Frequently Asked Questions and Answers Related to Resident Sexual Activity

Prepared by the Interdisciplinary Resident Intimacy and Sexuality Task Force

August 2014

These Questions and Answers are meant to serve as a source of information for staff and are not meant as a guarantee of compliance with regulations for Medicare/Medicaid Certified Facilities or Colorado Licensure Regulations. **These guidelines are not meant to serve as legal advice.** Each care community must develop written policies and procedures/best practices, specific to the care community, which provides instruction to staff for their use. It is recommended that the legal counsel for the care community review the policies and procedures/best practices prior to implementation.

1. Can a guardian or Medical Durable Power of Attorney make decisions about a resident's right to engage in sexual activity with another resident? Does the answer change if one of the resident's has a sexually transmitted infection?

Generally, a guardian cannot decide whether or not the resident (protected person) can engage in sexual activity with another resident without specific orders from the court in the guardianship proceedings. However, if one of the resident's has a sexually transmitted infection and the resident (protected person) is engaging in sexual activity that carries a substantial risk of infection or harm to the resident (protected person), and the resident (protected person) is not capable of understanding and assuming the risks, then a guardian can decide to disallow a resident (protected person) from engaging in the risky sexual behavior with another resident. If there is any question raised about this decision, the guardian should petition the court for specific instructions. Every effort should be made to educate the resident (protected person) about safe sex practices and staff from CDPHE, STI/HIV and Infectious Disease Section should be contacted to provide counseling and education. Every effort should also be made to protect the resident's (protected person) right to engage in sexual activity with proper safeguards and efforts to mitigate any substantial risks of harm.

In addition, an agent holding a Medical Durable Power of Attorney cannot make decisions about a resident's (the principal) right to engage in sexual activity unless the resident is deemed incompetent by his/her physician and the MDPOA document gives the MDPOA (the agent) the specific authority to make this type of decision. If the power of attorney designation does not authorize the ability to make this decision, the agent should consider pursuing guardianship of the resident to clarify his/her authority regarding this decision.

2. What are the rights and responsibilities of the guardian?

A guardian has the responsibility to assure that the resident (protected person) maintains the greatest degree of independence possible, and to encourage the resident to make as many decisions as possible. Therefore, a resident with a court appointed guardian would generally retain the right to make decisions about his/her daily life, e.g., food, schedule, activity and clothing choices. The resident also retains the right to vote and marry if they choose. The involvement of the guardian would only be necessary when

the decision/behavior in question raises questions that may affect the health or safety of the resident. Sexual activity would generally fall into the category of normal adult behavior over which a resident retains the right to make his/her own decisions, barring significant medical considerations. Significant medical considerations could include STI's, HIV and Hepatitis B&C. It is important to remember that a guardian does not have financial responsibility for the expenses incurred by the resident, even though the guardian may be making financial decisions for the resident, and the guardian is not legally liable or personally responsible for the behavior of the resident.

3. When should a resident's physician be notified of sexual activity of a resident and what role does the physician play in decisions about the safety/continuation of/ ability to consent to sexual activity of the resident?

Physician notification about a resident's sexual activity would not be appropriate or necessary, in the absence of medical complications or considerations related to the resident's physical condition. Physicians do not have the authority to mandate treatment, abridge rights, or determine a resident's activities or relationships. Physicians prescribe treatments, make recommendations, coordinate with care providers, monitor, assess and educate. A physician's role can include discussion with residents under their care regarding the risks and benefits of any activity or treatment, including sexual behavior and consultation with staff related to the medical considerations for a particular resident's sexual activity.

Note: Regulations in both SNFs and ALRs require a physician to be notified whenever:

- There is a significant change in resident's condition
- Evidence of possible infection
- Injury or accident sustained by the resident which might cause a change in condition
- Known exposure to a communicable disease/infection

4. Should staff notify family members (spouse, children, and siblings) of a resident's consensual sexual activity?

NO, except when:

1. the resident is not capable of understanding and assuming risks, AND
2. is engaging in sexual activity that carries a substantial risk of harm to the resident, AND
3. the family member has legal authority over the resident, i.e. guardianship or power of attorney.

Per regulations, §483.10 (e)

Residents have the right to personal privacy and confidentiality. Personal privacy includes accommodations, medical treatment, written and telephone communications, personal care, visits, and

meetings of family and resident groups. "Right to privacy" means that the resident has the right to privacy with whomever the resident wishes to be private and that this privacy should include full visual,

and, to the extent desired, for visits or other activities, auditory privacy. Resident may also refuse the release of personal and clinical records “to any individual outside the facility.”

If staff suspect abuse and sexual activity was without consent, care communities are required to report, Investigate, and notify an emergency contact within 24 hours of becoming aware of any allegation. See #7 about assessing consent.

5. Do issues regarding a resident's sexual activities ever need be care planned?

The sexual activity of residents is normal behavior and therefore definitely **NOT** care planned unless a problem arises. This could be compared to a resident’s eating and sleeping habits, behavior which is not routinely care planned unless a concern is identified related to the care and well being of the resident. When an issue related to the sexual activity of a resident develops, e.g., physical harm, medical risk, need for medication, problematic pre or post sexual activity behavior, regular violations of others rights to privacy, or public masturbation, it is appropriate to open a care plan problem for that issue. Notation should also be made in the resident’s record of educational efforts regarding safe sex practices. This could also include information about the ability of the resident to understand and retain the information and any staff efforts at continuing and tailoring the education to the particular resident’s needs. If such an issue is entered into the care plan, make assurances that the resident’s right to the confidentiality of this information is protected at the care conferences and special consideration given to the delicate nature of this information, especially in regards to non staff members, at care conference.

When including family members in care planning, when the portion dealing with sexuality is to be discussed, the family should be advised that the resident is allowed some privacy related to certain issues. If this type of approach regarding privacy and sexual behavior is established in the beginning, it is easier to handle when difficulties arise. Such clarification early on about what information a family does or does not have access to may be helpful.

6. Do I as a staff member intervene when a resident engages in consensual sexual activity with someone other than his/her spouse?

No. Residents have the right to engage in mutually consenting relationships, regardless of their marital status or sexual orientation. In the outside community, individuals have the right to engage in extramarital relationships, in spite of any existing religious, moral or societal norms. There should be no distinction in a long-term care community, provided both residents consent to the relationship.

Given the range of possible emotions and responses from the spouse or other family members to a resident’s sexual activity, it is important for staff to respond promptly and with sensitivity to family concerns, while maintaining resident confidentiality.

7. How do I assess a resident’s ability to consent to sexual activity? How can I tell if the sexual activity is consensual?

If there are concerns that a resident’s sexual activity is not consensual, trained staff should first discuss the matter with the resident. It may be helpful to seek assistance from mental health professionals,

master’s level social workers, psychologists, or psychiatrists in making the assessment as to a resident’s ability to give informed consent to sexual activity. Any conversation with resident must be pursued with discretion, dignity and respect. Possible questions could include:

I notice that you are spending a lot of time with _____, You seem angry, anxious, upset, sad (whatever you have observed), Is there anyone or anything here that makes you feel uncomfortable?

It is important to remember that a resident with dementia and/or cognitive impairment may have the ability to give consent regarding intimacy and sexual activity. Observe non-verbal clues. Does resident appear happy when with the other person? Do they seek each other out?When trying to determine consent, it is important to assess/monitor reactions (e.g., fear/comfort, anxiety/calm), interactions between partners and others, changes in mood and affect, emotions displayed, any positive and/or negative signs and symptoms, physical/medical changes/symptoms (e.g., bruising, UTI), and changes in routine(e.g., eating, activity level, socialization, sleep).

Keep in mind: people are complex and they change. Residents may give consent one day and not another. Also, an individual’s needs and behaviors normally change over a lifetime. Thus, current sexual activity may not be consistent with prior lifestyle, preferences, relationship patterns and beliefs.

Refer back to *Investigative Guidelines and Policies* and *Procedures Concerning Sexual Expression at the Hebrew Home at Riverdale*

8. What about the privacy and rights of the roommate of a resident who is sexually active?

Residents/roommates have the right to privacy and to not be imposed upon by being exposed to others’ sexual activity and related private, personal behavior.

Care communities are required to provide accommodations for privacy to ensure that residents have a safe, comfortable private environment for intimate expressions of affection and sexual activity. It can also be appropriate to explore and discuss options with roommates to mutually agree on some private time for each resident in the room or other reasonable arrangements.

9. What should be staff response to sexual activity between residents of the same sex?

Staff response to resident sexual activity should be the same whether or not the partners are of the same or a different sex. The same considerations of privacy and confidentiality, safe sex practices, safety, and consent apply. It is important for staff to separate their personal views of the sexual behavior from their professional responsibility to the residents to provide for their expression of affection and intimacy with another resident in the care community which is their home. The same guidelines from question #4 apply to this question regarding when to share private information with families.

10. How should staff respond to residents who engage in sexual activity in public places, in view of other residents or staff?

Public displays of sexual activity, including masturbation, that go beyond hand-holding, hugs and kisses are generally more appropriate in a private setting, i.e., a resident's room. However, for some residents their disease process has altered the part of their brain that regulates these cultural norms and thereby reduces, for some residents, their inhibitions. Therefore, they fail to recognize what is and is not appropriate relative to the proper place to engage in sexual behavior. Staff is responsible for ensuring that the needs of all residents are met, both for privacy to engage in sexual activity and freedom for others to not be exposed to the private acts of other residents.

Staff should ensure they know in advance how they will handle the situation. For residents whom sexual activity in public places is an ongoing issue, the issue should be addressed in their care plan so that all staff will know how to respond appropriately. An appropriate staff response would be to quietly and tactfully redirect residents to a private space, never embarrass, tease or ridicule the behavior, and generally treat the behavior as normal. Redirect as you would someone who engaged in other acts that are normal but generally considered private behavior that may be offensive to those around them, e.g., undressing in public. Staff should be trained regarding these issues and have the opportunity to discuss what an appropriate response would be prior to such an event occurring.

11. How and when should residents receive information about birth control if appropriate, safe sex practices and sexually transmitted diseases?

All residents who may be sexually active should be offered information and the opportunity for education on safe sex practices. Offer age and medically appropriate information regarding birth control. Involve the primary care physician in the decision making process for medically appropriate birth control. Group educational opportunities normalize sexual activity and can be done in any setting. For example, it could be a topic at a resident council or neighborhood meeting. Residents should have several sources through which to access this information, e.g., their case managers, facility social services staff, nursing personnel, and outside agencies.

12. How should staff respond to a sexually active resident who chooses multiple partners?

The choice to engage in sexual activity with multiple partners is the right of the resident. Due to the delicate and complicated factors that arise when multiple relationships occur within the same facility, the psycho social needs and safety of each individual involved must be considered and monitored. It is expected that residents' physical and emotional needs will be identified, regularly evaluated and addressed as appropriate and that risk reduction education efforts be instituted. It should be emphasized that staff should be pro-active in their efforts to educate residents and increase the efforts when residents may be at risk.

13. What should I do if one of the residents in the long-term care community has an STI - Sexually Transmitted Infection?

You should notify the Colorado Department of Health, STI/HIV Field Services Program at 303-692-2700.

When an issue related to the sexual activity of a resident develops, e.g., physical harm, medical risk, or need for medication, it is appropriate to open a care plan problem for that issue. Notation should also be made in the resident's record of educational efforts regarding safe sex practices. This could also include information about the ability of the resident to understand and retain the information. If such an issue is entered into the care plan, make assurances that the resident's right to the confidentiality of this information is protected at the care conferences and special consideration given to the delicate nature of this information, especially in regards to non staff members, at the care conference.

If you know the resident with a sexually transmitted infection is engaging in sexual activity with another resident, also encourage the infected resident to disclose the information to his/her partner(s). Staff should also assist the resident in developing, if possible, the communication skills necessary for disclosure as well as provide the resident with emotional support to follow through with the disclosure. The CDPHE STI/HIV Field Services Program should be contacted and they can provide guidance and consultation to residents and staff regarding these important conversations and how they should be handled.

14. Is there a duty to warn residents who are or may be a partner in sexual activity with a resident who has a sexually transmitted infection?

Although state law provides for strict protection of the confidentiality of HIV infected individuals as well as others, this does not necessarily mean there is no duty to warn. Up until now, there has not been sufficient case law or legal precedent to determine whether or not there is a duty to warn in the case of an HIV infected person placing another at risk. Staff should consider referrals to appropriate STI/HIV prevention services such as HIV prevention case management provided by CDPHE as well as several local community-based organizations.

Physicians should also be contacted to ensure testing and treatment of partner(s), if they live in the facility. It is permissible to tell a resident that "you have been exposed to (a sexually transmitted infection)from a sexual partner". You cannot disclose the name of the infected party, but can encourage the resident to ask their sexual partner(s) about STIs and also encourage the exposed resident to have the medical tests necessary to determine if they are infected and require treatment. Staff have the same responsibility to protect resident confidentiality related to any diagnosis, including that of a sexually transmitted infection. This does not however, relieve the facility of its obligation to offer education and direct residents toward appropriate safer sex practices and to continue to make condoms and other appropriate materials readily available. It is advisable to direct your efforts at educating both the infected and uninfected resident.

15. What is the role/responsibility of staff to sexually active residents who regularly go out on a pass from the long-term care community?

In a SNF it is generally expected that residents will be evaluated upon admission to determine if it is safe and appropriate for them to have such pass privileges. Once this has been done, staff should be sure that the resident has been offered education in safe sex practices and free, confidential access to items needed, . The staff is responsible for ongoing education based upon the changes in the resident's social, psychological and medical circumstances. This would include continued efforts to educate residents about safe sex practices and reinforcement for less risky behaviors. These types of educational programs have been conducted with developmentally disabled adults and technical assistance from community center boards throughout the state may be helpful in developing specific steps staff could take to support risk reduction behavior. If the resident is at risk of being abused or victimized, their pass privilege should be regularly assessed and evaluated for the continued safety of the resident. Observe and evaluate the resident upon return to the building, if appropriate.

In an ALR all residents in a non-secure environment are guaranteed the right to leave and make visits outside the long term care community. ALR staff is not required to provide ongoing education to residents.