Royal College of Nursing

Older People in Care Homes: Sex, Sexuality and Intimate Relationships

An RCN discussion and guidance document for the nursing workforce

CLINICAL PROFESSIONAL RESOURCE

Second edition

Royal College of Nursing

Acknowledgements

The RCN would like to thank the following for their contribution to this new edition.

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The authors would like to thank Dr Amanda Thompsell for her advice on sexual expression in people living with dementia, The Order of St John for advice on care homes policy and Dr Isabel White for her advice on psychosexual issues and psychosexual support.

This publication is due for review in October 2021. To provide feedback on its contents or on your experience of using the publication, please email **publications.feedback@rcn.org.uk**

Publication

This is an RCN practice guidance. Practice guidance are evidence-based consensus documents, used to guide decisions about appropriate care of an individual, family or population in a specific context.

Description

This guidance has been developed to help nurses and care staff work effectively with issues of sexuality, intimate relationships, sexual expression and sex, particularly for older people living in care homes.

Publication date: October 2018 Review date: October 2021

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Evaluation

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Published by the Royal College of Nursing, 20 Cavendish Square, London, W1G 0RN

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Summary

Sexuality, in all its dimensions, remains an element of who we are as individuals throughout our lives.

Fundamentally, people who move to live in a care home should be able to have the same rights, choices and responsibilities they enjoyed at home provided that these do not impinge upon the rights of others in the home.

Care home service providers should strive to:

- develop policies which support the rights of all the people who live, visit or work in care homes
- offer environments which facilitate individual rights and choices in sexuality expression and intimate relationships
- offer support and appropriate education for staff in dealing with issues of sexuality, intimate relationships and sex.

Care systems and care delivery should:

- be person-centred
- focus on the perspectives of individuals within the context of their unique lives and experiences
- be open to learning about the person's significant experiences and relationships
- promote and support human rights, dignity, privacy, choice and control
- promote clear boundaries which protect and support residents and staff.

All decisions will depend on the individuals involved and individual circumstances, and a comprehensive assessment of individuals and individual circumstances, including risk, must be undertaken. The views of all key people should be acknowledged when appropriate; decisions should not be made in isolation but with the support of teams caring for individuals. Key decisions and actions should be 'above board' and documented in care plans but confidentiality must be maintained at all times.

Care home staff should strive to achieve a balance between an individual's right to privacy and control with the need for care and observation, for example, residents remaining in bedrooms undisturbed or with locked doors and staff waiting to be invited before entering.

Staff should strive to incorporate consideration of relationships and sex alongside other aspects of care; for example, sexual health advice, assistance with hygiene around sexual activity, and infection control to protect residents and staff from infections, including HIV.

In circumstances where an individual is unable to make choices, staff must adhere to legal and professional guidance, for example mental capacity legislation and UK Nursing and Midwifery Council (NMC) guidance, to ensure they act in the person's best interests (see Appendix 2). Specialist advice should be sought when appropriate, for example, for legal clarification, for psychosexual or relationship problems, on issues concerning mental or sexual health and for safeguarding concerns.

Staff must be able to justify any decisions they make, demonstrating that they are working on best evidence through best practice to promote the health and wellbeing of those in their care, their partners, families and carers.

1. Introduction

This guidance has been developed to help nurses and care staff work effectively with issues of sexuality, intimate relationships, sexual expression and sex, particularly for older people living in care homes.

Its goals are to facilitate learning, support best practice and serve as a resource to help nurses and care staff address the needs of older service users in a professional, sensitive, legal and practical way.

Alongside raising awareness of issues which can impact on the sexuality, intimate relationships and sexual activity of older care home residents, the document contains:

- legal and professional frameworks within which nursing and caring practice takes place
- considerations for policies that address sexuality and sexual health needs in care homes
- guidance on principles of good practice, including care environments, organisational systems and care practices
- ideas on how to identify barriers to expression of sexuality and work towards removing these in practice
- suggestions on how to broach issues concerning sexuality, intimate relationships and sex
- guidance on dealing with situations where sexuality expression is seen as a concern
- suggestions on how staff can develop their own confidence and competence in dealing with sexuality issues
- case examples, which can be used to highlight issues for discussion
- additional resources to support practice.

2. Sexuality, intimate relationships and sex in later life

Sexuality remains a fundamental aspect of being human throughout life. It encompasses gender identities and roles, sexual orientation, intimacy, sexual expression and sexual acts. Sexuality influences identity, self-image, self-concept and self-worth. It also affects mental health, physical health, social relationships and quality of life.

Sense of self and identity are also 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 help individuals to feel valued, wanted, desired and enjoyed. Sexual relationships and pleasure from sex do not necessarily diminish in later life, particularly in established couples. As international evidence is now highlighting, many people continue to enjoy sexual relationships to the end of their lives.

When older individuals become ill or disabled and consequently are unable to meet their own needs independently and privately, enjoying their rights to freedom of sexual expression and intimacy becomes more difficult. If they move to live in a care home the situation becomes more complex as not only are residents generally more dependent on staff to help them meet their needs, but care homes are communal environments where the rights of others in the home need to be considered. Dealing with sexual self-expression, intimacy and sexual relationships can pose difficulties for residents, partners, families and staff. However, the fundamental rights of individuals to autonomy, choice and consent are established in law and underpinned by human rights legislation. In addition, individuals have the right to remain free from discrimination.

2.1 Positive, normal and natural

A recent survey of a nationally representative sample of people aged 50-90+ (Lee and Tetley, 2017) found that men and women remain sexually active and sexually intimate into their 70s, 80s and 90s. While age-related changes are complex and sexual activity changes over time, partnerships can remain satisfying, caring and rewarding. This research highlights that sexual health in later life confers benefits on general health and quality of life.

It is important to recognise the diversity in older populations in terms of age, experiences, expectations, priorities, preferences and desires. Older people, like those in younger age groups, are diverse in their desire for sexual intimacy.

We do recognise that, as people age, there are changes both as part of normal ageing and pathological changes that can impact on sexual functioning. A key message is that older people can find other activities, as well as sexual intercourse, rewarding and life affirming. Such activities include:

- being close – both physically and mentally
- cuddling
- kissing
- music and dancing
- being naked
- sharing a bed
- sexual intercourse
- using sexual adjuncts.

Being close involves sharing time, smiles and friendly words, being totally available for each other and having control and choice over the engagement in these activities whether in existing or new relationships. The notion of being together, of spending intimate pleasant time, can contribute to improved mental health, decreased levels of stress and decreased feelings of loneliness. For some people older age is an opportunity for new and fundamentally different foundations for intimate relationships. Some enjoy progressing their sexual activity, some may wish to try new things and sometimes with different people. With less time pressures than in the earlier times of their lives, some older people report that sexual activity can be more leisurely, lasting over an entire afternoon or an entire day.

Cuddling is important as either a precursor to, or a proxy for, the release of oxytocin – the 'love hormone', which can modulate pain and anxiety and increase our feelings of connection to others.

Kissing is perhaps the most obvious and expected act of sexual intimacy; as humans we recognise the lips as being the most exposed erogenous zone. Kissing has many forms and many meanings. It can be a quick 'peck' – a playful exchange where both people keep their lips closed. It can also be a more meaningful behaviour that facilitates the human needs of romantic love (attraction), sex drive (lust) and a sense of calmness and security (attachment).

Music and dancing can be a means of foreplay, affording a longer period of stimulation prior to sexual intimacy. These activities are widely believed to reduce stress and to enhance motivation, pleasure and arousal. They are also believed to strengthen social affiliation and immunity. These processes parallel many of the known neurochemical systems including dopamine, opioids, cortisol, serotonin and oxytocin.

Sharing a bed is widely regarded as an act of intimacy and remains extremely important to many older people as confirmation that they 'come home' to each other and to provide a safe opportunity to engage in sexual intimacy.

The use of sexual adjuncts is not uncommon. As well as a strong desire to maintain sexual intimacy, older people speak of the wish to maintain their usual sexual practices which might include cross dressing, sadomasochism, etc. Many older people report that they enjoy trying new positions and incorporating sex toys into their sex life.

One of the most commonly used adjuncts to sexual intimacy is the use of phosphodiesterase-5 enzyme inhibitors for men experiencing erectile dysfunction. Guidance on the prescribing of these medicines is available from the National Institute of Health and Care Excellence (NICE, 2014).

An additional, and sometimes essential, adjunct to sexual intimacy in later life is the use of sexual lubricants. It has also been suggested that the use of sexual lubricants, along with more frequent sexual intercourse, can be helpful in promoting vaginal lubrication.

Talking about sexual intimacy can be extremely helpful to older people and surveys highlight that they welcome opportunities to talk to health care practitioners about this important aspect of their lives, particularly when they are experiencing sexual difficulties. This creates a pressing need for clinicians to engage in this subject. Health care staff need to be informed about physical, psychological and social interventions which would benefit older people and, most importantly, to be prepared, both professionally and personally, to raise issues related to sexual intimacy.

2.2 Changes in later life

As individual relationships change over time, the notion of what constitutes sex and the nature of sexual practice can change, with increasing emphasis on psychological contentment, celebrating love and companionship. Sexual activity enhances connection to partners, closeness and intimacy. Older people can be reluctant to discuss sexual concerns due to embarrassment or beliefs that sexual problems are an aspect of normal ageing.

When sexual activity ceases in later life this is often as a consequence of health problems such as rheumatoid arthritis, Parkinson's disease, diabetes, hypertension, cardiac disease, depression or the death of a partner. Some medications, particularly those used for hypertension and other cardiovascular disease, are also known to interfere with sexual functioning and performance.

Experiencing barriers to being sexually active can lead older people to place less importance on sex and this can be particularly apparent when health problems and widowhood are experienced.

Dementia impacts on all aspects of a person's life including sexual activity. In some individuals it increases apathy thereby reducing sexual expression. In others dementia increases disinhibition. It is useful to remember however that, in most people there is a reserve of a continued need for intimacy and interest in sexual satisfaction.

Incontinence can profoundly influence sexual intimacy but research into this is scarce. Faecal incontinence has been found to exert a

greater effect on sexual intimacy than urinary incontinence and some couples report sleeping in separate bedrooms, although they do not necessarily attribute this to incontinence. In some couples incontinence does not affect sexual intimacy but does affect sexual intercourse.

Ultimately, it is important to remember that, although some age-related and pathological physical changes that occur in later life may affect sexual functioning so that usual patterns of sexual activity cannot be maintained, this in no way prevents older individuals and couples enjoying sexual activity, sexual intimacy or coitus. Older people can be supported to understand that it is not always realistic to expect or try to force the same sexual responses they enjoyed in their youth. Conversely they should be encouraged to reject the common myths suggesting that decreased physical intimacy is an inevitable consequence of older age. A comprehensive review of sexual expression in later life highlights that, while normal ageing does cause physical changes, these do not necessarily result in a decline in sexual functioning (DeLamater, 2012).

Maintaining good physical health and a positive attitude to life are key to remaining sexually active in older age.

2.3 Living in a care home

Moving from a private dwelling to live in a care home, older people can experience additional barriers to sexual expression, including:

- attitudes, myths and stereotypes surrounding sexuality and ageing
- loss of a partner and limited opportunities to form new relationships
- ill health or disability, general tiredness, weakness or malaise leading to reduced energy available for self-care or social activities
- common health problems – such as constipation, bladder weakness or chronic pain which can affect every day functioning and intimate relationships
- loss of independence, reliance on others for help leading to lack of privacy in everyday surroundings
- the personal impact of moving into a care home, leaving one's home and the security of familiar surroundings and treasured possessions
- concern for how much time or care residents can reasonably expect from the staff.

Balancing the needs, desires, rights and choices of a number of residents in a care home is never straightforward for staff. Balancing the need of residents to be sexually active while simultaneously protecting residents from situations they would rather not experience, can raise dilemmas for staff. These are discussed further in Section 6 on page 28.

2.4 People currently living in care homes

The people currently living in UK care homes are highly diverse in terms of age, social background, culture and ethnicity, sexual identity, abilities/ disabilities, lifestyle choices and care needs. Sexuality, sexual need and sexual expression intersect with all of these elements.

The age of UK care home residents ranges from younger people, who commonly live with multiple disabilities and have complex care needs, to people well past their 100th birthday, also commonly with their own individual multiple complex needs. Each of these generations and cohorts will be influenced by their own experiences and also the sexual mores (the moral codes of acceptable sexual behaviour) prevalent in their formative years. It is important for staff to understand that the moral values of diverse generations and cohorts will likely be different.

Not everyone living, visiting or working in a care home is heterosexual. Surveys have estimated that around 5-10% of the population might be lesbian, gay or bisexual which, in a 120-bed care home, would equate to six to twelve residents. However, surveys highlight that all these figures are likely to be underestimated as many individuals choose not to disclose their sexual identity in surveys. This is particularly relevant for older people who lived through times when discrimination against same sex relationships was the norm and men having sex with men was illegal, as famous cases testify. The devastating effect of the persecution these people suffered,

solely because they loved someone of the same gender, should never be underestimated.

Valuing individuality and diversity in all aspects of sexuality care is paramount. Some individuals identify as neither male nor female – or non-binary. For some, the gender of their physical body is not in alignment with who they are as a sexual being. They may choose to dress or adorn their bodies in ways usually associated with a different gender or they may choose to change their physical gender to align with their sexual identity – to transition. Some individuals may be in a sexual partnership with someone of the same gender but not wish to identify with lesbian, gay, bisexual or transgender (LGBT) communities. All permutations celebrate the diversity of human life and all individuals have much to teach those who wish to care.

While currently the ethnic diversity in UK care homes does not mirror the broader population, people of black, Asian and minority ethnic origin (BAME) are living longer and the number in older age is set to increase markedly (British Medical Association, 2016). These individuals will have much to teach staff about their social, cultural and religious mores around sexual expression and relationships.

New generations of people are entering older age and, whereas previous generations may have grown up in eras when little information was available, this was not the case for the so-called 'baby boomer' generations. Sexually transmissible infections, including human immunodeficiency virus (HIV), are steadily increasing in the over 50 age groups.

3. Why is sexuality an issue?

Care homes are communities where people live, work or visit. Although residents should be able to enjoy privacy, choice and fulfilment in all aspects of their lives, the realities of facilitating this are not always straightforward. Addressing issues related to intimate relationships, sexuality and sex can be particularly complex, as nurses working with older people have told the RCN (including during an RCN-hosted Twitter chat in February 2017). A major issue raised in the RCN Twitter chat was mental capacity in care home residents and the dilemmas raised by trying to support individual rights while protecting the rights of others.

3.1 Barriers to sexuality expression

In our everyday lives, whatever our age or circumstances, we are surrounded by images and stereotypes of how we should look or behave, and these influence our views.

Some stereotypes suggest that nurses are either stern matrons or sexy young people. Other stereotypes suggest that certain groups of people in society, particularly those who are older or have health problems or disabilities, are not interested in relationships or sex. Older people expressing an interest in sex or intimate relationships can be subjected to particularly derogatory labels such as 'dirty old man' or 'mutton dressed as lamb'.

Nursing and care staff can feel embarrassed or ill-equipped to address issues of sexuality in their day to day practice as a consequence of:

- a lack of relevant experience
- inadequate training or education in sexuality or sexual health
- personal or religious beliefs about sexuality, including when people should or should not be sexually active, on homosexuality or on the appropriateness of various types of relationships, for example an older person with a younger person or between people from different backgrounds
- the culture of the home or care environment, its care regimes, or the style of management may not regard sexuality issues as either important or appropriate to address in care
- embarrassment or lack of confidence that prevent staff raising the issue, for example alerting a resident to the fact that some blood pressure medicines affect libido and sexual performance
- fear they might offend an older person.

Not uncommonly, nursing staff find ways to minimise their embarrassment and discomfort by avoiding situations, not incorporating sexuality-related aspects into their care, or by focusing on the aspects they find more comfortable to deal with, such as physical care, treatments or social activities.

It is vital to acknowledge these barriers so that these can be addressed. Exploring feelings and difficulties within supportive colleague relationships can be helpful in developing an effective team approach.

3.2 Your confidence when dealing with sexuality

How confident and equipped do you feel when it comes to dealing with issues of sexuality, intimate relationships and sex? It can be helpful to assess the knowledge, skills and experiences that you bring to your practice, but competency also encompasses your attitudes, values and personal beliefs. Open and honest discussion with trusted colleagues or supervisors can help identify aspects of your practice that are effective and those that would benefit from development.

Nursing staff vary in their knowledge, skills and experiences but all have a duty to work to their level of competence.

A useful tool to address sexuality and sexual health is the Ex-PLISSIT Model (Taylor and Davis, 2006). This can also be used to identify the contribution of nursing staff, dependent on their specific role and level of expertise, to supporting older people's wishes in terms of sexuality, intimate relationships, sex and sexual health.

Using the Ex-PLISSIT model, permission-giving is a core feature of all of the stages. All interventions should begin with permission-giving and interventions in terms of limited information, specific suggestions and intensive therapy are underpinned by permission-giving.

Figure 3: The Ex-PLISSIT model (Taylor and Davis, 2006) extended from The P-LI-SS-IT Model (Annon, 1976).

Level I – Permission

The environment, organisational cultures, care practices and staff attitudes communicate that sexuality, intimate relationships and sex are integral to life and care in the home: in other words, 'permission' for these issues to be acknowledged is implicit.

Level II – Limited information

General information is readily available to residents, families and staff. This could be in the form of information leaflets on sexuality-related topics or information signposting to organisations who could assist residents. Nurses are able, with residents' permission, to offer general information and to refer to specialist advice or services when appropriate.

Level III – Specific suggestions

Nurses offer residents opportunities to explore their specific issues or concerns within a therapeutic relationship. Nurses ensure that residents are aware of information, advice or specialist help available to them, their partners and significant others as appropriate.

Level IV – Intensive therapy

Professionals with specialist qualifications and usually working within specialist teams (such as psychosexual counsellors or specialists in erectile dysfunction) offer intensive therapy over time. Care home nurses make referrals, support residents and partners and monitor health and wellbeing on an ongoing basis.

I Permission

All registered nurses should feel confident about creating a climate of permission but this will involve an honest examination of personal beliefs, attitudes and values; for example, in relation to sexual issues in general, intimate relationships and sexual activity for older people, sexual relationships outside marriage or same sex relationships.

Creating a climate of permission could also challenge practices which have become normalised; for example, in supporting residents who want to be naked, to spend time in their rooms undisturbed or lock their bedroom doors.

II Limited information

Offering limited information encompasses acknowledgement of sexuality issues and offering general guidance. It requires a fundamental understanding of the impact of ageing, chronic illness and disability on individuals and in particular the residents within the specific care home (for example, people who are older, or have dementia, multiple chronic illnesses or a learning disability).

Working at this level also requires knowing what sources of help are available. When a specific issue arises – such as the effects of a disease or medicine on sexual wellbeing – the nurse can obtain information for the resident or family (for example, from the Alzheimer's Society or other associations, or from the internet).

Nursing staff should also know where to seek advice or help with specific issues and, either individually or through managers, be able to access specialist help and health care services when appropriate.

III Specific suggestions

This level of working encompasses working with the client group and having a general understanding of the impact of illness or disability on their daily lives, but also a specific knowledge of sexual wellbeing, sexual health and

sexual functioning. Establishing a therapeutic relationship with clients is fundamental to working in this way.

Specialist nurses and advanced practitioners can offer suggestions on specific issues such as techniques to optimise sexual activity for people who have chronic pain, severe breathlessness or an indwelling catheter.

Ideally, nurses should be able to access advice from relevant specialists in Parkinson's disease, dementia or continence, for example.

IV Intensive therapy

If adequate psychosexual support is offered few individuals or couples need intensive therapy. However, if this should be required nurses have a key role to play in referral.

Intensive therapy is offered by professionals or teams with specialist training over a period of time. This specialist help can be accessed through a range of sources, including general practitioners, social services, clinical psychology or psychiatry services, genitourinary medicine departments and psychosexual clinics.

3.3 Broaching issues of sexuality

Discussing personal or intimate topics requires skill and sensitivity and these are essential aspects of being a nurse. Asking highly personal and potentially intrusive questions in skilled and sensitive ways are fundamental in nursing. Nurses ask the details of people's bowel habits without embarrassment but asking about sex is more difficult for some staff. A starting point is for staff to explore their own understanding of sex and intimacy in later life, to seek to learn more and, if helpful, to discuss this with colleagues. It helps if staff appreciate that for many older people intimacy is positive, joyful and life-affirming. From this basis, staff can develop their understanding of what is likely to be acceptable to a resident or family and what might be their priorities.

Nurses can help reduce the discomfort felt by older people in discussions about sexual concerns by adopting a professional demeanour, showing comfort with the topic, being kind, understanding and empathic. 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 really important to him or her.

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. Routes into discussing sexual issues could be through exploring, for example:

- the direct impact of illness or its treatment on expression of sexuality or on intimate relationships
- 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.

4. Principles of good practice

All health and social care practice must work within the law and all relevant professional guidance and standards. In many aspects, the law is explicit concerning sexual behaviour. However, legislation and government guidance do not generally address the issue of intimate relationships other than in relation to the criminal law.

Legislation: Human rights and sexual rights

The Human Rights Act 1998 [HRA] incorporates into our 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. Further, 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 your other rights under the Convention.

The right to respect for privacy and family life, guaranteed under Article 8, is particularly relevant in care homes, and recognises both the fundamental ethical and legal principle in health care of human autonomy – that is, the right of the individual to make decisions and choices about his or her life without undue interference by others – and the right to respect for personal relationships. Sometimes, these two aspects of Article 8 can be in tension with each other. It should be noted that Article 8 does not confer an absolute right. In other words, it may be overridden in certain circumstances by the need to protect the rights and interests of others, and for the protection of morals, provided that to do so is necessary, proportionate, and in accordance with the law.

4.1 General principles

The law does not offer explicit guidance on achieving a balance between promoting individual rights and protecting people at risk. 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 the duty to respect the confidentiality of all patient information. It also encompasses issues of consent, for example within the mental capacity legislation in England, Northern Ireland, Scotland and Wales.

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

The Human Rights Act 1998 [HRA] 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.

Within this context, the World Health Organization (WHO, 2010) published a list of sexual rights, stating 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 health care 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.

An adult resident of a care home, within 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 the civil law) to do so and there is no breach of the criminal law (for example because of exploitation or an absence of consent), 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. Even if there were difficulties caused for other residents, the proportionate response might be to fix those problems by changing arrangements within the care home, rather than preventing residents from engaging in sexual relations. 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 the mental capacity legislation, and any relevant clinical and professional guidance. Where there is an appointed advocate, it may be appropriate for them to be consulted on the issue of capacity, although it must be remembered that if a resident lacks capacity to consent to sexual relations, consent cannot be given on the resident's behalf by way of a best interests decision.

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 not generally 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. If a resident has been judged to lack mental capacity, it does not follow automatically that it is appropriate to give information to other people, including family members, particularly if the resident has asked for information to be kept private.

Care home providers and managers also have a responsibility to ensure that all staff receive adequate and appropriate training. Supervision and guidance should be available when those 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 people are protected from unwanted or inappropriate intimate contact with others. Where intimate contact becomes an issue, the service provider must make an appropriate risk assessment. This may involve discussing the situation with other parties – which could include a representative or advocate of the resident, health or social services professional/s, or, in relevant circumstances, a relative. Details of relevant legislation and professional guidance can be found in the boxes within this section and a selection of case examples can be found in Section 6 from page 28 onwards.

Anti-discrimination legislation

The Equality Act 2010 protects people from discrimination in the workplace and in wider society. It is unlawful for providers of goods, services and facilities to the public to discriminate on the following grounds:

- race, colour, nationality, ethnic or national origin
- sex (gender) or marital status
- gender reassignment
- disability
- religion or belief
- sexual orientation
- age (currently only outlawed in employment).

Discrimination means that you: refuse to provide a service; provide a lower standard of service; or offer your service on different terms and conditions than you would to others not of the resident's disability or sexual orientation. In other words, it is only unlawful if the resident can show that another service user, without the same disability or of a different sexual orientation to the resident, was or would have been treated differently. Each case must be considered on its own facts. In practice, in the absence of discrimination by the service provider among different residents, it is likely to be difficult for a resident to successfully invoke this legislation.

Although discrimination on the above grounds is generally unlawful, some providers insist that residents satisfy certain criteria to be eligible to live at the care home. For example, some charitable services are run for people of a particular religion, such as Jewish Homes. In certain limited circumstances the legislation permits service providers (such as charities or religious organisations) to limit those services to particular groups. Other services are founded within specific sets of values and would not want to support people who do not live according to their beliefs, for example organisations which do not support alternative sexualities or same-sex relationships (Panich et al., 2004). Where individual lifestyles conflict with organisational values it can be difficult for sexual issues to be addressed.

4.2 Policies

Care home service providers should develop policies which support the rights of all the people who live, visit or work in the care home, and these policies should be developed in consultation with key stakeholders. Each person's background, culture and/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 individuality have, in the best ways possible, been recognised and respected.

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.'

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 health care services.

Policies should acknowledge and promote a resident's right to privacy, confidentiality, consent and support to live their lives as they choose so 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 in a long-term relationship should be able to share a room/rooms 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, provided this does not compromise the care of residents in any way. Staff should receive adequate education in all aspects of their work with residents.

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 within their comfort zones.

All policies should be reviewed on a regular basis with residents, families and staff. In the case of conflict, legislation will always override local policy statements.

4.3 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.

There should ideally be:

- totally private space where people can be naked if they wish, 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/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/educational material 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.

Information materials should be available in languages appropriate for residents and in accessible forms for people who have sight, hearing impairment or learning difficulties.

Criminal law

The Sexual Offences Act 2003 contains a number of offences that may be committed against a person with a mental disorder.

- Sexual activity with a person with a mental disorder impeding choice (ie, a person who is unable to refuse consent or to communicate that refusal for a reason related to a mental disorder).
- Causing or inciting a person, with a mental disorder impeding choice, to engage in sexual activity.
- Engaging in sexual activity in the presence of a person with a mental disorder impeding choice.
- Causing a person, with a mental disorder impeding choice, to watch a sexual act.
- Inducement, threat or deception to procure sexual activity with a person with a mental disorder.
- Causing a person with a mental disorder to engage in or agree to engage in sexual activity by inducement, threat or deception.
- Engaging in sexual activity in the presence, procured by inducement, threat or deception, of a person with a mental disorder.
- Causing a person with a mental disorder to watch a sexual act by inducement, threat or deception.

Criminal offences may also be committed if care home staff arrange for sex workers to visit a care home resident, or carry out sexual acts at a resident's request.

Section 76 of the Serious Crime Act 2015 introduced the new offence of controlling or coercive behaviour in intimate or familial relationships. The offence is constituted by behaviour on the part of the perpetrator which takes place "repeatedly or continuously". The victim and alleged perpetrator must be "personally connected" at the time the behaviour takes place. The behaviour must have had a "serious effect" on the victim, meaning that it has caused the victim to fear violence will be used against them on "at least two occasions", or it has had a "substantial adverse effect on the victims' day to day activities". The alleged perpetrator must have known that their behaviour would have a serious effect on the victim, or the behaviour must have been such that he or she "ought to have known" it would have that effect.

Mental capacity law

Where an adult lacks the mental capacity to make decisions on his/her own behalf, generally speaking, those caring for the person will need to make decisions for the person in their best interests. The Mental Capacity Act 2005 (MCA) and its Code of Practice contain detailed guidance about how to assess capacity and how to make best interests decisions. Importantly, where a person lacks capacity to consent to sexual relations, the inevitable consequence is that any sexual relations will constitute assault. It is not possible to say that even though a person lacks capacity to consent to sexual relations, it is nevertheless in the person's best interests to have sexual relations: sexual relations in the absence of capacity to consent is sexual assault.

In **England and Wales**, the assessment of capacity is governed by the Mental Capacity Act 2005, which requires capacity to be assessed in relation to particular decisions at particular times. The Mental Capacity Act 2005 identifies five fundamental principles that apply to all actions and decisions taken under the Act:

1. a presumption of capacity – every adult has the right to make his or her own decisions and must be assumed to have capacity to do so unless it is proved otherwise
2. the right of individuals to be supported to make their own decisions – people must be given all appropriate help before anyone concludes that they cannot make their own decisions
3. individuals must retain the right to make what might be seen as eccentric or unwise decisions
4. best interests – anything done for or on behalf of people without capacity must be in their best interests
5. less restrictive alternative: before the act is done, or the decision is made, regard must be had to whether the purpose for which it is needed can be as effectively achieved in a way that is less restrictive of the person's rights and freedom of action. However, the final decision must always allow the original purpose of the decision or act to be achieved.

The same principles apply to the assessment of capacity throughout the UK: the test is whether the person has a mental impairment or disorder which prevents the person from understanding, retaining, using, weighing or communicating a decision about the matter in question.

In the context of sexual relations, the Court of Appeal (England and Wales) has confirmed that to have capacity to consent to sexual relations, a person needs to understand the mechanics of the act, and the possible consequences of having sexual intercourse, including sexually transmitted infections and pregnancy. The person also needs to understand that he or she has a choice and can refuse consent. The ability to use and weigh information will not usually be a major consideration, as sexual relations are an area of decision making where decisions are taken in a formal manner, identifying risks and benefits and analysing them to reach a decision. The Court of Appeal has said that it is not necessary to factor in the risks posed by a particular sexual partner – capacity to consent to sexual relations should be assessed in general terms, not by reference to the particular relationship. So, a person may lack capacity to make decisions about whether to have contact with another person due to the risks that person poses, but retain capacity to make decisions about sexual relations (including with that other person).

In **Scotland** the MCA does not apply, but a similar test for incapacity applies, based on the common law. It is likely that Scottish courts would take a broadly similar approach to the courts in England and Wales when considering the test for capacity to consent to sexual relations. The Adults with Incapacity Act (Scotland) 2002 does not include any express provisions about sexual relations.

The equivalent in Scotland of the Sexual Offences Act 2003 is the Sexual Offences Act 2009, which explains that a person with a mental illness, personality disorder or learning disability is incapable of consenting by reason

of mental disorder if they are unable to do one or more of the following:

- understand what the conduct is
- form a decision as to whether to engage in the conduct (or as to whether the conduct should take place), or
- communicate any such decision.

In **Northern Ireland**, the Mental Capacity Act (Northern Ireland) 2016 has a very similar test for mental capacity to that in the MCA 2005, and also provides that best interests decisions about consenting to sexual relations cannot be made on behalf of someone who lacks capacity to make their own decision. At present the legislation is not yet in force, but the common law approach is likely to mirror the new legislation in this area.

The Sexual Offences (Northern Ireland) Order 2008 defines consent in terms of having capacity and the freedom of choice to make a decision. It also includes similar provisions to the Sexual Offences Act 2003 concerning having sexual activity with a person who has a mental disorder impeding choice, inducing a person with a mental disorder to engage in sexual activity, and the causing or inciting of sexual activity by a care worker.

4.4 Organisational systems and care practices

Organisational systems that do not take residents' sexuality or intimate relationships seriously will not acknowledge their real needs and can cause deep unhappiness. 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/her children to become aware of the desire for an intimate relationship. Well-designed documentation can also assist the preservation of confidentiality, and this 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 sharing information with named family members or friends, who should be informed in problem situations and legal provision the resident wishes to make, for example a Lasting Power of Attorney. Even if the resident does not wish to make legally binding arrangements, it may be helpful for them to write down their wishes and values to inform best interests decisions in the future.

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 individuality and uniqueness
- view individual residents within 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?

Medicines – both prescribed and those bought over-the-counter – can affect sexuality expression and sexual functioning, and the impact on all aspects of life should be considered before medicines are prescribed. Medicines should never be used to control sexual expression with the exception of crisis situations where there is threat to people's safety and when all possible supportive interventions, including multi-professional and specialist advice, have been tried and failed.

Professional issues

Sexuality and sexual health are important elements of patient care and employers should ensure that nurses are competent to deal with this. The policies should look at how to equip nurses with the relevant skills, knowledge, structures and procedures. All health care employers should have sexuality and sexual health guidelines in place and a policy to guide best practice. Both should include a requirement to complete ongoing training and systems for supervision in practice.

The NMC Code Professional Standards of Practice and Behaviour for nurses and midwives (2015) requires each nurse to act at all times in such a manner as to justify public trust and confidence. Nurses are personally accountable for their practice and, in the exercise of professional accountability must make the care of people their first concern, treating them as individuals and respecting their dignity. They must also work with others to protect and promote the health and wellbeing of patients in their care, their families and carers, and the wider community.

Registrants are responsible for ensuring that they safeguard the interests of their patients/clients at all times. The only appropriate professional relationship between a client and a registrant is one which focuses exclusively upon the needs of the client. Registrants should be aware of the potential imbalance of power in the relationship. This is generated by the client's need for care, assistance, guidance and support. It is the responsibility of the registrant to maintain appropriate professional boundaries within the relationship at all times.

Registrants must act as an advocate for those in their care, helping them to access relevant health and social care, information and support. In addition to the Code, the NMC has published advice sheets which provide information on the standard of professional conduct required of nurses in the exercise of their professional accountability.

Safeguarding adults

The fundamental principles underpinning all adult safeguarding work hold true around the UK. Set out in the Care Act 2014 Statutory Guidance (Chapters 13 and 14), these are:

Empowerment:	People being supported and encouraged to make their own decisions and informed consent.
Prevention:	It is better to take action before harm occurs.
Proportionality:	The least intrusive response appropriate to the risk presented.
Protection:	Support and representation for those in greatest need.
Partnership:	Local solutions through services working with their communities. Communities have a part to play in preventing, detecting and reporting neglect and abuse.

Accountability and transparency in delivering safeguarding.
www.gov.uk/government/publications/care-act-statutory-guidance/care-and-support-statutory-guidance#safeguarding-1

Safeguarding in Scotland: The Adult Support and Protection (Scotland) Act 2007:
www.actagainstharm.org/about-the-act

Safeguarding in Northern Ireland: **www.hscboard.hscni.net/niasp**

Safeguarding in Wales: **https://gov.wales/docs/phhs/publications/160404part7guidevol1en.pdfReferences**

5. When sexual activity is a concern

Situations arise in care homes where issues of sexuality, intimate relationships, sexual expression or sexual activity become a concern.

5.1 Methods for working through concerns

In terms of a resident's behaviour or actions, firstly, consider whether there is actually a situation of concern 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, then the situation can be monitored.

It is important for staff to reflect upon their own behaviours and interactions that may, albeit unintentionally, have contributed to a resident's behaviour; for example, if the way that staff have talked or joked has led a resident to believe that raising sexual issues or behaving in a sexualised way is acceptable.

It is important to record accurately what is happening, for example:

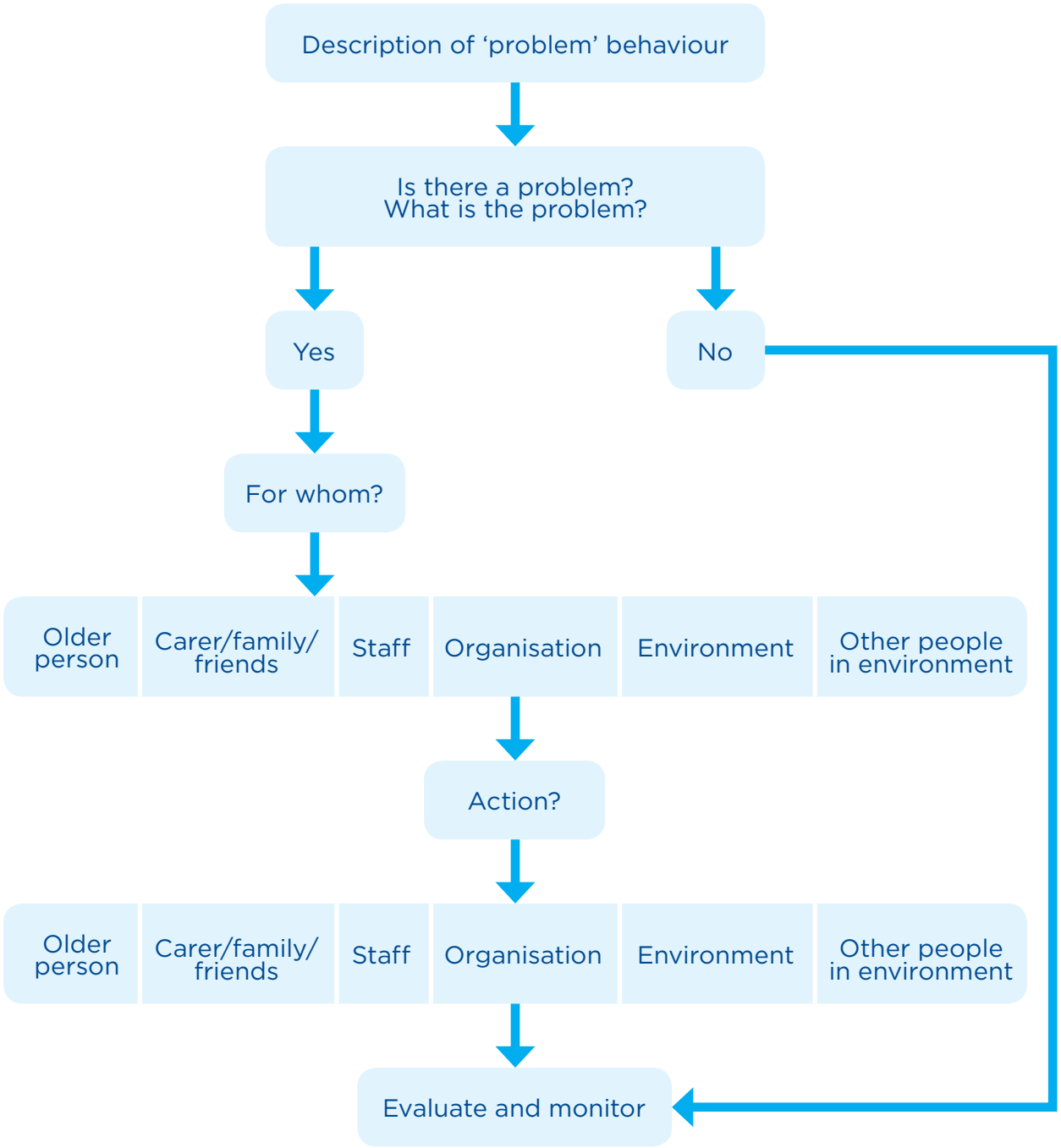
- when and where did the situation causing concern occur?
- what form did the behaviours take – what did the persons involved say or do?
- what else was happening?
- was there anything specific that seemed to prompt the behaviours?
- were other people involved?
- what were the responses?

If it is decided that there is a concern, for whom is this a problem? This will determine what action needs to be taken and where should this be focused; for example, 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 needs.

The framework below can help staff work through concerns in order to identify where the options for action and the solutions might lie (see Figure 5.1).

Figure 5.1 Framework for action when sexuality is seen as a problem (Archibald 1994).



Archibald C (1994) Sex: is it a problem? *Journal of Dementia Care*. 2, 4, 16-18

Situations become more complicated when they involve more than one individual or a couple.

5.2 Common situations of concern

In everyday care home life, staff skilfully manage situations where the adult individuals involved have the mental capacity to understand the actions they take and the potential consequences of these. The more problematic situations tend to involve individuals whose mental capacity in different situations is unclear or questionable, for example when the resident has a dementia.

The maxim "see the person not the dementia" is important in this context. Firstly, with a compassionate approach, trying to understand the person's motivations and what he/she is trying to communicate, for example are they feeling unwell, finding it difficult to express themselves or their needs, particularly when faced with a lack of understanding from those around them.

When sexual need is expressed through behaviours which primarily affect only the individual, for example masturbation or wanting to watch pornography privately, staff can generally arrange for these needs to be met. However, when sexual need infringes on the rights of others, staff need to be especially vigilant and seek to understand more about what might be motivating the resident's behaviours. Infringing the rights of others can start in seemingly innocent ways, such as making suggestive remarks, or touching staff or other residents in a sexual manner. These behaviours may be accompanied by jollity and dismissed as "only a bit of fun" but they are important to monitor and be open to investigating further.

It is also important for staff to be alert to, and even to explicitly seek, further information that could help to explain the motivations for the behaviours. For example, does the person have any history of domestic violence, sexual harassment or sexual abuse of others? This information could be vital not only in understanding the needs of the individual resident but also in protecting others in the vicinity from potential harassment, assault or abuse.

Framework 5.2 could be helpful in working through more complex situations.

Figure 5.2 A framework for assessment of concerns regarding sexual activity and intimacy for adults who are living in a residential setting (Phair, 2018)

Starting point: The presumption must be that both people are consenting adults

Step 1: The concern and who is concerned

- What is the sexual or intimate activity (the activity) that has caused someone concern?
- Who is concerned by the activity?
- What is it that concerns them about the activity?

Action:

- If the concerns expressed suggest a lack of understanding of the residents/ clients rights, wishes and desires as an adult; support the concerned person to understand and reflect on their opinions and perspective.
- Consider whether to ask the couple if they want to be supported in any practical, clinical or emotional way to enable their relationship to continue or be fulfilling.

If the concerns expressed relate to either person appearing to be unhappy or they are not able to refuse the activity move to step 2.

Step 2 (if above outcome does not apply)

- What verbal and non-verbal indicators were observed to suggest the person is unhappy with the activity?
- Are there any indicators that the behaviour may be grooming, coercive or controlling?
- Do either of the adults (residents/clients) who engaged in the activity have capacity to understand their desires and actions?

Action:

- Assess the capacity of either or both people.
- Consider their capacity to consent within the context of the law.
- Consider whether there is a need to safeguard either person who appeared unhappy, controlled, groomed or coerced.

Step 3: If both people are content but one person lacks capacity to consent to sexual intimacy

- Consider the nature of the intimacy and whether the person who lacks capacity can lawfully continue in the relationship. Remember that you cannot make a 'best interests' decision about consent to sexual relations if the person lacks capacity to make this decision for themselves – if a person is not able to give consent, then sexual relations with that person will be an assault.
- If both people are content with the relationship and there is no sexual intimacy consider who needs to know and how this may impact on partners or other family members. This includes the children of either person and whether they have the power to affect the adult's right to companionship or intimacy.
- Consider whether to ask the couple if they want to be supported in any practical, clinical or emotional way to enable their relationship to continue or be fulfilling.
- Consider how to record your actions and decisions and whether other members of the multidisciplinary team need to be informed.
- If sexual intimacy is occurring, staff should inform the partner who has capacity (sensitively) that the activity is unlawful.
- If the person with capacity continues sexual intimacy, a safeguarding alert should be raised, and action taken to protect the person who lacks capacity.

NB this applies to all couples if either lacks capacity to consent regardless of the marital, civil partnership or long-term basis of the relationship.

Step 4: If either person appear discontent, groomed or coerced

- Take immediate action to protect the affected person.
- Inform those who have a right to know of any adverse events relating to the people involved.

Establish exactly what the activity was and the impact this has had. Information can include:

- when and where the activity occurred
- what the activity was
- what the two people were doing before the incident occurred
- was there any grooming, coercive or controlling behaviour leading up the activity?
- was there anything that prompted the behaviour?
- how did both people react verbally and non-verbally?
- was there any misunderstanding by either person?

Step 5: Protection plan

By analysing the information gathered; not only report on what happened but consider how either person be engaged meaningfully at appropriate times in order to prevent or reduce the risk of further activity occurring and consider other interventions as appropriate.
Consider who needs to be informed and consulted, following local and national policy and guidance.

Phair L (2018) Based on original work by Archibald C (1994) Sex: is it a problem? *Journal of Dementia Care*. 2, 4, 16-18.

5.3 Sexual behaviour which becomes inappropriate

Occasions arise when residents behave in ways that staff deem to be inappropriate. Sexually inappropriate behaviour can be difficult to understand, detect and manage. It can encompass sexual harassment, sexual assault or sexual abuse (see definitions in Appendix 1). Sexual abuse can include rape, indecent assault and inappropriate touching. It may also include inappropriate sexual conversation, innuendo or joking. In some resident/resident or resident/carer relationships, the boundary between what could be considered appropriate adult to adult, respectful, positive, light-hearted chat and what is insensitive sexually inappropriate can be difficult to determine. Much will depend on the context, content, location, cultural norms and cultural background of the resident. Between residents, the consideration of appropriateness will include the ability of either party to have informed consent or demonstrate pleasure and enjoyment. Determining that a person is distressed or not consenting, if the person has communication and understanding difficulties will require skills observation and consideration of both profound and nuances verbal and non verbal communication. Staff should also consider if the person is "complying" simply because they have no ability to really understand what is happening to them or don't know how to remove themselves from the situation.

Sexual abuse, particularly grooming, and sexual assault, when committed by a resident who lacks capacity to understand their actions, can be labelled as "part of their dementia". However, it is important that staff do not excuse and rationalise behaviours that would be, in any other context, illegal.

Sexual assault includes unwanted touching, kissing, grabbing and rape. Simply because a person has dementia and does not understand their actions does not make the act legal.

As there is more public disclosure regarding non-consenting sexual activity, the depth and breadth of concerns is becoming better understood. Behaviour that was accepted as normal or inevitable in past generations, is now described as sexual assault and harassment, and the amount of disclosure and numbers of older men who are being prosecuted is increasing. Although no figures exist, if a care home population reflects society in other ways, such as sexual orientation, it must not be ignored that sexually inappropriate behaviour by some people with dementia may be due to activity in their past life.

Any sexual behaviour that involves a person with a mental disorder or impairment that affects their ability to make decisions must be seriously considered, as sexual activity with a person who lacks capacity to consent will be a criminal offence.

The assessment and response to the activity must be proportionate to the type of activity, and any interventions or support of the people involved must be undertaken using the principles of a rights based risk assessment model. The person's human rights, equality laws as well as mental capacity legislation. A useful guide for staff on positive risk taking is *Nothing Ventured Nothing Gained* (Department of Health, 2010).

The local safeguarding team should be informed and involved where there are concerns about incapacity or exploitation, both to safeguard and uphold people's rights and also to protect any adult at risk of harm.

If the residents have capacity, it must be their decision who sexual matters are discussed with, including whether they give permission for families to be informed.

6: Case examples

Addressing residents' sexuality and sexual health are appropriate and legitimate areas of nursing activity and nurses have a professional responsibility to address these. Of course this will not always be a priority for every resident and residents will sometimes choose not to share intimate issues with staff.

When care addresses sexuality, nurses must understand that there are professional issues at stake. Inappropriate or inadequate care has the potential to exploit and abuse people. Situations can be complex and involve fundamental principles of patient autonomy and consent, which are set out in legislation and underpinned by the Human Rights Act 1998.

The Nursing and Midwifery Council (NMC) Code (2015, p4) states that nurses must put the interests of people using or needing nursing services first. "You make their care and safety your main concern and make sure that their dignity is preserved and their needs are recognised, assessed and responded to. You make sure that those receiving care are treated with respect, that their rights are upheld and that any discriminatory attitudes and behaviours towards those receiving care are challenged".

In care homes, nurses must ensure that they always act in the interests of the resident and must be able to justify any decisions they make. Furthermore, such decisions should be made with the support of the entire care team in order to demonstrate the nurse has worked with others to protect and promote the health and wellbeing of those in their care, their families and carers. Nurses must also respect people's right to privacy and confidentiality. This includes making sure that they are informed about their care and that information about them is shared appropriately (NMC Code, 2015).

The following examples are offered as a basis for discussion and in all the following scenarios there would be a responsibility on the part of nursing staff to ensure the sexual health of the residents by involving colleagues with expertise in this area (for example, psychosexual counselling services and/or sexual health services).

It is important to emphasise, however, that every person you encounter in your practice will be unique and you should ensure therefore that all circumstances are evaluated before taking any action.

Case example A: Consenting adults in a new relationship where one is married

Resident Reginald tells staff that he and fellow resident Mary have begun a sexual relationship which they are both enjoying. Mary confirms this to her care staff. Reg tells staff that "under no circumstances" are they to let his wife know about Mary. This is a concern to staff as Reg's wife visits him every Tuesday and they feel embarrassed that she does not know.

Staff discussed the concern. They decided that:

- Both Reg and Mary have the mental capacity to make the decision to have a relationship and to have sexual relations, and have freely and clearly expressed their choices.
- They have a right to live in the way they choose, provided this does not impinge on the rights of others.
- The staff do not have any basis on which to inform Reg's wife, as this would be a breach of his privacy and there are no safeguarding concerns.
- Staff agreed that, if the wife should become aware, and confront the nursing staff, they should suggest that she discusses the situation with her husband.

Actions taken:

- Staff talked with Reg and Mary about their relationship including offering information and support with relevant health-related aspects of this. They also offered sexual health advice including on safer sexual practices and lubricants.
- Staff also agreed with the couple that staff would keep their relationship confidential but that, should Reg's wife find out about it, staff would suggest she speak to Reg.
- All decisions made and actions taken were documented (NMC Code, 2015 (Clause 10)).

Case example B: Consenting adults in a new same sex relationship facing family objections

Edward and Thomas recently moved to live in the care home. They tell senior staff that they have fallen in love and want to live together in the home. Both have mental capacity to make this decision but some physical difficulties. Edward has adult children who contribute to the cost of his care but strongly object to their father's new relationship.

Staff discussed the concern. They decided that:

- Both residents have the mental capacity to make this decision and have clearly and freely expressed their choices.
- They have a right to live in the way they choose, provided this does not impinge on the rights of others.
- Confidentiality must be maintained.
- Staff have a duty to treat people as individuals and uphold their dignity, including avoiding making assumptions, recognising diversity and supporting individual choice (NMC Code, 2015 (Clause 1)). Any discrimination on the part of staff, other residents or visitors to the home should be prevented through anticipatory management action or, if discrimination arises, handled appropriately.
- These residents should receive support and help, including everyday care, according to their rights and individual needs.
- Should they choose to form a sexual relationship, they have sexual rights including the right to fulfilling sexual relationship (WHO, 2010).
- Staff should always treat relatives with understanding and kindness, but families should not be encouraged to overrule the decision of a resident on how they live their life, even if they contribute towards the cost of his care.

Actions taken:

- Staff discussed with Edward and Thomas their wishes and plans for daily living and care were documented and signed.
- Agreement was reached on how to optimise practical arrangements in terms of living accommodation (for example, one room for sleeping, one for living space) and care needs were discussed, including the use of a hoist.
- Sexual health issues were discussed with Edward and Thomas and specific suggestions were made.
- Staff discussed with Edward what, if anything, he wants them to say to his son.
- Discussions were held with staff in order to emphasise the need for confidentiality, to identify any concerns and supportively address these with individuals.
- The home's policies on discrimination were reviewed to ensure these were sufficiently robust to deal with deal with any discriminatory actions on the part of staff, residents and/or visitors to the home.
- Discussions with staff emphasised the importance of being especially sensitive and supportive to family members. Staff encouraged Edward's family to speak with their father.
- Contact details for organisations or networks for LGBT couples that might be of interest to the residents, for example through Age UK or the Alzheimer's Society, were offered.

Case example C: Resident with mental capacity asking to watch pornography in his bedroom

Robert tells the staff he wants to watch pornography in his room and asks them to order this for him. He reassures staff that he only wants to access material that is legal.

Staff discussed the concern. They decided that:

- Robert has the mental capacity to make this decision for himself and there are no safeguarding concerns.
- Robert should be supported to be as independent as possible in accessing the entertainment he desires, provided this remains legal.
- Principles of sexual rights would support his right to a fulfilling sexual life through the viewing of legal pornography, provided that this does not infringe the rights of others living in, working in, or visiting the home.
- All staff must work within the law and nursing staff must work within the NMC Code (2015) specifically clause 20.6 to "stay objective and have clear professional boundaries at all times with people in your care". Breaching this code could result in problems with nurse's NMC registration. If staff are in doubt about where their professional boundaries lie, they should ask for management guidance before taking any action, and legal advice could be sought.
- If individual staff members object to the use of pornography then senior staff can discuss this with them or suggest they talk with Robert about his choices. However it must be clear that individual staff members' personal beliefs should not in any way compromise the care they offer. Under no circumstances should staff's personal views result in Robert being discriminated against in any way or deprived of any aspects of his fundamental care.

Actions taken:

- Robert's request, along with all other aspects of his care and treatment, were discussed with all staff involved in his direct care in the multidisciplinary meeting. It was agreed by all that his choice of entertainment contributed to his quality of life and was a legitimate aspect of his care. It was emphasised that everything should remain 'above board' and included in his care plan. Importantly, as with all other aspects of care, confidentiality should remain paramount.
- Robert's senior key worker discussed his request with him. It was mutually agreed that staff would in principle support Robert's rights and choices and his independence but that they must at all times act within the law and professional code of practice. Robert appreciated this.
- Robert agreed that he would purchase only legal pornography and watch this only in the privacy of his room. He agreed that the sound or visual material would not be able to be heard or viewed by residents or staff in any surrounding part of the home, and that he would store the material out of sight in a cupboard in his room.
- Staff supported Robert to purchase a laptop for his personal use through which he was able to order the material and equipment he wanted, including headphones.
- If at times Robert needed help to be independent in using his computer or DVD player, for example through an adapted remote control device or learning to stream material for his entertainment, staff could assist him to do this but nursing staff must be vigilant to ensure that they do not breach the NMC Code (2015) to "stay objective and have clear professional boundaries at all times" (Clause 20.6).
- The home reviewed and amended its locally agreed policies to incorporate procedures for supporting residents' choice of legal entertainment and their independence in accessing this.

Case example D: Resident with mental capacity asking to bring in a sex worker to the home

Howard tells staff he wants to bring into the home a sex worker for sex. He has mental capacity to consent to sexual relations and to make decisions about his finances, and he is insistent that this is his right. He understands that there are criminal offences that can be committed by paying for sex from someone who is under 18, or someone who has been exploited.

Staff discussed the concern. They decided that:

- Howard clearly has the mental capacity to make the relevant decisions for himself and the principles of human rights and sexual rights would suggest that he should be able to avail himself of the services of a sex worker. Staff discussions highlight that, if Howard was not living in a care home, and was physically able to live his life independently as he would choose, this would be relatively straightforward for him.
- However, managers are aware that it could be a criminal offence under sexual offences legislation for providers or managers of care homes to permit the use of sex workers on their premises, irrespective of who arranges this.
- The NMC Code (2015) Clause 20.4 states that nurses must at all times 'keep to the laws of the country'. Therefore, by booking a sex worker for the resident a nurse could risk breaking the law and could be in breach of the NMC Code.
- Staff already ensure that Howard has access to his money from his bank. If the situation arises they could ensure confidentiality and facilitate his privacy when the sex worker visits.
- Howard's request presented fundamental dilemmas for the managers, the staff and the home, because they all wanted to support his rights, choices and quality of life but, in doing this, they risked crossing legal and professional boundaries and there seemed to be limited guidance to support their decision making.

Actions taken:

- Confidentiality was maintained, all care continued, and actions taken in respect of this issue were documented in the care plan.
- The home sought legal and professional advice.
- The legal advice was that the law regarding potential criminal prosecution is not clear; lawyers were not aware of any case law directly answering the question of whether a nurse, care home manager or carer would be liable to prosecution in these circumstances. They advised the home to err on the side of caution.
- The NMC does not advise on individual matters of clinical practice. They do not provide legal advice and any statements they make should not be interpreted as predictors of an outcome in any fitness to practice referrals. The NMC emphasise Clause 20.4 of the Code that nurses must at all times 'keep to the laws of the country' and that breaking the law or aiding and abetting a breach of the law could also breach the Code.
- The managers decided that they could not accede to Howard's request. They talked through this decision with Howard, explaining that doing as he asked could place them in breach of the law, or at least aiding and abetting breach of the law, and in breach of their professional code.
- Howard understood the staff's dilemmas and thanked them for their trouble.

Case example E: Resident with mental capacity requesting help with masturbation

Jefferson, a resident who lives with multiple disabilities and is physically unable to care for himself, asks his key carer to assist him with masturbation. He says that his care worker in the community was prepared to do this for payment.

Staff discussed the concern. They agreed that:

- There is no concern that Jefferson lacks mental capacity to make decisions, and the principles of sexual rights would support his right to fulfilling sexual activity.
- However, under the sexual offences legislation, providing services such as masturbation, in the context of the particular financial and legal relationships arising in a care home, might give rise to an accusation that the carer is acting contrary to the criminal law.
- There are also risks of accusations of sexual abuse, given the potential vulnerability of the client.
- The NMC Code (2015) Clause 20.6 states that nurses must "have clear professional boundaries at all times with people in your care". Carrying out an act of masturbation for a resident is a breach of this professional requirement. It was agreed that staff should not engage in such activities.

Actions taken:

- Staff were informed that it was not appropriate for them to accede to Jefferson's request to assist him with masturbation and this was documented in his care plan.
- As the staff felt ill-equipped to deal skilfully with the situation, advice was sought from local services (eg, psychosexual counselling and/or sexual health teams) who came into the home to offer advice to the resident.
- Confidentiality was maintained and actions documented in the care plan.
- Following expert advice from sexual health services, mechanical assistive devices that individuals use themselves were procured.
- The home manager recorded Jefferson's allegation that his care worker in the community was prepared to assist him with masturbation and informed local safeguarding officers. The manager also informed the manager of organisation or agency employing the community care worker, who could decide to investigate the resident's claim and take action against the care worker.

Case example F: Resident with intermittent mental capacity in a partnership and sharing sexual intimacy

Rosie, who has lived with Alzheimer's disease for about five years, is deemed to have the mental capacity to make straightforward decisions in day to day life, but is not able to understand potential risks or consequences of some decisions. When her husband Bill visits her in the care home he has told staff that he wants to be intimate with his wife. Rosie seems to welcome him and is loving towards him.

Staff discussed the situation. They decided that:

- In this context it is important to recognise that the needs of both partners must be considered, and that someone with dementia may have sexual needs.
- Nurses caring for a person with dementia must be aware of the legislation regarding mental capacity, ensuring that people who lack capacity remain at the centre of decision making and are fully safeguarded. (Refer to the boxes in Section 4 of this document for details of the law in relation to capacity to consent to sexual relations and mental capacity legislation and Code of Practice for guidance in relation to capacity assessments).
- Rosie understood what sexual intercourse was and was not at risk of sexually transmitted infections from Bill. She was able to express her choices. This was sufficient for her to have capacity to give or refuse consent. If Rosie had lacked capacity to consent to sexual relations, the staff would have had to inform Bill that he and Rosie could not have sexual relations as this would be assault.

Actions taken:

- Staff involved with Rosie's care and support undertook detailed assessment of her capacity to consent to intimacy with Bill, for example whether she was able to understand the potential health consequences and risks of sexual intimacy, and whether she had the ability to say "no" and to express her wishes and views. Staff concluded that she did have capacity to consent to sexual intimacy even though she was not always able to retain information for a long period.
- Staff also spoke sensitively with Bill to ensure he was aware that the dementia may have affected his wife's ability to share an intimate relationship and support him in being able to read non-verbal signals and to respect any signs of fear or reluctance on the part of his wife. Staff also invited Bill to discuss with them any issues specific to their sexual relations, for example if lubricants might be helpful in preventing unnecessary discomfort.
- Confidentiality was maintained and all decisions made and actions taken were appropriately documented.
- Nursing staff monitored Rosie's mental health, particularly to identify if she became agitated or distressed. They also instructed staff on monitoring her physical health, particularly for any signs of physical force. Monitoring her genital area was particularly important and staff were instructed to immediately report any changes to senior staff. Were any detrimental changes to be noted, staff agreed they would speak immediately to the husband explaining their concerns.

Case example G.1: Residents whose mental capacity is unclear seeking sexual intimacy

Anthony and Clara, both of whom have a diagnosis of dementia, have formed a relationship in the home. They are happy in each other's company, hold hands, kiss and are relaxed together. One afternoon a carer inadvertently walked into Anthony's bedroom and found the couple in bed together. Their clothes had been placed on the chair together. The carer apologised and asked if both were OK. The carer listened to the response and assessed that neither party appeared distressed and left the couple in privacy. Later that day, when both residents came back to the lounge, the manager sensitively spoke to both of them individually about their relationship.

Staff discussed the concern. They decided that:

- There are fundamental issues of consent and capacity to consent here. Assessment should be made of each individual's ability to recognise the face of the other, their body language and the positive energy between them – all signs of positive understanding. However, mental capacity to make decisions involves the weighing up of risks and benefits. (Refer to the boxes in Section 4 of this document for details of the law in relation to capacity to consent to sexual relations and mental capacity legislation and Code of Practice for guidance in relation to capacity assessments).
- Anthony was known to have fluctuating capacity regarding aspects of his life. He did not know Clara's name but was able to indicate he enjoyed her company and wanted to be with her. The manager concluded that he had capacity to understand that he wanted to be close to Clara and enjoyed the relationship.
- Clara was able to say that, although she did not know his name, she knew Anthony and wanted to be in his company. The manager concluded that both residents wanted and enjoyed the relationship and had capacity to decide to spend time with each other.
- There are also important issues around the safeguarding of adults at risk (See box in Section 4).

Actions taken:

- Staff sought expert advice and assessment from a consultant nurse on mental health in older people.
- Staff undertook assessment of mental capacity to make decisions on intimate relationships, cognisant of other abilities to weigh up risks and benefits. Staff concluded that they both had the capacity to consent to sexual relations.
- Staff monitored their physical and mental health, observing whether either party demonstrated by their behaviour that they did not want the company of the other.
- Care plans, capacity assessment and risk assessments were updated accordingly and the GP was informed in order to discuss whether there needed to be any monitoring of health in respect of sexually transmitted disease.
- The local safeguarding team were informed and were in agreement that a rights based, positive risk taking approach was enabling the residents to have a fulfilling intimate relationship.

Case example G.2: Residents with deteriorating mental capacity seeking sexual intimacy

After about four months, staff became concerned that the mental capacity of both Anthony and Clara was deteriorating. The staff discussed their concerns.

Actions taken:

- Staff again sought expert advice from the consultant nurse on mental health in older people, who undertook detailed assessment of Anthony and Clara. The assessment identified that Anthony no longer had any appreciation of the risks of sexually transmitted infections, even in broad terms (part of the legal test) and therefore did not have capacity to consent to sexual relations. Clara clearly was not any longer able to understand that sex was something that could be refused and therefore she did not have capacity to consent to sexual relations.
- As neither resident had capacity to consent, staff needed to ensure they did not have sexual relations. In kind and supportive ways, staff ensured that Anthony and Clara were never alone together. They worked to identify meaningful ways for both to spend their time and also enjoyable activities they could share with other residents. When a room in another unit of the home became vacant, staff showed this to Clara and she loved it, particularly that she could see the birds in the trees close to her window. Neither Anthony nor Clara showed distress at being parted.

Case example H: Accusations of groping and sexual harassment in the context of cognitive impairment and dementia

Long-term resident Jean tells staff that Sidney, a new resident, tried to grope her. She says he has been sexually harassing other female residents by trying to touch them sexually and press his body close to theirs. Sidney has a diagnosed dementia.

Staff discussed the situation. They decided that:

- Staff have a duty of care to safeguard the female residents from all invasions of their rights and from personal assault but, importantly, in the process of doing this, staff should not infringe the rights of the female residents.
- It is important to 'see the person not the dementia' and, in order to prevent behaviour unacceptable to others, to understand Sidney's motivations and what he is trying to communicate.
- The safety, rights and dignity of others in the unit must be a priority.

Actions taken:

- Staff reassured Jean that they would manage the situation to ensure this does not happen again. They ask if she would like to tell her family about what has happened and whether she would like staff support to do this.
- Staff explained to Sidney kindly but firmly that this behaviour is not acceptable in any circumstances. They also explained to Sidney that, in order to protect other residents, staff will need to observe and intervene to prevent any approaches to other residents.
- Assessment of Sidney's health was undertaken in order to identify any physical health changes that may be influencing his behaviour.
- Assessment of Sidney's behaviour before the incident was analysed in order to identify the potential to intervene in case such circumstances might develop again. They identified ways of engaging Sidney in order to offer all appropriate therapeutic input and to divert his focus to other meaningful activities.
- Staff then looked back through the records in order to identify any previous reports of such behaviour. None were identified.
- Staff assessed Sidney's capacity to understand his actions. In order to decide on a course of action, a group discussion was held involving the family, local authority and other relevant people. If Sydney had demonstrated that he did not understand that other people needed to consent to sexual activity, then staff could make a safeguarding referral to the local authority. If he demonstrated that he did have the capacity to understand his actions, staff could refer to the police and local safeguarding authority. (The police are the only agency able to investigate if a crime has been committed). Staff were prepared that this situation could lead to a best interests decision to subject Sidney to 24-hour supervision.
- Staff continued to work with local safeguarding offices and/or the police.
- Staff reviewed the location of the residents' bedrooms to identify if Sidney's room could be moved further from the bedrooms of female residents.
- Staff undertook risk assessment in order to consider the need for increased staff at any particular time of the day.
- Staff continued to observe Sidney's behaviour and intervene to prevent him approaching other residents. Training on how to do this was given to junior staff. Throughout this process, while staff sought to protect Jean and the other female residents from unwanted attentions, great care was taken to ensure that their rights and freedoms were not curtailed of infringed in any way.

Case example I: Potential grooming or sexual harassment

Frank had lived with dementia for some years but was physically independent and able to hold conversations with other residents. He was known in the home for being good fun and chatting with everyone, particularly the female residents. Staff noticed that he seemed to be talking a great deal to Florence, who was able to walk around the home but had significant cognitive impairment. There was nothing to indicate that Florence did not enjoy Frank's company but the staff remained vigilant. This situation continued until one day a senior carer saw Frank taking Florence for a walk along the corridor and entering an empty room. She followed and found Frank had pinned Florence against the wall of the room and had his hand up her skirt. Florence was silent but did not appear to be demonstrating any pleasure from his actions. The senior carer insisted that Frank leave Florence alone. She took Florence back to her room and talked gently to her until she was sure that Florence was not distressed. She then alerted the manager on duty who went to see Frank.

Staff discussed the situation. They decided that:

- As in Case example H above, staff have a duty of care to safeguard the female residents from all invasions of their rights and from personal assault while not infringing the rights of female residents. They needed to establish whether Florence had the capacity to understand what happened and to consent to it.
- It is important to 'see the person not the dementia' and, in order to prevent behaviour unacceptable to others, to understand Frank's motivations and what he is trying to communicate. In addition, they needed to establish whether Frank had the capacity to understand what he was doing and that this may be a crime.
- The safety, rights and dignity of others in the unit must be a priority.

Actions taken:

- Staff reassured Florence that they would manage the situation to ensure this does not happen again. They asked if she would like to tell her family about what happened and whether she would like staff support to do this.
- Staff explained to Frank kindly but firmly that this behaviour is not acceptable in any circumstances. They also explained to Frank that, in order to protect other residents, staff will need to observe and intervene to prevent any approaches to other residents.
- Staff assessed Frank's capacity to understand his actions. If he demonstrated that he did not have capacity the staff would refer as a safeguarding concern. If he demonstrated that he did have the capacity to understand his actions, staff would refer to the police as a safeguarding concern. (The police are the only agency able to investigate if a crime has been committed).
- Assessment of Frank's health was undertaken in order to identify any physical health changes that may be influencing his behaviour.
- Assessment of Frank's behaviour before the incident was undertaken in order to assess the potential to intervene in case such circumstances might develop again. They identified ways of engaging Frank in order to divert his focus to other meaningful activities.
- Staff then looked back through the records in order to identify any previous reports of such behaviour. None were identified.
- Staff reviewed the location of the residents' bedrooms to identify if Frank room could be moved further from the bedrooms of female residents.
- Staff undertook risk assessment in order to consider the need for increased staff at any particular time of the day.
- Staff continued to work with local safeguarding offices and/or the police.

- Staff continued to observe Frank's behaviour and intervene to prevent him approaching other residents. Training on how to do this was given to junior staff. Throughout this process, while staff sought to protect Florence and the other female residents from unwanted attentions, great care was taken to ensure that their rights and freedoms were not curtailed of infringed in any way.
- The home manager thought it important to know more of Frank's past life history and sensitively broached the topic when his family when they visited. The family revealed that Frank had a long history of inappropriate sexual activity with women.
- Ultimately, in order to uphold Frank's rights and freedoms as far as possible, and maintain the rights, freedoms and safety of other people in the home, a care plan was put in place which afforded Frank one-to-one care together with a programme of meaningful activity. This was monitored and reviewed on a weekly basis, or more frequently if any concern was identified.
- An assessment of Florence's mental capacity could also be undertaken. If found to be lacking, then she may need 24 hour observation to protect her from other residents.

Summary points

- There can be a tension between supporting personal freedom and acting within legal frameworks. Decisions are often not straightforward but nurses must always act within the law (see boxes in Section 4 of this document) and within the NMC Code (2015).
- Nurses must strive to promote and support human rights, dignity, privacy and choice and also to prevent any kind of discrimination.
- All decisions will depend on the individuals involved and individual circumstances. Approaches must be person-centred and care provided in ways which are personalised, rather than based on assumptions and stereotypes.
- Comprehensive assessments of individuals and individual circumstances, including risk assessments and assessments of mental capacity, must be undertaken when appropriate. Care plans must be reviewed at appropriate times.
- The views of a range of key people should be incorporated into the care where appropriate, and specialist advice should be sought if needed.

Appendix 1: Glossary of terms

In literature on sexuality, sexual health and sex, definitions have been offered from a range of perspectives. The following descriptions clarify the way in which the terms are used within this document. On its website, the World Health Organization (WHO) offers working definitions designed to stimulate ongoing discussions on sexual health.

Sexuality: A central aspect of being human throughout life, sexuality encompasses sex, gender identities and roles, sexual orientation, eroticism, pleasure, intimacy and reproduction. Sexuality is experienced and expressed in thoughts, fantasies, desires, beliefs, attitudes, values, behaviours, practices, roles and relationships. While sexuality can encompass all of these dimensions, not all of them are always experienced or expressed. Sexuality is influenced by the interaction of biological, psychological, social, economic, political, cultural, ethical, legal, historical, religious and spiritual factors (WHO, 2010).

Sex: In terms of gender, sex refers to the biological characteristics that define humans as female or male. While these sets of biological characteristics are not mutually exclusive, as there are individuals who possess both, they tend to differentiate humans as males and females (WHO, 2010). In terms of sexual activity, sex encompasses physical acts of a sexual nature carried out in order to promote eroticism, sexual arousal or pleasure, or for reproduction. Sex can be a means of expressing intimacy, love or attachment. Sex can also be used destructively as a means of exerting power over another person or committing abuse.

Sexual identity: A person's feelings of and about his/her own maleness or femaleness (gender and gender identity) and the ways in which s/he expresses these feelings (whether heterosexual, homosexual, or bisexual). Some individuals identify themselves as transgender (which broadly means that their personal idea of gender does not correlate with their assigned gender or gender role).

Sexual orientation: Indicates the individuals or group of people to whom one feels attracted.

Intimate relationships: Close interpersonal relationships in which the participants know or trust one another very well or are confidants of one another, or a relationship in which there is physical or emotional intimacy.

Sexual health: Relates to the absence of disease, dysfunction or infirmity and also to a state of physical, emotional, mental and social wellbeing in relation to sexuality. Sexual health requires a positive and respectful approach to sexuality and sexual relationships, as well as the possibility of having pleasurable and safe sexual experiences, free of coercion, discrimination and violence. For sexual health to be attained and maintained, the sexual rights of all persons must be respected, protected and fulfilled (WHO, 2010).

Sexual harassment: Unwanted behaviour of a sexual nature which is intended to, or has the effect of, violating another person's dignity, making them feel intimidated, degraded or humiliated or if it creates a hostile or offensive environment. The other person does not need to have previously objected to someone's behaviour for it to be considered unwanted. Sexual harassment can include sexual comments or jokes, physical behaviour including unwelcome sexual advances, touching and various forms of sexual assault.

Sexual assault: An act of physical, psychological and emotional violation in the form of a sexual act, inflicted on someone without their consent. It can involve forcing or manipulating someone to witness or participate in any sexual acts. Not all cases of sexual assault involve violence, cause physical injury or leave visible marks. Sexual assault can cause severe distress, emotional harm and injuries which cannot be seen – all of which can take a long time to recover from.

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Legal guidance

Legislation is available online at www.legislation.gov.uk

The Mental Capacity Act Code of Practice is available at www.gov.uk/government/publications/mental-capacity-act-code-of-practice

Assessment of Mental Capacity. A Practical Guide for Doctors and Lawyers, 4th edition. The British Medical Association and the Law Society.

39 Essex Chambers (2017) A brief guide to carrying out capacity assessments. www.39essex.com/mental-capacity-guidance-note-brief-guide-carrying-capacity-assessments

39 Essex Chambers (2017) A brief guide to carrying out best interests assessments. www.39essex.com/content/wp-content/uploads/2017/11/Mental-Capacity-Guidance-Note-Best-Interests.pdf

Resources

Age UK

www.ageuk.org.uk

Information and advice on wellbeing and sex in later life.

Age UK (2017) *Safe to be me: Meeting the needs of older lesbian, gay, bisexual and transgender people using health and social care services. A resource pack for professionals*. November 2017.

Age Scotland

www.ageconcernandhelptheagedscotland.org.uk

Age Cymru

www.ageuk.org.uk/cymru

Age NI

www.ageuk.org.uk/northern-ireland

Alzheimer's Society

www.alzheimers.org.uk

Uncovering the challenge of sex and intimacy in care homes this Valentine's Day – Alzheimer's Society blog

The Society's Innovation investigated how to better support care homes with residents living with dementia on the subject of sex and intimacy. www.facebook.com/alzheimerssocietyuk/posts/10155993804534647

www.alzheimers.org.uk/info/20029/daily_living/12/sex_and_intimate_relationships

www.alzheimers.org.uk/info/20029/daily_living/12/sex_and_intimate_relationships/2

Alzheimer Scotland (2011) *Sexuality and dementia*, information sheet 28, Edinburgh: www.alzscot.org/information_and_resources/information_sheet/1774_sexuality_and_dementia

British Institute of Human Rights

www.bihr.org.uk/

Particularly the information on everyday practice.

Dementia Services Development Centre

www.dementia.stir.ac.uk

A range of resources and learning programmes on Sexuality and Dementia.

Archibald C (2005) *Sexuality and dementia: A guide for all staff working with people with dementia*, Stirling: Dementia Services Development Centre, University of Stirling.

Focus on Disability

www.focusondisability.org.uk

Resources on sexual and personal relationship for disabled and older people.

International Longevity Centre

www.ilcuk.org.uk

Work focuses on some of the biggest challenges facing government and society in the context of demographic change.

Lee D, Tetley J (2017) *How long will I love you? Sex and intimacy in later life.*

Bamford S-M (2011) *The last taboo: A guide to dementia, sexuality, intimacy and sexual behaviour in care homes.*

Joseph Rowntree Foundation

www.jrf.org.uk

An independent organisation working to inspire social change through research, policy and practice.

Knocker S (2012) *Perspectives on ageing: lesbians, gay men and bisexuals*. Joseph Rowntree Foundation.

NHS Choices

www.nhs.uk/Livewell/Goodsex/Pages/Oldersex.aspx

Advice on sex for older people.

Older People's Understandings of Sexuality (OPUS) Research Initiative

www.micra.manchester.ac.uk/research/projects-and-groups/opus/

The OPUS initiative was established to investigate older people and sexuality and intimacy. Its broader aims are to challenge stereotypes of older people as asexual or beyond or unworthy of being involved in sexual/intimate relationships and to contribute to understandings of older people as sexual and intimate citizens. This will involve clarifying the realities of older people's personal lives and challenging stereotypes of them.

Royal College of Nursing

www.rcn.org.uk

Resources on older people and sexual health.

www.rcn.org.uk/clinical-topics/older-people/supporting-healthy-ageing

Fair Care for Trans Guidance

www.rcn.org.uk/professional-development/publications/pub-005575

Skills for Health

www.skillsforhealth.org.uk

Skills for Health, a not-for-profit organisation committed to the development of an improved and sustainable health care workforce across the UK.

Skills for Care (2017) *Supporting personal relationships. Supporting people who need care and support to have meaningful relationships.*

www.skillsforcare.org.uk/About/News/News-Archive/Supporting-people-who-need-care-and-support-to-have-meaningful-relationships-new-guidance.aspx

Social Care Institute for Excellence

www.scie.org.uk

Courses and learning resources, including on sexual expression in people living with dementia.

www.scie.org.uk/dementia/living-with-dementia/difficult-situations/sexual-expression.asp

All links accessed 31 May 2018.

The RCN represents nurses and nursing, promotes excellence in practice and shapes health policies

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www.rcn.org.uk

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Published by the Royal College of Nursing
20 Cavendish Square
London
W1G 0RN

020 7409 3333

October 2018
Review Date: October 2021
Publication code 007 126

Royal College of Nursing