



Royal College  
of Nursing

# Older people in care homes: sex, sexuality and intimate relationships

*An RCN discussion and guidance document for the nursing workforce*





This document was developed by RCN members, staff, and a range of external stakeholders, including older people, as part of the RCN Nursing Older People Strategy.

It incorporates advice received from RCN legal advisors, lawyers and officers at the Care Quality Commission (CQC), and the Advisor for Nursing Older People at the Nursing and Midwifery Council (NMC).

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## Key point summary

Issues concerning sex, sexuality and intimate relationships in care homes are complex, and dealing with these can pose difficulties for older people, partners, families and staff. However, the fundamental principles of individual autonomy, choice and consent are established in law and underpinned by the *Human Rights Act 1998* and assumptions and stereotypes should be challenged.

Care home service providers should strive to:

- develop policies which support the rights of all the people who live, visit or work in care the 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.

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.

Care home 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, nursing 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 3). Specialist advice should be sought when appropriate, for example, for legal clarification, for psychosexual or relationship problems, and on issues concerning mental or sexual health.

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 and sex, particularly for older people living in care homes. Its goal is 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 is seen as a problem
- 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.

## 2

## 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.

Sexuality is not generally considered to be a priority for older people and the topic is rarely addressed in training. Assumptions on this topic mean there is often little provision for discussing needs in care settings:

*“Most staff think that sexuality and physical sex are the same and that people over 70 cease to be sexually active.”*

*“Because staff in general do not consider sexuality among elderly clients, there is not an atmosphere in which clients would feel comfortable discussing sexuality and their needs.”*

Broaching issues of sexuality can be also difficult for staff:

*“Sex and sexuality in older people has largely been a taboo subject, at least among nurses and carers.”*

*“Staff are generally not comfortable with the topic, and not knowledgeable about it either, thus they are powerless to help.”*

Addressing sexuality can be particularly difficult because of generational differences:

*“Although many older people talk freely about themselves, this area of life has not usually been discussed, even between married couples. Expectations of the more intimate aspects of life may be low and never brought up. The next generations may well approach things differently.”*

*“Sexuality issues are not easy to raise with older clients, for example concerning prostate problems. We discuss the practical aspects but often there is no willingness to discuss how their sexual function is affected, even though this might well be an important issue.”*

*“I presume that gay and lesbian partnerships exist in the older generation and think they should be treated the same, but I don’t know how I’d deal with this.”*

Care home buildings do not always facilitate privacy or intimacy, particularly in shared living space or if residents are unable to lock their bedroom doors. The residents’ need for assistance with everyday activities is generally high, necessitating the use of clinical equipment, such as single variable height beds. Although essential to prevent staff injury, these do not facilitate intimacy between two people.

*“In institutional care, maintaining relationships made before or during their stay is important but is not always facilitated. I recently learned of a married couple who had joint respite in a residential home, but were in separate rooms.”*

*“Our home offers holiday accommodation but does not have any double beds, even for married couples. If I get a permanent admission to either nursing or residential care, the spouse is entitled to come for a holiday, but is put into a separate room as none of the care beds are double.”*

Most care home residents have chronic, progressive conditions, typically neurological disorders such as stroke or Parkinson’s disease, resulting in multiple disabilities which make it difficult for individuals to live independently. It is estimated that something like three quarters of care home residents experience some sort of mental health need including dementia. Illness and disability, particularly limited mobility, chronic pain or incontinence can be challenging in terms of intimate relationships and sex, for example:

*“One resident, due to physical disability, is unable to masturbate himself. He confesses that he does become very sexually frustrated and I am at a loss as to how to address the issue for him.*

*Unfortunately he is not in a position to be able to go and meet women of his own accord. I understand his needs, but do not know what I can legally do to assist him in his quest for sexual gratification. We did assist him to purchase a mechanical device to perform this act, but he found it to be too clinical. I feel he is really looking for companionship and an outlet to express sexuality, not just the physical act.”*

Some nurses highlight how entrenched attitudes and standardised practice can inhibit the acknowledgement of sexuality in care settings:

*“Emphasis is placed on appearance and ensuring that residents have a good standard of personal hygiene, clothing and access to a hairdresser. They all appear clean and tidy (whether they want to appear clean and tidy or not!) and there is emphasis (driven by the regulatory authority) on providing activities for the residents, but are we providing what the residents REALLY want?”*

Education is not always readily accessible to staff working in care homes:

*“The majority of hands-on care is provided by care assistants, and training is often not provided routinely for staff in the private sector, with fewer care assistants having access to for example NVQ than those who work in the NHS.”*



## 3

## Principles of good practice

### 3.1 General principles

All health and social care practice must work within the law of the land and all relevant professional guidance and standards. In many aspects, the law is explicit concerning sexual behaviour. However, legislation, National Care Standards and government guidance do not generally address the issue of intimate relationships.

The law does not offer explicit guidance on achieving a balance between promoting individual rights and protecting vulnerable people. Legislation can, however, place boundaries on the extent to which staff caring for individuals may become involved in their choices for sexual expression.

UK civil law governs issues such as a nurse's duty of care towards patients, and 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, Wales and Scotland.

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

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

While it is not uncommon for relatives, such as sons and daughters or other residents or their family members, to object to intimate relations arising in care homes, it will often not be appropriate for staff or management of the home to discuss the situation with others without the

explicit consent of the resident concerned. Residents have legal rights to confidentiality, and registered providers and managers should ensure that staff who are aware of a relationship arising between residents, observe the law on client/patient confidentiality.

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 vulnerable 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 all relevant legislation and professional guidance can be found at Appendix 3, and a selection of case examples can be found in Section 6 of this document.

### 3.2 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. 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.

### 3.3 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 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 or hearing impairment.

### 3.4 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 next of kin, who should be informed in problem situations and legal provision the resident wishes to make, for example a Lasting Power of Attorney.

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?

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.

### 3.5 Broaching issues of sexuality

Discussing personal or intimate topics requires skill and sensitivity. Nurses can build on their understanding of what is likely to be acceptable to a resident or family and what might be their priorities.

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. Two routes into discussing sexual issues (suggested by White and Heath, 2005) may be worth exploring:

- 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

## 4

## When sexuality is seen as a problem

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

### 4.1 A framework for the assessment of problems

Archibald's (1994) *Framework for action when sexuality is seen as a problem* can help in identifying where both the problem and the solutions might lie (see Figure 1).

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

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

Consider whether there is actually a problem that needs to be addressed. For example, if the circumstances arose due to a misinterpretation or misunderstanding that has now been corrected and no further action is necessary, 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.

If it is decided that there is a problem, 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.

Understanding and compassion is essential when working with people who have a dementia or cognitive impairment. As Pritchard and Dewing (2001) emphasise: "it helps to try to look at a person's behaviour as communication from someone who may feel ill and frustrated, who may be finding it difficult to express themselves and their needs, and who may be faced with a lack of understanding from those around them."

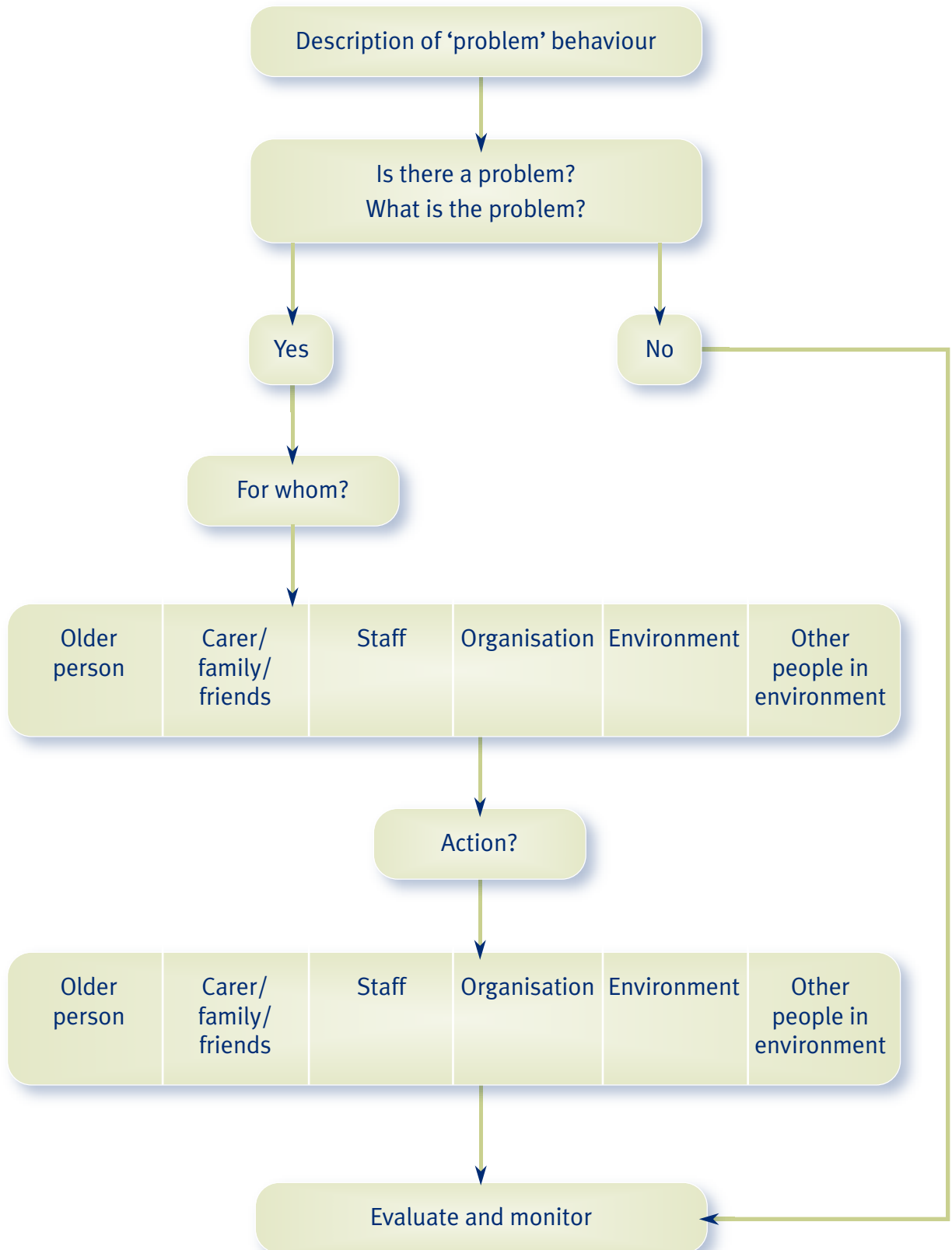
Further case examples are offered in Section 6.

### 4.2 Acknowledging barriers to expression of sexuality

In our everyday lives, whatever our age or circumstances we are all 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'.

**Figure 1: Sex: is it a problem? (Archibald, 1994)**



### Barriers for older people

For older people, barriers to expression of sexuality, intimate relationships or sex include:

- 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 everyday functioning and intimate relationships
- loss of independence, reliance on others for help leading to lack of privacy in everyday surroundings
- the impact of moving into a care home and all the factors that can surround this
- concern for how much time or care residents can reasonably expect from the staff.

Nursing practice should demonstrate an awareness of these barriers and that these are being addressed.

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.

Despite the embarrassment older people might experience in discussing sexuality issues, most believe that this should be a consideration as part of their clinical care, and welcome the opportunity to discuss their concerns.

### Barriers for the nursing and care workforce

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

- inadequate training or education in sexuality or sexual health
- a lack of relevant experience
- 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.

Nursing staff can also experience particular difficulties in addressing issues of intimate relationships and sex with older generations, influenced not only by societal stereotypes but also by not wishing to think of one's parents or grandparents as being sexually active. Such perceptions can lead to a resident's desire for intimacy being viewed as a behavioural problem rather than a need for loving contact.

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.



5

# 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 a trusted colleague or supervisor 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.

The RCN (2009) has defined levels of competence in nursing practice specific to sexual and reproductive health; based on the P-LI-SS-IT Model (Annon, 1976), these encompass broad aspects of nursing practice including creating an environment. The model 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.

## 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 lock their bedroom doors or remain unobserved all night.

**Figure 2: The P-LI-SS-IT Model (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. Nurses are able to offer general information and to refer to specialist advice or services when appropriate.

### Level III – Specific suggestions

Nurses offer residents opportunities to explore issues or problems within a therapeutic relationship. Information, advice or specialist help to address specific issues or problems is available to residents 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 monitor health and wellbeing on an ongoing basis.

## 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

## 6

## Case examples

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 GPs, social services, clinical psychology or psychiatry services, genito-urinary medicine (GUM) departments and psychosexual clinics.

Addressing residents' sexuality and sexual health are appropriate and legitimate areas of nursing activity and nurses have a professional and clinical responsibility to address these (RCN 2000, NMC 2009b). 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. (For more detailed information see appendix 3). Inappropriate or inadequate care has the potential to exploit and abuse vulnerable people.

The view of the Nursing and Midwifery Council (NMC) is that these are complex issues which cannot be easily resolved, and involve the fundamental principle of patient autonomy and consent, which are set out in common law and legislation and underpinned by the *Human Rights Act 1998*.

The NMC supports the concept of person-centred care where the focus is on the person's experiences, relationships and uniqueness as an individual, and where care is given from the patient's perspective. Indeed the NMC's Code (2008) makes it very clear that nurses and midwives must make the care of people their first concern, treating them as individuals and respecting their dignity.

In terms of providing care for patients/clients, nurses must be sure that they always act in the best interest of the patient. Nurses 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.

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 case 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

**A woman with dementia and intermittent capacity lives in a care home. Her husband wants to be intimate with her when he visits and she seems to accept this.**

#### Considerations

- 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.
- The view of the NMC is that the main issue is around consent and autonomy.
- 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. Clarification as to how this should be put into practice, particularly in relation to the protection of vulnerable people, is given in the NMC's *Mental Capacity Act 2005* advice sheet.

#### Options for action

- Those involved with the care and support of the woman should clarify firstly whether she still recognises her husband, and secondly whether she is able to say no or has the ability to express her wishes and views.
- It would be important to speak to her husband to ensure that he is 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.
- It may also be necessary to talk through these issues with nursing staff in order to dispel any myths there may be regarding older people and sexuality. The NMC's *Advocacy and autonomy* advice sheet states that nurses and midwives must never practice in such a way that assumes that they know what is best for people they are caring for.
- It is important to maintain confidentiality for the resident and her husband.

- Nursing staff should monitor the mental health of the woman, particularly to identify if she becomes agitated or distressed. If this occurs, nurses should offer supportive care to the woman and could speak tactfully to the husband explaining that they are concerned about her health.

### Case example B

**A resident with capacity starts a relationship with another resident who also has capacity and is married with a wife at home.**

#### Considerations

- Both residents have the mental capacity to make this decision and have 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 view of the NMC is that, as these are two consenting adults, the issue here is around confidentiality.
- The NMC's *Confidentiality* advice sheet states that nurses have a duty to protect confidential information. It further states "people have a right to expect that information given to a nurse or midwife is only used for the purpose for which it was given and will not be disclosed without permission".

#### Options for action

- Nurses should maintain the resident's confidentiality and not disclose the relationship to the wife.
- It may be advisable for the nurses to discuss the implications of their relationship with the two individual residents concerned.
- If the wife does become aware, and confronts the nursing staff, they should suggest that she discusses the situation with her husband.
- Decisions made and actions taken should be documented.

## Case example C

**Two men living in the home tell senior staff that they have fallen in love and want to be together. Both have mental capacity to make this decision but some physical incapacity.**

**One of the men has adult children who contribute to the cost of his care but strongly object to their father's new relationship.**

### Considerations

- Both residents have the mental capacity to make this decision and have 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.
- Confidentiality must be maintained
- 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.
- The NMC (2009b) defines discriminatory abuse as “oppressive attitudes towards a person motivated by negative attitudes towards ... gender, disability, age ... or sexual orientation.”
- 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.
- If staff have difficulty in understanding the perspectives of individual residents, the most direct course of action is to speak directly with them about these.

### Options for action

- Discuss the wishes of both residents with them, agree plans for daily living and care and document and sign.
- Make the best possible practical arrangements in terms of living accommodation (for example, one room for sleeping, one for living space) and consider

care needs (for example, a hoist). Maintain confidentiality.

- Discuss with staff, identify any concerns and supportively address these with individuals.
- Review the home's policies on discrimination to ensure these are robust.
- Be prepared to deal with discrimination on the part of staff, residents and/or visitors to the home sensitively and with reference to the home's policies.
- Be especially sensitive and supportive to family members – encourage the family to speak with their father.
- Consider offering contact details for organisations or networks that might be of interest to the residents, for example Age UK or the Alzheimer's Society.

## Case example D

**A resident with capacity wants to bring into the home a sex worker for sex.**

### Considerations

- The resident has the mental capacity to make decisions for him/herself and principles of human rights and sexual rights would suggest that the care home resident should be able to avail themselves of the services of a sex worker.
- **However, 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 states very clearly “you must establish and actively maintain clear sexual boundaries at all times with people in your care, their families and carers.”
- It is inappropriate for a nurse to book a sex worker for a resident: **In booking a sex worker for the resident a nurse would also be in breach of the NMC Code.**

### Options for action

- Advice could be sought from local services – psychosexual counselling and/or sexual health teams – and these professionals could come into the home to offer specialist advice to the resident.
- Confidentiality must be maintained and actions documented in the care plan.
- **It is recommended that any care home faced with such a decision should seek expert legal advice.**

## Case example E

**A resident who is disabled and physically unable to care for himself asks a staff member to assist him with masturbation. He says that his care worker in the community was prepared to do this for payment.**

### Considerations

- The resident has the mental capacity to make decisions for himself 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's Code states very clearly "you must establish and actively maintain clear sexual boundaries at all times with people in your care, their families and carers". The NMC Code would therefore suggest that carrying out an act of masturbation for a patient is likely to be a breach of this professional requirement.
- The NMC's *Clear sexual boundaries* (2009a) guidance states that a sexual boundary has been breached when a nurse or midwife inappropriately uses words or actions of a sexual nature with a person in their care.

### Options for action

- For the above reasons, staff are advised not to engage in such activities.
- If staff in the home feel they do not have the confidence to deal skilfully with the situation, advice could be sought from local services (e.g. psychosexual counselling and/or sexual health teams) who could come into the home to offer advice to the resident.
- Confidentiality must be maintained and actions documented in the care plan.
- Following expert advice, mechanical assistive devices that individuals use themselves could be procured.

Further to guidance contained in the NMC Code (outlined above) the home could consider informing the organisation or agency employing the community care worker, which may decide to investigate the resident's claim and take action against the care worker.

**It is recommended that any care home faced with such a decision should seek expert legal advice.**

## Case example F

**Two residents with dementia form a loving relationship and are seeking opportunities to lie together. Both are deemed not to have the capacity to make a decision about a sexual relationship.**

### Considerations

- There are fundamental issues of consent and capacity to consent here.
- Although the *Mental Capacity Act* (Section 28) and *Best interests* (British Psychological Society, 2008) guidance do not cover sexual relationships, it is recommended that the principles and procedures within these be followed, for example, assessing capacity and determining best interests.
- There are also important issues around the safeguarding of vulnerable adults.

### Options for action

- Seek expert advice and assessment from an old age psychiatrist or consultant nurse on mental health in older people.
- Seek assessment of mental capacity to make decisions on intimate relationships from an assessor accredited under mental capacity legislation.



## Summary points

- There is often a tension between supporting human rights and acting within legal frameworks. The NMC recognises that decisions are often not straightforward but nurses must always act within the law and within the NMC Code and guidance (NMC 2008, 2009a, 2009b).
- All decisions will depend on the individuals involved and individual circumstances.
- Comprehensive assessments of individuals and individual circumstances, including risk, must be undertaken.
- The views of a range of key people should be incorporated into the care if appropriate, and specialist advice should be sought if appropriate.
- Approaches must be person-centred and care provided in ways which are personalised, rather than based on assumptions and stereotypes.
- Nurses must strive to promote and support human rights, dignity, privacy and choice.

## 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 and/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).

## Appendix 2

# Sexuality, intimate relationships and sex in later life – key facts

Sexuality remains a fundamental aspect of who we are as individuals throughout our lives. It influences identity, self-image, self-concept and self-worth. It also affects mental health, social relationships and quality of life.

Sense of self and identity is 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.

Not everyone living, visiting or working in a care home is heterosexual. It is estimated that something like 5-10 per cent of the population are lesbian, gay or bisexual. In a 120-bed care home, this would equate to six to twelve residents.

It has generally been assumed that sexual relationships are most important in younger life and that pleasure in sex dwindles with age. However, as international evidence is now highlighting, many people continue to enjoy sexual relationships well into later life.

The importance of sex does not necessarily diminish in later life, particularly in established couples. 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. Increasing age and life experience can be seen as facilitating coping when sex became less frequent or stops altogether.

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. Men can find this particularly difficult. Despite this, many older people would welcome the opportunity to discuss sexual issues. Empowering older people to discuss sexual issues, including sexually transmitted infections, with younger people can enhance intergenerational understanding.

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 HIV, are steadily increasing in the over 50 age groups.

## Appendix 3

# Legal and professional frameworks for practice

This section identifies the legislation and professional frameworks relevant to sexuality, intimate relationships and sex in UK care homes.

### 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 privacy and family life guaranteed under Article 8, is particularly relevant in care homes, and recognises 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. It should be noted however, 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.

In this context however, the World Health Organization (2010) has 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
- respect for bodily integrity

- seek, receive and impart information related to sexuality
- sexuality education
- the highest attainable standard of sexual health, including access to sexual health care services
- pursue a satisfying, safe and pleasurable sexual life.

The responsible exercise of human rights requires that all persons respect the rights of others”.

### Anti-discrimination legislation

The Equality Act 2006 established the Commission for Equality and Human Rights, to investigate and enforce anti-discrimination legislation across England, Wales and Scotland, although the Commission takes no action where the Scottish Parliament has legislative competence. Northern Ireland has its own Equality Commission, established under the Northern Ireland Act 1998. The following section does not apply to Northern Ireland, though there are equivalent provisions in operation there.

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.

## Mental capacity

Where a vulnerable adult lacks the mental capacity to make decisions on his/her own behalf, the courts will step in to protect them. Two essential questions arise for the court: does the adult have the capacity to make that particular decision, and what would be in his/her best interests?

In determining capacity there are three broad legal principles to be drawn from common law:

1. An adult is presumed to have capacity unless the contrary is shown.
2. Capacity is 'issue specific', which means that someone may have the capacity for one purpose (for example, to decide where to live), but not for another purpose (for example, to marry). In other words, the court will consider the adult's capacity in relation to the specific 'transaction' in question.
3. Finally, even in relation to a particular type of transaction, such as deciding on whether to consent or withhold consent to medical treatment, the adult may have the capacity to decide on a simple medical procedure, but lack capacity to consent to a more complex medical procedure. As the Mental Capacity

Act 2005 Code of Practice provides: 'An assessment of a person's capacity must be based on their ability to make a specific decision at the time it needs to be made, and not their ability to make decisions in general' (paragraph 4.4).

The test of capacity generally in English law is the ability to understand the nature and quality of the relevant transaction. Concerning sexual relations, for example, the capacity to consent depends upon a person having:

- sufficient knowledge and understanding of the nature and character of the act in question and of the reasonably foreseeable consequences of such an act
- the capacity to choose whether or not to engage in it
- the capacity to decide whether to give or withhold consent to the act (*X City Council v MB, NB and MAB* [2006] EWHC 168 (Fam)).

In line with point 3 of the general principles above, capacity has to be assessed in relation to the particular kind of sexual activity in question.

In short, the court generally is concerned with determining whether the adult 'understands' the problem, and has the capacity to decide what to do about it. The various common law tests for determining capacity have recently been given statutory force in Section 3 of the Mental Capacity Act 2005.

The Mental Capacity Act 2005 and Mental Capacity Act Code of Practice now apply in England and Wales. Similarly, the Adults with Incapacity (Scotland) Act 2000 and the Age of Legal Capacity (Scotland) Act 1991 apply in Scotland. The legislation aims to protect adults (defined as people age 16 or over) who are unable to make their own decisions, and prescribes how those decisions may be made in the absence of capacity. Best interests guidance has also recently been issued by the British Psychological Society.

In almost all aspects of care, the Mental Capacity Act 2005 will apply to nursing practice. However, sections 27-29 of the Act set out those decisions that can never be made or actions authorised under the Act, whether by family members, carers, professionals, attorneys or the Court of Protection.

### Decisions that cannot be made under the Mental Capacity Act (Section 27)

There are some decisions that nurses are not entitled to



take on behalf of someone else (known as excluded decisions). These include:

- entering a marriage or civil partnership
- having sexual relations
- a decree of divorce or dissolving a civil partnership on the basis of two years separation.

These decisions are to do with ‘personal relationships’ and the statutory best interests framework does not apply here.

Notwithstanding the exclusions however, the act remains relevant in the following respects:

1. Apart from the requirement to observe the provisions of the Act when delivering health care generally, the High Court has held recently that when cases come before the courts, other than the Court of Protection, the Judges can adopt the new definition of capacity under the 2005 Act, if they think it is appropriate, having regard to the established common (or judge made) law (*Re MM (an adult)* [2007] EWHC 2003 (Fam)). Paragraph 4.33 of the Code to the 2005 act reflects this: “The Act’s new definition of capacity is in line with the existing common law tests, and the Act does not replace them. When cases come before the court on the above issues [e.g. capacity to make a will, enter into a contract, litigate, marry etc], judges can adopt the new definition if they think it is appropriate. The Act will apply to all other cases relating to financial, health care or welfare decisions.” In other words, the statutory definition of consent is likely to influence future decisions on capacity and consent generally in relation to vulnerable adults, including the circumstances in which they may be held to either have the capacity, or lack the capacity, to enter into sexual relations.
2. Under sections 16 and 17 of the Act, the Court of Protection may exercise its power to make ‘substitute decisions’ for persons lacking the required mental capacity, about their social welfare, including where they may reside and with whom they may have contact. This may be because of the need to protect them from the risk of harm or abuse by another. These provisions may of course be relevant in the context of an adult lacking capacity, who desires to enter into sexual relations with another.
3. The court, when exercising its power in relation to

vulnerable adults, must focus on the best interests of the adult. This involves a ‘welfare’ appraisal in the widest sense, taking into account a range of ethical, social, moral, emotional and welfare considerations. The court will also take account human rights principles and case law, in particular Article 8 and the right to respect for an individual’s ‘private life’. The 2005 Act provisions on best interests may in future influence the determination of this issue outside of the areas expressly covered by the Act.

4. Finally, paragraph 1.11 provides a helpful reminder that: “Although the Act does not allow anyone to make a decision about [excluded] matters on behalf of someone who lacks capacity to make such a decision for themselves (for example consenting to have sexual relations) this does not prevent action being taken to protect a vulnerable person from abuse or exploitation.” Causing a person to have sexual relations without consent is clearly unlawful under sexual offences legislation, for example rape, indecent assault, and specific offences involving those with a mental disorder. The 2005 Act therefore remains relevant to the handling of situations where the resident is exposed to the risk of harm or abuse in sexual relations with another.

The Mental Capacity Act 2005 identifies five fundamental principles that apply to all actions and decisions taken under the Act that reflect the general legal principles relating to capacity (as described above):

- 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
- 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
- individuals must retain the right to make what might be seen as eccentric or unwise decisions
- best interests – anything done for or on behalf of people without capacity must be in their best interests
- 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.

**Best interests: guidance on determining the best interests of adults who lack the capacity to make a decision (or decisions) for themselves [England and Wales], British Psychological Society (2008)**

The legal framework for making best interests decisions is defined in the Mental Capacity Act 2005, and further policy guidance is to be found in the statutory Code of Practice. The BPS guidance adds further to the Code of Practice by looking in more detail at the types of factors that might need to be considered in making a best interests decision and in considering the process of best interests decision-making.

The 2005 Act draws together established case law and policy into a legal framework, ensuring that those who provide care for someone act in accordance with explicit statutory requirements. It requires that carers and professionals:

- ensure that capacity is appropriately assessed – you should not be making decisions on behalf of other people until it is clear that those in their care lack the capacity to do so for themselves, and that this lack of capacity has been properly established
- once a decision has been made that someone lacks capacity, you need to follow the process described in section 4 of the Act, and the guidance in the Code of Practice, for determining the best interests of the patient
- enhance decision-making capacity amongst those who may lack it – the Mental Capacity Act requires that you do as much as you can to support and help people make decisions for themselves
- record the rationale behind any decisions that are made – you need to make sure that the factors you have considered and the judgments you make about best interests can stand up to scrutiny.

In a 'best interests' decision, the decision-maker decides what the 'best course of action' is for the person who lacks capacity. It considers both the current and future interests of the person, weighs them up and decides what is the best course of action, on balance, for them.

The Act does not give a clear definition of best interests, but instead outlines the factors that need to be considered when you are trying to make a decision on behalf of someone else.

The care plan should document the assessment of capacity.

## Sexual Offences Act

Passed in 1956, there have been various amendments including the Sexual Offences Act (2003).

The provisions of the sexual offences legislation are particularly relevant in care homes where individual residents request:

- that a sex worker be brought into the home to visit them within the privacy of their room
- that a member of staff assist with meeting sexual needs, for example through masturbation.

In relation to respecting a patient/resident's human rights, there are arguments that may be made for allowing them in care homes to avail themselves of the services of a sex worker. These would likely revolve around Article 8 – the right to a private life.

Bringing sex workers into care homes could, however, legally compromise the provider and/or manager as they may be liable for a criminal offence under sexual offences legislation, for example that of "keeping a disorderly house". This is an offence that involves keeping a "common, ill-governed and disorderly house" and can be committed by someone who only "acts or behaves as master or mistress, or as the person having the care, government or management of it – notwithstanding that they are not in fact the real owner or keeper."

A disorderly house is one that is "found to be kept open to, and frequented by, persons who conduct themselves in such a manner as to violate law and good order." A care home manager or provider (who is indisputably the person having government or management of a house) might be liable for such an offence, assuming the conduct of any sex workers there could be said to "violate law and good order." What specific conduct could be said to amount to a violation of law and good order could be debated, though there may be individuals who would find the presence of a sex worker at a care home violated 'law and good order'. The offence, though arguably somewhat archaic, still remains enforceable and there appear to have been convictions as recently as the 1970s.

It is also a specific offence under the Sexual Offences Act to keep a brothel, and, although a visiting sex worker does not turn a care home into any sort of brothel, case law says that whether premises amount to a brothel is a question of fact and degree. A brothel is “a place resorted to by persons of opposite sexes where the women offer themselves as participants in physical acts of indecency for sexual gratification of men. It is not essential that there is evidence that normal sexual intercourse is provided on the premises: evidence of masturbation provided for clients is sufficient.” There would be a risk, for example in a care home, should more than one resident seek to use the services of a sex worker in a way that is permitted by the provider/manager.

While for most purposes a resident’s own room within a care home is deemed to be their ‘own home’, individual contract terms may vary. For the purpose of the offences described however, that might not necessarily affect a provider/manager’s potential liability, in the event that they knew about the activity and to the extent that it occurred with some regularity.

There are also concerns about the possible implications for staff. Under no circumstances should staff play any part in making arrangements for a sex worker as, in doing so, they may well risk liability for an offence under the Sexual Offences Act (such as exploiting a prostitute). Even without direct involvement, it would be difficult for the Care Quality Commission as the regulator to offer any guidelines on how such arrangements could be made, and what providers should be saying in their statement of purpose etc that would not expose staff to the risk of criminality.

In some cases, staff have been asked themselves to perform services akin to a sex worker, such as masturbation. There are very obvious risks to which any staff member would be exposing him or herself in such a situation – for example, risk of criminal prosecution, or exploitation. Nurses would be at risk of breaking the NMC Code and guidance on registrant/client relationships, and the prevention of abuse. The conclusion has to be that engaging in these activities is not advised.

In addition, there are offences relating to people with a ‘mental disorder’ and the management of homes under the legislation that may, in certain circumstances, be relevant – see, for example, the first illustration provided in the case examples in Section 6 of this publication.

## Professional issues

Sexuality and sexual health are important elements of patient care and employers should ensure that nurses are competent to deal with this.

To prevent potential abuse of the nurse/patient relationship, employers must have clear policies for nurses to identify levels of competence and the professional boundaries of their work.

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 Nursing and Midwifery Council

The NMC has clear standards and guidelines which are explicit in relation to what is expected of a registered nurse and midwife in terms of delivery of care. The NMC Code: standards of conduct, performance and ethics for nurses and midwives (2008) 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 well being of patients in their care, their families and carers, and the wider community. This is particularly relevant and important when caring for patients from vulnerable groups including those who live in care homes.

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.

### **NMC guidance for the care of older people (NMC 2009b)**

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.

Discriminatory abuse is defined as: "Oppressive attitudes towards a person motivated by negative attitudes towards race, gender, disability, religion and belief, age, culture or sexual orientation."

Sexual abuse is defined as: "Forcing someone to take part in any sexual activity without their consent."

While clients are the focus of this document, the NMC recognises that their needs will not be met while registrants are themselves vulnerable to abuse within the workplace. All employers and health services managers are responsible for ensuring that registrants can practice within the requirements of the Code in an environment that is safe, supportive and free from abuse.

### **Safeguarding vulnerable adults [Current arrangements for safeguarding adults are under review]**

Registered nurses and care workers are increasingly regulated when delivering health and social care to vulnerable members of society. Alongside the consequences of disciplinary action against a nurse by the NMC and employer, both nurses and care workers are at risk of being banned from working at all with vulnerable people, whether adults or children, where they are found to have harmed or placed at risk of harm those in their care, and are considered unsuitable to work with them.

As a result of the Safeguarding Vulnerable Groups Act 2006 the present scheme for regulating health and social care workers came into force in October 2009, replacing

the previous Protection of Vulnerable Adults (POVA) List scheme that regulated those providing care in the independent health care sector.

The inclusion of someone on a 'barring' list prevents that person working with vulnerable adults if that involves 'regulated' activity, as defined under the 2006 Act. In addition, the Act introduced monitoring arrangements, which mean that if carers wish to work with vulnerable adults they must first be registered with the Independent Safeguarding Authority.

Finally, although the Act applies to England, Wales and Northern Ireland, broadly equivalent provisions apply in Scotland under the Protection of Vulnerable Groups (Scotland) Act (2007).

A person will be included on the barred list where they have been:

- convicted of certain sexual offences
- convicted of a wide range of other offences which indicate a very probable risk of harm to vulnerable adults or
- have engaged in 'relevant conduct', defined as: conduct endangering or likely to endanger a vulnerable adult; which, if repeated would endanger or be likely to endanger a vulnerable adult; involving sexual material relating to children; inappropriate conduct involving sexually explicit images depicting violence against human being; inappropriate conduct of a sexual nature involving a vulnerable adult (Schedule 3 of the act).

In the light of the risks of barring it is critical that decisions about how to meet the reasonable sexual needs of a resident are taken at a senior level in the organisation and only after a very careful assessment of all of the circumstances of the case, good professional practice and the relevant law as outlined above, and following appropriate expert and legal advice. An organisational policy addressing the issue is also critical.



## Appendix 4

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## Appendix 5

# Additional resources

### Department of Health

The Department of Health has produced a series of 13 briefings for health and social care staff on reducing health inequalities for lesbian, gay, bisexual and trans (LGBT) people. One briefing focuses specifically on older lesbian, gay and bisexual people.

These are available at the publications section of the Department of Health's website [www.dh.gov.uk](http://www.dh.gov.uk)

### Royal College of Nursing

The RCN has produced a wide range of documents designed to help nurses provide safe, effective and accountable care to clients. The following documents are all available for download at [www.rcn.org.uk](http://www.rcn.org.uk):

*Sexuality and sexual health in nursing practice: an RCN discussion and guidance document* (2000)

*Sexual Health Strategy: guidance for nursing staff* (2001)

*The nursing care of lesbian and gay male patients or clients: guidance for nursing staff* (2003)

*Sexual health competencies: an integrated career and competence framework for sexual and reproductive health nursing across the UK* (2009)

#### Sexual health skills course

This 13-week sexual health skills course, now delivered on behalf of the RCN through the University of Greenwich, is also available as an e-learning provision. Visit the University of Greenwich website [www.gre.ac.uk/schools/health](http://www.gre.ac.uk/schools/health) to download a brief programme and booking form.

### Social Care Institute for Excellence

*Sexual and reproductive health for mental health professionals*

Free on-line course incorporating issues for older people with mental health needs.

[www.scie.org.uk](http://www.scie.org.uk)

### Age UK

Age UK (formerly Age Concern and Help the Aged) is the UK's largest charity working with and for older people.

A range of resources and information guides are available from Age UK websites at:

[www.ageuk.org.uk](http://www.ageuk.org.uk)

[www.ageconcernandhelptheagedscotland.org.uk](http://www.ageconcernandhelptheagedscotland.org.uk)

[www.ageuk.org.uk/cymru](http://www.ageuk.org.uk/cymru)

[www.ageuk.org.uk/northern-ireland](http://www.ageuk.org.uk/northern-ireland)

These include *Later life as an older lesbian, gay or bisexual person*.

The Opening Doors programme, originated by Age Concern England, incorporates publications, resources and events for and about older lesbians, gay men, bisexual and transgender people in the UK.

### Alzheimer's Society

The Alzheimer's Society produces a range of publications and resources, from guides to implementing good practice and planning quality care services. The Society has a LGBT support group for carers and provides a number of resources – including on understanding and respecting lesbian and gay people, legal issues for lesbian and gay people, choosing residential accommodation and caring for a person with dementia if you are a member of the LGBT community.

Much information is available for download free from the Alzheimer's Society website [www.alzheimers.org.uk](http://www.alzheimers.org.uk)

## Lesbian Information Service

The LIS provides a range of resources and publications for older lesbians, which are available at [www.lesbianinformationservice.org](http://www.lesbianinformationservice.org)

## Other organisations

### Association to Aid the Sexual and Personal Relationships of People with a Disability (SPOD)

Offers advice on sex, sexuality and personal relationships tailored to the needs of people with disabilities. Website: [www.spod-uk.org](http://www.spod-uk.org)

Contact details: 286 Camden Road, London N7 0BJ

Helpline: 020 7607 8851 Email: [info@spod-uk.org](mailto:info@spod-uk.org)

### Office of the Public Guardian

The Public Guardian website offers an overview of mental capacity legislation in England and Wales, along with a range of booklets for the public and professionals. See [www.publicguardian.gov.uk](http://www.publicguardian.gov.uk)

In Scotland, the Public Guardian registers continuing and welfare powers of attorney, authorisations to access funds, guardianship orders and intervention orders pronounced in terms of the Mental Capacity Act in Scotland. See [www.publicguardian-scotland.gov.uk](http://www.publicguardian-scotland.gov.uk)

### Older Lesbian, Gay, Bisexual and Transgendered People's Network and University of Salford Learning Pack

This teaching and training resource pack has been produced by members of the *Older Lesbian, Gay, Bisexual and Transgendered People's Network* based in the North West of England in association with the University of Salford. To purchase a pack, contact Steve Pugh at The University of Salford on 0161 295 2375 or email: [s.e.pugh@salford.ac.uk](mailto:s.e.pugh@salford.ac.uk)

### Scottish Transgender Alliance

Aims to improve the lives and experiences of all transgender people living in Scotland.

See [www.scottishtrans.org](http://www.scottishtrans.org)

### The International Longevity Centre

*The Last taboo, A guide to dementia, sexuality, intimacy and sexual behaviour in care homes.*

Aimed at care home workers and managers, the guide provides essential information on this aspect of dementia care and offers practical advice to support current work-based practices. Set out in an accessible and easy-to-read format, this guide includes case studies, questions, suggestions and a self assessment quiz to promote easy learning. It also provides a possible pathway for care home managers to develop a guiding policy on sexual expression in dementia. Published July 2011.

See [www.ilcuk.org.uk](http://www.ilcuk.org.uk)



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