented in the literature provides clarity of the knowledge gaps related to nurse leaders' ethical decision-making about evaluating and managing nurse-patient relationship boundary breaches and unethical behaviors. As such, uncovering the gaps provides insights into the need for education and training to further develop nurse leaders' ethical decision-making process.

Integrating the descriptive, inferential, and thematic findings gave rise to generating a grounded theory, thus finalizing the outcome of this study. The emergence of this theory represents the nurse leaders' underlying beliefs, views, values, and motivations affecting their ethical decision-making about nurse-patient relationship boundary breaches and unethical behaviors. As well, the grounded theory lays out the nurse leaders' decision-making process in mitigating nurse-patient relationship boundary violations and unethical behaviors by invoking the conation to act on moral judgment in light of individual characteristics, situational context and organizational influences. Ascertaining the gaps in knowing and doing what is right in

making ethical decisions to resolve nurse-patient relationship boundary breaches and unethical behaviors contributes to knowledge gained from this study and provides direction for developing programs for building nurse leaders' moral efficacy.

In finalizing this chapter, this study shows moral, cognitive, and organizational predisposing factors impact nurse leaders' ethical decision-making when evaluating and managing professional nurse-patient relationship boundary breaches. As such, the interconnectedness among the predisposing factors affect nurse leaders' ethical decisions made in bridging moral thought to moral action. Based on the findings, three main implications, moral cognition, self-reflection, and moral agency, are essential to nurse leaders making ethical decisions about these types of ethical dilemmas and successfully following through with actions resolving nurse-patient relationship boundary breaches and unethical behaviors. Utilizing this knowledge gain, designing and implementing an education program specifically promoting a skill set aimed at improving nurse leaders' volition to organize and execute ethical actions resolving boundary breaches may in turn be adaptable to successfully tackling varying ethical dilemmas.

Ending this chapter includes a reflection on the research process and the study, as well as recommendations for future research. Considering the findings of this study, recommendations center on conducting similar studies in various health care settings to include different branches of service within the Department of Defense, as well as considering civilian health care settings. By gaining an understanding of nurse leaders deliberating confronting and taking action to mitigate nurse-patient relationship boundary breaches due to predisposing factors affecting thought to action, suggestions for future research focusing on nurse leaders' moral maturity and moral potency may prove beneficial to furthering nurse leaders' ethical decision-making about

this topic. Realizing from the findings of this study that nurse leaders perceive nurse-patient relationship boundary breaches occur in various forms, such as patients' aggressively pursuing nurses attention, nurses sharing patients' private information, as well as diverting patient pain medications, may be considered for future research. These types of ethical dilemmas fall within the purview of nurse leaders' positional obligation requiring ethical decision-making about evaluating and managing nurse-patient relationship boundary breaches and unethical behaviors.

In conclusion, this study, a mixed methods sequential explanatory design, met the purpose of the study by answering the overarching research question, "What factors influence nursing leaders' ethical decision-making in their perceptions of and actions toward nurse-patient relationship transgressions?" The findings reveal a clearer understanding of the nurse leaders' ethical decision-making about nurse-patient relationship boundary breaches and unethical behaviors, factors influencing knowing and doing what is right, and level of moral maturity in carrying out actions in resolving boundary transgressions. Uncovering moral, cognitive, and organizational factors that impacted nurse leaders' ethical decision-making and moral agency provided a better understanding of the nurse leaders' ethical decision-making process. Hence, the information derived from this study adds to the current body of literature and contributes to closing a knowledge gap.

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Appendices

Appendix A
Study Information Sheet

Hello, my name is Pam Scott, RN, MSN, MBA. I am a graduate student in the doctoral program for Organizational Leadership at the University of the Incarnate Word and the Principal Investigator for this research study: *Nursing Leaders' Ethical Decision-Making about Professional Boundaries and Nurse-Patient Relationships.*

You are being asked to participate voluntarily in this study because you are a nurse leader working at San Antonio Military Medical Center, Fort Sam Houston, Texas. If you choose to take part in this study, you may stop at any time during survey completion and you may skip any questions you do not wish to answer. You may choose not to participate without negative harm or consequence. The survey is anonymous, you will not be identified, please DO NOT write any identifiable information on the survey. This study has been reviewed and approved by the San Antonio Military Medical Center and the University of the Incarnate Word Institutional Review Boards.

What Will You Be Asked to Do?
If you decide to participate in this study, you will be asked to complete two surveys. One is a demographic survey that asks about your experience as a nurse and nurse manager. The second instrument was developed for use in this study to examine your feelings toward ethical decision-making in situations regarding nurse-patient professional boundaries.

If you decide to participate in the study, please complete the survey on-line as directed by the survey site.

Again, thank you for your time and effort in participating in this study.

Sincerely,

Pam Scott
Principal Investigator

Appendix B
Information Sheet for Content and Face Validity Experts

You are being asked to participate voluntarily in this study, by completing this survey you give your permission to participate. If you choose to take part in this study, you may stop at any time during survey completion and you may skip any questions you do not wish to answer. You may choose not to participate without negative harm or consequence. The survey is anonymous, you will not be identified, please DO NOT write any identifiable information on the survey. This study has been reviewed and approved by the San Antonio Military Medical Center and the University of the Incarnate Word Institutional Review Boards.

Content Validity Experts: Four nurse leader subject matter experts with a minimum of four years' experience providing mid- and senior- level supervisory responsibilities in Army medical military treatment facilities will be asked to review the instrument for content validity.

Please do the following: Complete the Content Validity Index

Please answer the following questions and provide written comments on the demographic questionnaire and ethical decision-making instrument based on the questions below:

Do you consider the ethical dilemmas as actual or potential situations?

Do you believe the vignettes present valid ethical dilemmas that could be experienced for a nurse leader?

Face Validity Experts: Four nursing staff (RN, LVN, CNA, medic), who are not in a supervisory position will be asked to review the instrument for face validity.

Please do the following: Provide written comments on the demographic questionnaire and ethical decision-making instrument in regards to the instruments' readability, understandability, and grammatical correctness.

Please answer the following questions:

Are there any grammatical or spelling errors on the instruments?

Are there any words or sentences that are unclear or misused?

Were the questions confusing or difficult to answer?

Was the font and size of the text easy to read?

Appendix C
Survey Instrument

You are being asked to participate voluntarily in this study, by completing the questionnaire you are providing your permission to participate. If you choose to take part in this study, you may stop at any time during survey completion and you may skip any questions you do not wish to answer. You may choose not to participate without negative harm or consequence. The survey is anonymous, you will not be identified, please DO NOT write any identifiable information on the survey. This study has been reviewed and approved by the San Antonio Military Medical Center and the University of the Incarnate Word Institutional Review Boards.

Nurse Manager Ethical Decision-Making Instrument

Nurse-Patient Professional Relationships

Vignette 1:

Ms. Peters, a 23 year-old single dependent female, was admitted from the Operating Room to the inpatient medical-surgical unit for an open reduction-internal fixation of a fractured right tibia. The charge nurse assigned CPT Linn, a male registered nurse with six years of experience in medical-surgical nursing, as Ms. Peters' primary nurse. SGT Jones, a licensed vocational nurse assigned to CPT Linn's nursing team, was in Ms. Peters' room, providing care to his patient in the adjacent bed while CPT Linn was performing his admission assessment. Later, you overhead SGT Jones' conversation with another enlisted member while they were eating lunch in the break-room. This is what was said by SGT Jones: "Yeah, CPT Linn was flirting with Ms. Peters; he was making all sorts of comments to her about how good looking and in-shape she was and was asking her questions about whether she had a boyfriend. He made some comment about how he was sure her scar would heal nicely and her right leg would look as beautiful as her left leg. I doubt my patient heard the interaction because she was asleep at the time and the curtain was pulled. Didn't seem like Ms. Peters minded the attention; in fact after CPT Linn left the room, she asked if she could have CPT Linn as her primary nurse every day. She obviously didn't miss how hard he was hitting on her. This is not the first time I've heard him hitting on female patients." From the supervisory perspective, CPT Linn has had exceptional performance ratings as a junior officer, is well-liked by his nursing peers, and although he is very friendly with patients, this is the first time you have heard about this type of behavior.

Mark the box that most closely describes your beliefs and feelings related to the statements that describe

Vignette 1.

V1		Strongly Disagree	Moderately Disagree	Mildly Disagree	Mildly Agree	Moderately Agree	Strongly Agree
a.	I believe the nurse's behavior toward the patient violated appropriate nurse-patient boundaries.						
b.	I believe the nurse's behavior toward the patient was unethical.						
c.	As this nurse's mid-level manager, I feel comfortable speaking with the nurse about his behavior.						
d.	As this nurse's mid-level manager, I do not feel it is my responsibility to speak to the nurse about his behavior.						
e.	As a mid-level nurse manager, I believe I have the knowledge to appropriately manage this situation.						
f.	As a mid-level nurse manager, I believe I have the skills to appropriately manage this situation.						

Vignette 2:

SPC John Mills is a 28 year old male, with a traumatic, unilateral above-the-knee amputation from a roadside bomb explosion in Afghanistan. He is seen monthly as an outpatient in the Orthopedic Clinic for assessment of his prosthesis, gait, and balance while awaiting the outcome of his medical board. Kathy Lewis is an experienced contract LVN who has worked in the clinic for just over two years. She is responsible for checking in patients and assisting the physicians with dressing changes and procedures. Ms. Lewis is friendly, reliable, and competent in her job. Just today you, as the Orthopedic Clinic Nurse Manager, received a hand written complaint from SPC Mills' wife. In the letter Mrs. Mills states the following: "Kathy Lewis, the clinic nurse, is getting out of hand. I found several text messages on my husband's phone from an unknown number; when I called it, I found out it was Ms. Lewis's cell phone number. It was obvious when reading the messages that they were more than just friends. When I confronted my husband about it, he admitted to having an affair with her over the last two months. He said after meeting her during a clinic visit and exchanging phone numbers, they went out a few times and one thing led to another. He has apologized and we are working through this with marital counseling. He admitted that since he lost his leg, he just didn't feel very attractive anymore, so it was nice to get the attention of another woman. I know she still calls him even though he has tried to end the relationship. I want it to stop, now."

Mark the box that most closely describes your beliefs and feelings related to the statements that describe

Vignette 2.

V2		Strongly Disagree	Moderately Disagree	Mildly Disagree	Mildly Agree	Moderately Agree	Strongly Agree
a.	I believe the nurse's behavior toward the patient violated appropriate nurse-patient boundaries.						
b.	I believe the nurse's behavior toward the patient was unethical.						
c.	As this nurse's mid-level manager, I feel comfortable speaking with the nurse about her behavior.						
d.	As this nurse's mid-level manager, I do not feel it is my responsibility to speak to the nurse about her behavior.						
e.	As a mid-level nurse manager, I believe I have the knowledge to appropriately manage this situation.						
f.	As a mid-level nurse manager, I believe I have the skills to appropriately manage this situation.						

Mid-level Nurse Manager

Demographics

1. What is your age? _____

2. What is your gender? (Circle one): Male Female

3. How many years have you worked as a registered nurse? _____

4. While working as a registered nurse, have you ever observed situations in which nursing staff have crossed what you consider to be appropriate nurse-patient relationship professional boundaries?

   Yes

   No

5. How many years have you worked as a mid-level nurse manager? _____

6. How many years have you worked in a military health care setting? _____

7. What is your highest level of education as a registered nurse? (Circle one)

   Associates Degree RN

   Bachelors Degree RN

   Masters Degree RN

   PhD/DNP

8. What is your current status as a mid-level nurse manager? (Circle one)

   GS Civilian with no prior active duty or reserve service time

   GS Civilian with prior active duty or reserve service time

   Active Duty Military

Appendix D
SUBJECT CONSENT FORM TO TAKE PART IN A STUDY OF

Nursing Leaders' Ethical Decision-Making about Professional Boundaries and Nurse-Patient Relationships

I am a graduate student at the University of the Incarnate Word working towards a doctorate degree in education with a concentration in organizational leadership.

You are being asked to take part in a study that will examine ethical decision-making among mid- and senior- level nurse managers/supervisor about professional boundaries and nurse-patient relationships. I want to learn the types of things that help or do not help mid- and/or senior-level managers/supervisors make ethical decisions. You are being asked to take part in this study because you are a mid- or senior-level nurse manager/supervisor/educator with a minimum of one year experience in managing and/or supervising staff and/or student nurses.

If you decide to take part in the study, I will conduct a one hour long, audio recorded, individual interview and request that you answer a short demographic questionnaire at the time of the interview. I will do everything possible to prevent any discomfort or inconvenience to you, and do not foresee anything more than a low risk to you from participating in the study. There is no guarantee that you will receive direct benefit from taking part in this study; however, the knowledge you receive from the study as a result of your study participation will lead to an increased understanding of how nursing managers/supervisors make ethical decisions and factors perceived as relevant to ethical decision-making.

Everything I learn about you in the study will be confidential. Published results of the study will not identify you in any way. Your decision to take part in the study is voluntary. You are free to choose not to take part in the study or to stop taking part at any time. If you choose not to take part or to stop at any time, it will not affect your present or future status at the University of the Incarnate Word.

If you have questions now, feel free to ask me. If you have additional questions later or you wish to report a problem that may be related to this study, contact:

Pamela T. Scott
210-460-9631
pscott@student.uiwtx.edu

A committee that reviews all research on human subjects, the Institutional Review Board, will answer any questions about your rights as a research subject (210-829-2757—Dr. Kevin B. Vichcales, Dean of Graduate Studies and Research). You will be given a copy of this form to keep. A summary of the final report will also be available to you if requested.
YOUR SIGNATURE INDICATES THAT YOU CONSENT TO TAKE PART IN THIS STUDY AND THAT YOU HAVE READ AND UNDERSTAND THE INFORMATION GIVEN ABOVE AND EXPLAINED TO YOU. I will provide you with a signed copy for your records.

_____	_____
Signature of Participant	Signature of Researcher
_____/_____	_____/_____
Date Time	Date Time

Appendix E
Interview Study Information Sheet

Hello, my name is Pam Scott, RN, MSN, MBA. I am a graduate student in the doctoral program for Organizational Leadership at the University of the Incarnate Word and the Principal Investigator for this research study: *Nursing Leaders' Ethical Decision-Making about Professional Boundaries and Nurse-Patient Relationships*

You are being asked to participate voluntarily in this study because you are a nursing leader with more than one year of experience managing and/or supervising staff/student nurses. If you choose to take part in this study, you may stop at any time during the interview and you may skip any questions you do not wish to answer. You may choose not to participate without negative harm or consequence. The interview will be maintained as confidential. If the results of the study are published, you will not be identified in any way. This study has been reviewed and approved by The University of the Incarnate Word Institutional Review Board (IRB).

What Will You Be Asked to Do?
If you decide to participate in this study, you will be asked to participate in an audiotaped personal interview. During this interview, you will be asked several questions about your experiences as a manager/supervisor/educator of staff/student nurses, specifically related to professional boundaries and nurse-patient relationships. The interview should last approximately one hour. We may need to meet on more than one occasion. There are minimal risks to the participant. We do not guarantee you will benefit from participating in the study. However, the information you offer may be used to develop an educational offering geared toward ethical decision-making about professional boundaries and nurse-patient relationships. There are no incentives for participating in this study.

Again, thank you in advance for your time and cooperation in participating in this study.

Sincerely,

Pam Scott
Principal Investigator

Appendix F
Content Validity Index Score Sheet

You are being asked to participate voluntarily in this study, by completing the questionnaire you are providing your permission to participate. If you choose to take part in this study, you may stop at any time during survey completion and you may skip any questions you do not wish to answer. You may choose not to participate without negative harm or consequence. The survey is anonymous, you will not be identified, please DO NOT write any identifiable information on the survey. This study has been reviewed and approved by the San Antonio Military Medical Center and the University of the Incarnate Word Institutional Review Boards.

Instructions:
Please circle on the content validity index the number that best represents your opinion of the relevance of the survey items to nurse leaders' beliefs, knowledge, and skills related to ethical decision-making

***Construct*: N**urse leaders' ethical beliefs related to appropriate nurse-patient relationships and managerial knowledge and skills to act on those beliefs.

	Not relevant	Unable to assess relevance without item revision	Relevant but needs minor alteration	Very relevant
Vignette 1a: I believe the nurse's behavior toward the patient violated appropriate nurse-patient boundaries.	1	2	3	4
Vignette 1b: I believe the nurse's behavior toward the patient was unethical.	1	2	3	4
Vignette 1c: As this nurse's supervisor, I feel comfortable speaking with the nurse about his behavior.	1	2	3	4
Vignette 1d: As this nurse's supervisor, I do not feel it is my responsibility to speak to the nurse about his behavior.	1	2	3	4
Vignette 1e: As a nurse supervisor, I believe I have the knowledge to appropriately manage this situation.	1	2	3	4
Vignette 1f: As a nurse supervisor, I believe I have the skills to appropriately manage this situation.	1	2	3	4

	Not relevant	Unable to assess relevance without item revision	Relevant but needs minor alteration	Very relevant
Vignette 2a: I believe the nurse's behavior toward the patient violated appropriate nurse-patient boundaries.	1	2	3	4
Vignette 2b: I believe the nurse's behavior toward the patient was unethical.	1	2	3	4
Vignette 2c: As this nurse's supervisor, I feel comfortable speaking with the nurse about his behavior.	1	2	3	4
Vignette 2d: As this nurse's supervisor, I do not feel it is my responsibility to speak to the nurse about his behavior.	1	2	3	4
Vignette 2e: As a nurse supervisor, I believe I have the knowledge to appropriately manage this situation.	1	2	3	4
Vignette 2f: As a nurse supervisor, I believe I have the skills to appropriately manage this situation.	1	2	3	4
Demographics 1: What is your age?	1	2	3	4
Demographics 2: What is your gender? (Circle one) Male Female	1	2	3	4
Demographics 3: How many years have you worked as a registered nurse?	1	2	3	4
Demographics 4: While working as a registered nurse, have you ever observed situations in which nursing staff have crossed what you consider to be appropriate nurse-patient relationship professional boundaries?	1	2	3	4
Demographics 5: How many years have you worked as a nurse supervisor?	1	2	3	4

	Not relevant	Unable to assess relevance without item revision	Relevant but needs minor alteration	Very relevant
Demographics 6: How many years have you worked in a military health care setting?	1	2	3	4
Demographics 7: What is your highest level of education as a registered nurse? (Circle one) Associates Degree RN Bachelors Degree RN Masters Degree RN PhD/DNP	1	2	3	4
Demographics 8: What is your current status as a nurse supervisor (Circle one) GS Civilian with no prior active duty or reserve service time GS Civilian with prior active duty or reserve service time Active Duty Military	1	2	3	4

For Content Validity Reviewers:

Please list any additional items I may have forgotten or additional practice items I should include:

_____

_____

Appendix G
ANOVAS

Table 27

Analyses of Variance Results for Gender and Vignettes 1.3 and 2.3 Questions for Ethical Decision-Making about Nurse-Patient Relationship Boundaries

Source	df	SS	MS	F	η2
		Between subjects			
Gender	1	1.18	1.18	.94	.34
Error	37	46.36	1.25		
		Within subjects			
EDM3	1	.01	.01	.03	.00
EDM3 x Gender	1	.94	.94	2.11	.05
Error (EDM3)	37	16.45	.45		

Note. η2 = effect size.

Table 28

Analyses of Variance Results for Gender and Vignettes 1.4 and 2.4 Questions for Ethical Decision-Making about Nurse-Patient Relationship Boundaries

Source	df	SS	MS	F	η2
		Between subjects			
Gender	1	.04	.04	.08	.00
Error	37	18.76	.51		
		Within subjects			
EDM4	1	.14	.14	.26	.01
EDM4 x Gender	1	1.16	1.16	2.22	.06
Error (EDM4)	37	19.33	.52		

Note. η2 = effect size.

Table 29

Analyses of Variance Results for Gender and Vignettes 1.5 and 2.5 Questions for Ethical Decision-Making about Nurse-Patient Relationship Boundaries

Source	df	SS	MS	F	η2
		Between subjects			
Gender	1	.05	.05	.05	.00
Error	37	35.75	.97		
		Within subjects			
EDM5	1	.38	.38	.79	.02
EDM5 x Gender	1	1.41	1.41	2.88	.07
Error (EDM5)	37	18.08	.49		

Note. η2 = effect size.

Table 30

Analyses of Variance Results for Gender and Vignettes 1.6 and 2.6 Questions for Ethical Decision-Making about Nurse-Patient Relationship Boundaries

Source	df	SS	MS	F	η2
		Between subjects			
Gender	1	.00	.00	.00	.00
Error	37	27.38	.74		
		Within subjects			
ED61	1	.43	.43	.90	.02
EDM6 x Gender	1	2.28	2.28	4.76	.11
Error (EDM6)	37	17.72	.48		

Note. η2 = effect size.

Table 31

Analyses of Variance Results for Past Observations of Perceived Boundary Crossings and Vignettes 1.3 and 2.3 Questions for Ethical Decision-Making about Nurse-Patient Relationship Boundaries

Source	df	SS	MS	F	η2
		Between subjects			
BB	1	.03	.03	.03	.00
Error	39	47.53	1.22		
		Within subjects			
EDM3	1	.20	.20	.42	.01
EDM3 x BB	1	.00	.00	.00	.00
Error (EDM3)	39	18.19	.47		

Note. η2 = effect size.

Table 32

Analyses of Variance Results for Past Observations of Perceived Boundary Crossings and Vignettes 1.4 and 2.4 Questions for Ethical Decision-Making about Nurse-Patient Relationship Boundaries

Source	df	SS	MS	F	η2
		Between subjects			
BB	1	.34	.34	.66	.02
Error	39	19.76	.51		
		Within subjects			
EDM4	1	.00	.00	.01	.00
EDM4 x BB	1	.00	.00	.01	.00
Error (EDM4)	39	20.48	.53		

Note. η2 = effect size.

Table 33

Analyses of Variance Results for Past Observations of Perceived Boundary Crossings and Vignettes 1.5 and 2.5 Questions for Ethical Decision-Making about Nurse-Patient Relationship Boundaries

Source	df	SS	MS	F	η2
		Between subjects			
BB	1	2.03	2.03	2.31	.06
Error	39	34.36	.88		
		Within subjects			
EDM5	1	.56	.56	1.20	.03
EDM5 x BB	1	1.78	1.78	3.81	.09
Error (EDM5)	39	18.22	.47		

Note. η2 = effect size.

Table 34

Analyses of Variance Results for Past Observations of Perceived Boundary Crossings and Vignettes 1.6 and 2.6 Questions for Ethical Decision-Making about Nurse-Patient Relationship Boundaries

Source	df	SS	MS	F	η2
		Between subjects			
BB	1	.90	.90	1.30	.03
Error	39	27.05	.69		
		Within subjects			
EDM6	1	.26	.26	.50	.01
EDM6 x BB	1	.55	.55	1.08	.03
Error (EDM6)	33	19.94	.51		

Note. η2 = effect size.

Table 35

Analyses of Variance Results for Education and Vignettes 1.3 and 2.3 Questions for Ethical Decision-Making about Nurse-Patient Relationship Boundaries

Source	df	SS	MS	F	η2
		Between subjects			
Education	3	2.99	.99	.81	.06
Error	36	44.19	1.23		
		Within subjects			
EDM3	1	.01	.01	.03	.00
EDM3 x Education	3	.66	.22	.45	.04
Error (EDM3)	36	17.53	.49		

Note. η2 = effect size.

Table 36

Analyses of Variance Results for Education and Vignettes 1.4 and 2.4 Questions for Ethical Decision-Making about Nurse-Patient Relationship Boundaries

Source	df	SS	MS	F	η2
		Between subjects			
Education	3	1.13	.38	.72	.06
Error	36	18.86	.52		
		Within subjects			
EDM4	1	.07	.07	.13	.00
EDM4 x Education	3	1.18	.39	.74	.06
Error (EDM4)	36	19.31	.54		

Note. η2 = effect size.

Table 37

Analyses of Variance Results for Education and Vignettes 1.5 and 2.5 Questions for Ethical Decision-Making about Nurse-Patient Relationship Boundaries

Source	df	SS	MS	F	η2
		Between subjects			
Education	3	3.64	1.21	1.33	.10
Error	36	32.75	.91		
		Within subjects			
EDM5	1	.07	.07	.13	.00
EDM5 x Education	3	.29	.10	.18	.02
Error (EDM5)	36	19.19	.53		

Note. η2 = effect size.

Table 38

Analyses of Variance Results for Education and Vignettes 1.6 and 2.6 Questions for Ethical Decision-Making about Nurse-Patient Relationship Boundaries

Source	df	SS	MS	F	η2
		Between subjects			
Education	3	2.67	.89	1.27	.10
Error	36	25.28	.70		
		Within subjects			
EDM6	1	.05	.05	.09	.00
EDM6 x Education	3	.34	.11	.21	.02
Error (EDM6)	36	19.61	.55		

Note. η2 = effect size.

Table 39

Analyses of Variance Results for Work Status and Vignettes 1.3 and 2.3 Questions for Ethical Decision-Making about Nurse-Patient Relationship Boundaries

Source	df	SS	MS	F	η2
		Between subjects			
Status	2	2.59	1.29	1.09	.05
Error	38	44.98	1.18		
		Within subjects			
EDM3	1	.15	.15	.32	.01
EDM3 x Status	2	.19	.10	.20	.01
Error (EDM3)	38	18.00	.47		

Note. η2 = effect size.

Table 40

Analyses of Variance Results for Work Status and Vignettes 1.4 and 2.4 Questions for Ethical Decision-Making about Nurse-Patient Relationship Boundaries

Source	df	SS	MS	F	η2
		Between subjects			
Status	2	.44	.22	.43	.02
Error	38	19.65	.52		
		Within subjects			
EDM4	1	.00	.00	.01	.00
EDM4 x Status	2	1.06	.53	1.03	.05
Error (EDM4)	38	19.43	.51		

Note. η2 = effect size.

Table 41

Analyses of Variance Results for Work Status and Vignettes 1.5 and 2.5 Questions for Ethical Decision-Making about Nurse-Patient Relationship Boundaries

Source	df	SS	MS	F	η2
		Between subjects			
Status	2	3.717	1.86	2.16	.10
Error	38	32.63	.86		
		Within subjects			
EDM5	1	.09	.09	.17	.00
EDM5 x Status	2	.44	.22	.43	.02
Error (EDM5)	38	19.56	.52		

Note. η2 = effect size.

Table 42

Analyses of Variance Results for Work Status and Vignettes 1.6 and 2.6 Questions for Ethical Decision-Making about Nurse-Patient Relationship Boundaries

Source	df	SS	MS	F	η2
		Between subjects			
Status	2	2.05	1.02	1.50	.07
Error	37	46.508	1.257		
		Within subjects			
EDM6	1	.00	.00	.01	.00
EDM6 x Status	2	.36	.18	.34	.02
Error (EDM6)	38	20.13	.53		

Note. η2 = effect size.

Appendix H
Nurse Leader Theme Summations

Table 43

Summation of Jade's Responses to Themes One, Two, Three and Four as Related to Ethical Decision-Making about Nurse-Patient Relationship Boundaries [NL1]

Theme One – Ascribing Conscience

Cultivating Coauthored Care Requisites:

> You have to figure out how you can advocate for the patient, without over stepping the boundary taking over. You don't want to overstep the bound, but you also, you also don't want to take completely over and then the patient doesn't have any active participation in their care. I mean I think you have to, you have to feel out what they need and then the way you advocate is by helping them through that process.
>
> ***Author Interpretation:***
> Patient advocacy is meeting the patient's needs in providing care while ensuring the patient actively participates in their own care. Staff nurses are perceived as "feeling out" patient needs and helping the patient through the process without "taking over" and over-stepping professional boundaries.

Effecting Trust:

> Build the relationship and that trust by either just talking to them [patient] and making them the center, the focus of it.
>
> ***Author Interpretation:*** A patient's trust is earned when the nurse places the patient at the center of the nurse-patient relationship and the patient's care is focused on meeting their needs.

Composing Synergetic Interactions:

> I would say that relationship building is probably, I think, I definitely think it's individual; …and so I would think that, you know, they're pulling off their personal, their personal relationships, and how they interact with people that are close to them that they aren't caring for; and, that's how they build their relationship with their patients. The nurse wants to get to know how their feeling, how they deal with their disease process, and how it interferes with their day-to-day.
>
> ***Author Interpretation:*** A nurse-patient relationship is built by earning a patient's trust, focusing care on meeting the patient's needs, and by keeping lines of communication open and focused on the patient. Staff nurses are perceived as building nurse-patient relationships similar to building close personal relationships.

Theme Two – Codifying Knowledge Repertoire

Recollecting Educational Lessons Learned:

> I don't really remember discussing, like step by step, like say in school, about the nursing code of ethics and the Nurse Practice Act. I think that, if people understand the code of ethics and we're required to really understand the Nurse Practice Act better, or that it's brought up more in our day-to-day work, or as we educate our nurses and say look this relates to, the Nurse Practice Act section …and we relate that to the Nurse Practice Act, I think that's going to help us to prevent any boundary questions, any professional boundary questions. For which I lacked in the Nurse Practice Act, not knowing it or not using it or not making it a forefront of my practice, I probably made up for it other ways. I think I drew more from my personal strengths…how I was raised, and how I practiced and used that in my practice. Morally and ethically what was right in treating people, you know, just the basics. And that's probably what I used in place of really knowing the Nursing Code of Ethics or the Nurse Practice Act. When you're on the Nurse Practice Act website, it's very hard to get to, it's set-up very funny. We don't really keep it in front of us, and we don't revert back.

Author Interpretation: The nurse leader relied on personal values; "morally and ethically what was right in treating people" in place of "knowing" the Nurse Practice Act and Nursing Code of Ethics doctrine about nurse-patient relationship behavior. Training about the Nurse Practice Act and the Nursing Code of Ethics specifically related to nurse-patient relationship boundaries was perceived as non-existent in two-year prepared, diploma, and undergraduate nursing programs. Navigating the website for the Nurse Practice Act was perceived as difficult, not well known and not referred to.

Understanding Experiential Capacity:

> Like I would not be, but the way I looked at it then [nurse-patient boundary breaches], I think back and I go, oh, my gosh, maybe I should have said something. But I think it has to do again with age, you're, how comfortable you are with being a nurse, and how comfortable you are with confrontation. I mean I really believe that, I think a lot of it is age, and just experience level and then how you're brought up.

Author Interpretation: Maturation in age and experience as both an RN and a nurse leader was perceived as fostering the knowledge and skill required in evaluating and managing nurse-patient relationship boundaries. Decision-making was perceived as impacted by "not only your ethical point of view and how you're brought up, but also maybe your age, your comfort level, your ability to communicate with your fellow co-workers, and your ability to communicate with your patients.

Theme Three – Summoning Support Systems

Humanizing Leadership Traits:

> I think you have to lead from the front. And that's really where you see the rubber meets the road if people are doing the right thing. At this time in my life I would absolutely feel comfortable approaching the staff about a boundary breach. I would be like, what are you doing? And I mean, it depends on what it is, the course that you take. Obviously, if it's not so egregious, the breach of patient, the nurse-patient relationship, you know, you would want to correct it. That would be my thought. Correct, teach them, and I think that makes the best advocate for that patient, because now they know, hey, that's not so appropriate. Maybe they didn't know.
>
> ***Author Interpretation:*** Leads from the front by actively engaging with staff nurses in order to "know" if "people are doing the right thing." Maturation and experience have provided the nurse leader with a comfort level in confronting and taking action with staff nurses about nurse-patient relationship boundary breaches. If the nurse-patient relationship boundary transgression is "not so egregious," "correct it" and "teach them" that their behavior is "not so appropriate."

Employing Resources:

> I need to be smarter on the code of ethics. I mean I think it's something we as professionals probably need to look at and really look at it and know it. It makes me want to run out, really post up our Nurse Practice Act and get it out there. If people understand the code of ethics and we're required to really understand the Nurse Practice Act better, or that it's brought up more in our day-to-day work, or as we educate our nurses, and say look this relates to, the Nurse Practice Act, section six… and we relate that to the Nurse Practice Act. I think that's going to help us to prevent any boundary questions, any professional boundary questions. Additionally, I don't think as nurses that we, unlike physicians, may tap into ethics committees about patients and discuss things that are, you know, discuss with others, be collaborative. Do you basically raise things to the attention of an ethics board? You have questions about your patient care, and practice, and what practice you're delivering. And we really don't do that very much in nursing. I think maybe advanced practice nurses do, but I don't think we do.
>
> ***Author Interpretation:*** Identified ethics committees and ethics boards as available resources to raise questions and collaboratively discuss patient care, practice, and the practice being delivered by nurses. The nurse leader perceived ethics committees and ethics boards as not readily "tapped" into by nurses for assistance with nurse-patient relationship boundary transgressions. Additionally, the nurse leader perceived the need to better understand the Nurse Practice Act and Nursing Code of Ethics and educate staff nurses on professional nurse-patient boundary setting through relatable examples.

Theme Four – Weighing Elements Affecting Judgment

Deliberating Dispositional Impacts:

> I think what impacts decision-making, is not only your ethical point of view, but also your age, your comfort level, your skill level, your ability to communicate with your fellow co-workers, and your ability to communicate with your patients. That would impact, definitely impact your decision-making on how you look at those boundary breaches.
>
> ***Author Interpretation:*** Jade expressed hesitancy about her ability to evaluate and manage boundary breaches during her early years in nursing, predominately all related to personal growth factors.

Tackling Organizational Barriers:

> Maybe I didn't know a lot of time, which is not always an excuse, but it's an honest one. I didn't know it was a breach. Remember, a lot of times we were two year prepared or diploma prepared and I don't think that they really touched a lot upon that.
>
> ***Author Interpretation:*** She described her educational foundation as a barrier in understanding nurse-patient relationship boundary breaches.

Calculating Discretionary Challenges:

> I guess I really never looked at them in the terms of a breach. I felt like you were still doing good …because we are like family. I guess if we look at the thing with my staff and with me, you know, getting close to the family that way, maybe overstepping outside of the hospital area, I guess the way I dealt with it, is I didn't feel that it was a breach. So I basically just you know, business as usual. It wasn't unusual to me, to think that way. And a code of ethics, it's how you interpret them right? Probably just personal view that I didn't feel that it was truly a breach.
>
> ***Author Interpretation:*** The nurse leaders' perception of the military health care setting differs from a civilian health care setting in that "we are like family" and you "tend to want to take care of them". From this perspective, overstepping nurse-patient relationship boundaries were not perceived as transgressions; but, were viewed as "you were still doing good." The nurse leader stated that her evaluation and management of nurse-patient relationship boundary breaches evolved with maturation and experience. As a novice nurse leader, close ties to a patient and family were perceived as "business as usual"; whereas, as an experienced nurse leader, close ties to a patient and family were perceived as "it is a breach". Accepting responsibility and accounting for one's actions were based on a personal interpretation of a code of ethics in alignment with maturation and experience as a nurse leader.

Table 44

Summation of Kali's Responses to Themes One, Two, Three and Four as Related to Ethical Decision-Making about Nurse-Patient Relationship Boundaries [NL2]

Theme One – Ascribing Conscience

Cultivating Coauthored Care Requisites:

> You're advocating for your patient for care, maybe with the medical team, maybe with the nursing team, or ancillary services, and often time we may have to kind of help the person. You want to teach nurses how to help their patients through difficult health care decisions and kind of advocate for them, vote for the underdog but without crossing the boundaries of becoming too familiar.
>
> ***Author Interpretation:*** Patient advocacy is perceived as "helping patients through difficult health care decisions" by speaking up for them with the health care team; as "voting for the underdog but without crossing the boundaries of becoming too familiar."

Effecting Trust:

> You still have that level of, develop a level of trust, a level of maybe how a person, how to communicate with your patient, like a cultural understanding of how to communicate with your patient. The patient should be able to trust us. I went home having the families feel like they didn't trust us… so I developed a focus group and…we ended up having a tremendous amount of coaching and training on how to build trust.
>
> ***Author Interpretation:*** The nurse leader described the role of nursing as an intimate relationship, requiring nurses to consider patient's cultural backgrounds, communicate appropriately, provide follow-through with patients, and safeguard patient information; thereby, building trust with patients. The nurse leader also described the challenges associated with rebuilding nurse-patient relationships when a patient's trust has been violated. The nurse leader described the effort and "tremendous amount of coaching and training on how to build trust" with staff nurses by utilizing focus groups.

Composing Synergetic Interactions:

> Frequently discussing the role of the patient-nurse boundary, when your, depending on the role, when you're at the bedside, obviously a pretty intimate relationship with patient's; whereby, if you are a nurse case manager, a little bit less intimate, you don't have that physical contact. Often times we may have to, we kind of help the person, help the patient navigate the complexity and without building too intimate of a relationship.
>
> ***Author Interpretation:*** Building a nurse-patient relationship is perceived as forming through nurses "helping the patient navigate the complexity" of their care by the nurse placing the patient at the center of care. The therapeutic nurse-patient relationship lies centered between under- and over-involvement in the relationship.

Theme Two – Codifying Knowledge Repertoire

Recollecting Educational Lessons Learned:

> Being in the military, we again, the Nurse Practice Act and other specific requirements…reminds us of obviously our ethical obligations, to do what's right, to cause no harm with our care, to be compassionate….and of course not breaking the law. The Nurse Practice Act is very simple; I mean it supports us as nurse professionals. Certainly we have some work to do still as a nursing profession, but the Nurse Practice Act definitely gives us a straw man to be able to say no. To be able to say, no, it's against the Nurse Practice Act.
>
> ***Author Interpretation:*** The nurse leader described receiving education on the Nurse Practice Act and the Nursing Code of Ethics in undergraduate, orientation with the military and through nursing leadership courses. The training was geared towards "how to interact with patients, not violating privacy, and obviously those common sense things care, compassion, communication, and not breaking the law." Training related to nurse-patient relationship boundaries was specifically described; however, ethics refresher training was acknowledged and was geared toward "ethical obligations, to do what's right, cause no harm with our care, to be compassionate." The Nurse Practice Act was described as a "straw man" available for use in referring to "rules" when addressing conflict related to nursing conduct.

Understanding Experiential Capacity:

> Depending on the role, you know within the military, like becoming a case manager, a CHI person, or a chief nurse, we had formal training…and then of course, just experience. You have different experiences, um, you know and things come at you at a different pace. Those different types of environments we get to be in probably play a role in the way that we help each other and educate outside of a formal education, like working side by side with each other…as a nurse leader, coaching, coaching people through experiences. And then there's obvious things in the military, we don't fraternize with our staff, but we also don't fraternize with our patients, to disrupt that boundary of health care decision-making, so that it remains private and clear. If I had a situation [boundary breach] I could rely back on my own personal ethic.
>
> ***Author Interpretation:*** The nurse leader described her "positions" held as a nurse, the different types of units in which she worked, and her experience within the military as having influenced her perceptions of nurse-patient relationship boundaries, and interventions taken related to the nurse-patient relationship boundary breach. The nurse leader also addressed the military "non-fraternization rule with colleagues" as applicable to nurse-patient relationships, "we don't fraternize with our staff, but we also don't fraternize with our patients." Additionally, she described utilizing her "own personal ethics" in concert with her experience as having influenced her ethical decision-making related to nurse-patient relationship boundary breaches.

Theme Three – Summoning Support Systems

Humanizing Leadership Traits:

> But looking back, I think my personal approach has really had, has really had an ebb and flow based on where I was working. Sometimes it took a lot of verbal coaching and other times it just took rolling up your sleeves and participating to really emulate the behavior and the activities that you wanted to be followed. And I think, for me, always, even in nursing school I think that's always been my steadfast approach. Do what you say you're going to do, do what is right, and others will definitely follow that same path. I think that leading by example is the catch phrase, leading by example is my consistent approach to leadership, leadership challenges, and coaching nurses either senior to me or junior to me in experience. Um, that would be my consistent approach. Lead by example.
>
> ***Author Interpretation:*** Leadership styles varied depending on "where I was working" and "when I was in the role of supervisor." The nurse leader described her consistent approach to leadership and leadership challenges as leading by example. "Rolling up your sleeves and participating to really emulate the behavior and the activities that you wanted to be followed" was employed in order to coach and mentor staff nurses about "doing what is right."

Employing Resources:

> To maintain for nursing licensure, occasionally they'll have us review where I have had to go back and sign off that I have the Nurse Practice Act. I think that what that does is reminds us, we have that refresher training and that there are resources and lines of communication when we observe unethical behavior whether that maybe abuse of a patient…you're reminded that there is an outlet to communicate, to help kind of stop that situation. I think that what that does is reminds us of obviously our ethical obligations. There is always an ethics committee in your organization to help support ethical decisions, or ethical clinical decisions. I've had to visit the ethics board…that's been a long time ago though. But anyway, so obviously we had an ethics board so you have a fair and balanced decision-making at a facility, I know within the military which is primarily my experience.
>
> ***Author Interpretation:*** The nurse leader described the completion of refresher training on the Nurse Practice Act as a Nursing State Board periodic requirement for maintaining licensure. The nurse leader stated the refresher training re-establishes the Nurse Practice Act as an available resource for identifying unethical behavior and providing rules for stopping the behavior. Additionally, ethics committees were described as resources within military health care facilities, providing neutral positions for reviewing situations requiring "fair and balanced decision-making" regarding ethical versus unethical situations.

Theme Four – Weighing Elements Affecting Judgment

Deliberating Dispositional Impacts:

With my experiences in the military I've had staff members violate HIPPA violations, with personal information on social media, and also with communicating in the hallway or such, and also leaving health records out and about. So it's important to halt that behavior, but it's important to also recognize, to teach, where they don't realize that leaving a stack of medical records on the desk is a breach. And that violates patient boundaries.

Author Interpretation: Lessons learned through experiences acquired in the military health care settings impacted her ethical decision-making about nurse-patient relationships. With experience, Kali expanded her views of what constitutes nurse-patient relationship boundary breaches to extend outside the scope of an over-involved personal relationship between a nurse and patient. The nurse leader perceives behavior that violates any type of patient privacy as a violation of patient boundaries and trust.

Tackling Organizational Barriers:

They were sort of banking on not having to process since their issue had been resolved. And I remember they were really upset with me…because they were making an assumption that I was going to do a different process. And so I remember feeling like, wow, I let them down, but I couldn't let the process down, if that makes any sense. And I remember thinking, and they had used the word, you broke our trust.

Author Interpretation: Organizational barriers in the form of set processes do not allow for skipping tasks/ steps based on having prior knowledge about a patient and/or patients' situation.

Calculating Discretionary Challenges:

I would first really take the approach to, to kind of halt the situation. To try to figure out what could be rectified at that time. Like what was going to be safe for the patient and the staff member. And then determine if there was some sort of policy or breach to mitigate that breach. I do feel comfortable being able to say, okay stop what's going on here, we need to re-direct, and pulling in appropriate resources, whether that's like the Chief of the Medical Staff or the Chief of the Nursing Staff. So, yeah, I feel very confident in my own ability to be able to re-direct in the short term and then to process in the longer time.

Author Interpretation: The nurse leader described the steps she would take in handling the nurse-patient relationship boundary breach by first putting a halt to the situation, identify what could be rectified at the time, determine safe actions for the patient and the staff member, and pull in appropriate resources.

Table 45

Summation of Allie's Responses to Themes One, Two, Three and Four as Related to Ethical Decision-Making about Nurse-Patient Relationship Boundaries [NL3]

Theme One – Ascribing Conscience

Cultivating Coauthored Care Requisites:

> So, what I would do and what I would see others do also is; if the patient needed something or anything where the patient needed advocacy, you would go up the chain and explain the reason for the need until you felt you got what you needed for the patient. If they [nurses] are too timid, that's a big thing, or they don't care, one of those two or they don't know, don't realize it, as a nursing supervisor we're their [nurses] resource a lot of the time so they'll call and say for various reasons we're not getting any results. So, what we try to do is guide them…give them the courage to do it [advocacy] through mentoring or coaching. I have seen as a supervisor more often the nurse not engaging with the patient, I haven't seen them cross any boundaries being too familiar with the patient.
>
> ***Author Interpretation:*** Patient advocacy is perceived as seeking to meet a patient's needs by the nurse speaking up for the patient in order to provide appropriate care for the patient. From a supervisory role, guiding, coaching, and mentoring nurses is perceived as giving nurses the courage to advocate for the patient without under- or over-stepping therapeutic nurse-patient boundaries.

Effecting Trust:

> From what I know, you know, you're supposed to have the trusting relationship which implies ethical boundaries and then, you know you're the patient advocate, so there again, professional boundaries.
>
> ***Author Interpretation:*** Setting ethical boundary limits was described by the nurse leader as a means of establishing trust between a nurse and a patient.

Composing Synergetic Interactions:

> Actually I think it starts with getting report, and people start forming their impressions of the patient at that point. And then, they will introduce themselves and meet the patient, just chatting back and forth …and then interacting with the family. I think that's mostly how they [nurses] build the relationship. I mean that's pretty much it, it travels on from there the longer amount of time they spend with the patient.
>
> ***Author Interpretation:*** Building a nurse-patient relationship hinges on "getting to know the patient" through open communication with the patient and family. The greater amount of time spent with the patient was perceived as instrumental in furthering a nurse-patient relationship.

Theme Two – Codifying Knowledge Repertoire

Recollecting Educational Lessons Learned:

> The only education I remember, now that I'm, working on my Master's [in Nursing] I had a policies and ethics class about a year ago, which was divided up between policy and ethics; probably two-thirds was on policy and one-third was on ethics. It wasn't a lot [nurse-patient professional boundaries] but, yeah that was part of it. It was fairly brief; the larger portion was on policy. The function of the Nursing Code of Ethics and Nurse Practice Act in preventing boundary breaches seems rather vague, it's implied.
>
> ***Author Interpretation:*** The nurse leader did not recall receiving any education on the Nurse Practice Act or Nursing Code of Ethics related to professional nurse-patient relationship boundaries in her undergraduate nursing school program. The nurse leader described the Nurse Practice Act as "rather vague…implied".

Understanding Experiential Capacity:

> Really the only thing I have seen as a supervisor is more that the nurse will, I haven't seen them cross any boundaries being too familiar with the patient, more often the only thing I would see is them not engaging with the patient. In my prior life as an ER nurse I would see it being you know, one of the herd. I would see it with my co-workers or myself even, you know a lot more frequently. There was one guy who was very, not friendly, well not like sexually inappropriate but inappropriate friendly to a certain type of woman that he really liked and he could like, it's like his little spiny senses went up whenever one came in the ER and he would be in there helping her, talking to her, and he would spend a lot of time in there, ignoring his own patients and just chatting, sitting at the bedside which is really pushing the boundaries I thought. It was a male nurse who would respond differently to a different type of female patient. So with the male nurse, I mean while it was pushing the line, it wasn't I'm not sure it, well I'm not sure; I don't know that it crossed the line with anything outside of the hospital. It was accepted, it was kind of like, more of a herd mentality, you know it, and everybody knew. And it was just how it was and when you're kind of the newer one, I mean I wasn't that young in my career, but I was new in the area, new in that unit, and so you just like [think] oh, this is how this goes here?
>
> ***Author Interpretation:*** The nurse leader described experiences she observed related to nurse-patient relationship boundary breaches and how she was influenced by the situations based on her position and the department/ organizational environment she was working in at the time. The lack of leadership management of the boundary breaches, the staff nurses acceptance of the situations, and the fear of reprisal created a lasting effect on how she evaluated and managed the events at the time. With additional experience, education, and a change in position to that of supervisor, the nurse leader acknowledged regret for her lack of action at the time, but has since "felt" comfortable with her knowledge and skill in evaluating and managing nurse-patient relationship boundary breaches.

Theme Three – Summoning Support Systems

Humanizing Leadership Traits:

> I try to be like a, like a leader, like a um, kind of get people to go, to go along with you know, because I deal with like the Charge Nurses 100 times a day it seems like. It's best if we're on the same team. And I can, you know give them, you know, sometimes I'll try and give them reasons why they should. But in the end, if I have to be, it's going to be my way or the highway, because my way is right. You know, it's just like; I'm going to do all I can to get you going in the right direction. We're going to do it this way and we're all going to be happy. But if you're going to be miserable then, you're going to be miserable then, because you still have to do it.

Author Interpretation: Leadership styles varied depending on the situation. The nurse leader described first appealing to staff nurses behavior through reasoning and justification. If this style did not fit the situation or was met with opposition, the nurse leader would switch to an authoritative leadership style. The nurse leader described trying to "get people to go along" and try to "give them reasons why they should." The nurse leader would "try to get you going in the right direction" first, but if this style did not work, then would change leadership style to a direct approach.

Employing Resources:

> As a nursing supervisor we're kind of their [nurses] resource a lot of the time, where you step in just basically try to guide them through mentoring or coaching. There's new leadership and they've cleaned house, so that kind of business [under- and over-stepping boundaries] has improved; it's good for everybody.

Author Interpretation: The nurse leader described herself as a resource for staff nurses due to her experience and supervisory position. She described being available to coach and mentor staff nurses. Additionally, the nurse leader described utilizing the chain-of-command as needed for guidance with any type of nurse-patient relationship situations.

Theme Four – Weighing Elements Affecting Judgment

Deliberating Dispositional Impacts:

> And it was just how it was and when you're kind of the newer one, I mean I wasn't that young in my career, but I was…new in that unit and…so you're just like 'oh, this is how this goes here?
>
> ***Author Interpretation:*** Deciding not to intervene in perceived nurse-patient relationship boundary breaches was impacted by the unit's culture of acquiescing to inappropriate behaviors. Allie described the unit culture as that of a "herd mentality." Coming to terms with the realization that nurse-patient relationship breaches were ignored, status quo unchallenged, and 'cover-ups' deep seated, impacted the decision to not report the reach.

Tackling Organizational Barriers:

> There just were certain people that really could make your life miserable". Capitulating to staying on the 'good side' of 'influential' co-workers caused barriers in carrying out actions aimed at resolving nurse-patient relationship boundary breaches. You just knew they were the people to stay on the good side of… going against what the norm was, would have been; I've seen them with people. But it was a barrier and nobody cared at that point, none of the leadership…you could say stuff and nothing changed. That was actually part of my decision to leave the ER [emergency room].
>
> ***Author Interpretation:*** Allie described succumbing to the 'norm' of co-workers threats of retaliation creating barriers to intervening in nurse-patient relationship boundary breaches. The fear of retribution was disconcerting and generated doubt in making decisions about nurse-patient boundary breaches. Leaderships' lack of concern and knowing nothing would change, was a barrier to reporting. Dreading peer pressure, fear of retaliation and non-leadership engagement, incentivized Allie's transfer out of unit.

Calculating Discretionary Challenges:

> It's hard to say what you would do. I regret not stepping in and being more vocal about the male nurse who would spend a lot of time with a type of female patient… chatting, sitting at the bedside really pushing the boundaries. It also depends on when in our careers some of these events have taken place and what our experiences are. But, you know, it's just, that was a barrier and nobody cared at that point. It was like you could say stuff you know about other things and nothing changed.
>
> ***Author Interpretation:*** The nurse leader described "regret for not stepping in and being more vocal" about the inappropriate nurse-patient relationship boundary breaches she observed in past situations; however, fear of retaliation from co-workers at the time was a legitimate concern. With experience, a change in work settings, advancement to a supervisory position, and graduate education, the nurse leader described comfort with her ability to evaluate and manage nurse-patient relationship boundary breaches.

Table 46

Summation of Josie's Responses to Themes One, Two, Three and Four as Related to Ethical Decision-Making about Nurse-Patient Relationship Boundaries [NL4]

Theme One – Ascribing Conscience

Cultivating Coauthored Care Requisites:

> I think in my experience, I've seen nurses kind of over advocate for patients. You know, I've always thought that it came from a good place. But, sometimes I think it was because they didn't quite understand the nature of what they were utilizing to help make the patient comfortable.
>
> ***Author Interpretation:*** Based on the nurse leaders' experience, she described nurses as over advocating for patients because "they didn't quite understand the nature of what they were utilizing to help make the patient comfortable."

Effecting Trust:

> You want them to trust you, you want them to open up, but at the same time you want them to respect that boundary. And so it's delicate. The top thing would just be making sure that you communicate effectively the things that you're going to do before you do it, so that you can establish kind of a sense of trust between the nurse and the patient. If the patient needs anything to be able to intervene and get them the things that they need so that they can continue to foster that trust relationship between the nurse and the patient.
>
> ***Author Interpretation:*** The nurse leader described the "value" of trust as "delicate" whereby open communication is encouraged with the patient, but at the same time professional boundaries are set through mutual respect between the nurse and patient.

Composing Synergetic Interactions:

> I guess the processes are really in how the nurses start their shift and then are able to say what they're doing and do it, and if the patient needs anything, to be able to intervene and get them the things that they need so that they can continue to foster that trust. So I think that's helpful, just having that introduction period and being able to make sure that whatever things are communicated are in a respectful manner. I think a huge part of this has to do with their [nurses] attire. Just making sure they are dressed appropriately, to start things off on more of a professional manner.
>
> ***Author Interpretation:*** Predicated on effective communication through introductions and establishing a rapport with the patient prior to delivery of care. Communication occurs in a "respectful manner." Additionally, the nurse leader described her perception of building a professional relationship with the patient through "attire." She described nurses should be "dressed appropriately" to "start things off on more of a professional manner."

Theme Two – Codifying Knowledge Repertoire

Recollecting Educational Lessons Learned:

> I basically took an Ethics class for my MSN. I'm pretty sure I had an Ethics class in my undergraduate nursing program, and certainly a communication class for nurses, therapeutic communication…where they kind of teach you how to talk with people in a professional way. I remember studying it [Nurse Practice Act] with my MSN, but the wording seemed very vague, so I was just trying to figure out what the definition…like where the line in the sand would be drawn for crossing the line as far as professional nurse-to-patient boundaries. I would say more or less its role in preventing it [boundary breaches]… basically delineating what the legal ramifications would be for any major transgressions like sexual assault or contact or negligence or anything like that; or, just inappropriate contact in anyway. I felt like it sort of came at it from more of a disciplinary…at least that was my impression. I guess in order to establish what the boundary is. Like you know if you go beyond this boundary then you kind of you break the law. You could end up having to face disciplinary action for it.
>
> ***Author Interpretation:*** She described taking a communication class that taught "you how to talk with people in a professional way." The nurse leader described studying the Nurse Practice Act in her graduate nursing program and felt the wording was "very vague." From a work perspective, the nurse leader described receiving instruction about "ethical issues" in orientation and did not touch on professional nurse-patient relationship boundary limits.

Understanding Experiential Capacity:

> I've been a nurse or in nursing for 20 years at various levels and this really isn't a topic I've given a lot of thought to. And I was kind of surprised by that because it's something that is part of your daily interactions. I think its good conversation to have. I think in health care and nursing we should pay extra attention to this [social media]. It makes me think of something else too, which is so often there are times where patients will behave inappropriately to nurses. And I think there are times where, even if we maintain our professionalism, there are times we're put in situations where we're receiving the behavior and it's kind of like how do you maneuver with that.
>
> ***Author Interpretation:*** She was surprised that there wasn't more talk about nurse-patient relationship boundaries and thinks it's a "necessary one because we're only going to get in more complicated territory." She described "gender confusion" and "social media" as topics requiring "conversations to have" in regards to nurse-patient relationship boundary limits. The nurse leader described being "put in situations" where "patients have behaved inappropriately and I've had to think about how to deflect or redirect or what to do."

Theme Three – Summoning Support Systems

Humanizing Leadership Traits:

> I think the way I try to lead is really more by example…by example meaning the example that I want to send to be consistent, make swift, concise decisions. Admit when I'm not sure of an answer, so that everybody knows that that's okay. But at the same time find out what the best answer is. Utilize peers and other resources to make sure that we're giving the best possible answer and then just treating the people that I work for with respect…and that goes between workers and with patients. I think…if other nurses see you treating the patient's you know, really well and genuinely and they see the patients are so happy with that, they'll want to make the patients happy too. I feel like that's the environment that I've tried foster with the nurses that I work with and I look around and they're happy and they actually do these things and I don't have to tell them anything. I just make sure that the good and the way to do it starts at the top. And if there's something that doesn't go well then we just address it right then and you talk about it and we all move on.

Author Interpretation: The nurse leader described her primary leadership style as leading by example. Sending a consistent message of respect for each other and the patients, treating patient's well, fostering an environment that it's okay to admit when not sure of an answer; however, utilize peers and other resources to find the correct answer, and emulate the behavior associated with productive teamwork. If a problem arises, address the problem immediately, "talk about it and we all move on" and encourage a work setting where "all parts of the treatment team are valuable." The nurse leader describes active leadership engagement with staff nurses in order to emulate the behavior and actions desired.

Employing Resources:

> For breaches, if I would have witnessed one that I felt like needed to be addressed, I would have either gone to an administrator or manager for that unit or I know in certain hospital systems they have patient care advocates. And so, I might of gone and spoke with a patient care advocate. In orientation they always introduce all these folks to you that have varying positions and what their role is in the hospital….I really listened up to make sure that I knew if there was ever a situation where I needed to advocate for a patient I knew who to talk to. And I think that it also just comes from working in many different units and just sort of understanding the chain of command.

Author Interpretation: The nurse leader described that if she would have witnessed a nurse-patient relationship boundary breach that she felt like "needed to be addressed," she would have "either gone to an administrator or manager for that unit or gone and spoke with a patient care advocate" for assistance prior to intervening. The nurse leader spoke to "understanding the chain-of-command" and utilizing the personnel within the chain-of-command as a resource to confer with regarding nurse-patient relationship boundary breaches "if there was ever a situation where I needed to advocate for a patient.

Theme Four - Weighing Elements Affecting Judgment

Deliberating Dispositional Impacts:

I really listened up to make sure that I knew if there was ever a situation where I needed to advocate for a patient I knew who to talk to. I think that it also just comes from working in many different units and just sort of understanding the chain of command.

Author Interpretation: Josie described making a decision to take action and intervene in nurse-patient relationship boundary breaches was impacted by knowing what personnel within the organization possess the knowledge and skill to manage boundary breaches and knowing their positional structure.

Tackling Organizational Barriers:

I think barriers are that we try to pretend like… I guess we don't really want to have conflict in the work place. I think we're a little resistant to making people take responsibility for their actions in that realm. Unlike saying your behavior is inappropriate. Typically we're pretty easy to do this when it's nurse against nurse, but I think we're a little less apt to do it when it's nurse versus patient. Mainly because I think nurses often times are afraid to point fingers in that situation for fear that maybe I've done something that someone else thinks is inappropriate also. Just for fear of maybe it will come back to bite them. I think that's a barrier that so often affects nurses thinking. I think it is kind of a shame, but it is very real.

Author Interpretation: Fearing "to point fingers" at a peer due to fear of being accused of the same inappropriate behavior is a barrier to managing nurse-patient relationship boundary breaches. Fear of being on the receiving end of the same accusations levied against peers thwarts managing nurse-patient relationship boundary breaches and is described as a barrier.

Calculating Discretionary Challenges:

I had one patient…she recognized me at this car place…she struck up a conversation and told me how she was doing and…had all these different athletic activities she was participating in. So she was like, 'yeah, I'll Facebook friend you and show you what I'm doing and…I was like great'. So, at the time I just didn't really think that it was an issue. I could see now days where those lines, I mean it has to be a little bit more clear. I mean with social media those things that you think are kind of harmless, could easily gloss it over in your mind thinking that it's no big deal, but it could end up being a big deal. Like now with social media things like that can, I guess, happen more often.

Author Interpretation: Experience has since made the nurse leader aware of the blurring of nurse-patient relationship boundary lines such that "you could easily gloss it over in your mind thinking that it's not, that it's no big deal, but it could end up being a big deal. Like now with social media things like that can, I guess, happen more often.

Table 47

Summation of Cora's Responses to Themes One, Two, Three and Four as Related to Ethical Decision-Making about Nurse-Patient Relationship Boundaries [NL5]

Theme One – Ascribing Conscience

Cultivating Coauthored Care Requisites:

> You're the therapeutic person in this relationship and your responsibility is to advocate for the patient. Sometimes it comes down to you and the patient against the patient's family wanting them to do something the patient doesn't want to do or the doctor wanting the patient to do something the patient doesn't want to do and sometimes you have to align yourself that this is what the patient is saying and repeat that. They know their role as far as taking care of the patient. They're going to advocate for the patient.
>
> ***Author Interpretation:*** The nurse leader describes patient advocacy as a nurse's responsibility and expects the nurse to speak up and support the patient's wants. Therapeutic nurse-patient relationships are perceived as dependent on a nurse understanding the needs of the patient and taking action through advocacy in striving to meet the patient's health care needs.

Effecting Trust:

> And I expect to be able to help you to answer your questions, provide information for you, to help you get to feeling better, moving better, talking better, whatever your problem is. And your job is to tell me whatever you need to do that.
>
> ***Author Interpretation:*** Establishing an open dialogue with the patient, letting the patient know "I'm here for you" fosters a sense of trust allowing the patient to share their values, fears, and desires enabling the nurse to better understand the patient's needs. This in turn, allows the nurse to support the patient throughout their continuum of care.

Composing Synergetic Interactions:

> We were taught in my basic education that you form a contract with the patient the minute you walk into the room. You form a verbal contract and you establish a relationship that I'm here to be in charge of your care for the shift maybe for your stay. So what I see nurses' doing today is, much more fractionated and I don't think on a day-to-day basis there's any discussion about boundaries where I work currently.
>
> ***Author Interpretation:*** Building nurse-patient relationships by establishing a 'verbal contract' with the patient, a process geared toward developing and sustaining nurse-patient relationships within a therapeutic zone of helpfulness. The relationship is forged through a nurse-patient mutually agreed upon plan of care.

Theme Two – Codifying Knowledge Repertoire

Recollecting Educational Lessons Learned:

> You know, 'boundaries' was a different, it was just encoded differently. I do remember them talking about very specific things. Don't date your patients, don't flirt with your patients, don't have any kind of a sexual connotation to anything you're saying with your patients, don't get into their business issues, their personal family drama issues. Try to maintain distance with that. And beware that the line shifts with every, every statement that you make the line shifts a little bit. So boundaries were a much looser term I think. And most of my boundaries are my own interpretation I guess. Most of the things I've had to enforce, I've had to think where's the line. What should the prudent nurse do? So no, basically there was not a lot of discussion about boundaries.
>
> ***Author Interpretation:*** The Nurse Leader described receiving limited education about the Nurse Practice Act. More emphasis was placed on general ethics training, but not specifically the Nursing Code of Ethics as related to professional nurse-patient boundaries.

Understanding Experiential Capacity:

> There are things that are outside my comfort zone. You know because everybody has to kind of set their own comfort zone. I've seen nurses kind of cross, loosely cross…boundaries with patients that have a business…real estate agent…fund raising things…go to funerals. I don't think there's great guidance about boundaries, certainly not in the Practice Act. I read the ANA version, but it has a little bit more on boundaries. And you're supposed to stay in the middle. But, that's still your own barometer. Making decisions in evaluating and managing nurse-patient relationship boundary breaches was mostly somewhat loosely based on the job description. If the job description covered me at all and our HR policies, uhm, which depending on where I was working had better and worse guidelines, you know. But, again it came back to my gut, "This is outside your scope or outside what's ethical". Rarely was it outside what I thought was legal. You know, that was the easy one. But, it came down to again, what would the prudent practitioner here do in this situation, so. But this was not right. On some level, I can tell, this was not right. Um, so I guess you refer back to that [Nurse Practice Act]. In disciplinary relationships, when I was the supervisor, I have actually looked things up in the Practice Act to counsel staff members. You know, you have violated the Nurse Practice Act by A, B, or C here, um, and put it into written counseling. I find the Texas Nurse Practice Act very difficult to get a good answer from when you're actually reading it yourself.
>
> ***Author Interpretation:*** The role of a nurse influences perceptions of nurse-patient relationships, responses to them and interventions. Nurse-patient relationship boundary lines were initially pushed by the patient's, encouraged by the nurses, thereby creating blurred/breached boundaries.

Theme Three – Summoning Support Systems

Humanizing Leadership Traits:

> Supervisory role, mostly democratic. But, I mean I could pull it together and say now this is what you're going to do so. I kind of always tried to make people, I wish I could have been…about making people think it was their own idea. I wasn't that good, but I tried. You know, what do you all think we could do to make this better? Do you think, tell me your ideas and sometimes of course they had good ideas. You know and sometimes you could like throw one out there and they'd run with that and you'd go Yes! Because, if you don't get 'buy in' you're just going nowhere. Now in my role I am purely lead by example. You know, I don't counsel people, rarely. I don't have to, but um, I'm much more like, "Look, watch, we can do this". So, whatever that kind of leadership is. Lead by example, I hope.
>
> ***Author Interpretation:*** Active leadership engagement with staff nurses through democratic style. Authoritative as needed based on situation. Lead by example.

Employing Resources:

> I actually went as far as talking to colleagues before I would counsel someone, because I was like, 'Am I out of line here? HR is sometimes a good advisor, but sometimes not as far as what's out of the boundaries of nursing care. So, it was more often I was talking to peer directors or whatever, because we all know nobody wants to be sued. Nobody wants to do something illegal.
>
> ***Author Interpretation:*** Peer colleagues or peer directors were another resource often approached by one of the nurse leaders' in order to talk through a perceived nurse-patient relationship boundary breach and in seeking confirmation prior to carrying out any intervention with the staff nurse who crossed the line. Peer feedback was generally utilized in concert with the organizations policy guidelines regarding professional behavior and after considering if the staff nurse behavior was in line with the actions of a prudent practitioner.

Theme Four - Weighing Elements Affecting Judgment

Deliberating Dispositional Impacts:

But there were multiple, just almost on a daily basis, kind of boundary, and I think that's probably the nature of Psych, pushing the boundaries. It must be that long-term population again. Because they just were too intimate with the families and all the ins and outs. And you know, it was just this incestuous little population. So, I don't think there was any great long-term gains made from any of my decisions. We had one staff meeting where that was the topic, of boundaries, and it wasn't any one thing that had happened in our unit, it wasn't like a debriefing. But we talked about it kind of in general.

Author Interpretation: Boundary breaches recognized in long- term behavioral health unit and actions taken by nurse leader; however, sustained therapeutic nurse- patient relationships perceived as non-sustainable due to conditions within the unit.

Tackling Organizational Barriers:

The barriers are that everybody has their own boundaries. And to try to get a consensus is impossible. And so frequently you know you'd say, 'You can't do that'. And they'd go, 'Well why?' 'Why can't we have a fund raiser or why can't we have these people in or why can't we go to their house or you know?' And then you're stuck with, 'I don't have a really good answer to that why, except it crosses the boundaries of professionalism.

Author Interpretation: Nurses with individually defined nurse-patient relationship boundaries rather than boundaries based on nursing/organizational standards, are perceived as a factor in evaluating and managing nurse-patient relationship boundary breaches.

Calculating Discretionary Challenges:

A nurse…targeted a patient for lack of a better word. This elderly patient came in with a huge heart attack and needed somebody to take care of him. And he was actively looking for somebody to take care of him in the last couple of years of his life. And Sonja, I can remember her name, married him in the end. And I was like, okay, this is wrong somehow. But I didn't do anything about it. He wanted, she wanted somebody, whatever. But I thought, 'Wow, that's, that's just wrong on a lot of levels.' When I had Psych…one nurse in particular…got more and more friendly with one of the patient's that came in and out…she took care of him every time he was admitted. It came to my attention that she saw him outside the facility. I questioned her about this…and she denied it. I said okay, well I'm advising you, "Do not see this person outside of this facility." She wound up resigning luckily.

Author Interpretation: The nurse leader described her experience with nurse-patient relationship boundary breaches from two different perspectives, that of a colleague and as a supervisor.

Table 48

Summation of Mia's Responses to Themes One, Two, Three and Four as Related to Ethical Decision-Making about Nurse-Patient Relationship Boundaries [NL6]

Theme One – Ascribing Conscience

Cultivating Coauthored Care Requisites:

> To me that piece is a little bit opinionated, because some of that plays into your value system, how much you believe as far as over and/or under advocating. But I think nurses, I would say when you, a lot of times it's a fine rope when you over advocate because sometimes you give the appearance that you're stepping on toes, you may not be stepping on toes, you're just doing the right thing by your patient.
>
> ***Author Interpretation:*** Over- or under-advocating may in fact be reflective of the patients' situation and/or need and may not be outside the range of a therapeutic relationship.

Effecting Trust:

> The first step is just building the trust and rapport with the patient and the family.
>
> ***Author Interpretation:*** Open communication builds trust with a patient.

Composing Synergetic Interactions:

> The building process really starts with that rapport and just coming in, talking to the family and being able to articulate your know the needs of the patient and what they are there for to help the patient. So to me it just starts off by building that trusting relationship. Trusting meaning that they're doing everything they can to help the patient. And the patient feels comfortable telling the nurse whatever is going on with them at that point in time and the family feels comfortable. That they can disclose everything we need to know so we can effectively treat the patient. So to me it starts off with establishing that baseline level of trust and most of that just starts off with just a conversation.
>
> ***Author Interpretation:*** Relationship building is collaboratively forged between the nurse and the patient and patients' family.

Theme Two – Codifying Knowledge Repertoire

Recollecting Educational Lessons Learned:

> I can't necessarily remember on the block of instructions, but I know we took an Ethics class. As far as on the job, but I know we took an Ethics class. As far as on the job, I would say not very much. I don't recall having honestly any class that necessarily focused on Nursing Code of Ethics. Most of my classes have truly pertained to just military Ethics or Ethics in general, not necessarily the Nursing Code of Ethics or the Nurse Practice Act. And I don't recall even having a module in our APEX system of anything that addressed it. I really don't. Even during my Masters, which was very recent, I still do not recall that being a topic. Or at least that wasn't the elective that I opted to take. It was definitely not a mandatory class. So, as far as it preventing boundary transgressions, I know in nursing school we were taught about the nurse-patient relationship and what's acceptable and what's not. I think the Practice, the Code of Ethics, I think it's clear what we should and should not do, but I don't think that's something that's reiterated following class or undergraduate studies in Nursing. I would honestly say as far as part of the Nursing Code of Ethics, the Nurse Practice Act, I know the state of Texas has a lot of that information in their renewal process. It will probably not be a bad idea if other states implemented similar requirements. Because I think a lot of times nurses know but everybody's different we were, we have different values, we were raised differently. So sometimes certain things you do have to put in black and white. Based on each person's value system, sometimes you have to put it in black and white. It's sometimes easier just to spell it out so there'll be, well you hope to decrease confusion.
>
> ***Author Interpretation:*** Limited education about the Nurse Practice Act, with more emphasis placed on general ethics training, but not specifically the Nursing code of Ethics as related to professional nurse-patient relationship boundaries received in school, work, and military settings. Navigating the Nurse Practice Act and the Code of Ethics is difficult and vague: however, the Nurse Practice Act and Nursing Code of Ethics does contain rules of conduct for nurse-patient relationships.

Understanding Experiential Capacity:

> I mean just by being in the military, not necessarily reading the Nursing Code of Ethics, because we have such strict limitations [nurse-patient relationships expected to remain professional based on military fraternization rule].
>
> ***Author Interpretation:*** The nurse leader refers to military rule of non- fraternization with colleagues as basis for preserving therapeutic nurse-patient relationships.

Theme Three – Summoning Support Systems

Humanizing Leadership Traits:

> I definitely have the approach and most of us in uniform should have it as far as, I would not ask anything of my employees that I am not doing myself. So, I definitely have the style where um, if you follow, I'm not going to say if you follow me, but I'm definitely setting an example for them. And I expect them to do the right thing by their patient, peers, and everyone else on a daily basis just as I do by them. So, I definitely say I lead by example. That is my goal every day.
>
> ***Author Interpretation:*** Leading by example and role modeling were consistently described as methods of showing staff nurse's methods of emulating appropriate professional nurse-patient relationship behaviors. Setting an example for the staff nurses was consistently described as one way of demonstrating therapeutic relationships with patients.

Employing Resources:

> We have to have an ethics council practice; so yes, I do, I feel that I have the resources, I have ample support here". We'll involve JAG if it gets down to it. We've involved JAG before; just to help us walk through that process. Um, to make sure everything is okay. We'll use all our resources to make sure we're making the right decision. The first advocate that we often use for the patient will be the nursing supervisor. We also have a Health Clerk Disclosure Officer so she's a neutral person she's not Disclosure Officer so she's a neutral person she's not necessarily for the patient, she's not necessarily for us, she's in the middle, she's neutral, the patient's side, or the provider's side, whose ever side, and we also have the Chaplain services. So, we definitely have plenty of resources that we can use to advocate for our patients best wishes. She's neutral, she doesn't work with JAG. And nothing you tell her is reportable either, she does not report it, other than the normal stuff you have to report. But, no, she doesn't keep records like that. It's a neutral party. Health Clerk Disclosure Officer. She came on board this year, so that's new for us. Once a situation is brought to me, I would use my available resources to research exactly where this breach may fall or escalate to the Code of Ethics or the Practice Act and even within our own organization, um I would say it may not be called a Nurse Code of Ethics, but again in this organization we have our own set of ethics, rules, policies that govern a lot of this stuff also. So, I would just use my resources to determine where does this fall?
>
> ***Author Interpretation:*** Health Clerk Disclosure Officer, Chaplain, and JAG utilized as resources regarding nurse-patient relationship boundary breaches. Nursing Code of Ethics, Nurse Practice Act, or military organizations ethics, rules, and policies considered available resources.

Theme Four – Weighing Elements Affecting Judgment

Deliberating Dispositional Impacts:

I would seek information from my Section Chief. I would go all the way up to the DCCS [Deputy Commander Clinical Services] if I needed to, before I actually get deep into an investigation or anything. Once a situation is brought to me, I would use my available resources to research exactly where this breach may fall or escalate to the Code of Ethics or the Practice Act and even within our own organization, I would say it may not be called a Nurse Code of Ethics, but again in this organization we have our own set of ethics, rules, policies that govern a lot of this stuff also. So, I would just use my resources to determine where does this fall?

Author Interpretation: Mia described following the organizations chain-of-command as impacting her decision-making when managing nurse-patient relationship boundary breaches. She touted the organization's ample and supportive resources, available for making the right decisions. Mia perceived her organizational resources as supportive; thus impacting decisions made about nurse-patient relationship boundary breaches.

Tackling Organizational Barriers:

The barrier with that and anything else is um, individual's willing to come forward. Um, who may have information or some type of Intel about what actually happened. And again, another um barrier will be just our robust system and how we go through any type of disciplinary action for military and/or GS employees. I would say that would honestly be the biggest barrier is just the process of just getting down to the bottom line of what happened and what can we do to prevent this from happening again.

Author Interpretation: Individual staff nurses willing to communicate an observed nurse-patient relationship boundary breach to nursing leadership is perceived as a factor in evaluating and managing nurse-patient relationship boundary breaches.

Calculating Discretionary Challenges:

We work in a system where, hum, how can I say this, it's very, it's challenging. So, I would honestly say in a civilian hospital you can basically let somebody go at the drop of a dime, um, if they're not performing, and/or they've, um, if there's some type of a breach that you discover. But because we have a very robust system here and that we have to go through all the appropriate channels, that's why I would um, opt to get some expert opinion. Because I know we have a very tedious process in going through any type of investigation of any type of nurse-patient breach.

Author Interpretation: Multiple personnel systems in place within a complex organization are perceived as a factor in evaluating and managing nurse-patient relationship boundary breaches.

Table 49

Summation of Sarah's Responses to Themes One, Two, Three and Four as Related to Ethical Decision-Making about Nurse-Patient Relationship Boundaries [NL7]

Theme One – Ascribing Conscience

Cultivating Coauthored Care Requisites:

> I have seen it where maybe they breached it with the family. Way too close. I was manager then, and I took the nurse off from caring for the patient. You're pulling for your patient, but yet, you know, the family is here. And so finally they just, you know, just realized that it's a family dynamic that they're just going to have to work it out and they talked about it and we have to do the best we can, but. Sometimes, [you see under- and over-advocating] on the same day on the same patient. Because sometimes patients won't have that talk with the family member or the family member doesn't want to hear it. They [the patient] just want their wishes honored. And so then you maybe have a nurse who is on the extreme one end or the other. And then you have the physician on the opposite end. And so the patient's in the middle.
>
> ***Author Interpretation:*** Patient and family dynamics have an effect on nurse's under- or over-advocating for patients.

Effecting Trust:

> So you let those personal beliefs guide you in how you care for your patients and how you care for you staff and how you perceive the relationship that's going on between staff and patients. And I think as a person I would feel worse if I didn't do everything I could to try and help. I think it would probably bother me more that way then to have missed the situation.
>
> ***Author Interpretation:*** Intervening and helping to resolve any nurse-patient relationship boundary breaches maintains trust.

Composing Synergetic Interactions:

> I think a lot of the staff nurses, because working in the Critical Care most of our patients are unconscious, that the relationship starts with the family. That they find some kind of common bond and so when the patients can speak, or their unconscious and no longer unconscious that they can say, you know this is nurse Susie, she's been taking care of you. So it's kind of like you're the cheerleader for the family and the cheerleader for the patient and that's kind of how I see those relationships started.
>
> ***Author Interpretation:*** Family may hold a greater or same weight as the primary source in building a therapeutic relationship.

Theme Two – Codifying Knowledge Repertoire

Recollecting Educational Lessons Learned:

> We had like a whole one day on Ethics and Code of Behavior because it was a Catholic school. And so that was actually the only time I ever have had training. Just working with the Department of Defense, some classes that would borderline into the Ethics a little bit. It's usually after an event has happened, that they start bringing something up. But it's still I don't think it's a good, thorough Ethics.
>
> ***Author Interpretation:*** Navigating the Nurse Practice Act and the Code of Ethics is difficult and vague however, the Nurse Practice Act and Nursing Code of Ethics does contain rules of conduct for nurse-patient relationships.

Understanding Experiential Capacity:

> I was actually a prison nurse for a while. And that's where I got my hard line Ethics. It does not waver. And that was actually mandatory training, just working in a prison. And so you let those personal beliefs guide you in how you care for your patients and how you care for you staff and how you perceive the relationship that's going on between staff and patients.
>
> ***Author Interpretation:*** The nurse leader attributed her staunch ethical values to mandatory training in a civilian health care setting.

Theme Three – Summoning Support Systems

Humanizing Leadership Traits:

> The staff knows that you can approach me about anything. I'm not judgmental, I mean even if it's something I don't morally or ethically believe in, I'm still going to talk to you about it, or you can talk to me about it. I haven't met a patient or a staff I couldn't work with, regardless of any choices they had in their life. I believe in leading by example. I'm not going to ask anybody to do anything that I wouldn't do myself. And if all hell cuts loose on the floor, they know I will go out there and be the secretary, the CNA, the housekeeper, the plumber, whatever needs to be done to get it taken care of.

Author Interpretation: The nurse leader spoke to the importance of conveying to staff nurses your commitment to "being approachable"; but also, to impart to your staff a "non-judgmental" character trait, which in turn exudes an open, non-threatening work environment. Presenting an approachable, non-judgmental demeanor allows staff to feel comfortable when confronted by the leader for clarification of questionable professional behavior. Active leadership engagement with staff nurses. Lead by example.

Employing Resources:

> If I'm not making progress with subtle hints with administration, then I actually call the chaplain. And I think they pick up on it. And so if a chaplain or a religious person goes to administration and says you know I think this has really drained the staff and we need to give them breaks because we're having emotional, what's the fancy word for it, motional. They had some cute little word. I've called them twice. So they [chaplain] would go ahead and just talk and [de-escalate the situation]. I've learned how to go around it a different You know, you don't want to admit you have problems. Because then you have to deal with it. And so it's more problematic here. Well, we do have that, is it, the person, the sexual, it's not sexual harassment, but she, they always say you can go to her if you think boundaries are crossed. But that person's general reaction is to overreact and blow everything out of proportion, and so I don't go there. Because I don't need somebody coming in here and start hounding them. It needs to be handled tactfully and gracefully you know for that patient, as well as for the staff and the family members, to not feel threatened, if you know the staff are getting too involved. I can get around it here.

Author Interpretation: Chaplains were another resource requisitioned for their skill in evaluating and managing personnel issues. Chaplains hold unique positions in health care facilities as they are privileged to protect confidentiality and are exempt from disclosure of information. Chaplains generally perceived as non-threatening liaisons, clear communicators, and neutral mediators. Alternative resources utilized in lieu of leadership support within military organization. On the flip side, 'buddy systems' within organization perceived as a hindrance to available resources to assist nurse leader with nurse-patient relationship boundaries. Sexual Assault Response Coordinator is not utilized as expert resource in assisting with nurse-patient relationship boundaries due to perception of inappropriate management of events.

Theme Four – Weighing Elements Affecting Judgment

Deliberating Dispositional Impacts:

I think some of it though is their principle, their values, morals and ethics and all that. If you weren't brought up and ethics and all that. If you weren't brought up with them, weren't ever taught what yours are or how, or you even developed your own. But in Nursing you know, you're supposed to be the kind, caring, wonderful person that everybody thinks you are and that you sometimes don't think, you know, ethically that you should have these thoughts. I'll help you with anything, but you won't run over me and that's what I think, and so they don't have that as a defense. It's all about a balance.

Author Interpretation: Sarah expressed being impacted in her decision-making about nurse-patient relationship boundary breaches by her belief that staff nurses "principles, their values, morals, and ethics" influence their level of involvement in nurse-patient relationships. The nurse leader perceives these as factors in managing breaches.

Tackling Organizational Barriers:

I found in this place barriers. I think more of the barrier though is the socialization part, maybe 70%, organization 30%. But, yeah, I think it's more socialization. I found, in this place, yes, I found, I find barriers here. And then the difference in the percentages is just for being weird. After we got rid of that employee, the staff was talking and like, 'Why did you not talk to us about this? I thought it was just me.' And they didn't want to say anything in case they were wrong.

Author Interpretation: Sarah, expressed socialization issues, such as the buddy system as a barrier in evaluating and managing nurse-patient relationship boundary breaches. The fear of making a false claim about a perceived boundary breach was also described as a predisposing factor in delaying the nurse leaders' identifying and managing breaches.

Calculating Discretionary Challenges:

I think the challenge is trying to see is it really a breach or are they just being supportive; and you don't want to make that mistake. You never want to make that mistake, because then you look like a cold person and so, I think, and I'm not for sure sometimes yet if I maybe have missed a few. That maybe they were violating that relationship, you know.

***Author Interpretation*:** Professional nurse-patient relationships are in many situations developed through or in concert with a patients' spouse/significant other and/or extended family. With this, additional opportunities for boundary transgressions ensue.