Healthcare

CAREFULLY SPEAKING®

A Risk Management Resource for Aging Services | 2021 Issue 2

Resident-on-resident Sexual Abuse: Taking Aim at a Growing Risk

Compared with other forms of resident abuse in aging services settings, sexual assault claims are relatively rare.[1] Nevertheless, sexual misconduct is an ongoing problem for some aging services facilities. According to a report from CNN, more than 16,000 complaints of sexual abuse have been registered against skilled care and assisted living facilities since 2000.[2] Sexual abuse claims may potentially result in multimillion-dollar damage awards and significant reputational damage, if it can be proven that the facility failed to exercise reasonable care in ensuring resident safety.

Risk management efforts in this area should address both staff-on-resident (SOR) and resident-on-resident sexual abuse (RRSA). While SOR continues to be the larger liability exposure for the aging services industry, the threat of RRSA is growing due to the tendency to admit greater numbers of residents with dementia, as well as younger individuals with mental health conditions who may be prone to aggression. (See "Common Allegations Associated with Resident-on-resident Sexual Abuse," page 2.) This edition of *CareFully Speaking*® examines RRSA, an emerging risk that calls for a focused, proactive response.

The issue is divided into three sections, reflecting the following general risk control strategies:

- **Prevention** of resident-on-resident sexual misconduct.
- **Prompt detection** of assaults and other incidents.
- **Reporting and investigation** of occurrences in a consistent, timely and transparent manner.

In this issue…

Each of these sections contains a wide range of measures, which can be adapted as necessary, to help staff assess and minimize risk factors in the resident population, identify warning signs of both aggression and victimization in individual residents, and respond to assaults or other occurrences. A sidebar on page 7 suggests ways to create a safer environment of care. And included on pages 8-9 is a checklist of policymaking safeguards in the related area of resident sexuality.

1 According to the World Health Organization, only 1.9 percent of residents report sexual abuse per year, with the majority of assaults perpetrated by staff.
2 The 2017 CNN report utilizes data from the Administration for Community Living, a federal agency. Note that the figure represents only those cases in which state ombudsmen were notified and involved in resolving a complaint. The actual number of incidents is probably considerably higher.

Prevention

The first step in minimizing resident-on-resident assault is to review the organization's overall violence prevention program, ensuring that it specifically addresses sexual abuse. The following suggestions are intended to help leaders enhance policymaking in this area:

Define sexual abuse. Sexual abuse is typically and broadly defined as non-consensual sexual contact or interaction with a resident. This general description may encompass the following specific actions and behaviors, among others:

- **Sexual harassment,** including obscene or suggestive comments, derogatory nicknames and unwanted jokes of a sexual nature.
- **Sexually explicit photographs** of a resident taken without permission.
- **Attempts to compel another resident to watch sexual activity,** masturbation and/or pornography.
- **Forced nudity** or other coercive activities of a sexual nature.
- **Inappropriate interest in another resident's body,** intimate clothing or belongings.
- **Voyeurism** and stalking.
- **Public exposure** and masturbation.
- **Unwanted touching,** not limited to the genital area.
- **Sexualized kissing** and fondling.
- **Sexual assault** or battery with an object.
- **Vaginal penetration** without consent.
- **Sodomy** as a form of rape.

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Common Allegations Associated with Resident-on-resident Sexual Abuse

RRSA claims may include, but are not limited to, the following specific allegations:

- **Inadequate staffing levels,** leading to lapses in resident monitoring.
- **Lack of staff training** on the warning signs of sexual harassment and abuse.
- **Failure to screen for known perpetrators** during the admissions process.
- **Insufficient environmental protections,** including substandard lighting and security measures.
- **Absence of a sound response protocol,** including post-incident intervention and reporting practices.

Set realistic admissions criteria. By implementing sound placement policies based upon the facility's ability to safely care for residents with behavioral issues, organizations can reduce the likelihood of abuse, maintain a more orderly environment, minimize potential conflicts and complaints, and enhance the safety and well-being of all residents.

Screen residents. Residents should be screened for past criminal activity, including sex crimes. The following recommendations can help organizations identify potential offenders, assess the suitability of prospective residents and avoid admission decisions that violate state anti-discrimination laws:

- **Check public websites** to determine whether any registered sex offenders reside in the facility.
- **Investigate reports of past offenses,** evaluating residents with a criminal record on a case-by-case basis. Do not assume that higher-risk residents are harmless simply because they are disabled, wheelchair-bound, elderly and/or infirm.
- **Maintain regular contact with state and local law enforcement,** as well as corrections and human services agencies, regarding potential placement of parolees, ex-convicts and registered sex offenders.
- **Work closely with parole officers** to ensure that medical records of paroled residents are transferred and a sound plan of care is established to meet the individual's needs.

- **Check all applicants for a history of substance abuse,** as well as accounts of chronic anger, hostile behavior and violent incidents.
- **Be prepared to separate and/or closely monitor higher-risk residents,** such as known offenders and individuals with violent or abusive tendencies.
- **Address disruptive behaviors in the care/service plan**. (For advice in this area, see the box below.)
- **Consult legal counsel as to whether HIPAA or similar state laws apply** to disclosure of residents' prior convictions.

Develop policies and procedures addressing potentially aggressive residents. If such residents are admitted, assign their care to mental health practitioners and nurses who are specially trained to identify danger signs. In addition, schedule documented meetings with family members to review organizational policy on managing violent or abusive episodes. Most importantly, establish a process to transfer unmanageable residents to a more secure setting if findings and circumstances dictate. Prepare residents and families for this eventuality by informing them prior to admission and periodically thereafter that alternate placement may be necessary if resident needs exceed the organization's capabilities.

Care/Service Planning Tips for Managing Inappropriate Sexual Behaviors

As many as one quarter of residents with dementia or other forms of cognitive impairment engage in inappropriate sexual behavior (ISB). Among other undesirable actions, ISB can include sexually inappropriate language, unwanted touching and grabbing, public nudity and masturbation, and implied sexual acts, such as sharing of pornographic materials.

ISB should be addressed in resident care/service plans in a respectful, forthright and practical manner. The following planning tips can serve as a starting point for organizations seeking to evaluate their policies and procedures in this sensitive area:

- **Assess and document the resident's history of sexual habits,** noting what form the ISB typically takes, as well as when, where and how often it occurs. This will help determine whether current care/service plans reflect lifetime patterns and respond to evolving risks and needs.
- **Track and document inappropriate conduct,** such as obscene gestures, sexually explicit language, and unwanted touching or kissing.
- **Following abrupt onset of ISB, rule out organic causes,** utilizing appropriate neuro-imaging tools and laboratory tests.
- **Identify precipitating factors** – including physical, psychological and environmental conditions – that tend to activate ISB.
- **Craft care/service plan interventions to respond to these behaviors,** such as establishing toileting routines, checking for possible urinary tract infections or prostate problems, providing loose and comfortable versus restrictive clothing, and utilizing social cues to reorient a resident to appropriate behavior.
- **Detect and address personal factors that may contribute to ISB,** such as boredom and loneliness.
- **Schedule conjugal visits,** arranging for single-room placement to ensure privacy. (This applies to mentally competent residents who have consented to the arrangement.)
- **Take measures to control exhibitionistic behavior,** such as encouraging residents to wear clothing that lacks zippers or opens at the back.
- **Contact the resident's primary care physician regarding safe and appropriate use of medications** – such as hormonal agents, cholinesterase inhibitors, beta-blockers and psychotropic drugs – if non-pharmacological treatment fails to ameliorate unwanted behaviors.

Source: De Giorgi, R. and Series, H. "Treatment of Inappropriate Sexual Behavior in Dementia." *Current Treatment Options in Neurology*, August 11, 2016, volume 18:41.

Educate staff. All caregivers have a duty to be alert to the possibility of sexual abuse. Training sessions should address relevant topics, including facts about the aging process, specific vulnerabilities of the elderly, and techniques for both preventing misconduct and responding appropriately to an assault. Specifically, resident care staff should be able to …

- **Recognize the warning signs of sexual abuse,** as outlined in the box to the right.
- **Communicate with traumatized residents** in a calm, clear and reassuring manner.
- **Empathize with the needs and issues of residents with dementia,** chronic disease and physical handicaps, who are at greater risk of abuse.
- **Understand the ethical and professional duty to watch for signs of abuse** and to report concerns in a timely manner and according to written protocol.

Address the link between RRSA and understaffing. Organizations cited during state surveys for resident-on-resident violence tend to share certain characteristics, especially overcrowding and understaffing. To minimize irregular and unsafe staffing patterns, which are a significant risk factor for RRSA, facilities should take the following actions, among others:

- **Employ a sufficient number of qualified staff** to permit adequate supervision of both vulnerable and potentially aggressive residents.
- **Avoid overreliance on temporary help** and continuing, excessive overtime.
- **Monitor staff turnover rates** and, if necessary, take action to improve retention.
- **Direct supervisors to address signs of staff indifference toward resident sexual abuse,** including a tendency to ignore misconduct, or to treat it as normal and acceptable behavior.
- **Whenever possible, assign direct care workers to the same group of residents,** thus promoting trust and increasing staff familiarity with residents' habitual disposition, daily activities and usual whereabouts.

Physical and Emotional Signs of Sexual Abuse in Residents

Many sexually abused residents are unable or unwilling to clearly express what is happening to them because they are cognitively impaired and/or traumatized. For this reason, it is important for families and aging services staff to be aware of common physical and behavioral signs of sexual assault, such as the following:

- **Bruises** around the breasts, abdomen, thighs, hips, buttocks or genital area.
- **Bleeding** or other signs of injury in the genital or anal area.
- **Unexplained pain and itching in the genital area,** or other possible symptoms of a sexually transmitted disease.
- **Torn and/or soiled clothing** or other indications of a struggle.
- **Visible fear** of another resident.
- **Body rocking, nail biting** or other manifestations of agitation.
- **Noticeably defensive or timid posture,** or other signs of stress or trauma.
- **Sudden changes in behavior or disposition,** including panic attacks and inappropriate outbursts related to sexual behavior.
- **Abrupt decline in physical condition,** including difficulty walking or standing.
- **Depression** and withdrawal from customary activities.
- **Suicide attempts** or expression of suicidal thoughts.

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Detection

To protect vulnerable residents, caregivers must be aware of both the telltale signs and root causes of sexual abuse. The following strategies are designed to enhance staff risk awareness:

Know the profile of potential abusers and victims. By being aware of certain predictive traits of both sexual abuse perpetrators and victims, staff members are better prepared to prevent and detect assaults and other occurrences. Some of these common characteristics are listed in the table, below.

Identify and manage root causes. Behavioral deficits that are unnoticed and/or inadequately treated may be the underlying cause of sexually aggressive behavior.

Common Characteristics of Offenders and Victims

The typical offender …	The typical victim …
• Is usually **male**.	• Is usually **female**.
• May be any age, but is disproportionately **middle-aged or younger.**	• Is often **at least 80 years old;** if younger, may have **physical and/or cognitive disabilities,** e.g., traumatic brain injury or a neuro-muscular disorder.
• Has been diagnosed with **dementia** or mood disorder.	• Suffers from Alzheimer's disease or other forms of **dementia** or cognitive impairment.
• Has a history of **traumatic brain injury.**	• Is **frail** and possibly wheelchair-bound, bedridden, paralyzed or less than fully mobile.
• Has a **criminal history,** often including sexual abuse.	• Is **isolated** and unable to communicate effectively.
• Has a history of **substance abuse**.	• Has **wandering** tendencies.
• Is in physical and/or emotional **pain.**	• **Has a weak support system,** such as family, friends and other potential advocates.
• Has **difficulty interacting** in social situations.	• **Lacks cautionary instincts** and has difficulty reading social cues.

Admissions protocols and procedures should elicit and document the behavioral history of new residents, especially regarding the following potential sources of aggression:

- **Confusion or disorientation about place and/or time,** possibly leading to anger and acting out.
- **Use of antibiotics or other medications,** whose potential side effects may include anxiety, agitation and/or mood alteration.
- **Substance abuse,** potentially prompting violent or hostile behaviors during painful periods of withdrawal or rehabilitation.
- **Reactive personality,** manifesting as misinterpretation of routine interactions as personal threats or insults, as well as a tendency toward aggressiveness.

Assess residents for predisposition to violence. By training staff to identify latent aggressiveness in residents, organizations can help prevent sexual assaults and other violent acts. One useful tool is the Brøset Violence Checklist (BVC), which considers various traits and past events, including confusion, irritability, boisterousness, threats, menacing gestures and attacks on objects. (Information on obtaining and using the BVC is available here.)

Watch for red-flag behaviors. While sexual abuse is a crime of opportunity, it is often preceded by certain behavioral warning signs. Staff members should be trained to recognize the following potential indicators of predatory intentions in a resident:

- **Focusing attention exclusively on one other resident** and spending an inordinate amount of time with that individual.
- **Insisting on closing the door** during visits with another resident.
- **Appearing defensive or evasive** when asked about a relationship with another resident.
- **Ceasing to converse with another resident** when staff members approach.
- **Routinely giving gifts** to another resident.
- **Being preoccupied with sexually explicit material**, such as pornographic magazines or videos, and showing them to another resident.

Through the use of mock scenarios and video training aids, staff members can be trained to recognize these and other possible red flags. (A listing of resources is available at "Caregiver Training: Sexually Inappropriate Behaviors," from the UCLA Alzheimer's and Dementia Care Program.)

Address sexuality in the cognitively impaired. One potential side effect of dementia is hypersexual behavior, combined with a lack of self-control. By identifying residents with strong sexual urges, staff are more likely to prevent victimization of other residents, who also may suffer from a cognitive deficit and be incapable of resisting attacks or informing staff of ongoing abuse.

Leadership is charged with the legally and ethically complex task of balancing the right of residents to privacy and independence against the need to protect other residents from the threat of nonconsensual sex. (For a list of issues to consider when drafting or reviewing policy in this area, see "Sexuality in Aging Services Residents: A Checklist of Policy Safeguards" on page 8.)

Reporting and Investigation

While general elder abuse statistics are tracked by the U.S. Department of Justice, there is no national databank specifically dedicated to reported cases of sexual abuse involving the elderly and infirm. Some observers believe that sexual misconduct in aging services organizations may be significantly underreported, and that the scope of the problem historically has been minimized.

When evidence of sexual abuse is ignored, for any reason, victims are placed at risk of repeat assaults, and necessary safety measures may not be implemented. To help ensure prompt and comprehensive reporting of RRSA, consider implementing the following procedural suggestions, adapted to the specific needs and culture of your facility:

Resist the temptation to dismiss reports. Cases of resident sexual abuse may go unreported because observable signs are unnoticed, ignored, misinterpreted or downplayed by staff. In particular, caregivers may be reluctant to believe accusations of wrongdoing due to cognitive impairment in victims and/or alleged offenders. However, overlooking even minor transgressions can prove a costly misstep. Reiterate to staff that the following factors should not deter them from reporting events:

- **The perpetrator has dementia** and lacks a willful intent to abuse.
- **The victim blames him/herself** or believes that the abuse will intensify if reported.
- **The family is embarrassed by disclosure,** or believes an investigation may be humiliating and/or painful for their loved one.
- **The organization's leadership is concerned about negative publicity** and potential community fallout.

Investigate every complaint. Incidents of sexual abuse should be immediately reported and investigated. The follow-up process should include the following elements, among others:

- **Promptly report incidents** to medical and nursing directors, the victim's family or guardian, local law enforcement, protective service agencies, state licensing and certification agencies, ombudsman programs and insurers.
- **Isolate the suspected perpetrator** from other residents during the investigation.
- **Provide medical attention to the victim,** including both physical and emotional care.
- **Request a sexual assault examination** for recent incidents (i.e., those that have happened within 72 hours).
- **Take measures to protect the confidentiality of all parties** and to prevent retaliation against those who voluntarily report instances of sexual misconduct.
- **Strictly prohibit gossip among staff about the event** or any discussion that blames the victim.
- **Require a written post-incident action plan,** designed to prevent future abuse.

Leadership is charged with the legally and ethically **complex task** of balancing the **right of residents to privacy and independence** against the **need to protect** other residents **from the threat of nonconsensual sex**.

Preserve evidence. Following a suspected assault, evidence – which typically includes physical assessment findings, as well as resident clothing, bed sheets and other items from the immediate vicinity – must be preserved so that valid allegations can be confirmed, the perpetrator identified and other residents protected from harm. The task of identifying, handling and securing potential evidence of sexual abuse should be assigned to a single competent individual, who is instructed to work in consultation with law enforcement personnel. (For a sample sexual assault protocol, click here and scroll down to page 2, under "Acute Sexual Assault.")

Surveillance cameras and other authorized monitoring devices can serve as another potentially valuable source of evidence. Relevant recordings should be secured immediately for further review by the authorities. (For information on risk control strategies involving video footage, see the CNA *AlertBulletin*®, "Video Surveillance: The Pros and Cons of 'Granny Cams,'" republished in 2017.)

Support family members. Just as victimized residents suffer psychological trauma in response to sexual abuse, their family members also may feel guilt, anger, depression, anxiety and other manifestations of shock and grief. Inform relatives of ongoing investigative findings in a timely manner and offer access to both counseling services and a designated contact person within the organization to respond to their questions and concerns.

Sexual misconduct is a tragedy for victims and families, as well as a challenging and sensitive issue for aging services organizations, which must respect the rights of residents while protecting them against abuse and exploitation. By focusing on the three key procedural areas of violence prevention, occurrence detection, and post-incident reporting and investigation, facilities can create a more secure and less fearful environment for vulnerable residents, while reducing their own exposure to claims, regulatory sanctions and negative publicity.

These 10 Environmental Controls Can Help Thwart Potential Attacks

Design flaws within buildings make it easier to commit and conceal abusive acts. To protect residents and minimize potential liability, administrators should perform periodic environmental surveys, noting such hazards as isolated spaces and walkways, cramped corridors, inadequate lighting and unmonitored stairwells. In addition, leadership should take effective measures to avoid overcrowding, which can exacerbate stress and conflict and lead to violence.

The following measures are designed to enhance environmental safety, thus reducing the likelihood of resident-on-resident sexual assault and other types of abuse and misconduct:

1. **Ensure that nursing stations are centrally located**, so that rooms are more visible to staff, and residents do not walk down corridors unnoticed.
2. **Install prominently marked panic buttons and alarms** within resident rooms and in all activity areas.
3. **Control access to the building**, monitoring outer doors and locking them at a designated time.
4. **Implement 24-hour campus surveillance** to discourage criminal activity.
5. **Require visitors and volunteers to check in** at a designated reception area.
6. **Change keypad access codes periodically** and immediately upon discharging a disgruntled employee.
7. **Routinely examine residential living spaces** to identify and eliminate potential stressors, such as extremes in temperature, lighting and noise.
8. **Frequently check lighting levels**, especially in resident rooms, hallways and entrances.
9. **Provide for privacy** by permitting residents to close doors of living spaces and bathrooms, if the resident care/service plan authorizes independence.
10. **Designate secured units for sexual predators,** as well as psychotic and potentially violent residents, placing them under the care of professionals trained to care for individuals with severe mental illness.

Sexuality in Aging Services Residents: A Checklist of Policy Safeguards

The following policymaking principles are designed to help organizations respond to the reality of resident sexuality in a compassionate and respectful manner, while also shielding cognitively and physically impaired residents from harm. (For a sample policy statement on resident sexual expression, click here.)

Suggested Policies and Procedures	Present? Yes/No	Recommended Actions
Regulatory Compliance		
Policy statements are consistent with federal regulations and directives that promote resident autonomy and dignity. (See 42 C.F.R. § 483.10.)		
Residents are permitted to engage in consensual sexual relations, and written policy expressly permits married and domestic partners to share a room.		
The right of residents to privacy and sexual intimacy is delineated in written policy, as are staff responsibilities in upholding these rights.		
Staff Policies and Training		
Staff members are encouraged to explore and discuss personal attitudes, cultural values and beliefs regarding sexuality in the elderly, in order to promote an environment of acceptance, inclusion, safety and respect.		
Staff members are directed to speak with a supervisor if they are uncomfortable with a resident's sexual behavior, orientation or identity.		
Staff are educated regarding sexual expression in cognitively impaired residents, including how to respond when witnessing an unwanted sexual advance directed toward another individual.		
Caregivers are instructed to maintain confidentiality in regard to the sexual expression of residents and to obtain permission from mentally competent residents before discussing these matters with family members.		
Residents are permitted by caregivers to be alone with their partners, if they wish, in accordance with written procedures detailing how competent, consenting adults can schedule private time with each other.		
Staff members are strictly prohibited from assisting residents in any sexual activity, including positioning of bodies, even if asked.		

Staff are educated regarding sexual expression in cognitively impaired residents, including **how to respond** when witnessing an **unwanted sexual advance** directed toward another individual.

Suggested Policies and Procedures	Present? Yes/No	Recommended Actions
Resident Consent		
If a resident's capacity for consent to sexual activity is in question, a clinical determination is made after evaluation by an attending physician, medical director and/or psychiatrist.		
The date of this clinical evaluation is documented in the resident healthcare information record, including answers to the following basic inquiries, among others:		
• **Does the resident understand the nature of the activity in which he or she is engaging,** including awareness of the identity of the sexual partner and the risks of sexually transmitted diseases?		
• **Does the resident demonstrate the reasoning process inherent in sexual consent,** i.e., an understanding of the consequences of sexual choices, the ability to say no, and a decision-making pattern that is consistent with lifelong values and preferences?		
• **Is the resident's choice voluntary** and free from undue influence or coercion?		
The decision-making capability and physical condition of memory-impaired residents are reassessed at regular intervals, and the frequency of reassessment is noted in the resident's care/service plan.		
Resident Safety		
Residents are evaluated for their physical capacity to engage in sexual activity, based upon medical history and assessment findings.		
Sexual issues are considered and documented within the care/service plan, including the date of medical assessment and the level of activity deemed appropriate.		
Sexually active residents are checked regularly for sexually transmitted diseases, as well as signs of injury or trauma.		
Use of chemical and physical restraints is strictly prohibited for purposes of controlling sexual expression.		
Family Management		
Family members are encouraged to participate in sexuality work groups, in which social workers, psychiatric nurses, therapeutic recreation specialists and other professionals answer questions and establish policies relating to sexual expression and resident rights.		
If permission has been granted by the resident, family members and significant others are kept informed about his/her sexual behavior, including new relationships that have developed within the setting, in order to avoid later conflicts. (Note that family members have no say concerning the sexual activities of mentally competent residents.)		
A process is introduced for resolving family disputes regarding consent issues and residents' right to engage in consensual sex, including consultation with an ethicist, if necessary.		

Quick Links

- "Changes in Intimacy and Sexuality in Alzheimer's Disease," from the National Institute on Aging.
- *Sexuality and Aging,* a training video from mmLearn.org.
- "Sexuality and Intimacy in Long-Term Care Facilities," from the National Long-Term Care Ombudsman Resource Center.
- *Sexuality, Intimacy, and Dementia in Residential Care Settings,* a DVD training series available for purchase from Terra Nova Films, Inc.
- "What Is Resident Mistreatment?," a fact sheet from the National Consumer Voice for Quality Long-Term Care.

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