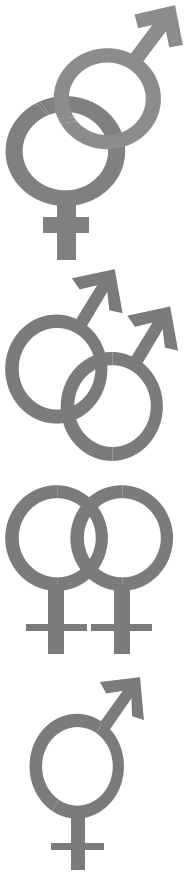

Lanark, Leeds and Grenville
Long-Term Care
Working Group

Intimacy and Sexuality in Long-Term Care

A guide to practice: resource tools for assessment and documentation

June 2013

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Revised with permission from Shalom Village LTCH, Hamilton Ontario.

Intimacy and Sexuality Practice Guidelines

Draft # 21 LLG LTC Working Group

June 2013

Introduction: This document was developed in response to the needs of the long-term care homes in Lanark, Leeds & Grenville as identified by the Lanark, Leeds & Grenville Long-Term Care Liaison Network in partnership with the Southeast CCAC.

The working group reviewed practice guidelines in place in Ontario and concluded, by consensus, that *the Intimacy and Sexuality Practice Guidelines (2002)* Shalom Village, Hamilton would serve as the template for Lanark, Leeds & Grenville. We wish to take this opportunity to thank Shalom Village, and notably Dr. Lori Schindel Martin for her support during this process.

This document has been developed in a systematic way incorporating the best available evidence. It is the intent of the LLG LTC Working Group that the *value statements* of this document are open for interpretation by each LTCH, but revisions to the contents of the guidelines will negate our endorsement and authorship. Note references to *Every Resident: the Bill of Rights for Persons in Ontario Residing in LTC*

Objectives: To develop a practice guide that assists Homes in responding to issues of Intimacy and Sexuality while maintaining the dignity and autonomy of the resident, while respecting their partner, families, co-residents, and staff.

To provide tools that have been developed and/or revised to aid staff in their assessment and documentation of sexual behaviour.

To provide an opportunity for open dialogue and education for resident(s), partners, families, staff and community support services.

Intimacy and Sexuality Practice Guidelines

Draft # 21 LLG LTC Working Group

June 2013

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Intimacy and Sexuality Practice Guidelines
Draft # 21 LLG LTCH Working Group
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VALUE STATEMENT:

_____(LTCH) is home to over____ adults. In their Home adults need to experience autonomy, belonging, comfort and security living in an environment that contributes to a quality of life where the expression of needs is encouraged and accepted. Intimacy, touch, tenderness, warmth, companionship and sexual expression are a natural part of adult's lives. The ability to nurture is a key aspect of providing high quality care. Many of our residents are limited in their ability to seek out, respond to and share these important aspects of their lives due to physical, and /or cognitive impairments.

Within the context of our mission statement ….*each LTCH add here*

- We believe that sexuality is integral to the experience of all people, and therefore, older adults are sexual beings;
- We believe as staff of _____, that to be consistent with the beliefs of our LTCH, we accept sexual expression as part of our residents lives;
- We recognize that sexuality and sexual expression is value laden and has different meanings for all of us;
- We recognize that all residents have the right to be treated with courtesy and respect, fully recognizing the resident's dignity and individuality.
- We believe that engaging the resident and family in a dialogue regarding intimacy, sexual expression and their own belief system is essential;
- We believe that the spouse/partner, POA for Personal Care (POA$_{PC}$) should be involved in a dialogue with the Team about resident's sexually expressive behaviour, only if the resident is unable to make these decisions for her/himself in this regard; and resident's expressed wishes and risks to well-being, be taken into account with regards to supportive care strategies.
- We accept that the population includes diversity in sexual orientation and gender identity (lesbian, gay, bisexual, transgender, transsexual: LGBTTTQ) and we do not discriminate on these grounds.

- We recognize that every resident has the right to form friendships and to enjoy relationships, and the right to meet privately with his/her spouse/partner (including same-sex partner) in a room that assures privacy; and where both adults are residents in the same home, they have a right to share a room according to their wishes, if an appropriate room is available (adapted from Every Resident: Bill of Rights for Persons Living in Ontario Long Term Care Homes. ACE Sept 2008).
- We acknowledge that educational opportunities must be provided for staff on an ongoing basis to assist in development of knowledge and skill, to respond with professionalism and respect, and to achieve a comfortable acceptance of sexual expression in LTC Homes.
- We recognize that staff will require ongoing support where the sexual expressions of their residents might contradict their own personal values and beliefs, in this way ensuring that response to these behaviours will be professional.

Intimacy and Sexual Expression in LTC

_____ LTCH acknowledges that there are different forms of sexual behaviour. It is important that staff observe, monitor situations, and assess level of sexual behaviour to determine if interventions are necessary for the resident's well-being. If the resident(s) &/or partners involved are capable of making decisions regarding their sexuality and are both consenting, then the LTCH may wish to meet with the individuals and discuss parameters such as environmental modifications, sexual health and education (Kamel & Hajjar, 2003). Otherwise their actions are not to be scrutinized by staff and/or family. The privacy of the resident(s) must be fully respected unless circumstances change and there is a degree of unreasonable risk.

Intimacy and sexuality are important aspects of the resident's life. Therefore an Admission Intimacy History (Appendix A) should be included in the Home's admission process, preferably after rapport has been established, (within 6-8 weeks or if issues arise).

For assessment purposes, the general classifications of sexual behaviour are identified as:

LEVEL 1	Intimacy/ Courtship behaviours
LEVEL 2	Verbal sexual talk/ language
LEVEL 3	Self-directed sexual behaviours
LEVEL 4	Physical sexual behaviours directed towards co-resident with agreement
LEVEL 5	Unwanted, overt physical sexual behaviours directed toward others

In order to determine the level of sexual behaviour and identify the significant and appropriate interventions the following steps should be taken, questions should be considered, and documented as appropriate.

1. A description of what was "observed" or discovered should be obtained, confirmed and validated with involved parties and persons witnessing the behaviour, and may include: resident(s), partner, family member(s), and/or staff. Objective documentation to include **Sexual Behaviour Assessment Part 1 & 2 : Appendix B**: verbal and physical actions of resident(s), antecedents (possible triggers to behaviour) and consequences including interventions/actions by staff .

2. Is there potential harm or risk to the person(s) involved? What is the degree of risk?

3. What is the awareness of the resident(s) involved? **See Assessment of Awareness of Actions: Appendix C**
    a. The results of the Awareness of Actions Assessment will determine next steps.

4. Has an **Admission Intimacy History: Appendix A** been completed? Is there information the resident(s) or partner may share to help the staff have a better understanding and support the relationship?

5. A team meeting and/or care conference involving the resident(s), spouse/partner, and the team is helpful in developing an appropriate care plan that preserves dignity, privacy, safety and a supportive environment. (Schofield, 2002)

Sexual Expression and the Cognitively Impaired Resident

_____(LTCH) acknowledges that there are different expressions of sexual behaviours associated with cognitive impairment and dementia. Memory loss, impaired judgment and impulsivity associated with cognitive impairment/ dementia may precipitate a resident(s) to seek comfort or reassurance, which may result in more overt sexual behaviours, or the behaviour may be responsive to internal or external antecedents and possibly misinterpreted by staff. It is important that staff observe, monitor situations, and assess level of sexual behaviour and risk to determine if interventions are necessary for the resident's safety and well-being. For assessment purposes, the general classifications of sexual behaviour and guidelines are identified and elaborated in the following:

RESPONSE TO THE CLASSIFICATIONS OF SEXUAL BEHAVIOUR:

For sexual behaviour classifications Level 1 - 4:

1. **A Sexual Behaviour Assessment (Part 1 & 2) is to be completed (see Appendix B) which includes risk, a holistic assessment of possible causes/triggers to behaviour and any evidence of injury.**
2. **An assessment of the resident(s) awareness of actions should be determined (Appendix C).**
3. **Discussion with the resident &/or the spouse/partner & POAPC/SDM to determine values, beliefs, life story, & level of comfort (see Admission Intimacy History: Appendix A) in order to identify the need for support and education (Hajjar & Kamel, 2003). Attending physician to be involved, and additional interventions will be identified through open dialogue with team, including resident & family.**
4. **Documentation to include the Sexual Behaviour Assessment: Appendix B. All staff to be aware of interventions for each level of behaviour for each resident involved, with inclusion in care plan.**
5. **All Infection Control precautions to be followed as per LTCH protocols as per LTCH Act 2007.**
6. **If the sexually expressive behaviour gives rise for concern or if evidence of distress or injury is noted a Critical Incident report must be submitted to MoHLTC office, followed by call to Director at MoHLTC if warranted. The LTCH should contact their local acute care hospital for Domestic Violence & Sexual Assault protocols and resources if in need.**

Level of Sexual Behaviour	Description of Sexual Behaviour	Response
Level 1	Intimacy/ Courtship • kissing, hugging, handholding, fondling, cuddling (not inclusive) • consensual (implies awareness of actions)	**No risk associated with this behaviour, if both persons consenting :** Overall goal of staff response is to provide socially appropriate context for relationship that offers comfort and reassurance. • This behaviour is viewed primarily as companionship, an intimacy relationship between two adults who are mutually consenting, implied by interactions with no evidence of distress. • Source of urgency associated with this behaviour is usually staff and/or family discomfort. Staff may wish to protect family. • The couple may need to have intimacy needs recognized and privacy respected. (Schofield, 2002)
Level 2	Verbal Sexual Talk • flirting, suggestive language, sexually laden language • not aggressive	**Low level of risk associated with this behaviour:** This behaviour may cause discomfort and reaction when directed toward staff; often occurring during personal care. • Staff response is to recognize their feelings of unease if contrary to personal values and beliefs. Staff to respond respectfully. • If suggestive language directed at co-resident, visitor or staff: the behaviour should be redirected into a more socially appropriate context. • Punitive language will not be tolerated, e.g., “I thought you were married. Nice married men don’t say those kinds of things to ladies”. This is a negative value judgment that the resident will interpret as punitive. An example of an appropriate response: “John, would you like to have a chat? Why don’t you tell me about….”

Level 3	Self-directed sexual behaviours • masturbating • exposing oneself	**Low level of risk.** For self-stimulating behaviours the staff needs to observe and answer the following questions: • For male: is there evidence of erection? Ejaculation? Skin irritation? Is this responsive behaviour his attempt to communicate he has a full bladder? • For female: is their evidence of injury as a result of masturbation? Is resident using a foreign object for stimulation? Rule out a yeast infection. • Does the resident engage in this behaviour in the presence of others? How does this affect others? Focus on creative solutions for the resident (this may include sexually-explicit materials &/or vibrators), while maintaining privacy, dignity, safety and least restriction (Zeiss & Kasl-Godley, 2001). Staff education may be necessary to remind staff to use the same infection control protocols when handling any body fluids, without judgment, teasing or ridicule. Male residents may be advised to use condoms to aid in disposal of ejaculate.

Level 4	Physical Sexual Behaviours • Directed towards co-resident(s) with agreement • Directed to resident by companion/ spouse/ partner with agreement • Risk immediately increases when sexual expression involves a partner	**Moderate level of risk associated with this behaviour**. • In early dementia the capacity to make decisions regarding basic needs and immediate gratification such as sexual activity is retained (Post, 2000). • The staff must be vigilant about observing the resident(s) for any signs of sexual overtures that are unwelcome. Are staff aware of the extent of sexual behaviours: one-on-one contact with the intent to kiss and caress, disrobing, oral sex or attempt to engage in penetrative intercourse? Does male resident(s) have evidence of (sustained) erections? • Does one partner in the pairing look distressed, upset, worried, anxious? • Can the residents give an account of behaviours they would find acceptable/unacceptable? • Do they have the ability to say “no” or indicate refusal and/or acceptance? • Do they have the ability to avoid exploitation? Complete Assessment of Awareness of Actions: Appendix C. • Does their life story indicate passivity in relationships? **If the resident is distressed or non-consenting move to Level 5.** • If resident(s) are incapable to make decisions regarding their sexual expression it is critical to have POAPC/ SDM involvement to establish resident values, beliefs and level of comfort, and to take part in a dialogue with the Team regarding decisions that act in the best interest of the resident. Staff to provide support and education. • The focus of interventions should be on creative solutions that allow the consenting couple privacy and dignity, plus opportunities to engage in social activities with others in a

		socially appropriate context.
Level 5	Non-consensual, overt physical sexual behaviours directed towards others that are a source of distress. • Aggressive or repeated sexual overtures that are unwanted and rejected by others in the environment	**A HIGH risk is associated with this series of behaviours:** • A resident may enter another's personal space and clearly touch them in a way that is unwelcome and upsetting for the person. (This could range from sexual touching to penetrative sexual intercourse). The incidence of sexual inappropriate behaviours in persons with dementia is very low ranging from 2.6%-8% (Harris & Weir, 1998). • The response indicates the person is objecting and the staff view it as an unwanted invasion of personal space. The appropriate staff response is to protect the resident/others from unwelcome sexual behaviour. The resident that is expressing overt sexual behaviour should be treated with respect and dignity. • What is the awareness of the known sexual behaviours: one-on-one contact with the intent to kiss and caress, disrobing, oral sex or an attempt to engage in penetrative intercourse? **For this type of sexual behaviour there <u>MUST be</u>:** **1. A Sexual Behaviour Assessment completed (see Appendix B) which includes a holistic assessment of possible causes/triggers to behaviour & any evidence of injury.** **2. Assessment may include working in partnership with the Geriatric Mental Health Community Outreach Team.** **3. An assessment of resident(s) Awareness of Actions: Appendix C, is required.** **4. Discussion with the resident, &/or the spouse/partner, POA$_{PC}$/ SDM to determine values, beliefs, life story, &**

		level of comfort (see Admission Intimacy History: Appendix A) in order to identify the need for support and education. Other parties may need to be consulted including extended family, volunteers, ministry, etc... Additional interventions will be identified through open dialogue. **5. Documentation to include the Sexual Behaviour Assessment. All staff to be aware of interventions for sexual behaviour for each resident involved, with inclusion in care plan.** **6. All Infection Control precautions to be followed as per LTCH protocols per LTCH Act (2010).** **7. A Critical Incident report must be submitted as soon as possible to the MoHLTC office, and the Director of the MoHLTC is to be contacted.** **8. Police are to be notified directly, if the act or behaviour is deemed as "sexual abuse" or "sexual assault" (see LTCH Act 2007 Reg definitions in Glossary, p. 14) as reported by the resident, or intervening staff.** *** Note the Criminal Code of Canada does not discriminate "sexual abuse" from "sexual assault".** **In a critical incident where an aggravated sexual assault is suspected staff are not to wash person involved or change clothing. Wounds can be tended to, and resident kept warm and comforted with blankets etc.. Call your local hospital to check Domestic Violence/Sexual Assault Protocols and request a sexual assault nurse be notified of incoming assault victim to ED. Victim or SDM /POA needs to give consent before a forensics evidence kit can be collected. Resident will require supportive staff/family escort to hospital.**

Glossary of Terms

Sexual orientation:	a term for the emotional, physical, romantic, sexual, spiritual attraction or affection of another person. Examples include heterosexuality, homosexuality and bisexuality.
Homosexual:	a term to describe a person whose primary sexual orientation is to members of the same gender. Most people prefer to not use this label, preferring to use other terms such as gay or lesbian. Older individuals may be more comfortable with this term over gay/ lesbian.
Bisexual:	a word describing a person whose sexual orientation is directed towards men and women although not necessarily at the same time.
Gay	a word to describe a person whose primary sexual orientation is to members of the same gender or who identifies as a member of the gay community. This word refers to men and women although many women prefer the term lesbian.
Autosexual:	a word describing a person whose significant sexual involvement is with oneself or a person who prefers masturbation over partnered sex.
Intersex	a person who has some mixture of male and female genetic and/or physical sex characteristics. Formerly call “hermaphrodites”. Many intersexed people consider themselves to be part of the trans community.
Transgendered	a person whose gender identity is different from his/her biological sex, regardless of the status of the surgical and hormonal gender reassignment processes. Often used as an umbrella term to include transsexuals, transgenderists, transvestites (crossdressers), and two-spirited, intersexed and transgendered people.
Transexual:	a term used for a person who has an intense long-term experience of being the sex opposite to his/her birth-assigned sex and who typically pursues a medical and legal transformation to become the other sex.

Two-spirited an English term coined to reflect specific cultural words used by First Nation and other indigenous peoples for individuals in their cultures who are gay or lesbian, are transgendered or transsexual, or have multiple gender identities. The term reflects an effort by First nation and other indigenous communities to distinguish their concepts of gender and sexuality from those of Western LGBT communities.

Reference: Barbara, A., Chaim, G., & Doctor, F. (2004). *Asking the right questions 2*. Centre for Addictions and Mental Health, Toronto: CAMH.

Hypersexuality: (Kuhn, 1998)

Persistent, uninhibited sexual behaviour directed at oneself or other people. May include compulsive masturbation in public and private places but usually involves an insatiable desire for sexual contact with others.

Hypersexuality typically involves inappropriate behaviour in relation to others such as lewd or suggestive language, fondling, flirtation, disrobing oneself or others, or other overt sexual acts. This behaviour is typically directed to a number of people and is not usually confined to one particular relationship.

Long Term Care Home Act (2007); Ontario Regulation 79/10. Filed March 29, 2010

"Abuse" — definition

2. (1) For the purposes of the definition of "abuse" in subsection 2 (1) of the Act,

"emotional abuse" means,

(a) any threatening, insulting, intimidating or humiliating gestures, actions, behaviour or remarks, including imposed social isolation, shunning, ignoring, lack of acknowledgement or infantilization that are performed by anyone other than a resident, or

(b) any threatening or intimidating gestures, actions, behaviour or remarks by a resident that causes alarm or fear to another resident where the resident performing the gestures, actions, behaviour or remarks understands and appreciates their consequences; ("mauvais traitement d'ordre affectif")

"financial abuse" means any misappropriation or misuse of a resident's money or property; ("exploitation financière")

"physical abuse" means, subject to subsection (2),

(a) the use of physical force by anyone other than a resident that causes physical injury or pain,

(b) administering or withholding a drug for an inappropriate purpose, or

(c) the use of physical force by a resident that causes physical injury to another resident; ("mauvais traitement d'ordre physique")

"sexual abuse" means,

(a) subject to subsection (3), any consensual or non-consensual touching, behaviour or remarks of a sexual nature or sexual exploitation that is directed towards a resident by a licensee or staff member, or

(b) any non-consensual touching, behaviour or remarks of a sexual nature or sexual exploitation directed towards a resident by a person other than a licensee or staff member; ("mauvais traitement d'ordre sexuel")

"verbal abuse" means,

(a) any form of verbal communication of a threatening or intimidating nature or any form of verbal communication of a belittling or degrading nature which diminishes a resident's sense of well-being, dignity or self-worth, that is made by anyone other than a resident, or

(b) any form of verbal communication of a threatening or intimidating nature made by a resident that leads another resident to fear for his or her safety where the resident making the communication understands and appreciates its consequences. ("mauvais traitement d'ordre verbal")

(2) For the purposes of clause (a) of the definition of "physical abuse" in subsection (1), physical abuse does not include the use of force that is appropriate to the provision of care or assisting a resident with activities of daily living, unless the force used is excessive in the circumstances.

(3) For the purposes of the definition of "sexual abuse" in subsection (1), sexual abuse does not include,

(a) touching, behaviour or remarks of a clinical nature that are appropriate to the provision of care or assisting a resident with activities of daily living, or

(b) consensual touching, behaviour or remarks of a sexual nature between a resident and a licensee or staff member that is in the course of a sexual relationship that began before the resident was admitted to the long-term care home or before the licensee or staff member became a licensee or staff member.

Sexual Assault **Criminal Code (R.S., 1985, c. C-46)**

271. (1) Every one who commits a sexual assault is guilty of

(*a*) an indictable offence and is liable to imprisonment for a term not exceeding ten years; or

(*b*) an offence punishable on summary conviction and liable to imprisonment for a term not exceeding eighteen months.

(2) [Repealed, R.S., 1985, c. 19 (3rd Supp.), s. 10]

R.S., 1985, c. C-46, s. 271; R.S., 1985, c. 19 (3rd Supp.), s. 10; 1994, c. 44, s. 19.

Sexual assault with a weapon, threats to a third party or causing bodily harm

272. (1) Every person commits an offence who, in committing a sexual assault,

(*a*) carries, uses or threatens to use a weapon or an imitation of a weapon;

(*b*) threatens to cause bodily harm to a person other than the complainant;

(*c*) causes bodily harm to the complainant; or

(*d*) is a party to the offence with any other person.

Punishment

(2) Every person who commits an offence under subsection (1) is guilty of an indictable offence and liable

(*a*) where a firearm is used in the commission of the offence, to imprisonment for a term not exceeding fourteen years and to a minimum punishment of imprisonment for a term of four years; and

(*b*) in any other case, to imprisonment for a term not exceeding fourteen years.

R.S., 1985, c. C-46, s. 272; 1995, c. 39, s. 145.

Aggravated sexual assault

273. (1) Every one commits an aggravated sexual assault who, in committing a sexual assault, wounds, maims, disfigures or endangers the life of the complainant.

Aggravated sexual assault

(2) Every person who commits an aggravated sexual assault is guilty of an indictable offence and liable

(*a*) where a firearm is used in the commission of the offence, to imprisonment for life and to a minimum punishment of imprisonment for a term of four years; and

(*b*) in any other case, to imprisonment for life.

R.S., 1985, c. C-46, s. 273; 1995, c. 39, s. 146.

Meaning of “consent”

273.1 (1) Subject to subsection (2) and subsection 265(3), "consent" means, for the purposes of sections 271, 272 and 273, the voluntary agreement of the complainant to engage in the sexual activity in question.

Where no consent obtained

(2) No consent is obtained, for the purposes of sections 271, 272 and 273, where

(*a*) the agreement is expressed by the words or conduct of a person other than the complainant;

(*b*) the complainant is incapable of consenting to the activity;

(*c*) the accused induces the complainant to engage in the activity by abusing a position of trust, power or authority;

(*d*) the complainant expresses, by words or conduct, a lack of agreement to engage in the activity; or

(*e*) the complainant, having consented to engage in sexual activity, expresses, by words or conduct, a lack of agreement to continue to engage in the activity.

Subsection (2) not limiting

(3) Nothing in subsection (2) shall be construed as limiting the circumstances in which no consent is obtained.

1992, c. 38, s. 1.

Where belief in consent not a defence

273.2 It is not a defence to a charge under section 271, 272 or 273 that the accused believed that the complainant consented to the activity that forms the subject-matter of the charge, where

(*a*) the accused's belief arose from the accused's

(i) self-induced intoxication, or

(ii) recklessness or wilful blindness; or

(*b*) the accused did not take reasonable steps, in the circumstances known to the accused at the time, to ascertain that the complainant was consenting.

1992, c. 38, s. 1.

http://laws.justice.gc.ca/en/showdoc/cs/C-46/bo-ga:l_VIII//en#anchorbo-ga:l_VIII

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Film Resources

"Freedom of Sexual Expression: Dementia and Resident's Rights in Long-Term Care Facilities" Produced by the National Alzheimer Centre of the Hebrew Home for the Aged at Riverdale. Distributed by Terra Nova Films. www.terranova.org. Check availability with local Psychogeriatric Resource Consultant.

Web site Resources:

(ACE) Advocacy Centre for the Elderly http://www.advocacycentreelderly.org/

(CLEO) Community Legal Education Ontario http://www.cleonet.ca/resources/1884

(NICE) National Initiative for the Care of the Elderly http://www.nicenet.ca/

Putting the P.I.E.C.E.S. Together www.piecescanada.com

Current Marital Status		
Number of marriages or serious relationships:		
Is there current involvement in a relationship?	Yes	No
Do you anticipate your companion will feel comfortable visiting/spending time with you in this place of residence? If not, how could we improve on this?	Yes	No
How do you, the resident identify your sexual orientation: Heterosexual___ Bisexual____ Homosexual___ Lesbian ___ Gay___ Transsexual___ Transgender ___ No comment___		
Are you comfortable with giving/receiving showing affection? i.e. a soothing touch, a hug …	Yes	No
Are you accustomed to sleeping alone in bed?	Yes	No
Have you noted any changes in behavior in the area of sexual expression or sexual health of which you feel our staff should be aware? Explain.	Yes	No
Are current behaviors consistent with formerly held beliefs and values? Explain	Yes	No
Would you be comfortable providing a narrative, your life story, to help us know you, the resident better? (refer to LTCH's practice of collecting Life Story)	Yes	No
Any known history of abuse (mistreatment) or trauma: sexual, physical, emotional or verbal?	Yes	No
Any known history of sexually transmitted infections?	Yes	No

Information received from:_____ Date:_____

Completed by:_____

References:(Brown, 2004; Kamel, 2001;Kamel, 2003)

Sexual Behaviourial Assessment: Part One **Appendix B**

1. A description of the behaviour observed should be obtained, confirmed and validated with persons involved (resident(s), spouse/partner,…) if possible, and with cognizant witnesses: POAPC, family, visitors &/or staff witnessing the event. Objective documentation to include verbal and physical actions of resident(s), antecedents (possible triggers) to behaviour: Think PIECES, and consequences including evidence of injury, and interventions by staff.

_____
_____
_____
_____
_____
_____
_____
_____

Is this a change in behaviour?_____

Consider RISKS:
R: Roaming/Wandering: _____
I: Imminent Physical Danger: (frailty, falls, fire)_____
S: Suicidal ideation:_____
K: Kinship: harm to, or from resident_____
S: Substance use/misuse, self-neglect, safe driving, STIs:

_____
_____
_____

What is the degree of risk? *See Classifications of Sexual Behaviour: Intimacy & Sexuality Practice Guidelines*
No anticipated risk_____ Low_____ Moderate_____High_____

Assessment: *(possible causes, antecedents, triggers, evidence of injury?)*
Physical: Disease, Drugs, Discomfort, Delirium, Disability & consider sensory loss, sleep disturbance, elimination, etc.., in addition to evidence of injury. Note bruising may not be evident for 4-24 hrs after incident.

_____
_____
_____
_____
_____
_____

NOTE: In a critical incident where an aggravated sexual assault is suspected staff are not to wash person involved or change clothing. Wounds can be tended to, and resident kept warm and comforted with blankets etc. Call your local hospital to check Domestic Violence/Sexual Assault Protocols and request a sexual assault nurse be notified of incoming assault victim to ED. Victim or SDM /POA needs to give consent before a forensics evidence kit can be collected. Staff or MRT (Mobile Response Team) should escort resident to hospital.

Intellectual (cognitive impairment, dementia, impaired judgment, disorientation, aphasia, altered perceptions, misinterpretation, impulsivity)

_____
_____
_____

Emotional: (fear, adjustment, anxiety, depression, bereavement, recent losses, delusions, …):

_____
_____
_____

Capabilities: (ADLs: continent/incontinent, self-care, ambulatory, assistive devices…)

_____
_____
_____

Environment:_____
_____
_____

Social/Cultural/Spiritual: (see Life Story):_____
_____
_____
_____

Name (or initials) of other resident or person involved:_____

Staff witnessing the event, or first staff responding:_____

Other witnesses:_____

Nurse In Charge:_____ Date:_____

Sexual Behaviour Assessment: Part Two Appendix B

1. Has an Admission Intimacy History been previously completed?
   Yes___ No ___

If an Admission Intimacy History was not previously completed:

- Is there information the resident, spouse/partner, POAPC, or family member(s), could share about the resident's life story that may help staff understand certain behaviours? Siblings usually a better resource than children. e.g. past traumas of sexual nature, passivity

_____
_____
_____
_____
_____

2. What is the awareness of the resident involved? (complete Appendix C before proceeding)

   _____
   _____
   _____

   If the resident is mentally capable the POAPC/SDM & family are <u>not</u> to be involved unless at the request or consent of the resident.

3. Is there a POAPC /SDM who should be consulted/contacted about the behaviour/ incident? (See LTCH Act 2007 s23 (1) reg 97)
   Person contacted:_____ Date/ time:_____
   Response: _____
   _____
   _____
   _____

4. Was a critical incident filed electronically with MoHLTC? Yes___ No___
   Completed and sent by:_____
   Were any recommendations/ actions received:

   _____
   _____
   _____
   Was the Director of MoHLTC contacted directly?_____

5. Do Police Services need to be contacted? Yes____ No____

(LTCH Act, 2007) reg 98 Police notification

98. Every licensee of a long-term care home shall ensure that the appropriate police force is immediately notified of any alleged, suspected or witnessed incident of abuse or neglect of a resident that the licensee suspects may constitute a <u>criminal offence.</u>

Note: If a call is made to "911" the dispatcher intakes pertinent information and an officer is dispatched to respond. If the call is directly to the local police catchment office, dispatch or communication centre, the dispatcher takes the information and relays to the officer on duty, in the area, to respond. Officer may call LTCH to clarify needs & response time.

Police Contacted on:_____ Time:_____
By:_____
Name or badge # of officer responding (phone call or visit)_____
What was the outcome of this contact:
_____
_____
_____
Date of investigating officer's visit to LTCH:_____ Time:_____
Outcomes:_____
_____
_____

6. A care conference involving all parties is valuable in developing an appropriate care plan & next steps: interventions, investigations, interaction and information that will be shared & communicated (Hamilton et al, 2006; Schofield, 2002, Kamel et al, 2003).
   If the resident is not mentally capable to make decisions it is the POA$_{PC}$/SDM who interprets the last capable wishes of the resident. If wishes unknown then the POA$_{PC}$/SDM should act in the resident's best interests (HCCA, 1996, c.2. Sched. A. s.59 (1)).

   Date of scheduled care conference: _____

Completed by: _____ Date:_____

Assessment of Awareness of Actions (Understanding & Appreciation)**: Appendix C**

Assessment of the sexual behaviour and identification of the terms under which the relationship between the two individuals/residents will be supported should also include a determination of the resident(s) awareness of actions: the ability to understand and appreciate, to participate in a relationship. Lichtenburg (1997) and Lichtenburg and Strzepak (1990) suggest that the following questions be asked to identify the conditions and circumstances a relationship is supported to continue.

1. **Resident's Awareness of the Relationship:**
   - **a)** Is the resident aware of who is initiating the sexual contact?
     Yes___ No___
     Comments:_____
   - **b)** Does the resident believe that the other person is a spouse or partner?
     Yes___ No ___ Comments:_____
   - **c)** Are they aware of the other's identity and intent? Yes___ No___
     Comments:_____
     _____
   - **d)** Can the resident state what level of intimacy they would be comfortable with?
     Yes____ No___
     Comments:_____
     _____

2. **Resident's Ability to Avoid Exploitation:**
   - **a)** Is the behaviour consistent with formerly held beliefs/ values?
     Yes___ No___
     Comments:_____
   - **b)** Does the resident have the capacity to say no (verbally or non-verbally) to any uninvited sexual contact? Yes___ No____
     Comments:_____
     _____

3. **Resident's Awareness of Potential Risks:**
   - **a)** Does the resident realize that this relationship may be time limited?
     Yes____ No____
     Comments:_____
   - **b)** Can the resident describe how they will react when the relationship ends?
     Yes____ No____
     Comments:_____
     _____

Is the resident able to respond to questions adequately (verbally or non-verbally)?
_____

Completed by:_____ Date:_____ Time:_____

Adapated from:
Lichtenburg, P.A. (1997). Clinical perspectives on sexual issues in nursing homes. *Top Geriatric Rehabilitation*, 12, 1-10.
Lichtenburg, P., Strezpak, D. (1990). Assessments of institutionalized dementia patient's competencies to participate in intimate relationships. *Gerontologist*, 30(1), 117-120