Sheffield Health and Social Care NHS
NHS Foundation Trust

STANDARDS for SEXUAL SAFETY.

This Document is for use in all in- service user settings.

The overall aim of using this document in a group session is to provide staff with a safe space where issues of Sexual Safety can be discussed.

The objectives of using group discussion in this way are to:

- Acknowledge a zero tolerance position of sexual activity between in hospital.
- Raise awareness of issues relating to Sexual Safety
- Lower individual thresholds of what staff will tolerate and consider acceptable in in-service user settings.
- Encourage thinking about alternative ways of working.
- Promote discussion in teams about achieving Sexual Safety
- Develop action plans for safer wards.

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IN PATIENT DIRECTORATE
SEXUAL SAFETY STANDARDS

These guidance notes are to promote discussion and are *not* a definitive list.

The overarching principle of Sexual Safety is that there should be no sexual activity between service users whilst in hospital.

Standard	Issues to consider
1. Acknowledge that sexual intimidation / abuse/ assault can have many forms, is often hidden and can happen in secret. (2,4,5)	• What can you do to ensure you that you know what is happening to service users in your ward? • It is entirely possible for service users or staff to be alone with other service users long enough for abuse to occur and for no one to be aware.
2. Service users should never under any circumstances be expected to share sleeping accommodation with a member of the opposite sex. Every service user should have the means to secure their bedroom or sleeping space. (1,8,11)	• See references for definition of Delivering Same Sex Accommodation (now EMSA) • Service user choice is at the heart of DSSA. How is service user choice established and recorded. • Dept of Health stipulates that women should access to a designated living space. (Women's Lounge) • Consider how you would feel if a friend or family member had to sleep in a space adjacent to a stranger and/or they couldn't lock their door. • Would they feel safe in that situation? • What would make you feel safe in this situation • Observation windows on bedroom doors should remain in the closed position
3. Service users who are sexually vulnerable or who are predatory will be **protected proactively not reactively.** Every service user should be assessed to ascertain their level of sexual vulnerability or their propensity to act in a sexually predatory/ intimidatory or inappropriate way. (1,3,4,13) This applies to both male and female service user's behaviour and is not dependant on sexual orientation.	• Known history of vulnerability, intimidation or predatory behaviour, should be documented in every service user's notes, whether there is a past or current risk, or if assessed not to be relevant. • Establish known history of stalking, assault, rape or if the service user has made previous allegations of a sexual nature. Assess the current implications that this may have for the service users care in the particular care setting. • Establish known history of abuse of any kind which may make the service user more vulnerable. • The management of vulnerability and/or predatory behaviour should consider other service users, staff, and visitors to the ward and should be detailed in the care plan. • Any changes in mental or psychological state or the use of substances should trigger a re assessment of need. • Intermittent Observation may be insufficient to keep a service user safe. • Ensure accurate documentation. An important predictor of future actions are past actions.

Standard	Issues to consider
4. Every service user should be given the opportunity to disclose their experience(s) of abuse. (2, 7)	• Refocused CPA guidance (2008) states that: "Questions should be asked by suitably trained staff at assessment about the experience of physical, sexual or emotional abuse at any time in the service user's life. The response, with brief details, should be recorded in case records/care plans. If the specific question is not asked, the reason(s) for not doing so should be recorded." • Evidence is clear that people are not offended by being asked about their experience of abuse. One reason people don't disclose a history of abuse is because they are not asked. Not asking gives a message that we are not concerned about their experience or that we don't consider its relevance to their mental health problem. • Acknowledge that disclosure can be very difficult for the service user, but can also be difficult for staff to hear. • Disclosures where the alleged abuser may still be in contact with children should always prompt a safeguarding discussion. Refer to Safeguarding policy and contact the Safeguarding Office. • Routine enquiry is a CPA requirement since Refocused CPA in 2008.
5. Staff of the same gender should conduct close constant, intermittent and routine observation when service users are in their room or bed space. Service users should always be offered the choice of same gender named nurse. (1,6)	• Assessment of current need and known history of abuse will inform the care plan of the appropriate gender. • Consider how traumatising it can be to have a person conducting routine checks. • A sense of being 'watched' or physically close to a person of the same gender as the person who has hurt them can be very frightening or distressing for service users. • There is a potential to re enact an abusive situation. • If resources are an issue discuss this with your manager.
6. Staff should be aware and mindful of the effects of traumatic life experiences, to avoid re traumatising and re victimising the service user. (1,2,6)	• Day to day routines and procedures on wards can be humiliating or distressing for service users. Whilst safety remains paramount and the primary concern, walking in to rooms without invitation, physical contact without permission, administering medication, physical restraint or seclusion are the most obvious situations were sensitivity should be employed. • Any situations where staff are required to use physical interventions this should be done in a manner which is respectful and considers faith, gender or cultural issues.

7. Staff should be aware of the effect or impact that the behaviour of other service users may have or that may be witnessed i.e. service users being partially clad, physically close, sexually disinhibited, verbally abusive or using sexually explicit language. (1,6,13)	• Due to the nature of inpatient work staff have to be vigilant and ensure they don't become de sensitised to behaviour that is frightening and distressing for others. • All staff should adopt a zero tolerance approach. Any service user who may have witnessed an incident or heard sexually explicit language should be offered support from staff and provided with an opportunity to discuss how they feel or how the have been affected. • Pornographic materials including DVD/magazines are **not acceptable** unless MDT specifically agree. This must be documented in detail and managed so it does not impact on others.
8. Acknowledge that alcohol and substances or prescribed medications can increase vulnerability and may increase the need for observation. (4)	• Substances can make vulnerable people even more vulnerable and service users who are not assessed as vulnerable potentially vulnerable whilst under the influence. • Service users who have been sedated or tranquilized or have recently commenced new medications may not be able to protect themselves as they would normally. • Substances can impact on an individuals capacity
9. Every service user is given the opportunity to be involved in their care planning. Care plans should be clear and unambiguous in respect of sexual safety. (1,6)	• Care is likely to be more effective if the service user is involved in the planning of their care and understands what their choices are. • Care plans should not be ambiguous or leave scope for individual interpretation, i.e. if a care plan specifies a specific gender then that should be provided in all instances, not just when the rota allows it. If there is a resource issue, discuss it with your manager. • Check to see if an Advance Statement is in place and work with the plan when possible. • Support service users to consider making an Advanced Statement about Sexual Safety especially if there are known issues for the service user or specific vulnerabilities. • Involve the Care Co-ordinator in this.

10. Service users will be supported to maintain relationships and will have the right to form relationships with other service users whilst in hospital. However service users can expect that staff will consider the effects of the individual's mental health on their capacity to make decisions about sexual or intimate relationships. (6, 10, 12, 13)	• It is possible that some prior relationships may be abusive in nature which the service user may feel unable to stop. This may include family members. • Suspicion of unwanted or inappropriate sexual relationships should be acted upon immediately by alerting your manager and discussing your concern in a MDT setting. • Decisions should not be made on moral judgements • Capacity to consent must be considered, assessed and documented. Refer to Mental Capacity Act, & Deprivation of Liberty Safeguards. Is the relationship in the service users best interests? • Discuss your concerns with a Safeguarding Office. • Refer to SHSC Safeguarding Children. Consider every individual in the context of a family and any impact on children. Children may be involved in this relationship. Always seek advice if children may be at risk. • Staff must intervene immediately if either party is considered to lack consent/ capacity It is an offence to have any kind of sexual relationship with a person who lacks capacity (Sexual Offences Act 2003) • If relationships form the most appropriate workers should discuss with each respective service users: the impact of the relationship on their partner/family, relationship breakdowns, and sexual health issues • If relationships develop with a service user who has a history of predatory behaviour or is known sexual offender, consult with the Safeguarding office immediately. Clare's Law may apply. • Sexual health advise/support should be available. • Discuss your concerns with each respective service user and document this. • Recognise that the grooming process can be extremely powerful and may override your advise • Practical interventions may include formal observation and/or relocation of sleeping space.
11. Promote an atmosphere and culture in the team where every concern raised by service users is reported and investigated. (1,3,4,6) Kerr Haslam	• It is vital that service users and staff can feel safe enough to raise issues • A service users concerns should never be dismissed on the grounds that they are ill or don't know what they are saying. This applies equally to the alleged or actual, victim and perpetrator. • Staff should report all complaints or allegations to their manager who will conduct an investigation in a timely and supportive manner. • Service users who may have made previous or frequent allegations will have a care plan that aims to reduce the likelihood of a similar allegation. • All allegations should be investigated and carefully documented. If in doubt what to record seek advice from your manager or Risk Management.

12. Staff will seek supervision/advice at the earliest opportunity to discuss any issues relating to close relationships between service users and staff where boundaries can become blurred. (4, 6, 9)	• Occasionally staff may find themselves in a situation where a service user is being over friendly or over reliant on them. This can sometimes manifest in sexualised behaviour towards the member of staff. • Staff can sometimes feel that they are becoming close to a service user and identify strongly with their history or situation. 'Special bonds' may form that can be dangerous for both service users and staff.. • It is important to recognise this either for yourself or a colleague and know that is important to talk about it as soon as possible with your supervisor. • Refer to your teams support advisor for further support and advice. .

References

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3. With Safety in Mind: Mental Health Services and Service user Safety. National Service user Safety Agency. 2006
4. Sexual Boundary Issues in Psychiatric settings. Royal College of Psychiatrists. 2007
5. Pathway to Recovery. A review of Acute NHS Mental Health Services Heath Care Commission 2008
6. Informed Gender Practice: Mental Health acute care that works for women. NIMHE/CSIP/RCN 2008
7. Refocused CPA, Policy and Positive Practise Guidance. DoH 2008
8. Delivering Same Sex accommodation: The storey so far. 2009
9. Clear sexual boundaries between healthcare professionals and service users. Information for service users and carers. NHS Employers 2009
10. Think Child, Think Parent, Think Family SCIE 2009
11. Delivering Same Sex accommodation in Mental Health and Learning Disability Services. The NHS Confederation 2010.
12. Domestic Abuse Disclosure Scheme (Claire's Law) http://www.gmp.police.uk/content/WebAttachments/88A190F67550078780257A71002E5DC8/$File/claire's%20law%20other%20people%20booklet.pdf
13. Sexual Offences Act (2003)

Definitions of Same Sex Accommodation in Mental Health.
(Now referred to as EMSA. Eliminating Mixed Sex Accomodation)

• Service users are accommodated in same-sex wards, where the whole ward is occupied by men or women only
• **Or** sleeping accommodation is in single rooms within mixed wards, with toilet and washing facilities en-suite or very close by; these facilities are clearly designated either male or female
• **Or** sleeping accommodation within mixed wards is in shared rooms used solely by men or women (good practise would suggest that bed bays are entirely enclosed with solid walls with a door that can be shut)
• **And** on mixed wards with single or shared bedrooms giving out on to one corridor, single bedrooms, toilet and bathing facilities are grouped to achieve as much gender separation as possible (for example, women towards one end of the corridor, men towards the other)
• **And** no one should have to pass through rooms occupied by the opposite sex to reach their toilet and washing facilities near to their bedrooms and bed bays. The exception is toilet facilities used while in day areas where are fully dressed. If there are limited disabled facilities which need to be used by both men and women, good practice would suggest that users should be escorted by a member of staff
• **And** on mixed wards good practice requires a day lounge for use by women only (mandatory for services provided in facilities built or refurbished since 2000) as well as spaces where men and women can socialise and take part in therapeutic activities together
• **And** every effort is made to ensure the availability of staff who are the same sex as the users they are caring for, especially for intimate care.
(9) Delivering Same Sex accommodation in Mental Health and Learning Disability Services. Briefing: Issue 195. The NHS Confederation 2010.
• **From January 2011** Service users should not need to pass through mixed communal areas or sleeping areas, toilet or washing facilities used by the opposite sex to get to their own. The only exception is fully dressed service users placed in day areas who need to access toilet facilities.

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