Sexuality in Nursing Homes – Healthy Sex Lives v. Sexually Aggressive, Demented Residents

http://hereandnow.wbur.org/2013/08/01/nursing-home-sex
Research shows that nursing home residents are more likely to be sexually molested by:

- A. Another cognitively intact resident.
- B. A staff member.
- C. A visitor.
- D. Another cognitively impaired resident.
Prevalence Of The Problem

- D. Dementia-driven resident-to-resident sexual abuse is the most common form of sexual abuse in nursing homes.
- As the nursing home population grows older, more feeble, and more demented, the opportunities for sexual abuse by demented residents increase.

Research on Sexually Inappropriate Behavior

  - Studies of the prevalence of sexually disinhibited behaviour in people with dementia report rates of 2-17%.

Disinhibition v. Intimacy Seeking

  - 7.9% of residents in facility with all long term demented exhibited sexually inappropriate behavior
  - 3.6% were disinhibited/aggressive. Rest were intimacy-seeking.
  - Disinhibition includes masturbation in public, propositioning others, groping, sexual assault.
  - ½ of the disinhibited had MILD dementia.
Reasons for Sexually Inappropriate Behavior are Complex

- Disease-related factors such as frontal lobe lesions, delusions or hallucinations
- Social factors: lack of privacy, missing former sexual partner
- Psychological factors such as depression and preexisting sexual patterns
- Medications: benzodiazepines and L-dopa may also cause sexual disinhibition
- Traumatic brain injury can also be a cause

Transition

Now that we have discussed the problem, let’s look at how one facility handled this type of problem.

Peace River – REAL CASE

Peace River – R 22

- Resident 22 – On June 25, 2005, Resident 22 was found in a female resident's room holding her down in bed and rubbing his body on top of hers saying “I sorry.” He was pulled off her and redirected.
- The next day he was found in her room kissing the same resident on one occasion and in her bed with her on another occasion. The female resident had her dress pulled up, but her brief was intact.
- Nurses notes indicate that Resident 22 was redirected after each of these incidents per his care plan.
Peace River – R 21

- Resident 21 – From May 2005 through October 2005 facility records show more than 20 separate instances of Resident 21 engaging in the following behavior:
  - “Staff reports that (R21’s) sexual behavior is getting worse. Noted to be putting hand down females’ pants all of the time.”

- “Called to room by CNA. Noted in bed - Resident 21 and female resident lying in bed. Resident 21 had his hand down her pants. When he saw staff he pulled his hand out. Resident became agitated when redirected. Charge nurse notified. Physician contacted, Seroquel ordered by physician and given PRN.”
  - “Sexual behavior has gotten worse. Was noted to be touching every female in his immediate surrounding, supervisor notified.”
Peace River

- Aside from the sheer volume of incidents, does anything in terms of documentation and facility response seem odd to you?

Peace River

- The female victims are almost never identified
  - Their families aren't notified of what is happening.
  - Nothing is done to attend to their physical or emotional concerns; no assessment as to any trauma.
  - There doesn't seem to be a pressing need to protect these women.
- Rarely a mention of notifying supervisors.
- Very few incident reports.
- Interventions limited to redirecting/1x1 for very short periods of time and sporadic pharmacological interventions.
- Did the facility consider this abuse? They didn't report it? Did they react like it was abuse?

Peace River

- Was this a sufficient response?
- What was wrong with it?
- In the absence of some evidence to suggest the facility corrected the problem, could the government start an investigation and run it up until the time of the survey?
Peace River

- Facility is treating the molestation of these women as though it is simply a problem behavior with no victim (in the absence of physical injury or sexual penetration).
- Many months where Quality Improvement Committee did not discuss protecting the female residents.
- Administrator said he did not consider the female residents to have been abused.
- Anti-Psychotic (Seroquel) Used Improperly

A Few Suggestions for Nursing Homes

NO role for PRN only antipsychotic medications.

Need non-pharmacologic strategies to manage individuals with dementia

“Behaviors” = attempts to communicate unmet needs

Peace River

- What do you think the Gov’t did with this facility?
- Found Immediate Jeopardy existed in the facility over 6 months
- Assessed a CMP of appx. $1 million dollars
- Terminated the facility from participating in the Medicare/Medicaid Programs
- No appeal – facility paid over $400K to settle CMP
Peace River

- Why was this facility terminated?
  - The inability of the management and staff to appreciate that the female residents were victims.
  - The ongoing nature of this violation - more than 6 months
  - This situation led to the conclusion that the operators of this facility could not meet minimum expectations of safety

Summary

- BIG PROBLEMS - SEXUALLY AGGRESSIVE RESIDENTS
- Boys will be Boys
- Not Recognizing the Victims
- Not Caring for Victims
- Redirection Not Enough
- Anti-Psychotic Improperly Used!
- Serious Regulatory and Civil Liability