OLDER PEOPLE IN CARE HOMES: SEXUALITY AND INTIMATE RELATIONSHIPS

Hazel Heath discusses the challenges that nurses face in supporting residents to express their sexual needs.

Summary
The Royal College of Nursing has developed guidance to help nurses and care staff work effectively with issues of sexuality, intimate relationships and sex, particularly for older people living in care homes. This article looks at the barriers to ensuring the sexual rights and freedoms of care home residents are protected and suggests how the new guidance might help.

Keywords
Care homes, intimate relationships, sex, sexuality

SEXUALITY is a fundamental aspect of who we are as individuals (Gott and Hinchliff 2003). It influences identity, self-image, self-concept and self-worth. It also affects mental health, social relationships and quality of life. Sense of self and identity is maintained through relationships with others and can become increasingly important in later life. Relationships, particularly those which are long term and close, can provide comfort and support to sustain individuals through multiple life changes and loss. Relationships can also help individuals to feel valued, wanted, desired and enjoyed (Heath 2002a).

Fulfilling the desires for sexuality expression, intimate relationships and sex of older people living in care homes is not straightforward. Most residents have chronic, progressive conditions resulting in multiple disabilities which make it difficult for individuals to live independently (Bowman et al 2004). It is estimated that three quarters of care home residents experience some sort of mental health need and two thirds have dementia (Alzheimer's Society 2008). Illness and disability, particularly limited mobility, chronic pain or incontinence can be challenging in terms of intimate relationships.

Broaching issues of sexuality can be difficult for staff (Forte et al 2007) and buildings do not always facilitate privacy or intimacy, particularly in shared living space or if residents are unable to lock their bedroom doors. The residents’ need for assistance with everyday activities of living is generally high, necessitating the use of clinical equipment, such as single variable height beds. Although essential to prevent staff injury, these do not facilitate intimacy between two people.

The RCN has developed guidance to help nurses and care staff work with issues of sexuality, intimate relationships and sex, particularly for older people living in care homes. It incorporates advice received from RCN legal advisers, along with lawyers and officers at the Care Quality Commission (CQC) and the Nursing and Midwifery Council (NMC). Its goal is to facilitate learning, support best practice, and serve as a resource to help staff address the needs of older service users in a professional, sensitive, legal and practical way (Box 1, page 16).

Legislation and sexual rights
All health and social care practice must operate within the law and in line with relevant professional guidance and standards. In many aspects, the law is explicit concerning sexual behaviour. However, legislation, national care standards and government guidance do not generally address the issue of intimate relationships.
The law does not offer explicit guidance on achieving a balance between promoting individual rights and protecting vulnerable people. Legislation can, however, place boundaries on the extent to which staff caring for individuals may become involved in their choices for sexual expression.

UK civil law governs issues such as a nurse's duty of care towards patients, and duty to respect the confidentiality of all patient information. It also encompasses issues of consent, for example, in mental capacity legislation in England, Wales and Scotland.

UK criminal law regulates people's sexual behaviour by making certain activities unlawful and prohibiting certain sexual activity. The purpose of the law is to prevent exploitation or an abuse of power.

The Human Rights Act (HRA) (1998) incorporates into UK domestic law the rights and freedoms guaranteed under the European Convention on Human Rights. Individuals can bring claims under the HRA against public authorities for breaches of convention rights. Furthermore, UK courts and tribunals are required to interpret domestic law, as far as possible, in accordance with those convention rights including a right not to be discriminated against on certain proscribed grounds when exercising other rights under the convention.

In this context, the World Health Organization (WHO) (2010) has published a list of sexual rights which state that 'sexual rights embrace human rights that are already recognised in national laws, international human rights documents and other consensus statements. They include the right of all persons, free of coercion, discrimination and violence, to decide to be sexually active or not; engage in consensual sexual relations; choose their partner; have respect for bodily integrity; seek, receive and impart information related to sexuality; receive sexuality education; achieve the highest attainable standard of sexual health, including access to sexual healthcare services; pursue a satisfying, safe and pleasurable sexual life'. WHO emphasises that 'the responsible exercise of human rights requires that all persons respect the rights of others'.

It is generally considered that someone living in a residential setting is living 'in their own home' and, although there may be legal caveats, this principle holds good in most circumstances. Adults living in residential settings, unless they have had certain rights and freedoms curtailed or restricted by the law, generally have the same basic rights and freedoms as any citizen to live their lives as they wish. This includes possibly doing things which others might consider to be unwise or inappropriate. The general constraint on anyone exercising their personal rights is only that doing so should not unreasonably have an adverse effect on the rights of others.

**Exercising choice**

An adult resident of a care home, in the privacy of his or her own room, may want to engage in consensual intimate relations with another adult. Where they both have the mental capacity, as defined in law, to do so it is difficult to see what constraints a care home provider could reasonably impose on residents with capacity exercising such a choice, as long as it had no detrimental impact on other residents. This would apply whether the resident and chosen partner were married or not, or of the opposite or same sex. Care providers should always take their own legal advice on any action they propose to take in relation to a resident, as it may have implications under human rights law or other legislation.

If there are concerns about a patient's mental capacity then the care home must observe the requirements of that country's mental capacity legislation, and any relevant clinical and professional guidance. Where there is an appointed independent mental capacity advocate, they should be consulted.

While it is not uncommon for relatives, such as sons and daughters or other residents or their family members, to object to intimate relations arising in care homes, it will often not be appropriate for staff or management of the home to discuss the...
situation with others without the explicit consent of the resident concerned. Residents have legal rights to confidentiality, and registered providers and managers should ensure that staff who are aware of a relationship arising between residents, observe the law on client/patient confidentiality.

Training
Care home providers and managers also have a responsibility to ensure that all staff receive adequate and appropriate training, as well as supervision and guidance when staff may be unfamiliar with handling situations concerning intimate relationships, particularly given the degree of public misperception which exists. In all circumstances it is vital that vulnerable people are protected from unwanted or inappropriate intimate contact with others. Where intimate contact becomes an issue – for example, if a resident is masturbating in front of other residents or touching other residents or staff – the service provider must make an appropriate risk assessment and carry out person-centred care planning. This may involve discussing the situation with other parties, which could include a representative or advocate of the resident, health or social services professionals, or, in relevant circumstances, a relative.

Policies
Care home service providers should develop policies that support the rights of all the people who live, visit or work in the care home, in consultation with relevant parties.

Each person’s background, culture or religious beliefs can fundamentally influence approaches to expressing sexuality, sex and intimate relationships. Policies, and the ways in which these are developed and implemented, can help to avoid misunderstanding and conflict and should ensure that all stakeholders feel that their rights and personhood have, in the best ways possible, been recognised and respected (Heath 2002b).

Care homes should also develop policies on non-discrimination; for example, that ‘no person or group of persons living or applying to live in the home, working or applying to work in the home or visiting the home will be treated less favourably than any other person because of race, colour, ethnic origin, religion, class, age, gender, gender identity, sexual orientation, marital, parental or HIV status, or disability’ (Springfield 2002).

When considering moving into a care home, prospective residents and their families should be made aware of the home’s policies and given the opportunity to discuss any concerns. Having made the move the resident should have the opportunity to discuss the environment and care to address all of their priorities, including facilitating space, time and privacy to continue intimate relationships. If appropriate, referral can be made to other healthcare services.

Policies should acknowledge and promote a resident’s right to privacy, confidentiality, consent and support to live their lives as they choose, as long as this does not adversely affect the rights of others. Care homes might also wish to develop policies covering specific aspects of sex or intimacy; for example, stating that residents who are married, in a civil partnership or long-term relationship should be able to share a room or have privacy during partner visits.

Policies should also acknowledge and promote the rights of staff to work in ways that are morally acceptable to them. Policies and local management systems should be effective in identifying sexual abuse, protecting staff from sexual harassment, exempting staff from situations where they might feel morally compromised, and supporting them to work in their comfort zones. All policies should be reviewed regularly with residents, families and staff. In the case of conflict, legislation will always override local policy statements.

Care environments and facilities
Environments should acknowledge that sexuality and relationships are aspects of the overall care agenda and challenge barriers to the fulfilment of these.

Ideally, there should be:

• A private space where care can be delivered and open discussions can take place without risk of being overheard.
• Space where people can sit together in privacy.
• Facilities for privacy between couples, including those of the same gender.
• ‘Do not disturb’ signs for doors.
• Private accommodation available for conjugal or partner visits, the use of which can be timetabled.
• The option for a double bed where possible.

Environments can also acknowledge sexuality and relationships as integral to life in the care home through pictures, posters, newsletters or leaflets, and educational materials on display.

Images can convey powerful messages about the acceptance of love and intimate relationships among people who are older, from diverse cultures, have disabilities or choose a partner of the same gender. Available materials could include, for example, information on where to obtain advice on psychosexual issues, sex following illness such as stroke or heart attack, and HIV. They should be
available in languages appropriate for residents and in accessible forms for people who have sight or hearing impairment.

**Systems and practices**

Organisational systems that do not take residents' sexuality or intimate relationships seriously will not acknowledge their real needs and can cause deep unhappiness (Heath 2002c). Staff should aim to work inclusively with people from all cultures, types of relationships and sexual orientations. Care home residents will have different lifestyles: single, celibate, married, in a partnership or seeking a relationship. Organisational systems should promote non-judgmental, non-discriminatory approaches, whatever the personal beliefs of individual staff.

Acknowledgement of individual cultural backgrounds and beliefs is essential in care homes. These can be fundamental – such as how different cultures view what is regarded as normal or abnormal, acceptable or unacceptable in terms of sexuality, relationships, sexual behaviour or intimate care (for example, accepting care only from a caregiver of the same gender) – or subtle, for example, in what is deemed to be appropriate humour. Homes should offer education to help enhance staff understanding in relation to culture, and learning resources and support should be readily available.

Documentation is central to facilitating the acknowledgement of lifestyle, sexuality and relationship issues for residents. Biographical details can give clues on whether these are issues for individuals and how best they might be approached in the most sensitive and appropriate manner. Significant relationships can be recorded, along with the resident's priorities for relationships; for example, that a couple want to spend uninterrupted time together or that a resident does not want his or her children to become aware of the desire for an intimate relationship.

Well-designed documentation can also assist the preservation of confidentiality, which is particularly important when working with individuals who have a disability which necessitates assistance with intimate personal activities of daily living. Documentation can also make explicit a resident's priorities in terms of next of kin, who should be informed in problem situations and legal provision the resident wishes to make.

Organisational systems can make explicit the boundaries, contained in policies, which promote safe practice and protect both residents and staff. Negotiating these in everyday practice requires judgment, skill and full support from senior staff. Organisational systems should:

- Value personhood and uniqueness.
- View individual residents in the context of their lives and biographies.
- Be open to learning about significant experiences and relationships.
- Promote individual choice and control.
- Promote clear boundaries which protect and support residents and staff.

In everyday care home practice, balancing the need for care and observation with an individual resident's right to privacy can be delicate. For example, are residents free to remain in their rooms undisturbed? If they choose to lock their door, is this wish respected? Do staff knock and wait to be invited into a resident's room before entering?

Supporting sexual activity alongside other activities of daily living can also be delicate. For example, while you assist residents who need help with hygiene before and after meals, using the lavatory or episodes of incontinence, do you help the resident with hygiene before and after sexual activity? In your everyday work do you follow infection control procedures in order to protect yourself and others from infections which can be related to sexual activity, such as HIV?

**Sensitive discussions**

A first step is to acknowledge potential barriers to sexuality expression both for the older person and the staff member (Mcauliffe et al 2007). Discussing personal or intimate topics requires skill and sensitivity. Nurses can build on their understanding of what is likely to be acceptable to a resident or family and what might be their priorities.

It is important to try to time sensitive conversations for when the person might be most ready to speak. Nurses should also aim to create an atmosphere conducive to uninterrupted discussion, initiating the conversation, using open-ended questions, being non-judgmental, avoiding abbreviations or jargon and being receptive to clues, however subtle, that the person may offer in terms of what is important to him or her (White 2002).

Opportunities to discuss sexuality issues can arise during conversations about physical health issues, and starting from general topics and progressing to more specific and sensitive topics can be helpful.

Two routes into discussing sexual issues proposed...
by White and Heath (2005) may be worth exploring. These are the direct impact of illness or its treatment on sexuality expression or on intimate relationships and the relationship context through such questions as ‘who is around for you?’, ‘who are you close to?’ or ‘who is important in your life?’

It is essential to be respectful of the person’s response. Although an initial reaction could be something like ‘that’s not important’ or ‘what, at my age?’, and further disclosure is unlikely at that time, such responses can indicate a willingness to discuss the subject and further opportunities for discussion should be sought. If individual staff feel they are unable to support a resident’s right to sexual expression, managerial support, supervision or education can be offered. In the meantime, the resident’s care can be referred to another member of staff who is comfortable dealing with sexuality issues.

Sexuality as a problem

Situations arise in care homes where issues of sexuality, intimate relationships or sexual expression are seen as a problem. A resident may demonstrate a wish for close physical contact with another, or may touch another resident or member of staff in an intimate manner. When residents have cognitive impairment, they may become disinhibited and behave in ways that can be offensive to others, such as removing clothing.

Archibald’s (1994) framework for action when sexuality is seen as a problem can help to identify where the problem and solutions might lie (Figure 1).

It is important to record accurately what is happening, for example:
- When and where did the ‘problem’ occur?
- What form did the behaviour take; what did the people say or do?
- What else was happening?
- Was there anything specific that seemed to prompt the behaviour?
- Were other people involved?
- What were the responses?

Consider whether there is a problem that needs to be addressed. For example, if the circumstances arose due to a misinterpretation or misunderstanding that has now been corrected and no further action is necessary, the situation can be monitored. It is important for staff to reflect on their own behaviours and interactions that may, albeit unintentionally, have contributed to a resident’s behaviour. This may include that the way staff have talked or joked has led a resident to believe that raising sexual issues or behaving in a sexualised way is acceptable.

If it is decided that there is a problem, it is important to decide who the behaviour is a problem for. This will determine what action needs to be taken and where it should be focused. If a resident is removing his clothes this could be seen as a problem for staff or visitors who feel uncomfortable. In fact the problem may be for the resident who wants to go to the toilet but is unable to communicate his needs, recognise where the toilet is, or make the journey independently. Action in this situation should focus on staff recognising the signals the resident is offering, the environment in terms of signs clearly indicating the location of toilets, and whatever aids or assistance will help the resident make the journey to the toilet safely.

It is not uncommon for staff to see a resident’s expression of sexual need as the resident’s problem, when in fact the problem is for staff who may feel embarrassed and unable to acknowledge residents as sexual beings with sexual need. Understanding and compassion are essential when working with people.
who have dementia or cognitive impairment. As Pritchard and Dewing (2001) emphasise ‘it helps to try to look at a person’s behaviour as communication from someone who may feel ill and frustrated, who may be finding it difficult to express themselves and their needs, and who may be faced with a lack of understanding from those around them’.

Conclusion
Supporting the expression of sexuality, intimate relationships or sex for older people living in care homes can be challenging for staff (Bauer et al 2007). There is often a tension between supporting human rights and acting within legal frameworks. The NMC recognises that decisions are often not straightforward but nurses must always act within the law and within the NMC code and guidance (NMC 2008, 2009a, 2009b). All decisions will depend on the people involved and individual circumstances. Comprehensive assessments of individuals and specific circumstances, including risk, must be undertaken. When appropriate, the views of a range of people should be incorporated into care and specialist advice should be sought. Approaches must be person centred and care provided in ways that are personalised, rather than based on assumptions and stereotypes. Nurses must always strive to promote and support human rights, dignity, privacy and choice.

Find out more
- Older People in Care Homes: Sex, Sexuality and Intimate Relationships: An RCN Discussion and Guidance Document for the nursing workforce will be available soon via the RCN website.
- RCN publications web page: www.rcn.org.uk/development/publications