Sexuality in Long-Term Care

PRESENTED BY WENDY BOREN, BSN, RN

QIPMO, UNIVERSITY OF MISSOURI SINCLAIR SCHOOL OF NURSING, COLUMBIA, MO

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I'm at the age where food has taken the place of sex in my life. In fact, I've just had a mirror put over my kitchen table. -- Rodney Dangerfield

Go Grammy! (Brought to you by SNL)

https://youtu.be/bUAF18jBHMU

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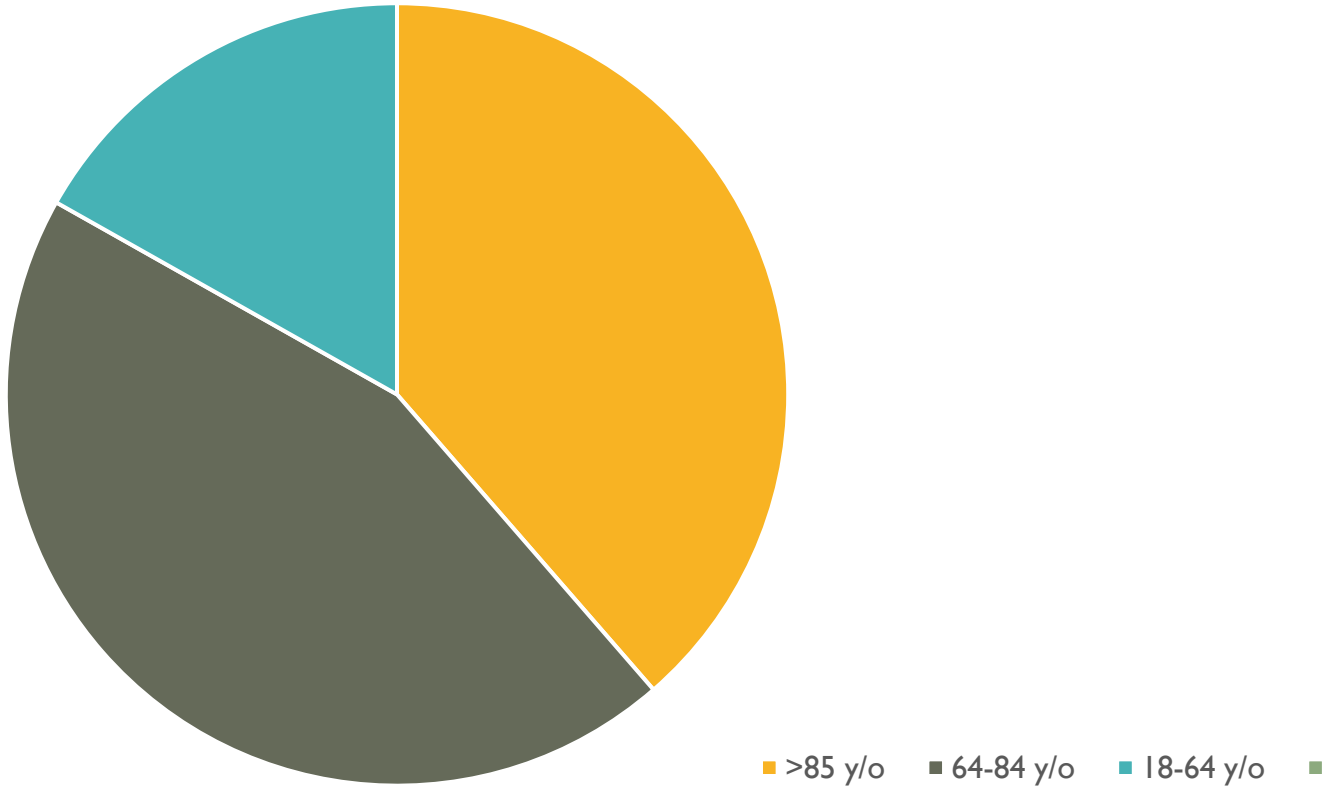
Overview

Demographics & Details

Who is in Your Home?



Source: https://www.statista.com/statistics/1222837/age-of-nursing-home-residents-us/

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Who's in Your Home?

People

All ages—and probably several "young old" or just young

People with cognitive impairments due to intellectual disabilities or traumatic brain injuries

People with dementia

People with chronic health conditions

Married couples

Dating couples

Same-sex or bi couples

PEOPLE

FYI, people have been having sex for a long time!

Ps, otherwise YOU wouldn't be here!

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Population Considerations

- Ageism
- Cognitive Disability: Intellectual Disability/TBI/Results of Substance Abuse
- Cognitive Disability: Dementia
- LGBTQ

Ageism

Myths and misconceptions about sex and aging 101

1. Old people can't do it.
2. They'll get hurt or it hurts too much.
3. They don't want to get emotionally attached, much less physically.
4. Their families forbid it.
5. Old people aren't attractive.
6. Sex causes heart attacks.

Intellectual Disability, TBI, Results of Substance Abuse

"…sexual behavior is monitored by different parts of the brain especially the frontal lobe and temporal lobe…Results…showed significant correlation between different cognitive functions and different domains of sexual functioning. These cognitive functions are controlled by different parts of the brain."

So if the brain is not functioning correctly for whatever reason—sexuality in terms of knowledge, practice, understanding, and ability are affected.

Keep in mind the AGES of residents with these issues in the nursing homes.

Source: https://www.ncbi.nlm.nih.gov/pmc/articles/PMC4038862/

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Intellectual Disabilities

"People with intellectual disability experience the same range of sexual needs and desires as other people. However, they experience many difficulties meeting their needs. They may be discouraged from relieving sexual tension by masturbating. They face a high risk of sexual abuse. They are likely not to be offered the full range of choices for contraception and sexual health screening. Poor education and social isolation may increase their risk of committing sexual offences. However, with appropriate education and good social support, people with intellectual disability are capable of safe, constructive sexual expression and healthy relationships. Providing such support is an essential part of supporting people with intellectual disability."

Source: https://pubmed.ncbi.nlm.nih.gov/18470354/

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Dementia

…may require a need to touch another human and to feel more secure and as a result may crawl into bed with another for warmth or reaching out to touch the nurse.

Residents with dementia may exhibit sexual disinhibition and inappropriate sexual behaviors related to the progression of the disease in the brain.

LGBTQ

- 2.4% of older adults in the United States currently self-identify as LGBT, accounting for 2.7 million adults aged 50 and older, including 1.1 million aged 65 and older.
- By 2060 the number of adults aged 50 and older who self-identify as LGBT will likely more than double to over 5 million.
- "There are three generations of LGBT older adults currently living in the United States (Fredriksen-Goldsen, 2016b).
  - The Invisible Generation, the oldest LGBT adults, who lived through the Great Depression and World War II.
  - The Silenced Generation.
  - The Pride Generation.

  Each generation handles their sexuality in a different manner. However, their rights are the same. Our job—provide an atmosphere without judgment or stigma, train our staff to be culturally competent, and treat everyone the same without regard to sexual orientation.

  For more info and resources: National Resource Center on LGBTQ+ Aging (lgbtagingcenter.org)

A Study in Perspective

Ohio Journal of Public Health. (2021). Sexually Transmitted Diseases Among Residents in Nursing Homes: The Nurses' Perspective. (Vol 4.) No. 1.

A 4-page pilot survey was mailed to nursing home directors of nursing in Northwest Ohio (n=99) with a response rate of 32%.

Most nurses did not see STDs or human immunodeficiency virus (HIV) as problems among their residents (100% and 96%, respectively) yet support for sex among residents was high. **All (100%) agreed sex among married residents should be supported, while 77% agreed sex among nonmarried residents should be supported.** Most nurses stated they were comfortable discussing HIV risk (84%), STD risk (84%), erectile dysfunction (75%), sexual desire and intimacy (72%), and correct condom use (66%). **The most commonly reported perceived barriers to STD education were family opposition (63%), resident embarrassment (56%), and lack of education regarding the prevalence of STDs in older adults (53%**). **The most commonly reported perceived benefits to STD education were** being seen as a leading facility for healthy initiatives (66%) and **promotion of healthy sexual relationships among residents (56%).**

Source: Sexually Transmitted Diseases Among Residents in Nursing Homes: The Nurses' Perspective | Ohio Journal of Public Health (ojph.org)

Barriers to Sexual Expression in LTC

- **Residents face significant barriers to sexual expression in LTC environments**
  - **Lack of privacy**
  - **Lack of opportunity; partner**
  - **Fear of staff reaction; ostracism**
  - **Family attitudes; involvement**
  - **Physicians and healthcare providers**
  - **Few learning opportunities**
  - **Medication, health changes, cognitive decline**

SOURCE: https://ltcombudsman.org/uploads/files/issues/nalc-branded.pdf

Check this out! Good info from the Iowa State Ombudsman office

Education

THE MORE YOU KNOW…

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Capacity And Consent

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"Under American law, all individuals who have reached the age of consent have the right, and are assumed to have the capacity, to consent to sexual relations. The age of consent varies across states from 16 to 18 years of age. The nature of sexual behaviors requiring consent can range from touching to sexual intercourse. Long-term care facilities tend to be the primary venue for the issue of sexual consent capacity to be questioned." -

American Bar Association, American Psychological Association

Case Study 1

A colleague of yours entered a resident's room and found two residents having sexual intercourse. One of them has dementia while the other does not.

What was your initial reaction?

Case Study 2

The CNA walks into a room where two residents, both with dementia, are having sexual intercourse.(3)

What was your initial reaction?

Discussion

Response Actions:

1. Apologize and quickly close the door.
2. Pretend nothing happened.
3. Discuss the situation with a supervisor or colleague.
4. Discuss the situation with the family.
5. Advise the couple how to do it to avoid risks.
6. Investigate.
7. Joke about it to colleagues.
8. Make sure it didn't happen again.
9. Scold or admonish the participants.

These situations were presented in a study by Villar et al. (2017) in order to explore staff responses to intimacy among persons with dementia in an institutionalized setting. The results were typical and varied. After offering these two scenarios, Villar et al. used a questionnaire to staff to gauge their responses and how they would react.

Determining Capacity

Grisso and Applebaum outline four criteria for determining mental capacity. The person must be able to:

- Communicate a choice
- Understand the relevant information
- Appreciate the situation and its consequences
- Display reasoning

Source: https://www.nejm.org/doi/full/10.1056/nejm198812223192504

Lichtenburg Model Capacity Assessment

- Mini Mental State Exam and an extended interview
- First the MMSE is conducted. If a resident gets a score below 14, they are **not** capable of consent.
- If the score is 15 points or above, the interviewer extends the assessment that identify awareness of relationship, ability to avoid exploitation, and awareness of potential risks.
- If all three areas of the extended interview are answered "yes," then the resident is considered competent for an intimate relationship.

Murphy & O'Callaghan Capacity Assessment

6 criteria required for capacity for consent

1. Knowledge of body parts, sexual relations, sexual acts
2. Knowledge of sexual relations, STDs, and pregnancy
3. Understanding of appropriate sexual behavior and its context
4. Understanding the sexual contact must be voluntary
5. Ability to recognize potentially abusive situations
6. Ability to show assertiveness in social and personal situations and reject unwanted advances

Model	Components	Measure of Capacity
Lichtenberg Model	Mini Mental State Exam and an extended interview	First the MMSE is conducted. If a resident gets a score below 14, they are <u>not</u> capable of consent. If the score is 15 points or above, the interviewer extends the assessment that identify awareness of relationship, ability to avoid exploitation, and awareness of potential risks. If all three areas of the extended interview are answered "yes," then the resident is considered competent for an intimate relationship.
Murphy & O'Callaghan	6 criteria required for capacity for consent	1. Knowledge of body parts, sexual relations, sexual acts 2. Knowledge of sexual relations, STDs, and pregnancy 3. Understanding of appropriate sexual behavior and its context 4. Understanding the sexual contact must be voluntary 5. Ability to recognize potentially abusive situations 6. Ability to show assertiveness in social and personal situations and reject unwanted advances

Capacity and Consent

Residents have the right to engage in consensual sexual activity. However, anytime the facility has reason to suspect that a resident may not have the capacity to consent to sexual activity, the facility must take steps to ensure that the resident is protected from abuse. These steps should include evaluating whether the resident has the capacity to consent to sexual activity

Appendix PP: CMS, 2022

Per CMS Appendix PP…

- CMS is not requiring facilities to adopt a specific approach in determining a resident's capacity to consent. However, the facility administration, nursing and medical director may wish to consider establishing an ethics committee, that includes legal consultation, in order to assist in the development and implementation of policy related to aspects of quality of life and/or care, advance directives, intimacy and relationships

Capacity to Consent

When a resident with capacity to consent to sexual activity and his/her representative disagree about the resident engaging in sexual activity, the facility must honor the resident's wishes irrespective of that disagreement if the representative's legal authority does not address that type of decision-making for sexual activity. If the resident representative's legal authority addresses decision-making for sexual activity, then the facility must honor the resident representative's decision consistent with 42 CFR §483.10(b)

GUARDIANSHIP

"A *guardian* is a person who has been appointed by a court (usually the probate division of the circuit court) to have the care and custody of a minor or of an adult person who has been legally determined to be incapacitated. A *conservator* is a person or a corporation, such as a bank or trust company, appointed by a court (again, usually the probate division of the circuit court) to manage the property of a minor or of an adult person who has been legally determined to be disabled.

Guardianship is the legal process by which a court determines that a person is incapable of making decision about some or all areas of life. Because of certain medical conditions, a developmental disability, mental retardation, dementia, mental illness, or the inability to communicate, a person may not be able to take care of his or her own finances, make medical decisions, or understand the need for assistance with the activities of daily living.

GUARDIANSHIP

After the court has heard medical testimony and other reliable evidence, it may declare a person to be 'incapacitated' and appoint a guardian to make decisions on the person's behalf. This determination of incapacity and the appointment of a guardian may take specific rights from the person. Once under guardianship, the court might refer to this person as the 'ward,' the 'incapacitated person,' or the 'protected person.'

The court should specifically state which rights it is taking from the ward. The ward keeps all rights that the court has not specifically given to the guardian. State laws may also restrict the ward's rights. The state Constitution, for example, may deny the ward the right to vote. The ward, however, has the right to the least restrictive guardianship suitable to his or her needs and conditions. The guardian also has the affirmative duty to advise the ward of his or her rights and to attempt to maximize the ward's self-reliance and independence.

GUARDIANSHIP

The ward keeps the legal and civil rights provided to all US citizens except those rights which the court grants to the guardian. Two of these rights include the right to marry and the right to procreate. Depending on the type of guardianship the guardian may have total control making decisions over the ward's life (for those with Full Guardianship status), versus control over some but all not all of the ward's life (for those with Limited Guardianship status). The decisions related to full guardianship include whether or not to marry and with whom the ward may associate. More information can be found at the Missouri Revised Statues, Chapter 475 Probate code-Guardianship http://revisor.mo.gov/main/Home.aspx.

Resident Rights

§483.10(a)(1) A facility must treat each resident with respect and dignity and care for each resident in a manner and in an environment that promotes maintenance or enhancement of his or her quality of life, recognizing each resident's individuality. The facility must protect and promote the rights of the resident.

§483.10(b)(1) *The facility must ensure that the resident can exercise his or her rights without interference, coercion, discrimination, or reprisal from the facility.*

Resident Rights

§483.10(b)(7) In the case of a resident adjudged incompetent under the laws of a State by a court of competent jurisdiction, the rights of the resident devolve to and are exercised by the resident representative appointed under State law to act on the resident's behalf. The court appointed resident representative exercises the resident's rights to the extent judged necessary by a court of competent jurisdiction, in accordance with State law. (i) In the case of a resident representative whose decision-making authority is limited by State law or court appointment, the resident retains the right to make those decisions outside the representative's authority. (ii) The resident's wishes and preferences must be considered in the exercise of rights by the representative. (iii) To the extent practicable, the resident must be provided with opportunities to participate in the care planning process.

Resident Rights

The facility staff must obtain documentation that the resident's representative has been delegated the necessary authority to exercise the resident's rights and must verify that a court-appointed representative has the necessary authority for the decision-making at issue as determined by the court.

For example, a court-appointed representative might have the power to make financial decisions, but not health care decisions. Additionally, the facility must make reasonable efforts to ensure that it has access to documentation of any change related to the delegation of rights, including a resident's revocation of delegated rights, to ensure that the resident's preferences, are being upheld. ***THIS IS A COMMON MISUNDERSTANDING AMONG NURSES.***

Resident Rights…Appendix PP

"Right to personal privacy" includes the resident's right to meet or communicate with whomever they want without being watched or overheard. Private space may be created flexibly and need not be dedicated solely for visitation purposes.

Facilities must create and sustain an environment that humanizes and promotes each resident's well-being, and feeling of self-worth and self-esteem. This requires nursing home leadership to establish a culture that treats each resident with respect and dignity as an individual, and addresses, supports and/or enhances his/her feelings of self-worth including personal control over choices, such as mealtimes, activities, clothing, and bedtime; privacy during visits, and treatments; and opportunities to engage in religious, political, civic, recreational or other social activities.

Resident Rights…19 CSR 30-88 Missouri Department of Health and Senior Services

(29) The facility shall permit a resident to meet alone with a person or persons of his or her choice and provide an area which assures privacy. II/III

(34) Each married resident shall be assured privacy for visits by his or her spouse. II/III

Resident Rights… United Nations Convention on the Rights of Persons with Disabilities

(a) (Article 25) Provide persons with disabilities with the same range, quality and standard of free or affordable health care and programmes as provided to other persons, including in the area of sexual and reproductive health and population-based public health programmes;

(b) (Article 5) Recognize that all persons are equal before and under the law and are entitled without any discrimination to the equal protection and equal benefit of the law.(10)

Understanding Intimacy

1. Physical intimacy: being inside someone's personal space, holding hands, hugging, kissing, heavy petting or other sexual activity.
2. Emotional intimacy: typically develops after a certain level of trust has been reached and personal bonds have been established.
3. Cognitive or intellectual intimacy: takes place when two people exchange thoughts, share ideas and enjoy similarities and differences between their opinions.

You don't have to have sex to be intimate with someone and you can reap the biological and mental well-being associated with intimacy.

Positive Forms of Sexual Expression

- Hugging
- Holding hands
- Stroking one's hair
- Sitting close together

Negative Forms of Sexual Expression

- Inappropriate sexual remarks
- Inappropriate touching or fondling other residents and/or staff
- Masturbating in front of others
- Soliciting sexual or intimate acts

Residents can have an intimate, respectful physical relationship that is absolutely appropriate anywhere else in society.

Reality Check

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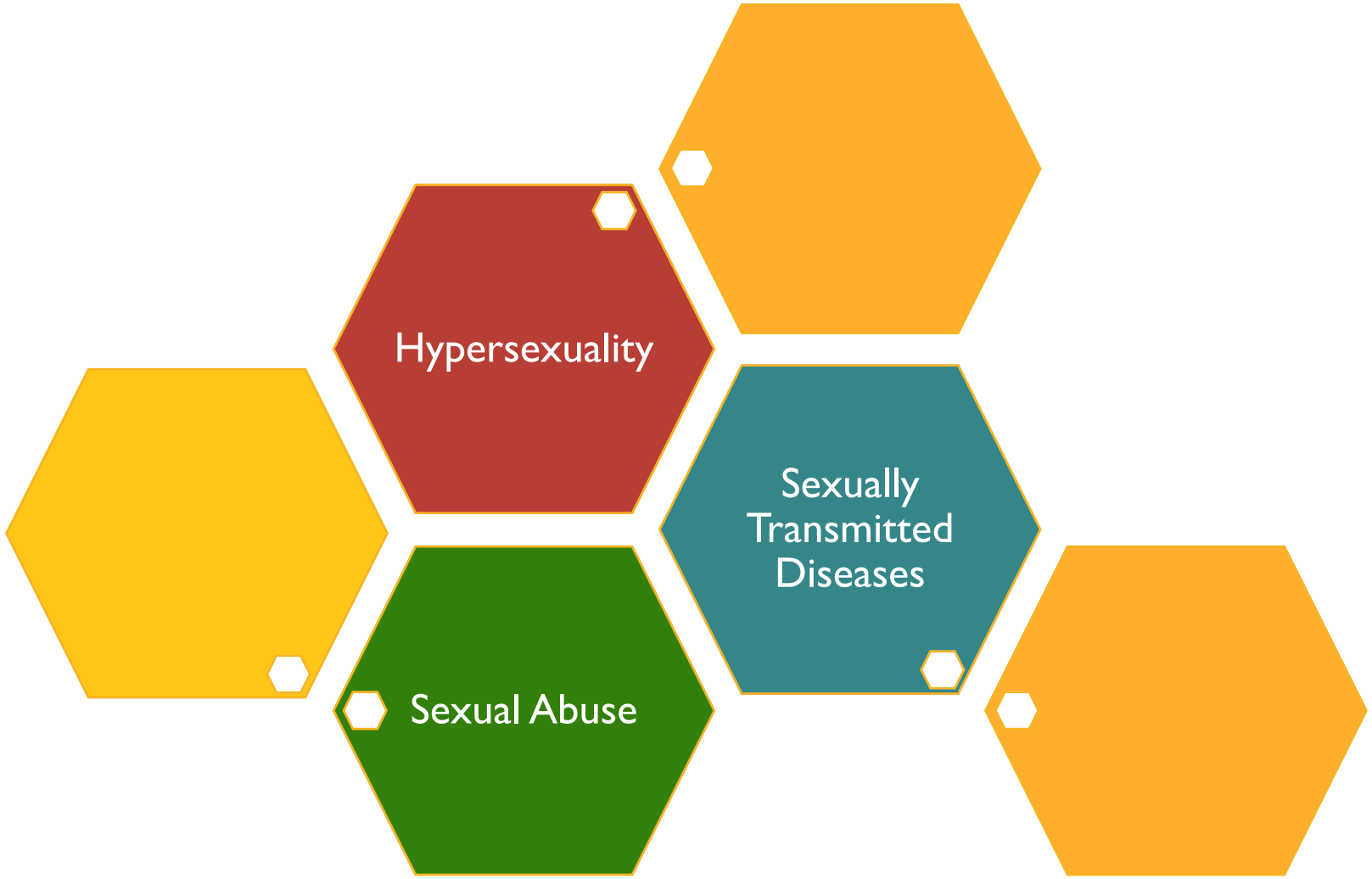
Policy Considerations



Hypersexuality

Hypersexuality is defined by Merriam-Webster as "exhibiting unusual or excessive concern with or indulgence in sexual activity."

Symptoms of hypersexuality include

- repeatedly engaging in sexual fantasies or urges,
- discussing sex and intimacy at inappropriate times or settings,
- making inappropriate suggestions to staff on a regular basis, and
- physically engaging in self-satisfaction to the point where health is compromised.

Drugs and Hypersexuality

#1 Drug of choice for treating hypersexuality

PROZAC

CELEXA

DEPO-PROVERA

ZYPREXA

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Sexually Transmitted Diseases (STDs)

- Gonorrhea
- Chlamydia
- Hepatitis
- Herpes
- Syphilis
- Genital warts
- HIV/AIDS

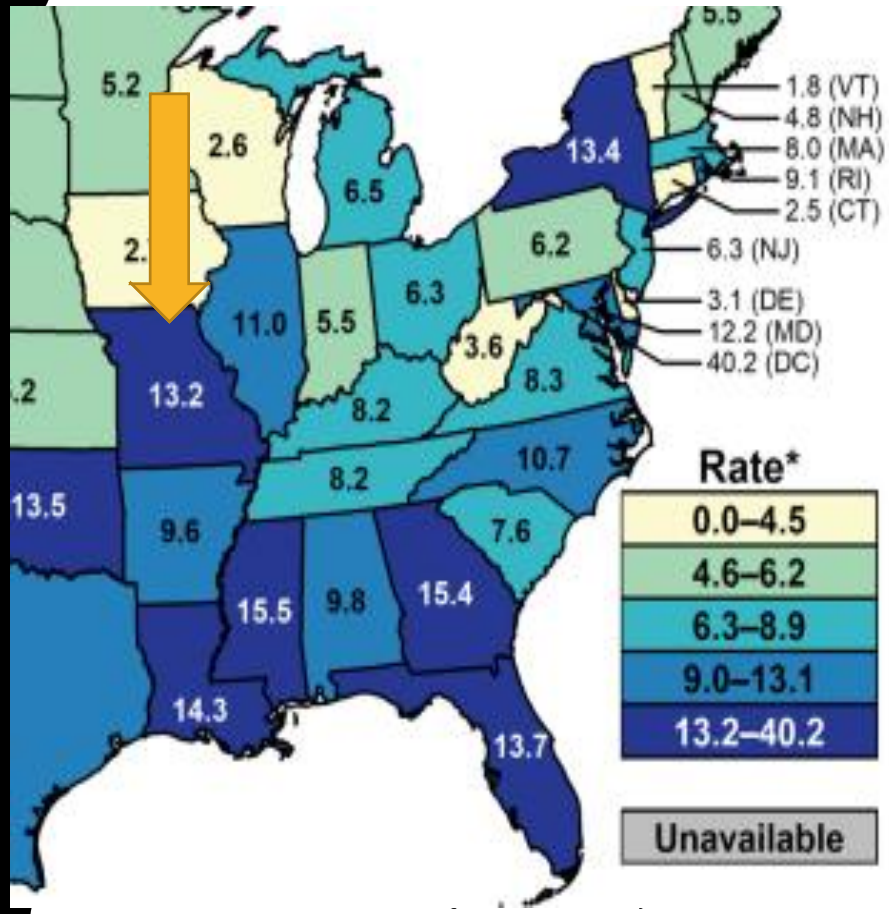
"Nearly 39,000 people were newly diagnosed with the virus that causes AIDS in 2017, but **about 17% of them were 50 or older.**"

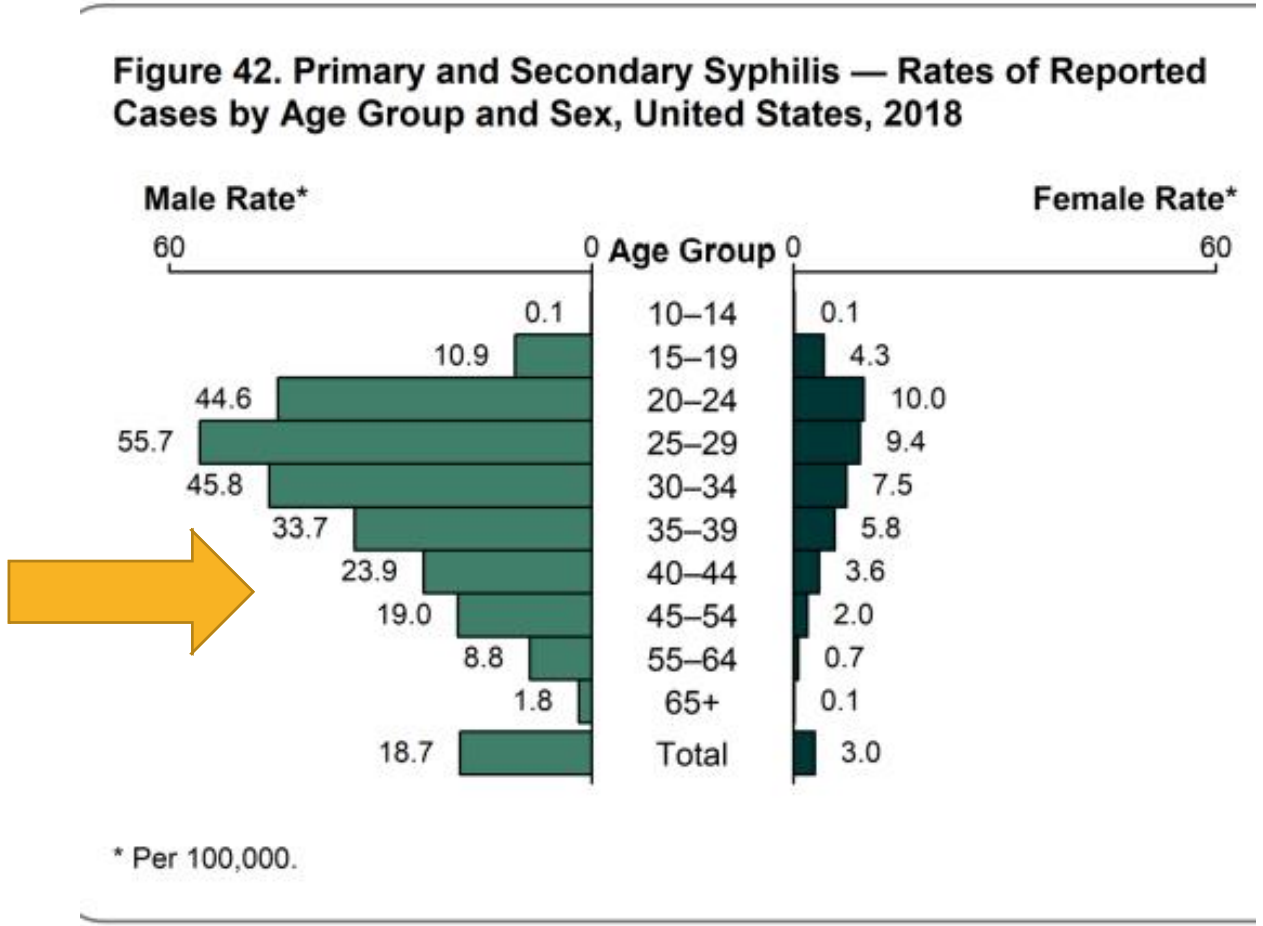
Source: Historic High Rates Of STI's Among Older Americans (forbes.com)

Source: HIV by Age | HIV by Group | HIV/AIDS | CDC

STD Prevalence-Syphilis

Prevalence of syphilis 2018
CDC Report





Primary and secondary syphilis by age 2018 CDC Report

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STD PREVALENCE-CHLAMYDIA

Table 10. Chlamydia — Reported Cases and Rates of Reported Cases by Age Group and Sex, United States, 2014–2018

	Age Group	Cases				Rates per 100,000 Population*		
		Total	Male	Female	Unknown Sex	Total	Male	Female
2014	0–4	603	200	388	15	3.0	2.0	4.0
	5–9	181	26	152	3	0.9	0.2	1.5
	10–14	11,406	1,342	10,041	23	55.2	12.7	99.2
	15–19	381,717	77,908	303,294	515	1,811.9	722.4	2,949.3
	20–24	566,385	159,804	405,876	705	2,472.0	1,361.3	3,632.7
	25–29	253,825	91,729	161,793	303	1,154.4	821.8	1,494.4
	30–34	113,208	45,990	67,060	158	525.9	425.5	625.6
	35–39	52,536	22,894	29,545	97	263.7	230.3	296.0
	40–44	27,426	13,711	13,662	53	133.2	134.2	131.7
	45–54	24,773	14,318	10,424	31	57.0	66.8	47.3
	55–64	6,527	3,911	2,603	13	16.3	20.2	12.5
	65+	1,449	871	570	8	3.1	4.3	2.2
	Unknown Age	1,753	621	1,033	99			
	TOTAL	**1,441,789**	**433,325**	**1,006,441**	**2,023**	**452.2**	**276.1**	**621.6**
2018	0–4	496	186	300	10	2.5	1.8	3.1
	5–9	144	19	125	0	0.7	0.2	1.3
	10–14	10,905	1,438	9,450	17	52.5	13.6	92.9
	15–19	446,008	103,582	341,635	791	2,110.6	959.0	3,306.8
	20–24	641,269	202,528	437,732	1,009	2,899.2	1,784.5	4,064.6
	25–29	333,561	135,059	197,966	536	1,427.3	1,134.7	1,726.2
	30–34	154,132	72,222	81,645	265	701.5	651.3	750.2
	35–39	78,094	39,320	38,635	139	367.8	370.4	363.9
	40–44	38,657	21,111	17,462	84	196.8	216.5	176.6
	45–54	38,323	24,067	14,173	83	90.4	115.1	66.0
	55–64	12,536	8,474	4,029	33	29.9	41.8	18.5
	65+	2,331	1,676	640	15	4.6	7.4	2.3
	Unknown Age	2,212	765	1,271	176			
	TOTAL	**1,758,668**	**610,447**	**1,145,063**	**3,158**	**539.9**	**380.6**	**692.7**

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Source: Sexually Transmitted Disease Surveillance 2018 (cdc.gov)

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Training and Education

https://www.cdc.gov/std/training/courses.htm

+ Reach out to your county health department—they can provide excellent training for your staff and free condoms for your residents.

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Sexual Abuse And Trauma

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F600 §483.12 Freedom from Abuse, Neglect, and Exploitation The resident has the right to be free from abuse, neglect, misappropriation of resident property, and exploitation as defined in this subpart. This includes but is not limited to freedom from corporal punishment, involuntary seclusion and any physical or chemical restraint not required to treat the resident's medical symptoms.

"Sexual abuse" is non-consensual sexual contact of any type with a resident, as defined at 42 CFR §483.5. Sexual abuse includes, but is not limited to:

- **Unwanted intimate touching of any kind especially of breasts or perineal area;**
- **All types of sexual assault or battery, such as rape, sodomy, and coerced nudity;**
- **Forced observation of masturbation and/or pornography; and**
- **Taking sexually explicit photographs and/or audio/video recordings of a resident(s) and maintaining and/or distributing them (e.g. posting on social media).**

This would include, but is not limited to, nudity, fondling, and/or intercourse involving a resident. Generally, sexual contact is nonconsensual if the resident either: • Appears to want the contact to occur, but lacks the cognitive ability to consent; or • Does not want the contact to occur

What is Trauma?

- Exposure to a deeply distressing or disturbing event
- The event can result in an emotional reaction that overwhelms the individual's ability to cope
- The emotional response to the event can have long-lasting effects, sometimes lasting decades after the event occurred if treatment wasn't sought afterwards
- Two individuals can be exposed to the same traumatic event and have very different emotional responses

Common Traumatic events frequently reported by LTC residents

- ✓ **Sexual Abuse/Assault (Childhood sexual abuse, rape as a youth or adult, sexual abuse of elderly person)**
- ✓ **Physical Abuse/Emotional Abuse** (being hit, yelled at)
- ✓ **Death of a loved one** (witnessing a spouse pass away, older adult experiencing the death of a child)
- ✓ **Serious Accident** (e.g., in rehab following MVA)
- ✓ **Violence** (work place violence, shot/stabbed, robbed, terrorism)
- ✓ **Military trauma** (combat exposure in military, sexually assaulted while in military)
- ✓ **Medical events** (fall, negative experience with surgery, delirium while in the hospital)
- ✓ **Natural disaster** (Hurricane, tornado)

Identifying Sexual Trauma in Residents

- 1) **Review of admission records.** Things to look for:
  - Recent or past involvement in traumatic event (e.g., MVA)
  - Mention of abuse or APS involvement
  - PTSD listed as a diagnosis
  - Sexual assault history
  - Mention of combat experience in military

2) **Interview resident.**

- During initial interview when you are gathering background history, you can ask whether they have ever experienced a traumatic event.

3) **Formal assessment measures.**

- Life Events Checklist: is a self-report measure designed to screen for potentially traumatic events by assessing exposure to 16 events known to potentially result in PTSD.
- Trauma Screening Questionnaire (TSQ): 10-item symptom screen that was designed for use with survivors of all types of traumatic stress.
- Primary Care PTSD Screen for *DSM-5* (PC-PTSD-5): 5-item screen that was designed for use in primary care settings. The measure begins with an item designed to assess whether the respondent has had any exposure to traumatic events.

Trauma Screening Questionnaire

	YES, AT LEAST TWICE IN THE PAST WEEK	NO
1. Upsetting thoughts or memories about the event that have come into your mind against your will		
2. Upsetting dreams about the event		
3. Acting or feeling as though the event were happening again		
4. Feeling upset by reminders of the event		
5. Bodily reactions (such as fast heartbeat, stomach churning, sweatiness, dizziness) when reminded of the event		
6. Difficulty falling or staying asleep		
7. Irritability or outbursts of anger		
8. Difficulty concentrating		
9. Heightened awareness of potential dangers to yourself and others		
10. Being jumpy or being startled at something unexpected		

Tips and Suggestions:

- Recognize trauma and associated emotional symptoms
- Respond with empathy and respect
- Keep the resident's personal trauma information private- provide the least amount of details that will still allow for personalization of care
- Create an emotionally and physically safe environment
- Refer for behavioral health services in order to provide appropriate assessment and treatment by competent professional

STEP 1: SUSPECTING ABUSE

Sexual abuse, like other types of abuse in the elderly or cognitively impaired, **may not be immediately visible. Be aware of these physical and psychological signs: Injury, bruising, or swelling of anus, genitalia, presence of STDs without known partner, difficulty in walking, sitting, defecating, urinating, anxiety, hypervigilance, depression, and withdrawal**.(11)

In a study completed by Tiedemann (2006), the researcher presents examples from case studies stating that the majority of victims were female, aged 60-70 years old, with nearly 75% living in a nursing home, the remainder living in the community with a family member. Of those at the nursing home, 69% of the perpetrators were other residents and 5% staff - a not-so-subtle reminder to be aware of resident-to-resident interaction in your homes!(11)

When confronted with suspected abuse, health care providers have to get past embarrassment or the idea that discussing these issues could be potentially undignified. It's difficult enough to have these conversations but knowing what to say and how to say it can guide you through the process.

- Provide a quiet, private environment free from distraction where the resident is comfortable, preferably not the DON's office or somewhere that could be perceived as "the principal's office."
- Include another staff member. Sit at the resident's level and be compassionate.
- Ask the following kinds of questions.
  - 1. Has anyone ever hurt you?
  - 2. Has anyone ever touched you in a way you didn't like?
  - 3. Has anyone ever made you do something you didn't want to do?
  - 4. Are you afraid of anyone here?(11)
- Be careful not to ask leading questions or anything that would place blame.
- Allow the person time to respond and note changes in their physical demeanor and response.
- Additional follow-up may be required.

STEP 2: INVESTIGATION

Sexual abuse has been suspected. Now what do you do? It's time to investigate. Start with these basic questions and assessments, as noted in Appendix PP.

1. Was it consensual? Any investigation of an allegation of resident sexual abuse must start with a determination of whether the sexual activity was consensual on the part of the resident. A resident's apparent consent to engage in sexual activity is not valid if it is obtained from a resident lacking the capacity to consent, or consent is obtained through intimidation, coercion or fear, whether it is expressed by the resident or suspected by staff. Any forced, coerced or extorted sexual activity with a resident, regardless of the existence of a pre-existing or current sexual relationship, is considered to be sexual abuse. A facility is required to conduct an investigation and protect a resident from non-consensual sexual relations anytime the facility has reason to suspect that the resident does not wish to engage in sexual activity or may not have the capacity to consent.

2. Are there any signs/symptoms? Indicators of Potential Sexual Abuse in addition to reports from residents and others that sexual abuse occurred, possible physical indicators of sexual abuse that would require investigation by the facility and survey team include, but are not limited to bruises around the breasts, genital area, or inner thighs; unexplained sexually transmitted disease or genital infections, unexplained vaginal or anal bleeding, and or torn, stained, or bloody underclothing. Also be aware of frequent, unusual urinary tract infections, bloody or other vaginal discharge, or fecal incontinence

3. Are there psychosocial changes? Depression, anxiety, and posttraumatic disorder, sudden or unexplained changes in the following behaviors and/or activities such as fear or avoidance of a person or place, of being left alone, of the dark, nightmares, and/or disturbed sleep.

4. For any alleged violation of sexual abuse, the facility must:

- Immediately implement safeguards to prevent further potential abuse;
- Immediately report the allegation to appropriate authorities;
- Conduct a thorough investigation of the allegation; and
- Thoroughly document and report the result of the investigation of the allegation

STEP 3: PROCESS FOR IMMEDIATE SUSPICION OF SEXUAL ABUSE

1. Remove the resident to a safe area and complete a thorough physical assessment (two nurses should be present). Offer comfort and support.
2. Do not wash any linens or clothing items. Bag and label with the resident's name, date, time, and initials of collector.
3. Do not wash the resident or allow to shower, brush teeth, or clean dentures (11).
4. Bag and retain any adult briefs, bed pads, or underwear. Label as above.
5. Notify the physician and obtain order for transportation to the ER.
6. Notify the family if appropriate
7. If resident needs to urinate or defecate prior to transport to the ER, collect the urine or feces in a graduated toilet container.
8. At the ER, a SAFE kit will be used for assessment (Sex Abuse Forensics Examination, aka Rape kit).
9. If abuse is confirmed, law enforcement will be called and further investigation will be conducted from their office.

STEP 4: PROCESS FOR SUSPICION OF SEXUAL ABUSE AFTER 12 HOURS

1. Retain all of the evidence possible.
2. Notify physician and discuss use of a SAFE kit (evidence can still be obtained up to 96 hours after the incidence).
3. Follow instructions as given by DHSS and local law enforcement.

STEP 5: EDUCATE, EDUCATE, EDUCATE!

The first and also final steps in preventing and managing sexual abuse is education. Educate all new staff at orientation, and all existing staff yearly, on their roles as mandated reporters and your home's abuse call tree. Post the abuse hotline number and remind staff that everyone has a responsibility to report suspicious behavior.

Provide additional in-services and education for your staff by reaching out to local resources such as the health department, Area on Aging, and reputable web sites such as the National Center on Elder Abuse. For help with in-services, you can also contact your QIPMO nurse or leadership coach.

Reporting Guidelines From Appendix PP

Examples of Sexual Contact

NOTE: See also guidance at F600 related to Sexual Abuse and Capacity and Consent.

Required to Report	***Not Required to Report (Unless it rises to the level of what's described in the first column)***
• *Unwanted touching of the breasts or perineal area* • *A resident who fondles or touches a person's sexual organs and the resident being touched indicates the touching is unwanted through verbal or non-verbal cues* • *Sexual activities where one resident indicates that the activity is unwanted through verbal or non-verbal cues* • *Sexual activity or fondling where one of the resident's capacity to consent to sexual activity is unknown* • *Sexual assault or battery (ex. rape, sodomy, coerced nudity)* • *Instances where the alleged victim is transferred to a hospital for examination and/or treatment of injuries resulting from possible sexual abuse* • *Forced observation of masturbation, or pornography* • *Forced, coerced or extorted sexual activity* • *Other unwanted actions for the purpose of sexual arousal or sexual gratification resulting in degradation or humiliation of another resident*	• *Consensual sexual contact between residents who have the capacity to consent to sexual activity* • *Affectionate contact such as hand holding or hugging or kissing a resident who indicates that he/she consents to the action through verbal or non-verbal cues* • *Sexual activity between residents in a relationship, married couples or partners, unless one of the residents indicates that the activity is unwanted through verbal or non-verbal cues.*

Best Practices

NOT

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Policies & Procedures

- All facilities where residents reside should have a policy on sexual expression, sexual consent, sexual education and protection, and resident rights. These policies should be communicated clearly to residents, families, guardians, and those with enacted power of attorney.
- Policies should also be clear on the role of guardians and families in determining capability for consent, including both heterosexual, homosexual engagement, and extramarital relationships.
- Homes should consider including a clinical assessment on sexual consent as part of the admission process, including provisions for those where capacity is questionable.

Policies & Procedures

Should be..

- in writing,
- communicate resident's right for sexual expression,
- provide education and protection (such as condoms and birth control options) for those residents wishing to engage in sexual relations (including access to physicians and therapists),
- educate caregivers on capacity requirement and when/if appropriate to intervene,
- provide support for staff to be educated on resident rights of sexual expression, questions and answers from residents, appropriate assistive techniques, signs/symptoms of abuse

Innovative and On-Point

The Hebrew Home through a grant from the New York State Department of Health created a comprehensive staff training video/DVD called "Freedom of Sexual Expression: Dementia and Resident Rights in Long-Term Care Facilities." The Home's policy and video provide the educational foundation and standard of practice for residential healthcare facilities across the state and the nation.

https://vimeo.com/77160261

Educate your Residents

- Consider offering a health fair, including information from your local health department on sexual safety, STDs, and signs of abuse.
- Print a letter that is delivered to each resident's room with information on risks, s/s of abuse, how to get privacy (provide a ribbon or a do not disturb sign), and where condoms can be obtained.
- Make condoms available without issue. While some residents may ask, others will not. Making them available discreetly, perhaps in a shower room, or somewhere more private.

Make Space

Residents rooms often serve as their bedroom, living room, and office all in an 8x8 foot area, usually with a twin-sized hospital bed, a roommate, and no lock on the door. All of these factors do not lend themselves to intimacy.

Consider a place in your home where residents can have complete privacy, including access without having to ask permission, and the ability to put a sign on the door to indicate privacy. The sign doesn't even have to say, "Do Not Disturb," but rather looping a ribbon around the door signaling "occupied" would be less obvious and more dignified. If another room isn't available, consider how give the resident privacy in their own room without jeopardizing the rights of the roommate.

Make the Occasion

Celebrate individuality by helping residents get dressed up for "date-night," offer special beverages or snacks. Ask if there is a particular movie or music they would like and provide a quiet place for them to enjoy it with their partner. We forget, particularly when it comes to couples in our homes, that there is still a need to feel physically special - a close shave, a nice sweater, a spritz of cologne. Take those few extra moments and help them enjoy their moments to the fullest. I even know of some homes where the administrator goes out and buys flowers for a resident from her husband. Memories, old or young, matter.

Create the Opportunity

Self-directed activity? Need I say more?! It's okay not to have that activity calendar packed to the gills. If intimacy is something your resident enjoys, make time for that in their schedule - not yours. Ask if there's anything you can do to help (with a wink and nod!) Don't make it awkward - make it special, whenever and however the residents wish.

Make Accommodations for Comfort

Newcastle ex-nurse Elaine White, a pioneering sex educator and author of *Dementia and Sexuality: The Rose That Never Wilts*, helps nursing home staff and residents tackle what can be an awkward issue. The 81-year-old great grandmother says sexuality is a human right and "the very thread of human existence."

Her presentations include practical advice. "I talk to the ladies about using KY gel for lubrication," she says. "People may need to plan sex beforehand – those who have had strokes may need to take pain relief and gentlemen may need to take Viagra. They may need pillows to support limbs. I bring in sex aids and vibrators. I talk about how to use them – you've got to check they are able to use them and know about hygiene skills like cleaning equipment afterwards."

Source: The truth about sex in nursing homes | Australian Women's Weekly (nowtolove.com.au)

Care Plan

	Problem Statement	Goals	Interventions
1.	At times I am sexually interested in the opposite sex and may act inappropriately by masturbating or displaying sexual acts in public or have indiscreet behavior.	I will have less than weekly episodes of indiscreet behavior thru the next 90 days.	Manage routine that encourages appropriate periods for companionship or intimacy
2.	I am capable of consenting and choosing another consenting partner for sextual activity.	I will be provided a quiet and private area to have sexual activity thru the next 90 days	Identify appropriate pleasureable activities and encourage acceptable behavior
3.	I am not able to consent for sexual activity even though at times I have indiscreet behavior.	I will be easily re-directed when I display indiscreet behavior thru the next 90 days.	Allow opportunities for my need for companionship, affection, inttimacy or privacy to be met.
		I will have less than daily indiscreet behavior thru the next 90	Identify events that may trigger my behavior

Add that they have been educated on safe practices, etc.

Person-Centered Strategies for Cognitively Impaired

- Use simple, concrete language. Remember that the behavior and inappropriate language is a symptom of the disease.
- When cognitive impairment is not severe, identify and describe the inappropriate behaviors to the resident.
- Remind the resident as needed and privately, that the behavior is inappropriate.
- Identify and explain only one concept of behavior at a time.
- When cognitive impairment is severe, identify what behaviors the resident may engage in: (e.g., “If you want to touch me you may shake my hand”, etc.).

Person-Centered Strategies for Inappropriate Behavior

- If the resident undresses, provide a robe or clothes.
- If a male frequently unzips his pants, provide pants with an elasticized waistband and no fly.
- If a female frequently removes her clothing, use clothing that buttons in the back.
- Remain calm and avoid overreacting. Do not argue, use logic or deny the person's needs. Do not scold.
- Speak with your Social Worker and DON about making a referral for a Psychological evaluation.

Conclusion

Sexuality in long-term care isn't about you or me. Being intimate and sharing sexual expression is a right every resident retains, regardless of their physical ability, age, or living situation.

By assessing capacity for appropriate consent, understanding the legalities, creating opportunities without discrimination or discourse, and knowing the difference between "safe" sex and sexual abuse, you can give your residents an environment for freedom of expression and intimacy where they feel comfortable and loved.

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Clinical Education Nurses

www.nursinghomehelp.org/qipmo-program
musonqipmo@missouri.edu

Wendy Boren
borenw@missouri.edu
Region 2

Katy Nguyen
nguyenk@missouri.edu
Regions 3, 4

Crystal Plank
plankc@missouri.edu
Regions 5, 6

Debbie Pool
poold@missouri.edu
Region 7

Amy Moenning
moenninga@missouri.edu
Region 1

Carol Siem
siemc@missouri.edu
Statewide Education

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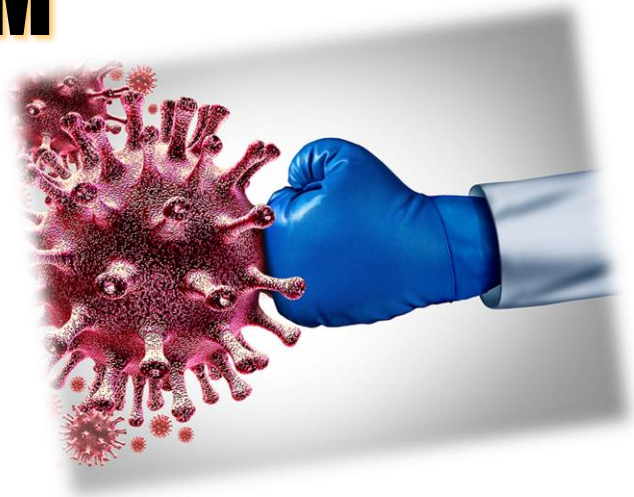
Sinclair School of Nursing
University of Missouri Health Care

Infection Control Team

www.nursinghomehelp.org/icar-project
musonicarproject@missouri.edu

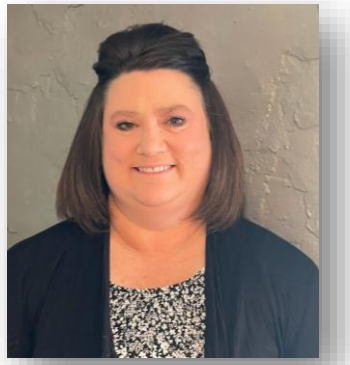


Janice Dixon-Hall
dixonhallj@missouri.edu
Region 7 SNFs

Shari Kist
kistse@missouri.edu
Regions 5, 6

TBA
musonicarproject@missouri.edu
Regions 3, 4

Sue Shumate
shumatese@missouri.edu
Region 2, 7 ALFs/RCFs



Amy Moenning
moenninga@missouri.edu
Region 1

Nicky Martin
martincaro@missouri.edu
Region 2 SNFs

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University of Missouri Health Care

Leadership Coaches and Admin Team

www.nursinghomehelp.org/leadership-coaching
musonqipmo@missouri.edu

Mark Francis
francismd@missouri.edu
Regions 1, 3

Nicky Martin
martincaro@missouri.edu
Region 2,

Libby Youse
youseme@missouri.edu
Regions 4, 5, 6

TBA
musonqipmo@missouri.edu
Region 7

Marilyn Rantz
Project Director

Jessica Mueller
Sr. Project Coordinator
muellerjes@missouri.edu

Ronda Cramer
Business Support Specialist
cramerr@missouri.edu

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