The opinions expressed in this document, which includes two appendices, are those of the Board on Aging and Long Term Care – Ombudsman Program. Wisconsin state statutes and case law were researched to assist in developing the four guidelines for the ability to consent to a sexual relationship. For facilities that are not located in Wisconsin, it is recommended to research your state's statutes for guidance on determining a person's ability to consent to a sexual relationship.

The Board on Aging and Long Term Care would like to thank the following for their contributions to this document and appendices: Deb Captain, Good Shepherd Nursing Home; Brian Purtell, Wisconsin Center for Assisted Living; John Sauer, LeadingAge Wisconsin; Tom Moore, Wisconsin Health Care Association; Alzheimer's Association.

Recommendations for Addressing Resident Relationships

This document provides guidance to facilities suggesting what might be included in a Resident Relationships Policy that addresses intimacy and sexuality issues. It does not in any way constitute a regulation, mandate or requirement. Facilities are encouraged to write their own policies related to these issues.

POLICY OBJECTIVE

The purpose of a resident relationships policy is to affirm and respect the rights of all residents to engage in consensual relationships, whether professional, platonic, married, non-married, intimate or sexual in nature. The policy should uphold the belief that healthy consensual relationships are central to quality of life, and promote an environment that allows individuality, autonomy, dignity and respect to thrive. A facility should welcome and respect all residents, whether lesbian, gay, bisexual, transgendered or heterosexual. A policy should address the right of the resident to engage in any consensual relationship even if the relationship creates challenges to religious, doctrinal, family or societal beliefs, including pertinent privacy and confidentiality issues. At the same time, a facility should acknowledge its responsibility to protect residents who may not be able to consent to sexual relationships. A policy provides guidance to the multi-disciplinary care team to carry out this balance of rights and protection in all relationships.

RESIDENT RIGHTS

Resident rights are the foundation for all decisions in long-term care organizations. Clearly, all resident relationships, including those of a consensual intimate and sexual nature, should be respected, protected and embraced by all. Educating residents, family members, Power of Attorney for Health Care agents and guardians regarding the inherent rights of every resident is imperative to assure all rights are respected, protected and promoted, while also balancing that with the need to protect vulnerable residents.

The facility needs to recognize the resident has the right:

- To be offered choices and to make choices about aspects of their life in the facility that are significant to the resident
- To be valued as an individual, to maintain and enhance self- worth
- To be treated with courtesy, respect and dignity
- To be free from humiliation or harassment
- To be free from physical, sexual, mental, verbal or financial abuse
- To live in an environment where personal privacy and confidentiality are respected
- To private and unrestricted visits with any person of choice
- To participate in planning of care and services
- To choose how to arrange personal time, and engage in what is important to her/him
- To share a room with any person of choice, as long as both agree to the arrangement
- To reasonable accommodation of individual needs and preferences

In addition to having rights, every resident has a responsibility to not infringe on the rights of other residents. In cases where resident rights are in conflict, the facility along with the residents must strive to find a balance of rights.

This list is not all inclusive and other rights may apply to this policy. All residents shall receive a copy of the complete resident rights upon admission. Resident Rights shall also be posted in the facility where residents may access them at any time.

DEFINITIONS & DISCUSSION of TERMS

Intimacy—generally, humans desire to feel that they are important to others, that they belong, that they feel valued and that they are cared for by another person, or a group of people. Intimacy, and what classifies as intimacy, is unique to each individual and is not necessarily intended as sexual. An intimate relationship can be two residents of the same or different genders that feel affection, closeness or tenderness for one another. Intimate expression may include holding hands, hugging, cuddling or kissing in an attempt to provide each person with a sense of belonging and emotional support. Intimacy should be distinguished from sexual contact in a resident relationships policy.

Sexual Contact—the meaning of sexual contact for this policy is derived from the Wisconsin Sexual Assault Statute. A facility's regulatory obligation to protect vulnerable residents from any form of abuse

and the legal implications related to ability to consent are paramount when discussing sexual relationships. Paraphrased from WI statute section 940.225(5)(b), sexual contact includes intentional touching of intimate body parts, either directly or through clothing by the use of any body part or object, for the purpose of sexual arousal, gratification, degradation or humiliation.

Consent—there are no definitions in Wisconsin statutes that address the issue of consent as it relates to sexual contact in anything other than the context of criminal activity. Consent, as used in the Sexual Assault section in the Wisconsin Statutes, means "words or overt actions by a person who is competent to give informed consent indicating a freely given agreement to have sexual intercourse or sexual contact." The statute goes on to say "the following persons are presumed incapable of consent but the presumption may be rebutted by competent evidence:

- a person suffering from a mental illness or defect which impairs capacity to appraise personal conduct
- a person who is unconscious or for any other reason is physically unable to communicate unwillingness to an act."

The difficulty is that neither WI Statute nor case law defines "capacity to appraise personal conduct." However, the discussion in an opinion filed on November 6, 1997, Wisconsin Court of Appeals case State v. Smith, provides clear guidance to the meaning of this phrase. It indicates that the common sense meanings of the words chosen by the legislature permit a person of ordinary intelligence to determine if someone has capacity to appraise her/his own actions. The phrase simply means "the ability to evaluate the significance of." The discussion further indicates Wisconsin would probably require a relatively high degree of capacity and knowledge to be able to consent to sexual contact.

In Guardianship of Adults, DHS 2011 (http://www.dhs.wisconsin.gov/publications/P2/p20460.pdf), Attorney Roy Froemming's analysis of State v. Smith was used to suggest four guidelines on which to base an assessment to determine a person's ability to consent to sexual contact. The four guidelines are:

- the individual must understand the distinctively sexual nature of the conduct
- the individual recognizes her/his body is private and that s/he has the right to refuse to engage in sexual activity
- the individual recognizes the sexual contact may create possible health risks and physical consequences
- the individual needs to understand there may be negative social or societal response to the sexual behavior

A resident relationships policy should include procedures on how to assess for consent to sexual contact. These four guidelines, from case law, are recommended as the basis for an assessment.

EDUCATION

Education should be provided to residents at the time of admission, at resident council meetings and individually as needed, to ensure that they are aware of their right to maintain and develop all mutually consensual relationships, including those which are intimate or sexual in nature.

Education should be provided to all employees upon orientation and annually regarding intimate and sexual relationships in the long-term care setting. Education provides staff with the knowledge and tools needed to address situations appropriately and with sensitivity. It allows for open discussion about the topic, which for some people is embarrassing. It also helps build teamwork skills and promotes interdisciplinary approaches. Education gives staff confidence, and leads to acceptance and appreciation for the aging individual and her or his right to self-determination. Education also helps staff to respect resident rights. The facility should consider the following topics for training: Intimacy & Sexuality including consent guidelines, Resident Rights, Abuse/Neglect/Misappropriation, Alzheimer's Disease & Related Dementias, Ethics & Boundaries, Domestic Violence/Sexual Assault and Legal Decision Making. Staff education is important and provides a mechanism for assisting staff in not allowing their own personal beliefs or opinions to influence or get in the way of resident relationships.

Education regarding resident rights, including rights to meaningful relationships, should take place with the resident's family and/or responsible party at the time of admission. The orientation process of this facility shall educate the family or responsible party of its general policy regarding resident intimate or sexual relationships.

Education should be provided to families, health care agents and guardians in relation to their perceived power or control in directing resident relationships. Family members or legal decision makers do not have the authority to restrict intimate or sexual relationships when the resident is assessed to be a consenting adult.

Agents under an activated Power of Attorney are responsible to make *health care decisions* based on the preferences of the principal. A decision regarding intimacy or a sexual relationship by a consenting adult will often not involve a health care decision. Guardian's powers and authorities are dependent upon the terms of the order provided by the court. This may or may not include authority related to intimacy and sexuality. A finding of incapacity or incompetence does not automatically preclude a resident from making all decisions, and depending on ongoing assessment a resident may maintain the ability to provide consent to an intimate or sexual relationship.

Determination of a resident's ability to provide consent is critical; only the resident can consent to intimate or sexual relationships. Guardians, health care agents or family members are not legally permitted to provide an individual's consent for someone that is determined to not have the capacity to consent.

Given the complexity associated with residents having sufficient capacity to consent it is imperative that there be open dialog with health care agents, guardians and family members. All shall have their roles and limitations in the decision process explained including education addressing how to appropriately

interact with the resident regarding choices to engage in intimate or sexual relationships. This process acknowledges that most sexual relationships in long term care settings happen over time and with observable behaviors initiated by those participating. This assumes that those who have good rapport with residents, staff and family alike, may have periodic conversations with participating residents as part of the formal and informal assessment process so that decisions about whether the relationship is consensual are made over time and are resident-driven.

OTHER CONSIDERATIONS

Environment—the typical long term care environment (no locks on doors, twin beds, lack of private space) is a reality, and may be a challenge for facilities when trying to provide appropriate space for residents engaged in intimate or sexual relationships. Although these barriers exist, they should not inhibit resident choices about their relationships. Internal policies should be distinct to each facility based on the amenities available. Use of do not disturb signs on doors when residents request privacy is acceptable. An assessment of resident wishes, and engaging them in approaches to accomplish their intimate and sexual desires is expected. Facilities may need to re-evaluate their approaches to design and function related to changing resident expectations and needs.

Sexual Identity—Special considerations may arise when serving residents who are lesbian, gay, bi-sexual, or transgender (LGBT). Many LGBT persons have experienced discrimination at some point in their lives and may worry that service providers will respond negatively to their LGBT identity. Now in need of long term care—and the vulnerability that comes with it—LGBT persons have unique concerns. Some individuals revert to a false identity that does not allow for their true expression of self. Facilities need to recognize reluctance to reveal LGBT identity for fear of abuse, mistreatment or disrespect. Family ties might be severed and a life partner/spouse may be introduced in a manner that does not reveal nor honor the true relationship. LGBT elders may die alone. The facility must honor all resident rights, all relationships and strive to make all residents comfortable regardless of sexual identity so that all residents live their days with dignity and respect.

INTIMATE OR SEXUAL EXPRESSION

The facility needs to recognize that there are many ways for a person to express their sexuality. The following table illustrates four ways of sexual expression and the appropriate facility responses. This is not a progressive table; residents may or may not start with the first expression listed. It is staff's responsibility to recognize an intimate or sexual expression. Based on observation, history and interaction with residents, staff shall provide the appropriate response.

Intimate or Sexual Expression	Response by staff
Self-stimulating expression • Masturbating • Exposing oneself • Cross-dressing • Or other self-stimulating expression	• Based on ongoing observation, history and interactions, staff should know and understand the resident's motivation behind the behavior. • Find out if the expression is sexual in nature or if the resident is communicating another unmet need (have to go bathroom, pain, itching, etc.). • Staff must respect resident rights. Make sure staff responses are respectful and dignified, setting their personal beliefs aside. • Assure privacy and confidentiality • Accommodate resident needs. This may include assisting resident in acquiring sexually explicit material, condoms, vibrators, etc. • If not already completed, staff should complete an "Intimacy & Sexuality History" (Appendix 1) with the resident. • Ensure care plans are updated to reflect current observations, assessments and interventions. • To ensure best outcomes, assessment, care planning and education with residents, responsible parties and staff will be ongoing, as appropriate.
Verbal Sexual Talk • Suggestive language, flirting, sexual jokes	• Based on ongoing observation, history and interactions, staff should know and understand the resident's motivation behind the behavior. • If not already completed, staff should complete an "Intimacy & Sexuality History" (Appendix 1) with the resident. • Identify possible triggers for verbal sexual language. • If the sexual language is directed at staff, residents or visitors: o Staff should redirect the resident to a more appropriate topic or area of the facility.

	• Private conversation should be held with the resident about socially acceptable interactions. Staff will assist resident with defining parameters for that outcome. • Caregiver approaches: o Staff should watch their body language – hug carefully; consider shaking hands instead of giving hugs o Watch how staff provide cares o Staff should watch what they wear o Staff should be aware of their own language and conversations they are having with coworkers, visitors and residents o Staff should explain their role upon entering the room and address the resident formally o Maintain their professionalism o Work as a team – go in the room in 2's, start a CNA support group • Ensure care plans are updated to reflect current observations, assessments and interventions. • To ensure best outcomes, assessment, care planning and education with residents, responsible parties and staff will be ongoing, as appropriate.
Intimacy/Courtship • Hugging, handholding, cuddling, kissing	• Based on ongoing observation, history and interactions, staff should know and understand the resident's motivation behind the behavior. • If not already completed, staff should complete an "Intimacy & Sexuality History" (Appendix 1) with the resident. • No one person can make the decision for another person to have intimate relationships. Not a staff member, family member, not a Power of Attorney and not a legal guardian. Intimacy is a personal decision. • Staff needs to be aware of when 2 residents are expressing themselves intimately, early identification of intimacy is important. • Intimacy is not sexual contact.

	• The intimate relationship needs to be mutual and respectful. • When intimacy is identified, staff should begin a consent assessment (Appendix 2) in the event the intimacy leads to sexual contact. • Ensure care plans are updated to reflect current observations, assessments and interventions. • To ensure best outcomes, assessment, care planning and education with residents, responsible parties and staff will be ongoing, as appropriate.
Physical Sexual Expression/Sexual Contact • Fondling of breasts or genitals • Sexual Intercourse • Oral Sex • Anal Sex • Or other physical sexual expression	` • Based on ongoing observation, history and interactions, staff should know and understand the resident's motivation behind the behavior. • If not already completed, staff should complete an "Intimacy & Sexuality History" (Appendix 1) with the resident. • Consent assessment (Appendix 2) should be completed. **If both residents have been assessed to be consenting:** • Allow the relationship to continue. • Respect rights of the residents. • Regardless of deemed capacity/activated POA/guardianship, the resident is in command of his or her choice to engage in a sexual relationship. Sharing of information, or reporting of activity of a consenting adult, may be considered a breach of rights if residents do not want the parties noted involved. • No one person can make the decision for another person to have sexual relationships. Not a family member, not a Power of Attorney and not a legal guardian. Sexuality is a personal decision – every person must be capable of deciding this for her or himself.

	If one or more residents are non-consenting: • Care planning needs to take place to balance the rights of residents (intimate relationship) while protecting them from abuse/exploitation (sexual relationship). • Consult facility policy for possible abuse investigation if sexual contact occurs without consent. • Ensure care plans are updated to reflect current observations, assessments and interventions. • To ensure best outcomes, assessment, care planning and education with residents, responsible parties and staff will be ongoing, as appropriate.

These recommendations try to address instances of intimacy and sexuality in long term care in an understandable manner. If you have further questions or specific situations regarding intimacy and sexuality in long term care, please contact the Wisconsin Board on Aging and Long Term Care – Ombudsman Program at:

1 800 815-0015
EMAIL: BOALTC@Wisconsin.Gov

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This appendix is not legal advice or mandated, but is intended to be used as a guide for facilities to obtain information about a resident's intimacy and sexuality history. This history is to be completed with the resident, and the information obtained may be helpful overall in assisting residents to feel at home, comfortable and secure. This information may be best gathered once rapport is gained between a resident and staff skilled at interviewing. If additional information is needed, a family member or legal decision maker could be interviewed. It may be helpful to take notes about the resident's statements, as the actual verbal response often reveals a lot about the person's level of understanding of the topic. It should also be understood that the resident has the right to refuse to participate in this conversation, and that refusal should not constitute an inability to consent to an intimate or sexual relationship.

Appendix 1 – Recommendations for Addressing Resident Relationships Intimacy & Sexuality History

Please tell me about your marital status.		
Number of marriages or serious relationships:		
How do you describe your sexual orientation? Heterosexual__ Bisexual___ Homosexual___ Lesbian___ Gay___ Transsexual___ Transgender___ No comment___		
Are you comfortable giving or receiving affection such as a soothing touch, a hug, or a kiss?	Yes	No
Are you accustomed to sleeping alone in bed?	Yes	No
Are you currently involved in a relationship?	Yes	No
If so, what do you think your companion will feel about visiting or spending time with you at this place of residence?		
Before living here, how did you show your companion that you care?		

Before living here, what was your comfort level with intimacy (hugging, handholding, cuddling, etc.)? Before living here, what was your comfort level with sexual contact?		
Since living with us, have you noted any changes in the way you show your companion you care? Explain.	Yes	No
Are you seeking to have a relationship with someone in the facility? If so, please explain.		
Do you have any concerns regarding your interactions with this person? Explain.	Yes	No
Is there anything we could improve on to accommodate you and your companion?		
Any known history of abuse (mistreatment) or trauma: sexual, physical, emotional or verbal?	Yes	No
Any known history of sexually transmitted infections?	Yes	No

Information received from:_____ Date:_____

Completed by:_____

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This appendix is not legal advice nor is it mandated, but is intended to provide practical suggestions and guidance in how to begin to assess a resident's ability to consent to physical sexual expression. Facilities may want to use this as a basis for developing their own policies as it relates to a resident's ability to consent to a sexual relationship.

Appendix 2- Recommendations for Addressing Resident Relationships Assessment for Consent to Physical Sexual Expressions

Wisconsin has not specifically defined what an individual must understand in order to consent to sexual contact. However, discussion in the "Guardianship of Adults" (http://www.dhs.wisconsin.gov/publications/P2/p20460.pdf), implies that there may be indications that the following four guidelines could be used as the basis for an assessment to determine a person's ability to consent to sexual contact. Depending on the uniqueness of each situation, additional considerations might be appropriate. Assessment efforts should focus on the resident revealing his/her understanding of the following four guidelines:

1. **The person understands the distinctively sexual nature of the conduct. That is, that the acts have a special status as "sexual".**
2. **The person understands that their body is private and they have the right to refuse, or say "no". They should also understand the other person should respect their right of refusal.**
3. **The person understands there may be health risks associated with the sexual act. (pregnancy, STD's, cardiac, other health risks)**
4. **The person understands there may be negative societal response to the conduct. (Gossip, name calling, social fallout, stigmatized.)**

As in any good assessment process, a skilled, multi-disciplinary team must be involved. The focus must, at all times, be on the individual resident, and should not include the opinions or comfort levels of staff, family members or surrogate decision-makers. Assessments are ongoing and documentation of the assessment and review of the assessment shall occur as part of the care planning process. Assessment protocols include:

- History
- Observations
- Interviewing
- Analysis
- Care Planning
- Re-Assessment

Through the assessment process, the resident reveals her or his ability or inability to consent to a sexual relationship at that point in time.

- **KNOW THE RESIDENT BY GATHERING HISTORY**

Staff can utilize Appendix 1 as a guide in their attempt to gather an intimacy and sexuality history. A social history should also be completed.

- **OBSERVATIONS**

All staff members (nurses, CNA's, social worker, housekeeping, dietary, laundry, maintenance, activities, management) will make unobtrusive observations of the resident in a variety of situations. It is recommended that the facility utilize a behavior flow sheet to track such observations. The following is a list of possible observations the facility might consider making:

- Resident interactions – how does resident interact with male and female residents, staff, family and visitors
- Body Language – is the resident showing signs of fearfulness, happiness, feeling troubled, agitated, calm? Are there facial grimaces, posturing that indicate discomfort or pain? Are they pushing away or waving hands in a defensive manner?
- Verbalizations – Does the resident sound angry, fearful, friendly, reserved or shouting?
- Response to care – Is the resident accepting, refusing of cares? What are their specific cares? How do they respond to staff? Does time of day make a difference in acceptance of care?
- Changes – any changes in medical condition, cognition, social circle or environment?

- **INTERVIEWING**

Utilizing professional interviewing techniques adapted for the abilities of the resident involved, is essential in the assessment process. Below are examples of questions a facility may ask a resident during the interview process. Answering the questions is voluntary. This is not an all-inclusive list or in any particular order. As the interview progresses, the interviewer may ask other pertinent questions not listed below. It may be helpful to write down verbatim what the resident verbally states following each question. The actual verbal response reveals valuable information about the person's level of understanding of the topic. It should also be noted the resident has the right to refuse participation in this assessment, and refusal should not be the sole basis for determining the ability of a resident to consent to an intimate or sexual relationship.

Tell me about your friends.
Do you have a special friend?
What do you do with your friend?
Does this friend touch you? How? Where on your body?
Do you like being touched this way?
Are you having sex with your friend?
Where do you have sex?

Do people here gossip? About what?
Does this concern you? Why?
Have you ever been the target of gossip?
What was it about? Did that upset you?
Have you noticed people being excluded from groups? Have you ever been excluded?
Has anyone scolded you, called you names,

Do you understand what sexual contact means?
Will you continue this relationship if your family and/or friends disapprove?
Do you feel comfortable & safe living here?
Is there anyone you are afraid of? Anyone who makes you feel uncomfortable?
Has anyone ever hurt you?
Did you tell them to stop?
What was their response?
If you do not like something, how do you say no?
Do you tell someone? Who?
Do you understand you have the right to say no?

judged your behavior, etc? How did that make you feel?
Do you have concerns that your family or friends would treat you differently because of this relationship? What are your concerns?
Do you have any health issues that limit your activity?
What are they?
How do they limit you?
Is having sex a health concern for you?
Do you know what a STD is?
Do you know anyone with a STD?
Is pregnancy a concern?

- **ANALYSIS**

In analyzing all the information gathered it is vital that participants not make assumptions, nor interject personally held values, and not reach erroneous subjective conclusions. The process of analysis must focus on the four consent guidelines and the facts, values and preferences as revealed by the resident.

- **CARE PLANNING**

Care planning to address a resident's sexual expression should be based on the information gathered in the assessment process. The care plan should state the needs and wants of the resident, how those needs and wants will be met, and who will be responsible. The resident should be a part of the care planning process and approve all aspects of the care plan. Content of that care plan will depend heavily on the individual's ability, or lack of ability, to consent to sexual contact. It should be noted that resident choice should be a part of the care plan at all times, including those residents who have guardians or activated powers of attorney for health care.

If it is determined that two residents are capable of consenting to sexual contact, the care plan focus will be on the rights associated with that relationship.

If one or both residents are not capable of consenting to a sexual relationship, care planning needs to focus on balancing the rights of the residents to associate and have a friendship, while protecting them from sexual contact that could be exploitive or abusive.

When it has been determined, through assessment, that one or both residents is/are unable to consent, and if the two residents are happy and comfortable with each other, the following are some approaches staff should take to ensure the residents are allowed to have a "friendship" but also protect them from sexual abuse/exploitation:

- Early identification of the relationship – it is imperative that staff know their residents, that they observe how they interact with other residents, how relationships develop. Talk with other team members.
- Offer socialization in public, supervised area – provide frequent checks to ensure that contact does not become sexual or that the affection does not become unwanted.
- Offer activities that the two residents can participate in together while staff is involved.

If staff have assessed the residents and find that one or both of the residents' sexual behavior is inappropriate or unwanted, staff should use the following approaches. These interventions need to occur before the sexual contact takes place.

- Address the real need – this should be identified in the assessment. Do residents need to be toileted, are they lonely or bored?
- Use distraction, redirection and activities – knowing the resident will help figure out what is going to socially and appropriately distract her or him. The resident is more likely to be redirected if it is something they are interested in. A good Social History is critical.
- Supervision – frequent checks, including 1:1 during times when the sexual activity is a pattern
- Use of the facility environment to separate residents, when necessary – the assessment will help determine if this is the only way to keep the two non-consenting residents safe. Rooms could be located on opposite wings, one resident on a secured unit, different floors, etc. This should be used as a last resort.

RE-ASSESSMENT

Assessments are ongoing. Facilities should be performing assessments for the ability to consent to physical sexual expression at least quarterly, and/or when there is a change in condition or resident behavior. Documentation of the assessments shall occur as part of the care planning process.

These recommendations try to address instances of intimacy and sexuality in long term care in an understandable manner. If you have further questions or specific situations regarding intimacy and sexuality in long term care, please contact the Wisconsin Board on Aging and Long Term Care – Ombudsman Program at:

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