



# **Resident's Sexuality and Intimate Relationships: An Evaluation of Nursing Guidelines in Long Term Care Facilities**

Joseph Hallam NS14

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Joseph Hallam

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Supervisor (Arcada):	Pamela Gray
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<p><b>Abstract:</b></p> <p>Sexuality and intimate relationships play an important role in human relationships. Guidelines for nurses in long-term care facilities have been reported to be insufficient and have even been reported affecting healthcare staff's ability to provide safe quality care. With the importance and need for guidelines in this area clear, this report seeks to analyse existing nursing guidelines against a framework for quality healthcare. The ten rules developed by the Institute of Medicine in 'Crossing the Quality Chasm' in 2001 were chosen as the measuring stick by which five chosen sexuality and intimate relationship guidelines for long-term care were analysed.</p> <p>The aim of this report was to determine why good quality guidelines are required, do the chosen guidelines fulfill the ten rules set out by the IOM for good quality care and, if found to be deficient, in what ways the guidelines may be improved.</p> <p>This report was conducted as a qualitative scoping review with a deductive aspect. The guidelines were analysed against the chosen theoretical framework to see if those guidelines followed the prescriptions for good healthcare provided by the IOM. It was found that, for the most part, the guidelines did adhere to the ten rules, however deficiencies were found in two guidelines which did not adhere to one rule each. Recommendations for their improvement were provided. Looking to areas of further research, information in this area is currently lacking. Analysis of presentation style and the effectiveness of guidelines being one potential area for research growth. Analysis of guidelines using other theoretical bases should also be explored. Limitations of this report include the small number of sexuality nursing guidelines analysed which could be expanded upon in further research through contacting long-term care facilities directly.</p>	
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## **FOREWORD**

I would like to thank my family for their deep wells of support, Pamela Gray and Denise Villikka for their expert guidance and advice, Arcada for providing me with the knowledge and skills to complete this work, my fellow classmates who took the time to commiserate with me, Jhonn Balance, Peter "Sleazy" Christopherson, Thighpaulsandra and the other members of Coil for providing the soundtrack to this thesis (The Ape of Naples, Black Antlers, Musick to Play in the Dark Vol.1 and Vol.2 and Horse Rotavator). Special thanks must go to Meri Salomaa for her never-ending patience as she listened to me analysing and repeating the same points continuously for far longer than it should have taken. Thank you all.

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## **ABBREVIATIONS**

ICN – International Council of Nurses

IOM – Institute of Medicine

LTC – Long-term care

RAI – Resident Assessment Instrument

RCN – Royal College of Nursing

UK – United Kingdom of Great Britain and Northern Ireland

USA – United States of America

WHO – World Health Organisation

# 1. INTRODUCTION

Sexuality and intimate relationships play an important role in human experience. This has been recognised for hundreds of years and has been included as an important factor in many psychological theories, for example, Maslow's Hierarchy of Needs (See Burton, 2012). Being thought of as integral to personal identity, it is often through sexual acts that individuals connect with others (Kalra et al. 2015, p. 463). The World Health Organisation (WHO) also recognised sexual health as

"...fundamental to the physical and emotional health and well-being of individuals, couples and families, and to the social and economic development of communities and countries." (Aggleton et al. 2010, p. iv)

When having to stay in long-term care (LTC) institutions such as hospitals and care homes, patient's everyday lives and routines are disrupted and this includes their sex lives. What role does the nurse play in alleviating this disruption?

A key facet of nursing that is covered by many nursing theorists such as Jean Watson and is often thought of as a primary aspect of nursing, is caring. With Jean Watson's theory, caring by the nurse is undertaken holistically, that is, it seeks to care for the "whole" person which includes the sexual dimension of the person (See Nursing-theory.org, 2017). The ICN (International Council of Nurses) Code of Ethics for Nurses (2012) also dictates that nurses must provide care that respects the human rights of their patients and recognises their values and beliefs. As such, it can be seen as part of a nurse's job to care for their patient's or resident's sexual health, both physical and emotional. To this end, the ICN also calls on national nurse's associations to

"Provide guidelines, position statements, relevant documentation and continuing education related to informed consent to nursing and medical care." (ICN, 2012, p. 6)

As this is the case, what sort of guidelines have been formulated to help nurses and healthcare professionals deal with this aspect of patient/resident care? This report will seek to assess a selection of guidelines against a theoretical framework in the form of a scoping review, this theoretical framework being designed in the 20<sup>th</sup> century to propose changes to healthcare to provide quality, efficient service into the 21<sup>st</sup> century.

The author first came to consider this area for research during the course of their practical training placements for their degree studies in nursing. Sexual guidelines were not discussed and it was not made clear what guidelines were in place to ensure the sexual health and wellbeing of residents on those wards

and in those facilities. During the authors theoretical studies, where sexuality of patients and residents was mentioned, the inappropriacy of nurse/patient romantic and sexual relationships and the possibility of experiencing sexual harassment from patients/residents and colleagues was discussed, however information on dealing with the sexual needs and drives of those in our care was somewhat lacking. Legislation concerning the responsibilities of the nurse were also mentioned but there was no clear indication of the responsibilities concerning the sexual health and wellbeing of patients. The availability and quality of nursing guidelines in this area of healthcare then became a point of interest for the author and was so pursued for this, their degree thesis topic.

## 2. BACKGROUND

Sexuality, as a phenomenon, covers a range of subjects and aspects. This is reflected in the World Health Organisation's working definition:

"...a central aspect of being human throughout life 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 include all of these dimensions, not all of them are always experienced or expressed." (See Aggleton et al. 2010, p. 3)

For this report, this same definition will be utilized when referring to sexuality. The Merriam-Webster dictionary definition of "guideline" will be used in this report:

"An indication or outline of policy or conduct" (Merriam-webster.com a. 2017)

Within the guidelines presented and analysed, the term "resident" is used. "Resident" is defined by the Oxford English dictionary as

"A person who lives somewhere permanently or on a long-term basis." (Oxford Dictionaries | English a. 2017).

This differs from the term most usually within a medical context for those under care "patient" which is defined by the Oxford English Dictionary as

"A person receiving or registered to receive medical treatment." (Oxford Dictionaries | English b. 2017).

Regarding long-term care, it can be argued as to which definition, whether resident or patient, is the most appropriate as they can both be accurate descriptions simultaneously. The theoretical framework chosen as the measuring stick by which the guidelines were to be analysed, covers healthcare as a whole, as such, they refer to those using healthcare services and receiving medical treatment as patients. The guidelines chosen for this report however refer to those living in long-term care facilities as residents. Due to this difference in terminology used, when discussing or referencing the theoretical framework in this report, "patient" is used and when the guidelines are discussed or referenced, "resident" is used. In this way, though the two terms have differing specific definitions, for the purposes of this report, they refer to the same group of individuals, those living and receiving care in long-term care facilities.

The focus of this report is on sexual and intimate relationship guidelines from a nursing perspective, however, due to the fact that these guidelines are often written for facility-wide use, they are often applied to all members of staff within the facilities they have been designed for. Due to this, references are made throughout the guidelines and this report to “staff”, “care staff”, “care teams” and “carers” these terms referring to those who monitor and administer care to those living as residents in a LTC facility. This includes nurses but also those other professions that administer care.

Various legal, ethical and practice guidelines surround the nursing profession but numerous articles have noted the lack of sexuality related health care policy in LTC facilities and nursing homes (Syme et al., 2016 and Horowitz, 2014). This lack of effective guidelines can have a severe detriment on patient experience and can place nursing care staff in confusing, awkward and potentially legally-troubling situations. This was found to be the case for a Worcestershire based nursing care team when faced with a severely physically disabled 15-year old male patient who could not satisfy his sexual urges and was becoming increasingly frustrated. In the course of attempting to solve this situation, they found that Worcestershire Primary Care Trust had no guidelines on addressing these needs. Because of this they were driven to (after discussing the issue with the boy’s parents) the solution of the service’s lead nurse Stephanie Courts buying him a sex toy, a vibrating vagina. When reporting the situation to the Royal College of Nursing (RCN) conference, Ms. Courts highlighted the need for national guidelines so as to guarantee prompt, safe and effective healthcare for patients, but also to provide guidance and support to healthcare professionals so similar situations did not arise again (Blakemore, 2008). Ms Courts said

“I feel guidance on this matter should be readily available from sexual health departments, but I struggled to get help and guidance on how we should meet this boy’s needs. It is about girls as well as boys and no one seemed to be able to give us the advice we needed. The feedback from this lad has been positive and we have all learned a huge amount through the experience.”

What is clear from this example is that without clear policy or guidance, nurses and care teams are left to make complex ethical and potentially legal decisions on their own. This problem of the lack of dedicated sexual guidelines in nursing homes has been pervasive enough to be reported on in news articles. An article titled “Why Nursing Homes Need to Have Sex Policies” written by Eliza Gray for Time magazine in 2015, opens up the growing problem of elderly people in care homes engaging in sexual behaviours and intimate relationships with very little guidance for those caring for them on how these situations should be dealt with. Within the USA, no national standard of best practices exists for this area of healthcare and the article reports elder advocates, physicians and nursing

home experts saying that, where individual policies do exist, they are often archaic and can even be ageist in their approach to sexuality expression. (Gray 2015)

The right to privacy and the freedom of thought and expression are protected by Articles 12, 18 and 19 of the Universal Declaration of Human Rights (UN General Assembly, 1948) which are often cited when discussing sexual rights (e.g. Sexualrightsinitiative.com, 2017). An example of this can be found in an article for the journal Long Term Living: For the Continuing Care Professional (Horowitz 2014). It talks of the balancing act that sexual guidelines must perform in guaranteeing the rights of residents living in LTC facilities and guaranteeing the safety of residents, ensuring they do not open up opportunities for abuse to occur. In his recommendations to facilities wishing to address these issues, he advises a proactive approach with the development of policies and procedures dealing with resident sexuality which are then implemented, monitored and revised as needed.

Hollomotz et al. (2008) has said in regard to those with learning difficulties living in residential homes, the infringing of individuals rights to privacy and freedom of expression through inappropriate and harmful rules and guidelines can have very real negative effects. Individuals, having no private space for sexual activity indoors, are forced into outdoor or isolated semi-private indoor locations which leads to rushed sexual encounters with little time or opportunity to decide upon agreed boundaries. This elevates the risk of harm for those participating in these activities greatly. (Hollomotz et al. 2008, p.93)

With the importance of sexual guidelines for nurse's clear, the form current guidelines take and how they can help provide good quality healthcare can now be explored.

### 3. THEORETICAL FRAMEWORK

To measure their effectiveness, sexual health nursing guidelines were collected and analysed against a theoretical guideline put forward by the Committee on Quality of Healthcare in America in 2001 in their second and final report, “Crossing the Quality Chasm: A New Health System for the 21<sup>st</sup> Century”. This committee was developed by the Institute of Medicine (now known as the National Academy of Medicine) which is itself part of the National Academies of Sciences, Engineering and Medicine a non-profit, non-governmental organisation based in the USA.

In the committee’s first report “To Err is Human: Building a Safer Healthcare System”, published in 2000, patient safety was highlighted as a severe problem in the American Healthcare system that needed to be urgently addressed. Patient safety being only one aspect of a high-quality healthcare system, “Crossing the Quality Chasm”, which was published in 2001, focused on those other aspects of healthcare that they found to be detrimental to the health of Americans. Within this report, six aims were identified for healthcare systems to try and achieve moving into the 21<sup>st</sup> century to ensure good quality care was being provided. It states that health care should be:

- *Safe*—avoiding injuries to patients from the care that is intended to help them.
- *Effective*—providing services based on scientific knowledge to all who could benefit and refraining from providing services to those not likely to benefit (avoiding underuse and overuse, respectively).
- *Patient-centered*—providing care that is respectful of and responsive to individual patient preferences, needs, and values and ensuring that patient values guide all clinical decisions.
- *Timely*—reducing waits and sometimes harmful delays for both those who receive and those who give care.
- *Efficient*—avoiding waste, including waste of equipment, supplies, ideas, and energy.
- *Equitable*—providing care that does not vary in quality because of personal characteristics such as gender, ethnicity, geographic location, and socioeconomic status.

(IOM 2001, p.5 - 6)

From these six aims, several recommendations were outlined for the improvement of healthcare in America. One of these recommendations was ten

new rules for healthcare which looked at the current approaches to these stated aims and then proposed alternatives to better achieve high quality patient care. These rules have been reproduced below (Table 1). In referencing “current” and “new” approaches, it must be understood that “Current Approach” refers to healthcare approaches in 2001, when they were developed and “New Rule” refers to how the IOM perceived healthcare should be approached into the 21<sup>st</sup> century.

*Table 1. Current Approaches and the New Rules outlined by the IOM (2001).*

<u>Current Approach</u>	<u>New Rule</u>
Care is based primarily on visits	Care is based on continuous healing relationships
Professional autonomy drives variability	Care is customized according to patient’s needs and values
Professionals control care	The patient is the source of control
Information is a record	Knowledge is shared and information flows freely
Decision making is based on training and experience	Decision making is evidence-based
Do no harm is an individual responsibility	Safety is a system property
Secrecy is necessary	Transparency is necessary
The system reacts to needs	Needs are anticipated
Cost reduction is sought	Waste is continuously decreased
Preference is given to professional roles over the system	Cooperation between clinicians is a priority

These “New rules” were then expanded upon:

1. Care based on continuous healing relationship  
Patients should receive care whenever they need it and in many forms, not just face-to-face visits. This rule implies that the health care system should be responsive at all times (24 hours a day, every day) and that access to care should be provided over the Internet, by telephone, and by other means in addition to face-to-face visits.

2. Customization based on patient's needs and values  
The system of care should be designed to meet the most common types of needs, but have the capability to respond to individual patient choices and preferences.
3. The patient as the source of control  
Patients should be given the necessary information and the opportunity to exercise the degree of control they choose over health care decisions that affect them. The health system should be able to accommodate differences in patient preferences and encourage shared decision making.
4. Shared knowledge and the free flow of information  
Patients should have unfettered access to their own medical information and to clinical knowledge. Clinicians and patients should communicate effectively and share information.
5. Evidence-based decision making  
Patients should receive care based on the best available scientific knowledge. Care should not vary illogically from clinician to clinician or from place to place
6. Safety as a system priority  
Patients should be safe from injury caused by the care system. Reducing risk and ensuring safety require greater attention to systems that help prevent and mitigate errors.
7. The need for transparency  
The health care system should make information available to patients and their families that allows them to make informed decisions when selecting a health plan, hospital, or clinical practice, or choosing among alternative treatments. This should include information describing the system's performance on safety, evidence-based practice, and patient satisfaction.
8. Anticipation of needs  
The health system should anticipate patient needs, rather than simply reacting to events.

9. Continuous decrease of waste

The health system should not waste resources or patient time.

10. Cooperation between clinicians

Clinicians and institutions should actively collaborate and communicate to ensure an appropriate exchange of information and coordination of care.

(IOM 2001, p.7 - 9)

These rules have been used in this report as a measuring stick to gauge the quality of the sexual guidelines that have been developed for use by nurses and care staff in LTC facilities. As they were specifically designed with the improvement of healthcare in mind, they were deemed to be an appropriate measure for this task. The fact that they were developed in 2001 looking forward into the future, means that using them now, in the 21<sup>st</sup> century, to analyse these guidelines, allows us to, at least to an extent, see if healthcare has moved forward with the ideas the IOM presented.

## **4. AIM AND RESEARCH QUESTIONS**

This report seeks to investigate guidelines that have been formulated for nurses and carers concerning resident sexuality in long term care facilities. The main questions this report seeks to answer are:

Why are resident sexuality and intimate relationship guidelines for nurses needed?

Do available sexuality guidelines for nurses in LTC facilities fulfil the ten rules set out by “Crossing the Quality Chasm” for quality, safe healthcare in the 21<sup>st</sup> century?

In what ways, if they are found to be deficient, can these guidelines be improved so as to better fulfil the ten rules?

## 5. METHODOLOGY

This report has been conducted as a qualitative scoping review with a deductive approach to analysing data. Qualitative refers to information gathered that is of a non-numerical type. This information is often an in-depth analytical look at a particular subject. This contrasts with quantitative research which is numerical in nature and seeks to identify patterns in collected data. (Boyd 2017)

With a deductive approach, research moves from a general position to a more specific position; the conclusion is deducted from a more general premise (Dudovskiy 2017a). This is in opposition to the inductive approach in which first observations are given and then from these observations theories are proposed. Data is collected and patterns and relationships identified so as to construct theories (Dudovskiy 2017b).

For this report, a scoping review methodology was used. A scoping review is described as having 6 steps by Arksey and O'Malley (see Djikers 2015, p. 2)

1. Identify the research questions: what domain needs to be explored?
2. Find the relevant studies, through the usual means: electronic databases, reference lists (ancestor searching), websites of organizations, conference proceedings, etc.
3. Select the studies that are relevant to the question(s)
4. Chart the data, i.e. the information on and from the relevant studies
5. Collate, summarize and report the results
6. (Optional) consult stakeholders (clinicians, patients and families, policy makers, or whatever is the appropriate group) to get more references, provide insights on what the literature fails to highlight, etc.

Using these steps, information can be collected from a broad range of sources and then analysed so as to give an overview of a subject though often this overview is not so in-depth. A wide synopsis is the outcome rather than a deep analysis. (Dijikers 2015, p. 2)

### 5.1 Data collection

For this report, sexuality and intimate relationship guidelines designed for care professionals, particularly nurses, for use in LTC facilities were collected through the Google search engine.

Search terms that were used in the collection of these guidelines:

“nursing sexuality guidelines”

“nursing sexuality guidelines long term care”  
“nursing intimate relationships guidelines”  
“resident relationships guidelines long term care”

With these search terms and the use of references used within the guidelines already collected, five documents were chosen to be analysed against the theoretical framework, the ten rules, provided by the IOM. These documents were chosen because they fulfilled the criteria of being guidelines as provided by the definition “An indication or outline of policy or conduct” (Merriam-webster.com 2017) and were all focused around resident sexuality, sexual activity and intimate relationships. These guidelines were also easy to access, they were not held behind a paywall or requiring specific membership to access at the time of writing which eased the writing process of this thesis.

Table 2. Guidelines used in analysis.

Guidelines	Further information
<p>1. Intimacy Guidelines Writing Group. 2006. <i>Considerations Regarding the Needs of Long-Term Care Residents for Intimate Relationships and Sexual Activity</i>. Centre for Practical Bioethics</p>	<ul style="list-style-type: none"> <li>- Missouri, USA</li> <li>- A report on policy creation for long term care facilities developed by the Centre of Practical Bioethics.</li> <li>- Strongly based on the RAI (Resident Assessment Instrument) process.</li> </ul>
<p>2. LTC Working Group. 2010 <i>Intimacy and Sexuality in Long-Term Care, A guide to practice: resource tools for assessment and documentation</i>. Lanark, Leeds and Grenville Long-Term Care Working Group</p>	<ul style="list-style-type: none"> <li>- Ontario, Canada</li> <li>- Draft of intimacy and sexuality policy.</li> <li>- Intended to be a base that individual care facilities build upon.</li> <li>- Based on a previous document, Intimacy and Sexuality Practice Guidelines, originally developed by Shalom Village in the late 1990's which was then revised and updated in subsequent years.</li> <li>- Sexual behaviours ranked from one to five to inform response of care staff.</li> </ul>
<p>3. Heath, H. 2011. <i>Older people in Care Homes: Sex, Sexuality and Intimate Relationships</i>. Royal College of Nursing</p>	<ul style="list-style-type: none"> <li>- United Kingdom</li> <li>- Guidance developed by the Royal College of Nursing for nursing and care staff in elderly care homes.</li> <li>- Contains discussion of the main issues surrounding intimacy in elderly care homes, example case studies and a decision flow chart to help inform and support decisions.</li> </ul>
<p>4. Carlson, M. Clements, G. Everett, B. Young, J. McBride K. 2013. <i>Supporting Sexual Health and Intimacy: A Pocket Reference Guide</i>. Spinal Cord Injury BC</p>	<ul style="list-style-type: none"> <li>- British Columbia, Canada</li> <li>- Designed as a pocket guide for care staff of those in long term care.</li> <li>- Expands upon the issues that may arise, includes case studies covering differing situations and a flow chart as an aid to decision making in this area.</li> </ul>
<p>5. Panosh. Button. 2014. <i>Recommendations for Addressing Resident Relationships</i>. Wisconsin Board on Ageing and Long Term Care</p>	<ul style="list-style-type: none"> <li>- Wisconsin, USA</li> <li>- Developed by the Board on Ageing and Long Term Care Ombudsmen program as an aid to policy creation for LTC facilities.</li> <li>- Focusses on aspects of consideration when creating sexual behaviour and intimate relationship policy and details a table of differing levels of patient sexual behaviour and the appropriate responses by staff to those behaviours.</li> </ul>

The focus for this report was initially exclusively guidelines designed for use by nurses, however it was quickly found that this was too restrictive. The guidelines presented here have been created with the intent of informing and guiding all care staff within a LTC setting, rather than specifically for nurses. They were designed in such a way that they would serve as guidelines for a facility and so the recommendations provided by them apply to more than just nurses. Because of this, the guidelines chosen are not specifically designed for nurses only however, the focus of this report is still maintained on sexual guidelines that can be used by nurses in LTC facilities.

## 5.2 Data analysis

Each of the guidelines were read through multiple times by the author and evidence was collected that each rule developed by the IOM was represented in the guidelines. By comparing what was suggested by the ten rules and what the guidelines outline as good practice, the guidelines could be analysed as to what extent they follow the requirements of modern 21<sup>st</sup> century healthcare as laid out by the IOM. The results of this analysis were written in prose and details how each guideline meets or does not meet each rule.

As an example, provided below is the part of the analysis of “Supporting Sexual Health and Intimacy: A Pocket Reference Guide” (Carlson et al. 2013) regarding the sixth rule “Safety as a system priority”:

*Table 3. Analysis of guideline according to the rule “Safety as a system priority”*

<p><b>(Carlson, M. Clements, G. Everett, B. Young, J. McBride K. 2013. <i>Supporting Sexual Health and Intimacy: A Pocket Reference Guide. Spinal Cord Injury BC</i>)</b></p>
<p>The assessing of the risk of harm to clients being a deciding factor in whether interventions are necessary in sexual activity or intimate relationships, can be seen as an aspect of safety being considered as a system priority (p.4). Risk being mitigated through assessment which is then used to formulate a response helps to protect residents from harm through an organized system. The decision-making flowchart found within the appendix (p.13) can also be seen as the standardisation of safety policy.</p>

Following the analysis of each of the guidelines according to the particular rule, a short summary is included for that rule as to whether the guidelines adequately followed it.

This form of analysis was conducted for all of the rules however, the ninth rule put forward by the IOM, “Continuous decrease of waste”, was ultimately not included in the final write up of the guidelines’ analysis. This is because this

aspect of the rules was not adequately represented. As the guidelines were developed to help inform policy development and decision making rather than the provision of services, decreasing waste did not factor into any of the guidelines to any great extent and so has been marked as “Not applicable”.

### **5.3 Ethical aspects of the research study**

In the process of writing this report, ethical aspects were considered. When working with resources produced by others, plagiarism is a concern and must be avoided. “Plagiarizing” is defined by the Merriam-Webster dictionary as:

“to steal and pass off (the ideas or words of another) as one's own to use (another's production) without crediting the source”  
(Merriam-webster.com b. 2017)

Arcada has produced, in accord with the National Advisory Board on Research Ethics in Finland’s “Guidelines for Good Scientific Practice” published in 2002, “Good Scientific Practice in Studies at Arcada” detailing the standards essays, research and thesis work must attain for it to be considered of good scientific quality. Those aspects that are considered violations of good scientific practice include:

1. Ethical carelessness
  2. The neglect to observe (indifference to) good scientific practice
  3. Dishonesty in scientific endeavours (cheating)
- (Arcada, “Good Scientific Practice in Studies in Arcada”)

To avoid this, all work used in the production of this report has been as accurately credited as possible to the respective authors. The presentation of content from sources has also been accomplished as accurately as possible, efforts being made to ensure information is presented in context and never knowingly misrepresented. In regards to the guidelines, as it was found that some had a number of different versions or had been subsequently updated, all efforts were made to use the most up to date versions so as to ensure the contemporaneity of this analysis.

## 6. FINDINGS

The five guidelines chosen for this report have been published in several different countries over a number of different years. These documents somewhat vary in intent and presentation however they all focus on sexuality in long-term care within elderly care or other forms of care facilities. For the purposes of this analysis, despite their differing presentation, they are all referred to as guidelines. This is because, as defined in this report's working definition, they are all indications or outlines of policy and as such are deemed to be appropriately labelled as guidelines.

The findings have been written in prose text with each IOM rule presented first followed by the analysis of each of the guidelines against that rule then given.

### 6.1 Care based on continuous healing relationship

Patients should receive care whenever they need it and in many forms, not just face-to-face visits. This rule implies that the health care system should be responsive at all times (24 hours a day, every day) and that access to care should be provided over the Internet, by telephone, and by other means in addition to face-to-face visits.

<b>Intimacy Guidelines Writing Group. 2006. <i>Considerations Regarding the Needs of Long-Term Care Residents for Intimate Relationships and Sexual Activity.</i> Centre for Practical Bioethics</b>
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These guidelines emphasise in their conceptual framework "protective oversight", defined within their working definitions as "An awareness twenty-four hours a day of the location of a resident; the ability to intervene on behalf of the resident; supervision of nutrition, medication, or actual provisions of care; and responsibility for the welfare of the resident, except when the resident is on voluntary leave." (p.2)
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<b>LTC Working Group. 2010 <i>Intimacy and Sexuality in Long-Term Care, A guide to practice: resource tools for assessment and documentation.</i> Lanark, Leeds and Grenville Long-Term Care Working Group</b>
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Within this guide, staff are advised to observe and monitor situations to determine if interventions are necessary for the resident's well-being (p.5). Development of care plans appropriate for the resident is also recommended to ensure the dignity, privacy and safety of the resident and to help provide to them a supportive environment. In this way, a continuous healing relationship is developed and supported (p.6).
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**Heath, H. 2011. *Older people in Care Homes: Sex, Sexuality and Intimate Relationships*. Royal College of Nursing**

Explicit mention of a continuous healing relationship in these guidelines is absent, however within the Key Point Summary, it is stated that there are a number of aims that care home service providers should aim to achieve:

“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.” (p.2)

It also speaks more widely about care systems:

“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.” (p.2)

With these sections, a holistic approach is advocated and as such could be seen as being reactive to the individual and so calling for that continuous healing relationship. In detailing recommendations about the care environment, the guidelines talk about how information can be made available to residents through a variety of different mediums including posters and leaflets and how these sources of information should be made available and accessible in a variety of languages including in formats for those who are sight or hearing impaired (p.7). Hence, healthcare can be provided in a variety of methods and at the discretion of the resident, all aspects called for by the IOM’s first rule.

**Carlson, M. Clements, G. Everett, B. Young, J. McBride K. 2013.**  
***Supporting Sexual Health and Intimacy: A Pocket Reference Guide.***  
**Spinal Cord Injury BC**

These guidelines are mostly based around responding to specific incidents concerning a resident's sexuality. No specific mention of a continuous healing relationship is made in these guidelines and there is very little reference to follow-up or reassessment after an incident.

**Panosh. Button. 2014. *Recommendations for Addressing Resident Relationships.* Wisconsin Board on Ageing and Long Term Care**

Within these guidelines is a table of various intimate or sexual expressions and how care staff members should respond. Throughout the table, in response to all the different activities, it is suggested that staff come to understand the motivations behind resident's specific behaviours through observation, history and interactions; by recommending continued observation it can be seen that monitoring and being aware of the resident's stasis and behaviour is advocated which supports a continuous healing relationship (p.5 – 8).

“Supporting Sexual Health and Intimacy: A Pocket Reference Guide” (Carlson et al. 2013) did not have a clear reference to a Continuous Healing Relationship and so could not be said to have adhered to the first rule put forward by the IOM. The other guidelines however, did adhere to this rule.

## 6.2 Customization based on patient's needs and values

The system of care should be designed to meet the most common types of needs, but have the capability to respond to individual patient choices and preferences.

**Intimacy Guidelines Writing Group. 2006. *Considerations Regarding the Needs of Long-Term Care Residents for Intimate Relationships and Sexual Activity*. Centre for Practical Bioethics**

Within the guidelines Principles of Ethics section, the authors note that ensuring residents understand their situation and are permitted to make fundamental choices involving their care they will feel more encouraged to participate in these decisions. (p.2) In this way they acknowledge the power of the fully informed resident to make choices about their care.

Again, with their recommendation to utilize the RAI process, the resident's needs are placed front and centre. As the authors make note of within the guidelines, the RAI process consists of five steps: assessment of the resident's situation, decision making on how the resident's situation should be considered by the care team, care planning so as how to incorporate those decisions, implementation of the actions designated in the care plan and finally an evaluation; an ongoing process that monitors, reviews and modifies the five steps to assure suitability to the individual resident. In this way, the resident's care is constantly being matched to their current needs and is never in a fixed state which could lead to a care deficit for the resident. (p.6)

**LTC Working Group. 2010 *Intimacy and Sexuality in Long-Term Care, A guide to practice: resource tools for assessment and documentation*. Lanark, Leeds and Grenville Long-Term Care Working Group**

The guidelines advocate that the resident's sexuality, beliefs and values are considered and that discussion with the resident is necessary to determine these aspects (p.7). The resident's awareness is also discussed with reference to completing an assessment of their capacity to be aware of their actions. This is included as one step in a full assessment of a resident's level of sexual behaviour and as part of the development of appropriate interventions where needed (p.6).

**(Heath, H. 2011. *Older people in Care Homes: Sex, Sexuality and Intimate Relationships*. Royal College of Nursing)**

The guidelines call for the care homes to develop for themselves policies on non-discrimination (p.6). It is also explained in the general principles of good practice laid out by the document that, as these guidelines were developed for UK-based care homes, UK law, incorporating the European Convention on Human Rights, protects the rights of individuals. The World Health Organization's (WHO) list of sexual rights is also explained, with everyone having sexual rights free of coercion, discrimination and violence (p.5). Within the 3.4 "Organisational systems and care practices" section, with regard to the wide variety of differing lifestyles of residents, the document calls for the recognition of diversity. Particularly it stresses that staff should work inclusively with all peoples and promote non-judgemental, non-discriminatory approaches in their organizational systems also describing the acknowledgement of individual cultural backgrounds and beliefs as "essential" in care homes. The guidelines further call for organisational systems to value individuality, look at residents in the context of their life histories and background and promote individual choice and control. These all support the idea of customizing care according to needs and values (p.7). The fact that the guidelines take note of and support these facets goes some way to show the customization for patient's/resident's needs.

**(Carlson, M. Clements, G. Everett, B. Young, J. McBride K. 2013. *Supporting Sexual Health and Intimacy: A Pocket Reference Guide*. Spinal Cord Injury BC)**

These guidelines do advocate the customization of the nurse or carer's response through the individual assessment of each resident. They focus on six questions that may arise in situations involving sexual health and intimacy and these help to focus in on the needs of the involved parties and the appropriate response:

- Is there a risk of harm in these sexual activities?
- Is the resident/s capable of making choices about sexual activity? If not, who should make decisions about the activities?
- Should others (e.g. the health care team/care providers) intervene in the activities? If so, when and how?
- Should care providers assist in facilitating these sexual activities?
- Who should make the decisions about assisting?
- If there is assistance, when and how should it occur? (p.3)

**(Panosh. Button. 2014. *Recommendations for Addressing Resident Relationships*. Wisconsin Board on Ageing and Long Term Care)**

With the table of different intimate or sexual expressions, the response to a resident can be customized to the specific situation. The call to understand the motivations behind behaviours, as already discussed above in relation to the first rule, can be seen as part of this individualisation of care as each person's motivations will be different (p.5 – 8).

The section on resident's rights calls for facilities to recognise the right residents have "to reasonable accommodation of individual needs and preferences" which is an even clearer indication of this idea (p.2).

All of the guidelines analysed against the IOM rule "Customization based on patient's needs and values" were found to observe it with the guidelines ensuring care is tailored to each individual.

### 6.3 The patient as the source of control

Patients should be given the necessary information and the opportunity to exercise the degree of control they choose over health care decisions that affect them. The health system should be able to accommodate differences in patient preferences and encourage shared decision making.

**(Intimacy Guidelines Writing Group. 2006. *Considerations Regarding the Needs of Long-Term Care Residents for Intimate Relationships and Sexual Activity*. Centre for Practical Bioethics)**

As previously discussed, these guidelines do wish to allow residents to participate in decisions affecting their care. That being said, procedural considerations are outlined relating to intimate relationships and sexual activities concerning residents and, within these considerations, it is advised that volition (defined as the capability of making a conscious choice or demonstrating a preference) be used as the evidence of a residents' willingness to engage in sexual activity or intimate relationships. (p.4)

The authors assert that by making use of the RAI process and accurately identifying problems, interventions can be properly implemented which can then help support residents whether they are entering an intimate relationship, maintaining one, retreating from one or expressing their sexuality in another way. Sexual activities and intimate relationships can, in this way, be maintained for as long as possible for the resident, despite potential declining health. (p.5)

The patient's right to privacy is also acknowledged with the interference of their volitional, intimate relationships being deemed a violation of that privacy. Interference is only advocated in the situation that there is a compelling need to protect a resident, thus highlighting the resident's right to control over their own privacy. (p.2 – 3)

**(LTC Working Group. 2010 *Intimacy and Sexuality in Long-Term Care, A guide to practice: resource tools for assessment and documentation.* Lanark, Leeds and Grenville Long-Term Care Working Group)**

Throughout the document, respect for the resident, their potential relationships and their privacy is emphasised. Within their value statements it is explicitly written that:

“We recognize that all residents have the right to be treated with courtesy and respect, fully recognizing the resident’s dignity and individuality.” (p.4)

Within the Response table, consent is also emphasised with regards to relationships and activities that include others, those behaviours that lead to one partner showing discomfort or showing a reticence to engage in, being categorised as the highest level and requiring urgent intervention to protect the resident in question. In these cases, the ability for the resident to be aware of their own actions and their capability to give consent, is given high priority. In this way, the patient’s ability to be in control of their behaviours and situations is shown to be important (p.11).

**(Heath, H. 2011. *Older people in Care Homes: Sex, Sexuality and Intimate Relationships.* Royal College of Nursing)**

As already discussed, the resident’s rights are extensively written up within the document and it is stressed that these rights are to be respected and protected (p.5). Further, the document’s call for care delivery systems to be person-centred and promoting and supporting human rights, dignity, privacy, choice and control have also been detailed above (p.2).

The provision of healthcare materials to be made available to residents also acts as an exercise in handing control to them through education (p.7).

Making information available is included in the description of the third rule put forward by the IOM and residents being informed will help them in any decision making regarding their own healthcare and living arrangements.

**(Carlson, M. Clements, G. Everett, B. Young, J. McBride K. 2013. Supporting Sexual Health and Intimacy: A Pocket Reference Guide. Spinal Cord Injury BC)**

When assessing reasonableness of harm to individuals, the importance of the activity to the resident is also taken into consideration. In this way the wishes of the resident is also considered an important factor in decision making (p.4).

Capability, in regard to decision making ability, and risk of harm are both factors which may strongly suggest to a carer, nurse or other care provider that they must intervene in a situation and thus remove control from a resident, however in these guidelines it is made clear that the purpose of intervention in an intimate relationship or sexual activity, whether with a partner or alone, is not to prohibit sexual activity but allow for the reduction of harm to one or more involved parties. The guidelines also make clear that stopping behaviour solely because care staff personally disapprove of the behaviour or find it offensive, but the behaviour otherwise is legally protected, goes against the rights of the individual (p.5).

Ultimately, if the resident is capable, there is no risk of harm to the individual or others and consent has been given by all parties involved, no intervention is required the aim of carers being to minimise risk and assist.

Page six of the document also states that “the resident should be involved in the decision-making process as much as possible” clearly indicating the understanding that the resident should be included and listened to.

**(Panosh. Button. 2014. *Recommendations for Addressing Resident Relationships*. Wisconsin Board on Ageing and Long Term Care)**

Within the Policy Objective section of the document on the very first page of the document, the very first sentence of the guidelines is

“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.”

(p.1)

This clearly indicates a respect for resident choice and control and is further expanded upon in the next section Resident’s Rights.

Within the list of resident’s rights that care facilities must recognize, the rights “to be valued as an individual”, “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 him/her” and “to share a room with any person of choice” all indicate a recognition of patient/resident autonomy and choice (p.2).

Consent to sexual activities and intimate relationships is also explored by the guidelines on page four of the document as part of the Education section. In relation to this, the guidelines indicate the importance of determining the resident’s ability to provide consent as only the resident can consent to intimate or sexual relationships. Neither legal guardians, family members or health care agents are legally permitted to provide consent for another even if that person has been found to lack the capacity to provide consent.

Looking at the IOM rule “The patient as a source of control”, the guidelines can be said to follow this. Extensive evidence was found where each guideline called for facilities to allow for patient (in the case of these guidelines “resident”) choice and decision-making.

## 6.4 Shared knowledge and the free flow of information

Patients should have unfettered access to their own medical information and to clinical knowledge. Clinicians and patients should communicate effectively and share information.

**(Intimacy Guidelines Writing Group. 2006. *Considerations Regarding the Needs of Long-Term Care Residents for Intimate Relationships and Sexual Activity*. Centre for Practical Bioethics)**

For effective care, resident information needs to be accurately shared in a timely manner as in the RAI process. To be successful this requires information to be shared carer to carer, carer to resident, resident to carer and may also include the resident's family. A large part of this effective communication comes down to clear documentation which the RAI process calls for. Through the sharing of information, effective care plans can be developed that ensure high quality care for the resident involved. Often seen as opposing this idea of the free-flow of information is the concept of confidentiality. Both of these aspects are addressed in these guidelines. Confidentiality is specifically defined as not disclosing information unnecessarily, and refers to already existing policies and laws that are set in place for healthcare facilities dealing with confidential health information but acknowledges the need for redisclosure of information in the case of the RAI process. (p.2 – 3)

**(LTC Working Group. 2010 *Intimacy and Sexuality in Long-Term Care, A guide to practice: resource tools for assessment and documentation*. Lanark, Leeds and Grenville Long-Term Care Working Group)**

When determining the level of sexual behaviour being exhibited by a resident (in these guidelines ranging from level one to level five), documentation and assessment is stressed. With this information and assessment of the resident's intimacy history collected, team meetings and meetings with the resident (or residents) in question and their spouse or partner can be organised, in this way keeping all those involved in the resident's care as informed as possible as to any situations that arise (p.6).

In the case of non-consensual, physical sexual behaviours that distress others in the environment, this being classified as level five by the guidelines, there are a number of advices given in how to respond to these situations. One aspect of these is the submission of a Critical Incident report to the Ministry of Health and Long-Term Care (MoHLTC) and the Director of the MoHLTC as well as notifying the police. In this way, incidents of sexual abuse are properly documented and those that require notification receive that notification (p.12).

**(Heath, H. 2011. *Older people in Care Homes: Sex, Sexuality and Intimate Relationships*. Royal College of Nursing)**

Discussion is strongly encouraged throughout the document. The fact that sexuality can be an awkward subject, particularly when talking about sexuality in old age, is considered (p.3 – 4) and guidance is provided on how to go about broaching the subject of sexuality (p.8).

Documentation is an important aspect that is also examined. Being described as “central to facilitating the acknowledgment of lifestyle, sexuality and relationship issues for residents”, the guidelines explain how documentation of biographical details of a resident can give important clues to issues that resident may have and will then help inform decision making (p.7). When discussing sexuality when it is seen as a problem, for example, through inappropriate sexual expression or unwanted sexual actions, documentation and the need to record and report behaviour or situations that can be seen as problematic is emphasised. With accurate reporting, the surrounding circumstances can be assessed and solutions can be found (p.9).

Once again, as discussed above in regard to the first and third rules, providing access to information in a variety of mediums is encouraged (p.7).

**(Carlson, M. Clements, G. Everett, B. Young, J. McBride K. 2013. *Supporting Sexual Health and Intimacy: A Pocket Reference Guide*. Spinal Cord Injury BC)**

In reference to capable residents that do not require assistance, the guidelines state that the resident should be offered information to help educate them and help them to reduce risk in the future for themselves. The choice of whether the information given is taken on and put into practice, is the resident's to make (p.6).

**(Panosh. Button. 2014. *Recommendations for Addressing Resident Relationships*. Wisconsin Board on Ageing and Long Term Care)**

A large section of the guidelines is listed under the title “Education” and details how free access to information for residents, their families, staff and administrators is of great importance. For residents, it allows them to be informed on their rights to maintain relationships including intimate and sexual relationships. For staff, it gives them information and tools that help to support their decision making and foster sensitivity to what can be a very sensitive subject. Team building, increased confidence and an increased respect for resident’s rights are also cited as positive outcomes of greater staff education (p.3 – 4).

The free flow of information, the 4<sup>th</sup> rule put forward by the IOM is strongly represented in each of the guidelines. Discussion, documentation, education and the difficulty of navigating confidentiality are all touched upon.

## 6.5 Evidence-based decision making

Patients should receive care based on the best available scientific knowledge. Care should not vary illogically from clinician to clinician or from place to place

**(Intimacy Guidelines Writing Group. 2006. *Considerations Regarding the Needs of Long-Term Care Residents for Intimate Relationships and Sexual Activity*. Centre for Practical Bioethics)**

The RAI process calls for all decisions on resident care to be evidence based, this evidence being gathered in the assessment phase of the process. Once decisions have been implemented further evidence for the effectiveness of those care decisions is gathered during the evaluation stage which is then combined with previous knowledge to fine-tune individualized care. (p.6)

**(LTC Working Group. 2010 *Intimacy and Sexuality in Long-Term Care, A guide to practice: resource tools for assessment and documentation*. Lanark, Leeds and Grenville Long-Term Care Working Group)**

Within the introduction of the document it is stated that the guidelines themselves have been developed systematically “incorporating the best available evidence” (p.2).

From this, the requirement of evidence is shown to be highly placed and this is further shown in the rest of the document. Evidence is called for through a number of different assessments which are all required for the assessment of the resident’s sexual behaviour and how the staff of the long-term care facility respond. The classification of sexual behaviour and activities into levels helps with this process (p.8 – 12).

**(Heath, H. 2011. *Older people in Care Homes: Sex, Sexuality and Intimate Relationships*. Royal College of Nursing)**

Throughout the report, staff education is discussed with the guidelines recommending that care facilities offer support and education to staff to help them approach issues surrounding sexuality (p.2).

With an educated staff, evidence-based decisions can be made. Documentation has previously been discussed in this analysis and with all available information collected, as the guidelines advocate (p.7 and 9), it can be used to make an informed decision.

**(Carlson, M. Clements, G. Everett, B. Young, J. McBride K. 2013. *Supporting Sexual Health and Intimacy: A Pocket Reference Guide. Spinal Cord Injury BC*)**

The way in which these guidelines suggest situations of residents engaging in sexual activity or intimate relationships should be dealt with is based very much on evidence gathered about the individuals involved. Some of the key questions that they say must be answered include whether there is a risk of harm for the resident(s) or others and whether the resident(s) involved are capable of making choices regarding sexual activity which can only be answered through a thorough understanding of the situation and people involved (p.3).

When analysing risk, the reasonableness of the risk is a determining factor and the manner in which it is determined is clearly outlined and should include an experienced group of care providers from a number of different clinical backgrounds in consultation with the resident or their representative. All of the information for making this decision must be collected together to form the nature of the response (p.4).

In the course of explaining how to go about determining the capability of a resident to make the choice to engage in sexual activity, it is clearly stated on page 5 “Any intervention will require assessment of the unique circumstances of the resident with a view to developing a client-centered plan.”

**(Panosh. Button. 2014. *Recommendations for Addressing Resident Relationships. Wisconsin Board on Ageing and Long Term Care*)**

The guidelines call multiple times for staff to have an understanding of the resident’s sexual history, through discussion and through an “Intimacy and Sexual History” form, so as to help form care planning and decision making (p.5 – 8).

As mentioned previously, when looking at the rule “The patient as the source of control”, assessing the capacity for the resident to provide consent to sexual activities is of very high importance (p.4). Knowing the resident’s level of ability with giving consent is important so that effective care can be given to that individual and their level of consent can go on to affect all future decisions regarding questions about sexual activity and intimate relationships.

All of the analysed guidelines had evidence of an evidence-based approach to structuring care, being presented through the advocacy of gathering as much information about the resident(s) and their situation as possible to be used in decision making.

## 6.6 Safety as a system priority

Patients should be safe from injury caused by the care system. Reducing risk and ensuring safety require greater attention to systems that help prevent and mitigate errors.

**(Intimacy Guidelines Writing Group. 2006. *Considerations Regarding the Needs of Long-Term Care Residents for Intimate Relationships and Sexual Activity*. Centre for Practical Bioethics)**

In the conclusions of the guidelines, the authors advocate for long-term care facilities to implement policies that help to support residents in their sexual activities and intimate relationships so long as those activities and relationships are not so problematic that support cannot be given. As a part of this policy creation, they call for two forms of support; support that is both anticipatory and situational. By covering both aspects, the safety of residents can be best protected. (p.3 – 4)

Within the Procedural Considerations, the authors also talk of the role of facility staff. Staff have a responsibility for assessing, reporting and supporting (or not supporting) a resident's behaviour and the guidelines outline the need for staff to receive training in responding to residents with compassion. This helps to provide residents with appropriate support and so help to ensure their safety. Staff safety is also acknowledged and that they also have the right to a safe work place. (p.5)

**(LTC Working Group. 2010 *Intimacy and Sexuality in Long-Term Care, A guide to practice: resource tools for assessment and documentation*. Lanark, Leeds and Grenville Long-Term Care Working Group)**

The protection of the resident's dignity, individuality, freedom from discrimination and human rights are enshrined in the guidelines value statements (p.3 – 4).

The guidelines themselves are designed in such a way as to promote the protection of residents and staff through the differentiation of different levels of sexual behaviour and standardized assessment protocols and responses. The existing laws governing sexual abuse are also used as a basis for responses to incidents helping to standardize responses to incidents which in turn will help to ensure safety (p.8 – 12).

**(Heath, H. 2011. *Older people in Care Homes: Sex, Sexuality and Intimate Relationships*. Royal College of Nursing)**

Clearly indicating the importance of protecting the resident's rights (p.5), the guidelines can be seen as the demonstration of the idea of safety as a system priority. The document also detailing a framework for the assessment of problems (p.9 – 10), puts forward a clear system that will go some way to solving problems and keeping resident's safe. Barriers to the free expression of sexuality for older people are also addressed by the guidelines as well as the barriers facing nurses and care staff in addressing issues in this area (p.9 and 11). Acknowledging these barriers, already goes some way to moving past them.

**(Carlson, M. Clements, G. Everett, B. Young, J. McBride K. 2013. *Supporting Sexual Health and Intimacy: A Pocket Reference Guide*. Spinal Cord Injury BC)**

The assessing of the risk of harm to clients being a deciding factor in whether interventions are necessary in sexual activity or intimate relationships, can be seen as an aspect of safety being considered as a system priority (p.4). Risk being mitigated through assessment which is then used to formulate a response helps to protect residents from harm through an organized system. The decision-making flowchart found within the appendix (p.13) can also be seen as the standardisation of safety policy.

**(Panosh. Button. 2014. *Recommendations for Addressing Resident Relationships*. Wisconsin Board on Ageing and Long Term Care)**

Safety of the residents and staff is protected in part through the guidelines advocacy for education. As discussed previously, education allows those involved in decision making to make informed decisions. The guidelines state "Education provides staff with the knowledge and tools needed to address situations appropriately and with sensitivity." (p.3)  
In this way education acts as an additional safety feature in helping provide quality care. Consent assessment also helps to inform staff of a patient's abilities and so help them to keep the resident safe (p.4).

Safety being a system priority, the sixth rule put forward by the IOM for 21<sup>st</sup> century healthcare, is well represented in the guidelines chosen for this analysis. Through the protection of human rights and the importance of education stressed, safety is actively supported.

## 6.7 The need for transparency

The health care system should make information available to patients and their families that allows them to make informed decisions when selecting a health plan, hospital, or clinical practice, or choosing among alternative treatments. This should include information describing the system's performance on safety, evidence-based practice, and patient satisfaction.

**(Intimacy Guidelines Writing Group. 2006. *Considerations Regarding the Needs of Long-Term Care Residents for Intimate Relationships and Sexual Activity*. Centre for Practical Bioethics)**

As part of the guideline's Procedural Considerations section, it is stated that facilities ought to involve family members and encourage their participation in pre-admission assessments, an essential aspect of the RAI process. In developing situational responses, the guidelines also state that family members may also be important participants. When a resident is no longer capable of decision making in regard to their care and have been assigned a legal guardian, the legal guardian ought to be informed and included when considering the resident's sexual activities and intimate relationships. (p.5)  
As previously mentioned, the RAI process requires extensive intrastaff communication. As such, transparency is well encouraged. (p.6)

**(LTC Working Group. 2010 *Intimacy and Sexuality in Long-Term Care, A guide to practice: resource tools for assessment and documentation*. Lanark, Leeds and Grenville Long-Term Care Working Group)**

In ensuring transparency, discussion between the resident, care staff and, where appropriate family members and partners of the resident, is encouraged, both in the assessment of the resident's sexual history at admission and in the event of an incident including the resident (p.5).

The documentation of the resident's intimacy history and incidents, also helps to ensure transparency by providing detailed objective information that can be then be used in assessment and decision making.

**(Heath, H. 2011. *Older people in Care Homes: Sex, Sexuality and Intimate Relationships*. Royal College of Nursing)**

As previously mentioned, discussion with the resident is recommended throughout the document and, where appropriate, the resident's spouse/partner and/or family. One aspect that is mentioned is discussing with the family the care home's policies at admission ensuring transparency between the home and the resident's family (p.6).

**(Carlson, M. Clements, G. Everett, B. Young, J. McBride K. 2013. *Supporting Sexual Health and Intimacy: A Pocket Reference Guide. Spinal Cord Injury BC*)**

Transparency and discussion is encouraged throughout the guidelines but this is tempered with the reminder of the individual resident's rights. When considering the case example of Sid and Jean in Case Example A, it is determined that Sid is capable of sexual consent and as such his family can only be consulted by care staff with his permission. As Jean is considered incapable of giving consent, her representative must be informed (p.9).

**(Panosh. Button. 2014. *Recommendations for Addressing Resident Relationships. Wisconsin Board on Ageing and Long Term Care*)**

These guidelines do not specifically talk about transparency however discussion is mentioned throughout as a means of communicating information and policy to residents and, where appropriate, to their family and/or guardians which can be seen as acknowledging transparency. In this way, the rule can be inferred but it is not expressly written into this set of guidelines.

The seventh rule developed by the IOM "The Need for Transparency" was found to be broadly followed by the guidelines however "Recommendations for Addressing Resident Relationships (Panosh and Button 2014) was not explicit in its support for this rule.

## 6.8 Anticipation of needs

The health system should anticipate patient needs, rather than simply reacting to events.

**(Intimacy Guidelines Writing Group. 2006. *Considerations Regarding the Needs of Long-Term Care Residents for Intimate Relationships and Sexual Activity*. Centre for Practical Bioethics)**

These guidelines call for two types of support, both anticipatory and situational. In this way, quite explicitly, it calls for the anticipation of needs. (p.3 – 4) The RAI process, when focussed on sexual activities and intimate relationships as in these guidelines, is also very much focussed on the development of early interventions and constant monitoring and evaluation of resident's needs. (p.6)

**(LTC Working Group. 2010 *Intimacy and Sexuality in Long-Term Care, A guide to practice: resource tools for assessment and documentation*. Lanark, Leeds and Grenville Long-Term Care Working Group)**

The capacity of the resident to understand their actions, their awareness, is considered and assessed at admission to the LTC facility and may be reassessed in light of an event involving that resident (p.6, 7 and 11).

The way in which the guidelines are designed seeks to anticipate needs, in that they outline differing levels of sexual behaviour and activity and give responses based on that particular level. In this way, a number of different situations can be covered and advice on appropriate responses given. In this way, a number of different situations can be covered and advice on appropriate responses given (p.8 – 12).

**(Heath, H. 2011. *Older people in Care Homes: Sex, Sexuality and Intimate Relationships*. Royal College of Nursing)**

The guidelines speak very clearly on the need for care homes to develop policies that protect the rights of those living in, working in or visiting the care home (p.6). They also call for organisational systems that recognise the importance of sexuality and intimate relationships and give recommendations on how organisational systems can go about addressing this (p.7). In this manner, it is calling for an anticipation of situations arising, the anticipation of a need for policy and guidance.

Another way this is exhibited is through the inclusion of case examples which it offers as topics of discussion for nursing and care staff. By giving example situations and circumstances, they acknowledge some of the common issues addressing resident sexuality can throw up (p.13 – 17).

**(Carlson, M. Clements, G. Everett, B. Young, J. McBride K. 2013. *Supporting Sexual Health and Intimacy: A Pocket Reference Guide. Spinal Cord Injury BC*)**

With the aforementioned inclusion of case examples (p.9 – 11), the needs of residents have been shown to be anticipated with numerous differing situations outlined and guidance in how to deal with these situations offered. The same can also be said of the decision-making flowchart found in the appendix of the document (p.13).

**(Panosh. Button. 2014. *Recommendations for Addressing Resident Relationships. Wisconsin Board on Ageing and Long Term Care*)**

The guidelines outline a number of different situations and how care staff should respond to them and in this way, anticipate the needs of residents (p.5 – 9). The observation of residents and understanding the patient's sexual history as methods outlined to help inform decision making and build care plans can be seen as the anticipation of needs and helps to ensure that those needs are met (p.5 – 8).

The anticipation of resident's needs was very present in the guidelines with it being shown as an essential step in the care process for all of the analysed guidelines.

## **6.9 Continuous decrease of waste**

The health system should not waste resources or patient time.

Not applicable. Analysis of guidelines did not produce any data.

## 6.10 Cooperation between clinicians

Clinicians and institutions should actively collaborate and communicate to ensure an appropriate exchange of information and coordination of care.

**(Intimacy Guidelines Writing Group. 2006. *Considerations Regarding the Needs of Long-Term Care Residents for Intimate Relationships and Sexual Activity*. Centre for Practical Bioethics)**

Extensive intrastaff communication has already been discussed as being an integral part of the RAI process and so advocated for by these guidelines.

**(LTC Working Group. 2010 *Intimacy and Sexuality in Long-Term Care, A guide to practice: resource tools for assessment and documentation*. Lanark, Leeds and Grenville Long-Term Care Working Group)**

The inclusion and informing of various groups and individuals regarding the sexual behaviour of residents shows a recognition of the need for cooperation (p.8 – 12).

The guidelines also encourage holding team meetings involving all staff that are involved with the resident's care (p.6).

**(Heath, H. 2011. *Older people in Care Homes: Sex, Sexuality and Intimate Relationships*. Royal College of Nursing)**

One facet mentioned in the guidelines, is the assertion that decisions based around an individual's care should never be made in isolation with all care decisions being made with the support of the designated care teams (p.2).

The guidelines also note the importance of support between colleagues when considering the barriers facing nursing staff when talking about sexuality. They suggest this sharing and exploring of feelings on difficult subjects between staff as helpful in developing an effective team approach (p.11).

**(Carlson, M. Clements, G. Everett, B. Young, J. McBride K. 2013. *Supporting Sexual Health and Intimacy: A Pocket Reference Guide. Spinal Cord Injury BC*)**

There is no explicit mention of cooperation between clinicians other than in regard to determining reasonableness where, as mentioned previously, it states

“Ideally, the reasonableness of the level of harm will be determined by an experienced group of interdisciplinary care providers...” (p.4)

Other than this, throughout the document, the care facility at large is mentioned which would suggest a cooperation and an interdisciplinary approach to care are recommended.

**(Panosh. Button. 2014. *Recommendations for Addressing Resident Relationships. Wisconsin Board on Ageing and Long Term Care*)**

Explicit reference to clinician cooperation is absent however, within the education section of the guidelines, intra-staff communication and communication with family and guardians, is described as “imperative” (p.4).

Cooperation between clinicians is referenced in all of the guidelines and so these chosen guidelines can be said to abide by this tenth rule of the IOM.

## 7. DISCUSSION

In this report, five guidelines centring around the sexuality and intimate relationships of residents in LTC facilities designed for use by nurses and care staff were analysed against the ten rules set out by the Institute of Medicine as part of recommendations made in 2001 to improve healthcare moving into the 21<sup>st</sup> century. In the course of analysing these five guidelines, it was found that, for the most part, they all adhered to those rules. However, one example of where the guidelines fell short is within “Supporting Sexual Health and Intimacy: A Pocket Reference Guide” (Carlson et al. 2013) which had little to no reference to follow up or reassessment. This was seen as not adhering to the rule of fostering a “continuous healing relationship” with residents as the rule states:

“Patients should receive care whenever they need it and in many forms, not just face-to-face visits.” (IOM, 2001 p. 7)

Without any form of reassessment, the effectiveness of interventions is impossible to determine which then would lead to the resident’s care not being responsive. “Considerations Regarding the Needs of Long-Term Care Residents for Intimate Relationships and Sexual Activity” (Intimacy Guidelines Writing Group, 2006) recommends the use of the Resident Assessment Instrument (RAI) process which advocates constant evaluation and reassessment (see Intimacy Guidelines Writing Group 2006 p. 6). The use of the RAI process helps to ensure continuous, customised healthcare which collects and shares evidence through extensive intrastaff communication which can then be used for decision making; all aspects that chime with the theoretical model. For this reason, systems, such as the RAI process, can be of great help in the formation of guidelines as they help to ensure a basis of quality care for residents in LTC.

The set of guidelines created by Panosh and Button (2014) for the Wisconsin Board on Ageing and Long Term Care, “Recommendations for Addressing Resident Relationships” was also found to have a deficiency when compared against the IOM’s ten rules. The seventh rule “The Need for Transparency” which is explained as

“The health care system should make information available to patients and their families that allows them to make informed decisions when selecting a health plan, hospital, or clinical practice, or choosing among alternative treatments. This should include information describing the system’s performance on safety, evidence-based practice, and patient satisfaction.”

was not clearly represented. Support for this rule could be inferred from frequent mention of discussions to be had with resident's and their families, however, as was shown in the case detailed by Blakemore (2008) of the head nurse that was left without guidance in a sensitive situation involving the sexuality of a disabled teenager, clear guidance that is unambiguous is required to ensure nurses and carers feel supported in their decision making. With regard to the rule on transparency, making guidelines that explicitly call for information to be made available and understandable to resident's will inform nurses and care staff of their obligations and can aid the resident's decision-making and greatly impact their future care.

Looking at the presentation and structure of the guidelines, it is also worth noting the variety of ways the guidelines are presented. For example, the guidelines "Older people in Care Homes: Sex, Sexuality and Intimate Relationships", formulated for the Royal Nursing Council (Heath, 2011), are written as a discussion in prose, much like "Considerations Regarding the Needs of Long-Term Care Residents For Intimate Relationships and Sexual Activity" (Intimacy Guidelines Writing Group, 2006) but are also presented as a decision flow diagram and with case examples. "Intimacy and Sexuality in Long-Term Care, A guide to practice: resource tools for assessment and documentation" (LTC Writing Group, 2010) and "Recommendations for Addressing Resident Relationships" (Panosh & Button, 2014) both make use of a graduated system of distinct levels of sexual behaviour with the differing approaches to those behaviours being explained alongside these levels. The presentation style of the guidelines was not included as part of the analysis of whether the guidelines are of sufficient quality; the IOM's ten rules are not geared around presentation effectiveness, however this is a factor that could be explored in further research. Whether the guidelines are clear for staff to follow, understand and use in practice would be invaluable research and could be used in the formation of guidelines that would help to ease the confusion which has been reported by nurses that don't have these clear guidelines (Gray 2015).

The theoretical framework, the ten rules for healthcare developed by the Institute of Medicine, was used as the measuring stick to analyse the sexuality and intimate relationship guidelines because it was designed to act as a guide for healthcare into the 21<sup>st</sup> century. Having been developed in 2001, it offered a perspective of how healthcare should be, the guidelines showing, to some extent, what healthcare has now become. The analysis, finding that the majority of the rules were expressed in most of the guidelines, deficiencies being found in only two of the guidelines, indicated that the ideas of the IOM have broadly been brought into the present. Through this, the guidelines can be said to be successful in their purpose (providing guidance for nurses and care staff to

implementing high quality, respectful, safe care to LTC residents) according to the theoretical theory.

The author has previously mentioned their own nursing experiences on practical training placements being part of the impetus for pursuing this area of research. In conducting this data collection and analysis, it has been clear that material relating to nursing sexual guidelines is difficult to obtain which accords with the experiences of the author. Where those guidelines exist, it seems they are of a good quality, however the quality of the guidelines means nothing if those guidelines are not easily accessible and well understood. Greater awareness of the sexual needs of patients and residents and the responsibilities nurses have to these aspects of their healthcare would go some way to ensuring the sexual facets of individuals are not ignored.

## 8. CONCLUSION

This report sought to answer the three research questions

1. Why are resident sexuality and intimate relationship guidelines for nurses needed?
2. Do available sexuality guidelines for nurses in LTC facilities fulfil the ten rules set out by “Crossing the Quality Chasm” for quality, safe healthcare in the 21st century?
3. In what ways can these guidelines be improved so as to better fulfil the ten rules?

In this regard, this report can be deemed successful, these questions having been answered. As can be seen in the research collected, good quality guidelines and clear guidance is required for nursing and healthcare staff to effectively make decisions regarding resident sexuality in LTC facilities. Considering the resident sexuality guidelines, it can be seen that those guidelines that have been created and are freely available online are generally in accordance with the ten rules for healthcare in the 21<sup>st</sup> century put forward by the IOM. Those guidelines that were in some way lacking or would require improvement in order to more fully accord to those ten rules could be improved with the inclusion of a care system such as the Resident Assessment Instrument process that would ensure adherence to the first rule, “care based on continuous healing relationship”, and more explicit reference to transparency and informing and educating the resident so that the resident can better make informed decisions.

Further study into the effectiveness of sexuality and intimate relationship guidelines for nurses is required. During research for this report, it was noted that information on this area was limited and the guidelines themselves were difficult to find through open sources. Further research would require contacting multiple LTC facilities directly so as to have a greater pool of resources. This would also allow for comparison between different countries, different forms of LTC and potentially how these guidelines have changed over time. Areas of further research might also include whether presentation style has any bearing on the accessibility of the guidelines and whether this in turn has an effect on how these guidelines are used in facilities. Various presentation styles were utilized but it was not in the purview of this report to investigate this aspect. The question of “what makes nursing guidelines effective?” was far too wide a question for this report.

The theoretical theory used in this analysis, the ten rules developed by the IOM, offered a unique perspective, having been developed in 2001 as a guide to future healthcare approaches and applied to contemporary sexuality guidelines. Using a more contemporary guide for healthcare may yield different results due to the evolutionary nature of healthcare and the development of, perhaps differing, contemporary ideas on the purpose and execution of good quality, safe healthcare. This is another avenue of research that could be explored.

All efforts were made to ensure that this report was thoroughly sourced and that those sources were accurately presented.

When considering the limitations of this report, only five guidelines were analysed against the theoretical framework chosen. As such this only gives a small view into sexuality and intimate relationship guidelines. The guidelines that were chosen were also developed for differing forms of LTC facility so comparison between them may not be entirely appropriate. This situation arose due to the time constraints imposed and the difficulty in finding suitable material for use in this report. As has been previously discussed, future research may include contacting LTC facilities directly for access to their resident sexuality and intimate relationships guidelines so as to create a larger sample group of guidelines.

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