



## Considerations Regarding the Needs of Long-Term Care Residents for Intimate Relationships and Sexual Activity

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# Considerations Regarding the Needs of Long-Term Care Residents for Intimate Relationships and Sexual Activity

by the Center for Practical Bioethics

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## Background and Scope

This document is a response to the requests of licensed long-term care facilities — skilled nursing, intermediate care, residential care, and assisted living — for practical, ethically informed policy guidance to help them address their residents' needs and desires for privacy, intimate relationships, and sexual activity. These are emotionally charged issues about which long-term care providers, residents, the families of residents, and facilities do not always agree. This document is not intended to force a prescriptive one-size-fits-all resolution of these issues. Rather, it is intended to provide a conceptual framework and methodology that will help long-term care facilities and staffs address these issues.

The document directly addresses two issues; (1) the intimate relationships of residents and (2) the sexual activities of residents that involve sexual contact. These topics cannot be neatly compartmentalized. Some intimate relationships involve sexual contact, some don't; some sexual contact occurs within an intimate relationship, some is self-contained (e.g., using erotic photos for self-stimulation). Although this document specifically addresses the sexual activities of residents that involve sexual contact, it may also help a facility address sexual activities that do not involve contact.

The issue of sexual abuse is outside the scope of this document. Because long-term care residents may be victims or perpetrators of sexual abuse, facilities must have policies and procedures that protect residents from sexual abuse and deter residents from sexually abusing others. Such policies, however, are not included in this consideration of the needs and desires of long-term care residents for intimate relationships and sexual activity.

The Center for Practical Bioethics developed this document in consultation with more than fifty dedicated volunteers who worked tirelessly for more than a year to help formulate the question and propose solutions. The Center also gratefully acknowledges the many surveyors, medical directors, administrators, social workers, and nurses who reviewed and commented on the document.

The Center for Practical Bioethics has a long history of working with and providing guidance to long-term care facilities on a range of ethical issues related to the dignity and autonomy of residents in long-term care. Previous documents, for example, address the process of determining decisional capacity, making life-prolonging treatment decisions in long-term care facilities, and improving the care of seriously ill and dying patients in long-term care, home health, and hospice.

## 1. Purpose/Rationale/Goals

1.01 To provide practical policy guidance to licensed long-term care facilities regarding their residents' needs for intimate relationships and sexual activities.

1.02 To establish a framework for managing the tension between the competing values of respecting the personhood of long-term care residents and providing protective oversight for them in the context of their intimate relationships and sexual activities.

## 2. Working Assumptions

2.01 Long-term care residents are social. The need for intimate connectedness is a universal human

characteristic or trait that extends throughout one's lifespan.

2.02 Long-term care residents are sexual. Sexuality is a universal human characteristic that extends throughout one's lifespan.

2.03 Human relationships are informed by the personal values that individuals bring to them. Intimate relationships between long-term care residents may involve competing values.

2.04 A long-term care facility's policy regarding its residents' intimate relationships should address the advent, continuation, and conclusion of those relationships.

2.05 Long-term care surveyors will respect fully articulated, written policies of support for the intimate relationships and sexual activities of consenting residents.

2.06 Provided the facility has a fully articulated, written policy of support for the intimate relationships and sexual activities of its residents, long-term care surveyors will respect the right of residents to accept the risks of their intimate relationships and sexual activities.

2.07 Long-term care facilities are responsible for educating and informing residents, families, staff and surveyors regarding their processes for accommodating residents' needs for intimate relationships and sexual activities.

### 3. Working Definitions

3.01 Intimacy— An expression of the natural desire of human persons for connection; a state of reciprocated physical closeness to, and emotional honesty with, another. Physical closeness to another includes physical touch as demonstrated by nongenital, nonsexual touching, hugging, and caressing. Intimacy is not a synonym for sex; however, sexual activity frequently occurs within an intimate relationship.

3.02 Licensed Long-Term Care Facility – A facility that is licensed either solely or in combination

as a skilled nursing facility, an intermediate care facility or a residential care facility.

3.03 Protective Oversight – An awareness twenty-four hours a day of the location of a resident, the ability to intervene on behalf of the resident, supervision of nutrition, medication or actual provisions of care and the responsibility for the welfare of the resident, except where the resident is on voluntary leave.

3.04 Sexual Abuse – Subjecting another person to sexual contact by use of forcible compulsion. Sexual abuse includes, but is not limited to sexual harassment, sexual coercion, and sexual assault.

3.05 Sexual Contact – Includes sexual intercourse, oral sex, masturbation, and sexual touch.

3.06 Sexual Activity – Includes sexual contact and other activities intended to cause sexual arousal (e.g., viewing sexually explicit photographs and video, reading sexually explicit text, and phone sex).

3.07 Volition – A resident's clear, unequivocal, unforced willing participation in an intimate relationship or sexual activity. Freedom from coercion is a trait of volition. In this document, "consenting resident" means a resident whose participation in an intimate relationship or sexual activity is volitional.

### 4. Principles of Ethics

4.01 The principle of respecting residents as persons: The staff of licensed long-term care facilities ought to support residents' efforts to maintain and improve their quality of life. Establishing and maintaining intimate, sometimes sexual, relationships with other people enriches the lives of residents.

It is good for staff to support the residents of licensed long-term care facilities who want to participate in decisions that affect their lives. Residents are most likely to participate effectively when they understand their situation and are

permitted to make fundamental choices involving themselves and their relationships with others.

4.02 The principle of doing good and avoiding harm: The staff of licensed long-term care facilities ought to act for the benefit of residents and refrain from acting in ways that harm residents. The principle of doing good and avoiding harm can also support actions that protect residents even if the residents do not perceive the actions to be beneficial.

Some things can both benefit and harm a resident, or benefit one resident but harm another resident. Staff ought to think about the likely consequences of actions so they can avoid causing unintended harm to all residents.

4.03 The principles of privacy and confidentiality: Privacy refers to the right people have to control access to their interior lives. The principle of privacy permeates the physical, emotional, spiritual, intellectual, and social aspects of everyday life. The principle of privacy allows people to enter into an infinite variety of human relationships – from the most intimate to the most impersonal. Interfering with a resident's volitional, intimate relationships violates the resident's privacy. For this reason, absent a compelling need to protect a resident, the staff of a licensed long-term care facility ought not to interfere with the intimate relationships of its residents.

We commonly think of privacy in terms of withholding information; however, providing information may also be an exercise of privacy. In order to receive healthcare, residents share personal information with their healthcare providers that they wouldn't otherwise share. In order to receive care from direct care-providing staff, residents reveal themselves in ways they normally would not. Residents relinquish control over some aspects of their lives in order to obtain the benefits of congregate living. Each of these situations illustrates how residents routinely exercise privacy by permitting others to obtain information about them.

Confidentiality refers to the obligation that recipients of such information have not to

rediscover private information unnecessarily. When a resident of a licensed long-term care facility discloses private information to a member of the facility's staff, the staff member ought to refrain from redisclosing the information to anyone who does not need the information. In many cases, laws, regulations, policies, and professional codes of conduct reinforce the confidentiality obligations of facilities and staff members. However, in other situations these same sources of authority require disclosures that would otherwise violate confidentiality.

The Resident Assessment Instrument Process (RAI Process) requires staff to redisclose otherwise confidential information concerning the intimate relationships and sexual activities of residents.

## 5. Conceptual Framework

5.01 The document's conceptual frame is the proposition that licensed long-term care facilities owe two primary obligations to their residents – respect for their personhood and protective oversight. Therefore, regardless of the response that a facility makes to an intimate relationship involving sexual activity by a resident, the facility ought to be able to affirm that its response shows respect for, and provides necessary protection of, the resident.

5.02 Facilities show respect for residents by supporting their efforts to fulfill the traits of their personhood. One trait of personhood that is recognized across cultures is that persons are generally social, that is, associations with other persons cause them to flourish. A second universally recognized trait of personhood is the lifelong sexual nature of persons. When facilities support the intimate relationships that residents establish with each other, they show respect for those residents. When facilities support the nonabusive sexual activities of residents, they show respect for those residents.

## 6. Conclusions

6.01 Licensed long-term care facilities are obliged to show respect for their residents' personhood, including the residents' lifelong needs for social relationships and sexual activities. Consequently, the policy of licensed long-term care facilities ought to be conditional support for their residents' intimate relationships and sexual activities. However, some social relationships and sexual activities are so problematic that the facility ought not to support them.

6.02 The policy ought to require the facility to provide two types of support.

- (1) Anticipatory Support: Facilities need to
  - (a) Routinely inform their staffs regarding this policy. Special care should be taken to inform staff members regarding the policy's privacy implications.
  - (b) Provide training that prepares staff members to perform their roles with respect to the policy.
  - (c) Develop and implement plans for communicating the policy to residents, families, and surrogates.
- (2) Situational Support: By using the RAI Process, facilities can
  - (a) Identify specific actions that staff may take in support of a particular intimate relationship or sexual activity. Some sexual activities are so problematic that they ought not to be supported.
  - (b) Identify and develop specific responses to problematic sexual activities.
  - (c) Provide the array of situational supports required to respond to the infinitely various intimate relationships and sexual activities of their residents.

6.03 While some of the intimate relationships and sexual activities of residents share common traits,

and while some generalizations based on shared traits is necessary, each relationship and activity is essentially unique. Therefore, a set of one-size-fits-all situational supports is an inherently insufficient response.

## 7. Procedural Considerations

Long-term care facilities should carefully address the following issues relating to the intimate relationships and sexual activities of their residents.

7.01 How to Determine Willingness: By what standard ought a resident's willingness to participate in an intimate relationship or engage in a sexual activity be measured? The standards of informed consent and assent that measure willingness to participate in healthcare are not the standards for willingness to participate in an intimate relationship or sexual activity. Volition (i.e., the capability of making a conscious choice), is the evidence of willingness that facilities ought to require of residents.

7.02 The Possibility of Imbalance within Intimate Relationships: How would material differences in the salient traits or capabilities of two residents, for example, in their cognitive capability, emotional vulnerability, or physical power, inform a facility's response to their formation of an intimate relationship?

(1) When the relationship does not involve sexual contact? Such imbalances should be assessed. If the assessment raises concern that the lesser situated resident's participation in the relationship is not volitional, the facility ought to provide situational supports that protect the lesser situated resident. By itself, however, such an imbalance ought not to cause the facility to withdraw support for the relationship.

(2) When the relationship involves sexual contact? Sexual contact is a powerful confounding factor: the risk that sexual contact poses to lesser situated residents is high, and the propensity of lesser situated long-term residents for acquiescence in

situations of imbalance is great. Facilities are not obliged to oppose imbalanced relationships that involve sexual contact; however, support should be withheld unless or until the RAI Process for the relationship yields an evidence-based finding that the lesser situated resident's participation in the relationship is volitional. When facilities conclude that they cannot support such an imbalanced relationship, they ought to explore the possibility of providing situational supports for the intimate relationship that will prevent the occurrence of sexual contact.

7.03 The effect of the Congregate Setting: To what extent should congregate living inform a facility's response to the intimate relationships or sexual activities of its residents? By regulation, long-term care facilities are to be home-like settings for their residents. However, the fiction that living in a licensed long-term care facility is, or ought to be, equivalent to living in a single family residence ought not to be indulged. Even if it is otherwise attractive, this fiction inevitably leads facilities to fail to show respect for some residents and fail to provide needed protections for others. The more accurate understanding — that facilities are home-like *congregate* residences — better serves the residents who are involved in intimate relationships or sexual activity and has the further advantage of giving all residents a stake in how their facility responds to the intimate relationships and sexual activities of other residents.

7.04 The Federal Privacy Rule (HIPAA): Assuming that a licensed long-term care facility is a covered entity, in what ways will HIPAA influence the facility's responses to the intimate relationships and sexual activities of its residents? Intimate relationships and sexual activities that occur in a home-like residential setting are not protected health information. Consequently, such relationships and activities are not covered by HIPAA. Unnecessarily imposing HIPAA restrictions on these issues would be particularly problematic because of the artificiality it would impose on the RAI Process. It would, for example, require facilities to plan situational supports for

intimate relationships without identifying the people who comprise the relationship.

7.05 Reliance on the Resident Assessment Instrument Process: Realizing the promise of the RAI-Process requires a significant commitment. Is it too much to also expect it to be the means by which facilities identify specific actions to take to support or oppose a particular intimate relationship or activities of sexuality? There is no established standard of care against which to test a facility's proposed response to a resident's intimate relationships or sexual activities. Applying the RAI Process to these issues will stretch many facilities, but without such a rich process, facilities will have no hope for making the resident-centered situational responses that are required to address these issues.

7.06 Relating Family Members to the Intimate Relationships and Sexual Activities of Residents: In responding to the intimate relationships and sexual activities of its residents, to what extent ought a facility involve a resident's family? Families need to know what the facility's policy is. They should be encouraged to participate in pre-admission assessments of their relative-resident regarding the issues of intimate relationships and sexual activity. They may also be important participants in a facility's RAI Process for developing situational responses to the intimate relationships and sexual activities of their relative-resident. To the extent that information about their relative-resident's intimate relationships and sexual activities is not private, it may be provided to families. Families do not typically have a management role in these matters, unless it is explicitly afforded to them by the facility.

## 8. Methodology

Federally certified licensed long-term care facilities use the RAI Process for clinical problem identification/resolution. Licensed, but not federally certified long-term care facilities are required to use a clinical problem identification/resolution process that is substantially similar to the RAI Process. In this document, RAI Process

refers to the problem identification/resolution process employed by licensed long-term care facilities regardless of whether they are federally certified.

8.01 The authors recommend that facilities use the RAI Process to develop situational supports for the intimate relationships and sexual activities of residents and to operationalize all facility policies and procedures related to intimate relationships and sexual activities.

8.02 The RAI Process helps long-term care staff gather definitive information concerning the intimate relationships and sexual activities of residents and to form care plans that reflect the strengths and needs of residents in relationships.

8.03 In the RAI Process, accurate problem identification leads to sound intervention — care plans are unique pathways for supporting residents seeking to achieve, maintain, or retreat from intimate relationships or otherwise express their sexuality. Even when residents experience unavoidable declines, the discipline of the RAI Process can guide facilities to use their resources in ways that allow residents to participate in intimate relationships and sexual activities for as long as possible.

8.04 The RAI Process consists of five steps:

a. Assessment — Making informed resident-centered, values-based determinations: (1) that a resident has questions about the facility's policies pertaining to intimate relationships or sexual activity, or (2) that residents have established an intimate relationship, or (3) that a resident is otherwise expressing his or her sexuality.

b. Decision Making – Deciding (1) to show respect for an intimate relationship between residents by providing supports for the relationship or to provide protections from the relationship to one or both of the participants; or (2) to show respect for some sexual activities by providing supports, or to provide protections to residents from untoward sexual activities.

c. Care Planning—Deciding (1) how to support (or discourage) an intimate relationship between two residents or (2) how to support (or discourage) residents from otherwise expressing their sexuality.

d. Implementation – Supporting (or discouraging) (1) an intimate relationship between two residents or (2) other sexual activities of residents.

e. Evaluation – On an ongoing basis, critically reviewing and modifying as necessary the assessment, decision making, care planning, and implementation steps undertaken to identify and resolve issues related to the needs and desires of residents for intimate relationships and sexual activity.

8.05 The RAI Process works for several reasons:

a. Residents respond well to individualized care plans.

b. The process requires serious intra-staff communication and coordination among staff at all levels.

c. Residents and their families are essential participants in the process.

d. The process encourages clear documentation.

## **APPENDIX A: Seven-Point Strategy for Responding to the Needs of Long-Term Care Residents for Intimate Relationships and Sexual Activities**

*Clarence J. Sundram proposed a strategy for responding to issues of intimacy and sexual relationships involving people with major mental illness, which can be adapted for responding to these issues when the people involved are long-term care residents.*

A.01 Inform, train, and educate staff regarding applicable laws, regulations, policies, and procedures.

A.02 Use the Resident Assessment Instrument Process to develop relationship-centered care plans for providing services and supports that address the residents' capacities, their need for information, education, and training, and the limitations on their capacities that involve the facility's duty to provide protective oversight.

A.03 Develop clear policies and procedures that address the issues of intimacy, sexuality, privacy, and event reporting. Train staff regarding these policies. Provide staff an accessible source of advice regarding the operational problems they confront. Whenever the facility's duty to provide protective oversight is required because of a resident's sexuality, be very clear and unambiguous with staff regarding their duty to provide protective oversight. Scrupulously comply with laws, regulations, and policies relating to protective oversight.

A.04 When providing needed information, education, and training to residents regarding their expressions of intimacy and sexuality, address methods of resident self-protection from the foreseeable adverse consequences of their sexual activity.

A.05 Provide adequate supervision for residents who require protection from harm, for example, residents who have diminished cognitive capability or who have physical limitations that require special accommodation as a prerequisite to intimate sexual activity.

A.06 Remind staff to expect and report the intimate and sexual activities they observe. Honestly confront deficiencies in policies, practices, or staff training; and use the investigation process as an opportunity for critical self-examination. Institute appropriate preventive and corrective action.

A.07 As prevention is always better than cure, inform the medical director when the facility confronts issues relating to a resident's intimate relationships or sexual activities. Talk with regulators about how they view such issues. Inform the facility's attorney about such issues. Involve families and guardians earlier rather than later. It is far better to engage in these discussions before they become an untoward situation or an incident in which someone has been harmed.

*Adapted from Clarence J. Sundram's "Sexuality and Mental Retardation: Unmet challenges," *Mental Retardation* 32(4): 255 (August 1994); and from Clarence J. Sundram and Paul F. Stavos, "Sexual Behavior and Mental Retardation," *Mental and Physical Disability Law Reporter* 17(4): 448-457 (July-August 1993).*

## APPENDIX B: Sample Facility Policy

(actual policies will vary from facility to facility based on factors such as level of care)

(NAME OF FACILITY and DATE)

### POLICY MEMORANDUM

Intimate Relationships of and Sexual Activities by Residents

#### PURPOSE

To affirm the facility's support for the intimate relationships of and sexual activities by its residents

#### POLICIES

- I. The facility supports and places no unreasonable conditions on the intimate relationships of its residents.
- II. The facility supports and places no unreasonable conditions on the sexual activities of its residents.
- III. The facility provides both anticipatory and situational supports for the intimate relationships and sexual activities of its residents.
- IV. The facility provides appropriate risk-related health information relating to its residents' intimate relationships and sexual activities to residents and their healthcare surrogates.
- V. The facility provides staff training and education regarding this policy, the procedures and the role of staff in relationship to this policy, and related procedures.
- VI. Notwithstanding its policy of providing support for its residents' sexual activities, some resident sexual activities may be so problematic that they cannot be supported.
- VII. Upon admission, the facility informs the resident's primary contact person of policies I and II.
- VIII. Upon admission, the facility seeks information from the resident's primary contact person that may be helpful in anticipating and supporting the resident's intimate relationships and sexual activities.
- IX. The facility informs the primary contact person of observed sexual contact involving the resident.
- X. The facility's care-plan process includes review of the intimate relationships and sexual activities of residents.
- XI. The facility's policies concerning abuse, including sexual abuse, are contained in separate policy memoranda.
- XII. The facility will assess whether observed intimate relationships or sexual activities are abuse. Each such assessment will be documented.

DEFINITIONS (omitted)

PROCEDURES (omitted)

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