SEX Talk:
Love and Belonging in Long Term Care

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On behalf of the Lanark, Leeds & Grenville SEX Talk Working Group

Land Acknowledgement

Presenter Disclosure

Kelly Davies and Kim Schryburt-Brown

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Learning Objectives:

At the end of this session, participants will be able to:

- Describe the theoretical frameworks underlying every person's need for love and belonging throughout the lifespan;
- Employ decision algorithms to identify the need for staff involvement when residents of LTC engage in verbally or physically intimate encounters; and
- Analyze situations of risk using an assessment for intimate encounters between residents of LTC.

Who Are We?

- Lived Experience Facilitator, Lived Experience Network South East Ontario
- Provincial Lived Experience Facilitators
- LTC home representatives, in-house Behavioural Supports Ontario (BSO) staff
- LGBT Community Representative
- Mobile Response Team (external BSO)
- Adult Community Mental Health Outreach RN
- Seniors Mental Health Outreach RN
- Clinical Resource Project Consultant SE
- Behavioural Therapist, ROMHC
- SE LHIN Home and Community Care
- Psychogeriatric Resource Consultant
- Legal representative from Elder Law

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Need Versus Behaviour

Our Philosophy

The Stages of Human Development

Providence Care

more than healthcare.

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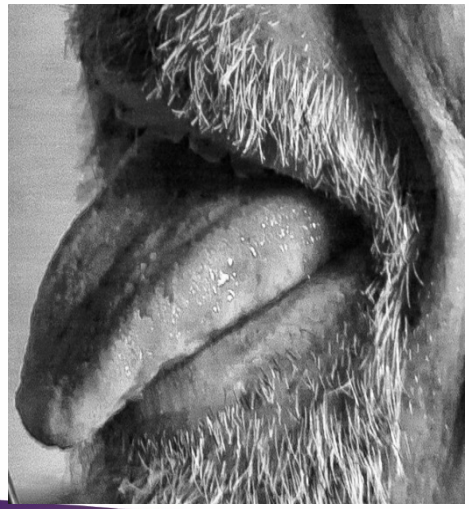

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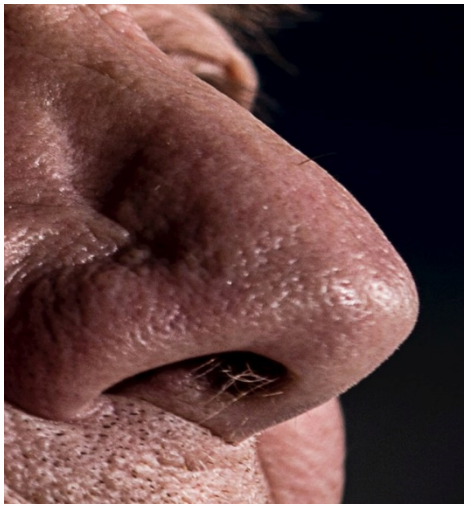
The 5 Senses:

How People Living with Dementia Experience the World



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The Difference

Sexuality

- A central aspect of being human throughout life and encompasses sex, gender identities and roles, sexual orientation, eroticism, pleasure, intimacy and reproduction. (World Health Organization, 2006)

Abuse

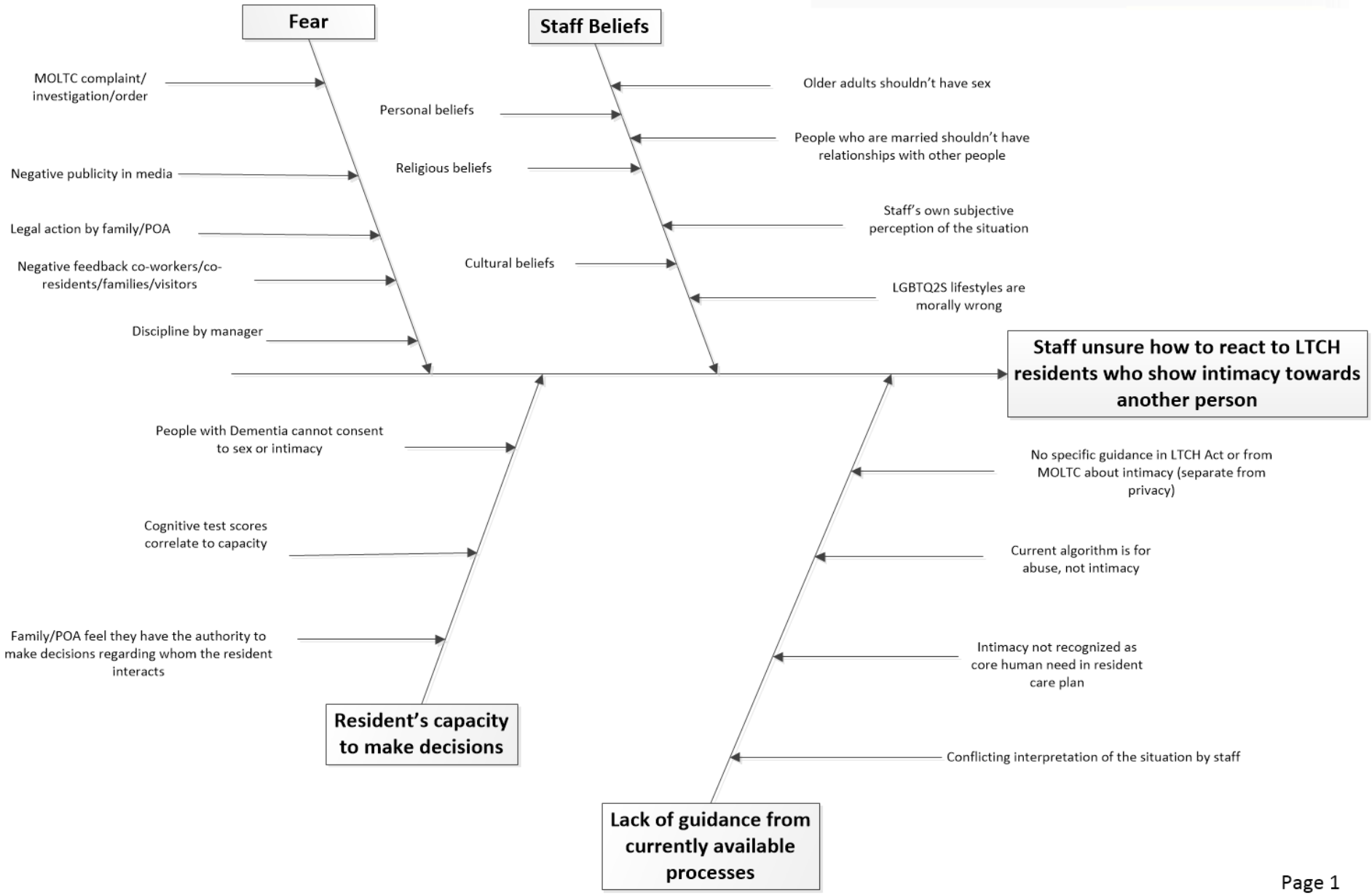
- A behaviour that scares, isolates, or controls another person. It may be a pattern or a single incident (Government of Canada)
- Sexual Abuse is non-consensual touching, behaviour or remarks of a sexual nature or sexual exploitation (Ontario LTCH Act, 2007)

What We Knew:

- Existing tools, guidelines from the previous LL&G Working Group established in 2005, last draft 2011
- Policies within homes were vague, procedures remained absent
- MOLTC mandated Policies on abuse i.e. ‘Zero abuse” policy, algorithm for sexual abuse
- Care Plans did not reflect Sexuality and Intimacy as a need, but instead a behaviour deemed “inappropriate”
- Individual morals, values and beliefs
- Protectionist mode as the default
- MoCA, MMSE assessments and RAI-MDS CPS scores a means of establishing a baseline for the capacity to consent

Why do LTCH Staff Have Difficulty Responding to Residents Who Show Intimacy Towards Other People?

May 29, 2020



Where We Began

- Draft Procedure was created
- Circulated to the LTC homes
- Updates were initiated
- Process was simplified to include the following criteria:
  - Admission screening to establish a baseline
  - Assessment of Awareness- The person, their intention and risks
  - Risk Guide-Establishing degree of risk if any and action required, if any

What We Know Now

- Screening on Admission;
- Families, let alone people entering long term care do not want to be asked questions of this nature
- Admission is never a good time
- The need to establish a baseline when the baseline is no longer relevant
- The baseline of the need may change from one moment to the next
- Current assessments i.e. MoCA, MMSE, CPS scores do not ask the right questions

Where We Are Now

- Admission Process
- Domain for Love & Belonging within the Care Plan-1st Page!!!
- Algorithm establishing Sexuality and Intimacy as a need, both verbal and physical
- An assessment relevant and within context of the need; one's comfort, discomfort and capacity to consent;
- Ability to Appreciate & Understand the relationship, potential risks, unwanted contact and corresponding levels of risk (verbal, non-verbal, physical)

Meet Dorothy and Serge

Dorothy is a 78 year old woman living in a secure unit in LTC. She has a diagnosis of Alzheimer's Disease and her MoCA was 15/30 about 6 months ago. She is independently mobile around her home area and attends activities she enjoys, leaving on her own before the activity ends. She has a history of multiple male partners while living in the community.

You find Dorothy in Serge's room, with her blouse unbuttoned. She is standing and leaning over Serge, who is sitting in his wheelchair. Serge is a new resident on the floor. You know nothing about Serge other than he was admitted from home due to caregiver stress. He has his hand on Dorothy's breast but seems confused.

What do you do?

Poll

Question #2

The Sequelae

- Dorothy and Serge are separated
- PSWs are struck in the process
- Medications are initiated
- DOC initiates investigation and mandatory reports
- POAs are informed of incident

Poll

Question #3

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Question #4

DOC Investigation:

- 3 PSWs and 1 RPN interacted with Dorothy and Serge over the past 3 days and documented in clinical chart
- DOC interviews staff involved
- DOC calls POAs and physician

Despite these interventions, Dorothy and Serge continue to be found together in common and private areas of the home.

Poll

Question #5

Despite these interventions, Dorothy and Serge continue to be found together in common and private areas of the home.

BUT…

Serge loses his ability to self-propel his wheelchair and Dorothy has an injurious fall.

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Assessment and Care Planning

How do we incorporate the need for love and belonging of those under our care?

Guiding Questions to Reflect Upon in the Development of the Care Plan

- Staff morals/values/beliefs/attitudes/culture
- Is this an innate need for human connection or is there intent to harm?
- Personhood information
- How will you assess capacity?
- How do you determine the degree of risk?

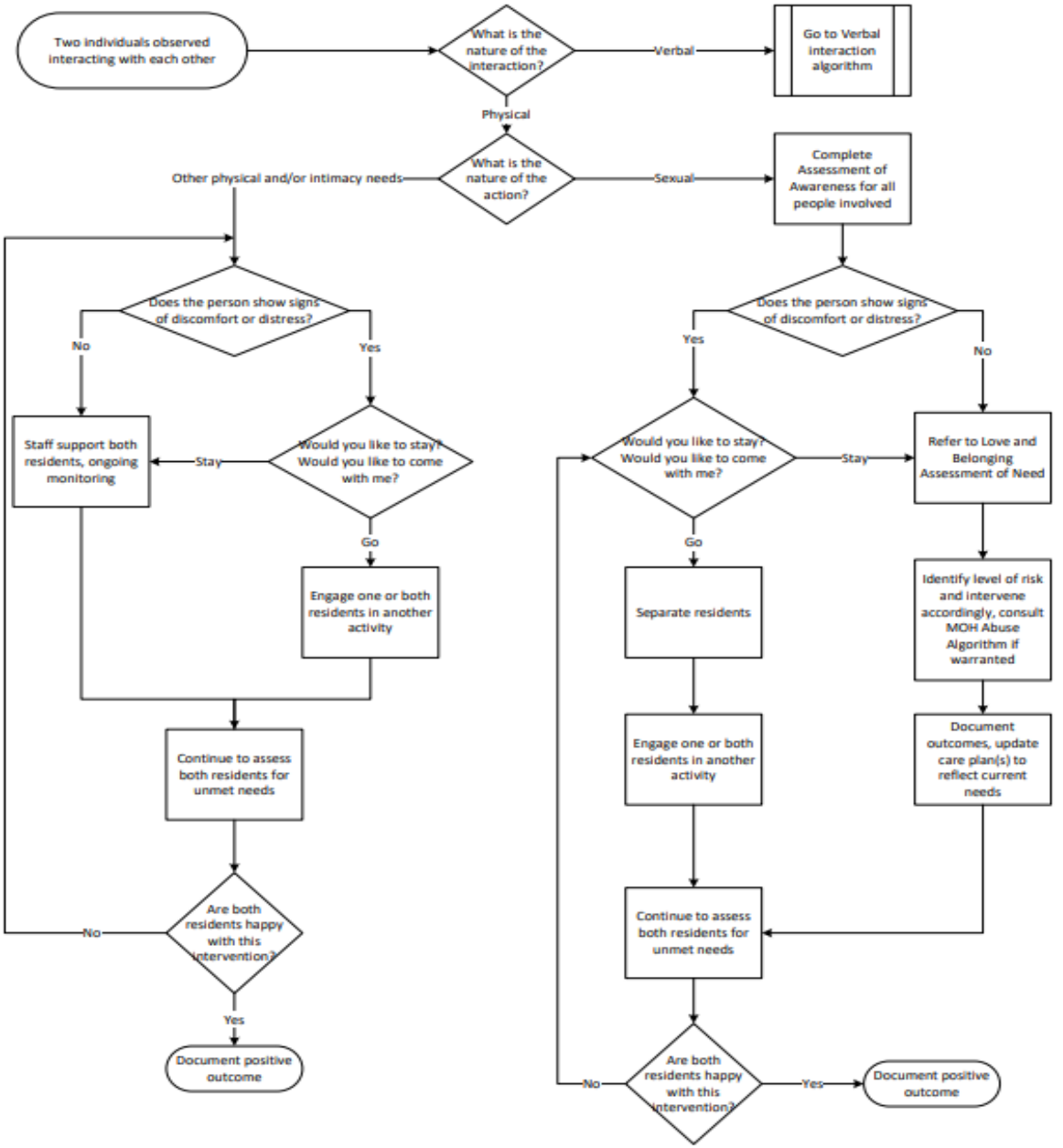
Care Planning: Love and Belonging

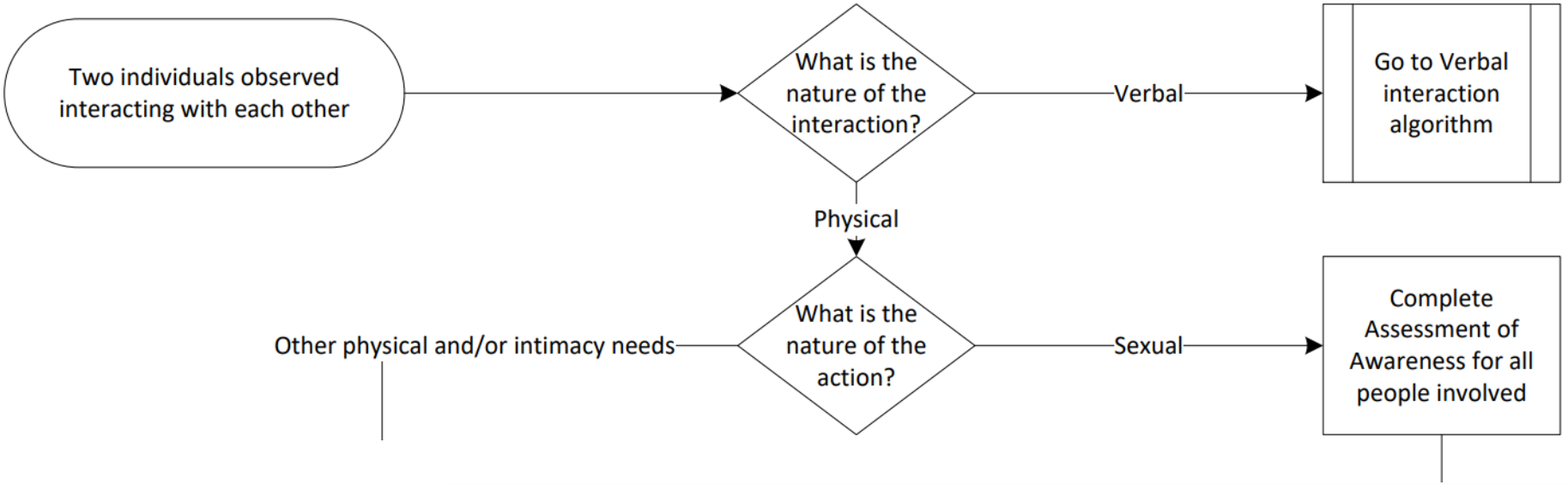
Focus	Goals of Care	Care Approaches
Companionship – being with other people, receiving touch from others	Dorothy will be supported by staff to connect with co-residents in the manner of her choice	Dorothy will be included in group activities, with obvious visual cues to facilitate leaving if desired
Personal Space	Respect Dorothy's personal space boundaries	Dorothy enjoys close contact (less than 1m) with others. Staff will explain what they are doing when entering her whisper zone for personal care.
Non-Judgmental Care	Dorothy will be supported to form relationships with co-residents	Dorothy enjoys the company of men, especially when they sit beside her or hold her hand.

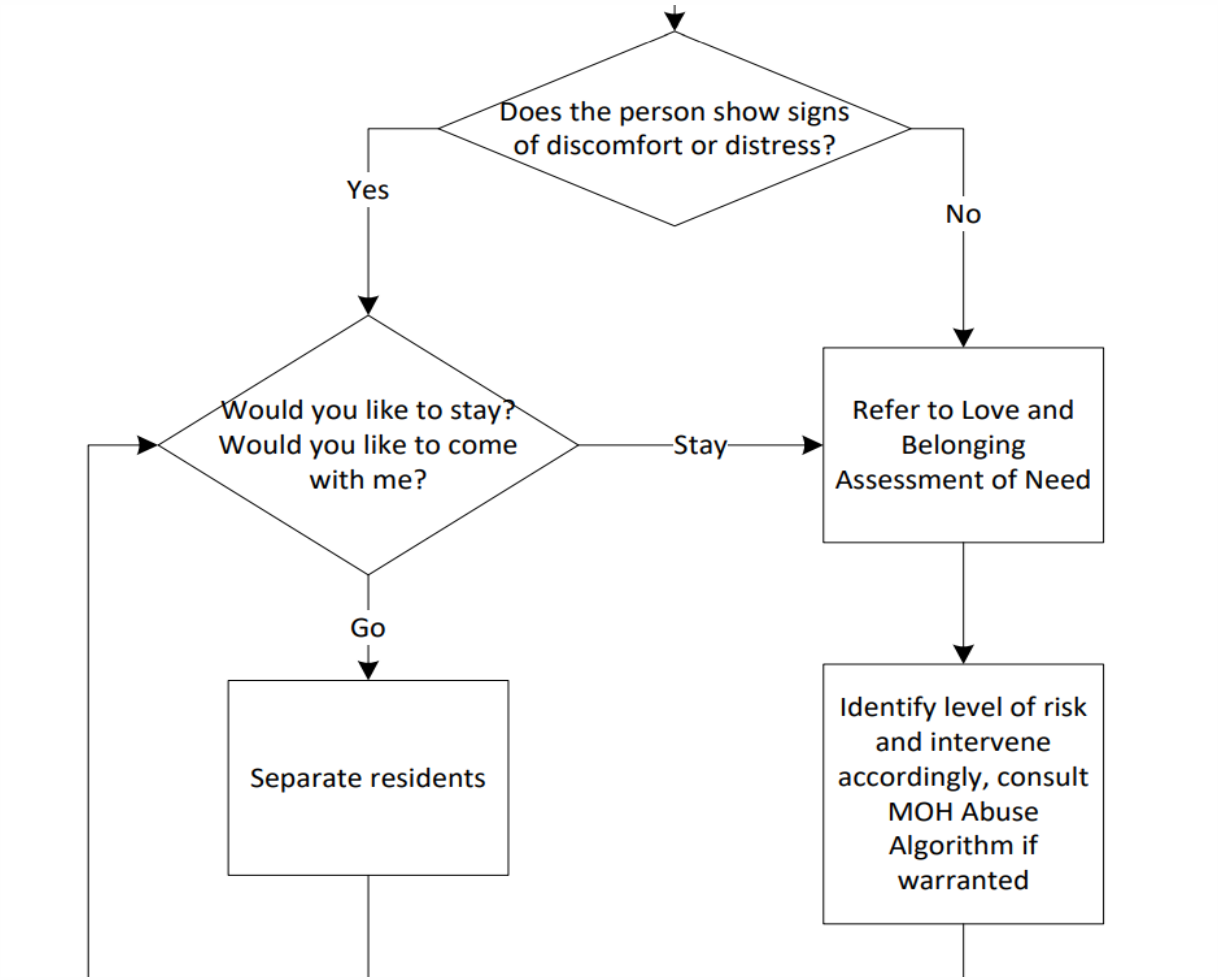
Care Planning: Love and Belonging

Focus	Goals of Care	Care Approaches
Companionship – being with other people, receiving touch from others	Serge has a need to be around people at all time (see personhood assessment), staff. He will be supported in connecting with other residents.	Staff will assist Serge to sit in common areas and attend activities involving 2-5 other people. Staff will assist Serge in having virtual visits with family who live at a distance.
Connect with others through the senses	Serge has high tactile sensory needs, which will be met through a variety of care approaches.	Staff will provide Serge with tactile opportunities (other people, textures/fabrics, hand massage). Staff will recognize Serge's attempts to reach out as a need for touch and use comforting sensory inputs to meet his needs
Non-Judgmental Care	Serge will live in an environment that is free of bias from others (staff, other residents, families)	Serge had both male and female intimate partners throughout his life, he will be supported in developing intimate relationships with others who wish to interact in this way with him.

Love and Belonging Assessment of Need - Physical

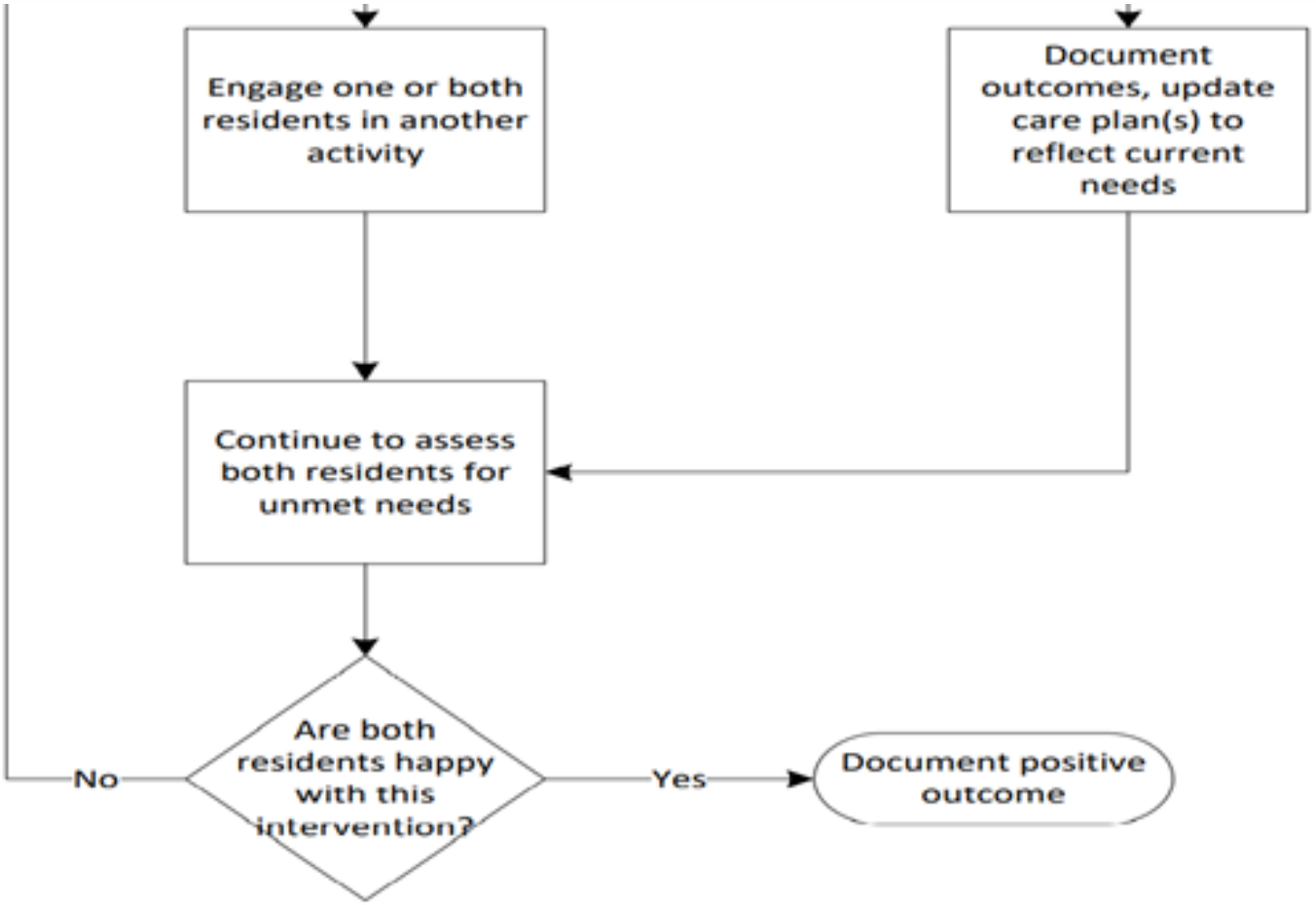






Providence Care

more than healthcare.



Providence Care

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Question # 6

Assessment of Awareness

Families and people living with Dementia told us they do not want an assessment on admission, so how do we get to know our new resident's needs?

Assessment of Awareness of Actions (Understanding & Appreciation): Appendix B

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 Lichtenberg and Strzepak (1990) suggest that the following questions be asked to identify the conditions and circumstances to support finding of capacity.***

Resident's ability to Appreciate and Understand

1. **Resident's Awareness of the Relationship:**
   The purpose of this section is to determine the residents understanding of who the other person is in the interaction. Here are some guiding questions to consider;
   a) ***(Who is this? Can you introduce me?)***
   b) Do you like to spend time together?
   c) How do you like to spend your time together? I.e. holding hands, talking with one another, hugging, arm around one another, and hand on the other person lap…
   d) I noticed you were…. (Action) with…. (Name of person), were you comfortable with that? (For example… holding hands, hugging, kissing, fondling)
   e) Is there anything you wouldn't be comfortable with?

   Consider: Sexual activity without a partner's consent is illegal, Inability to differentiate between reality & fantasy, Ability to plan ahead & problem solve, Awareness of partners feelings, their verbal & non-verbal cues, knowing that participating in sexual activity is a choice, cultural backgrounds of the individuals including common greetings and or practices of people, example: a kiss on both cheeks.

   2) **Resident's Ability to refuse unwanted contact:**

Consider verbal and non-verbal refusals i.e. Does the person refuse medications, personal care, bathing, assistance with meals? ADL's, what does this look like?

a) Do you like it when…? (Name of person) does… (Name of action)?

b) How do you say "No"? If you don't like it, how would you say No if you wanted them to stop?

c) Does the person have a history of refusing care, medications etc….. If so, what does this look like?

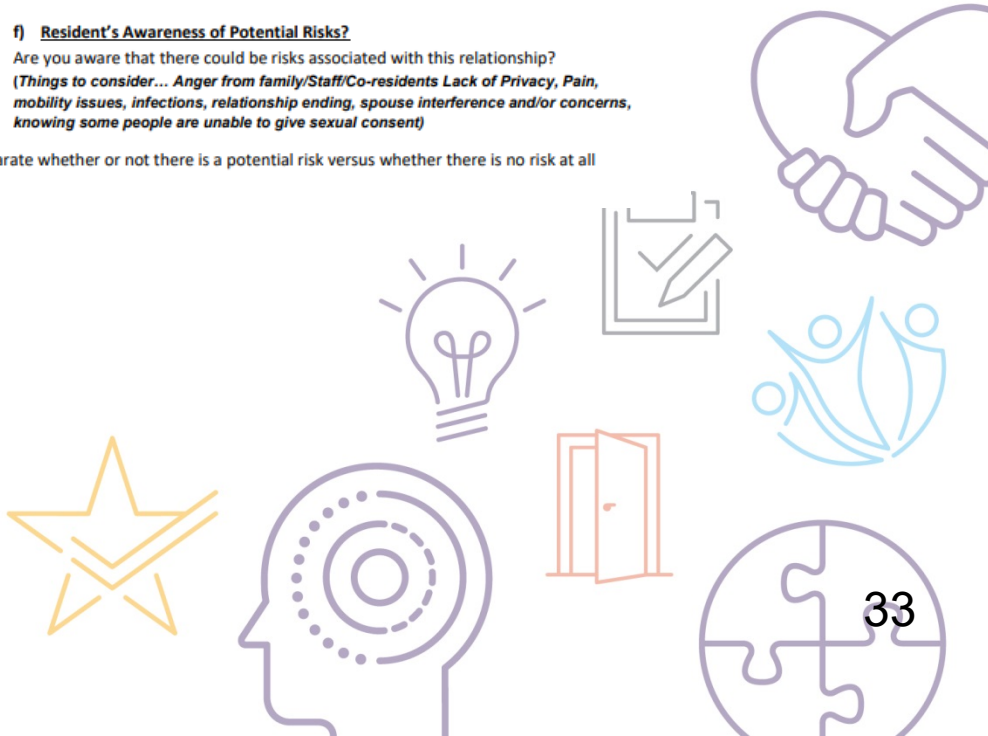
d) Are there any past cultural or negative experiences that would have an impact on how the person is responding to the interaction? Past assaults, past abusive relationships, passive nature……

e) *How did the other person react when told "No" either verbally of physically? (Consider adding this piece into the levels of risk in terms of the other individual continuously seeking the person out, even when it is unwanted.)*

f) Resident's Awareness of Potential Risks?

a) Are you aware that there could be risks associated with this relationship?
(Things to consider… Anger from family/Staff/Co-residents Lack of Privacy, Pain, mobility issues, infections, relationship ending, spouse interference and/or concerns, knowing some people are unable to give sexual consent)

****Separate whether or not there is a potential risk versus whether there is no risk at all



Assessment of Awareness

Serge's Answers

- He was confused, peripheral vision loss, didn't know where he was or that the breast was attached to Dorothy
- Dining staff noticed Serge never eats off his plate – they realized he cannot see the plate in front of him

Dorothy's Answers

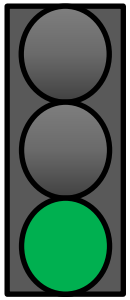
- Dorothy walks out of activities she doesn't like
- Was trying to get into bed, thought this was her room, didn't realize Serge was there d/t lower quadrant visual field loss
- Said she was enjoying the physical contact but didn't realize who was giving it to her

Poll

Question #7

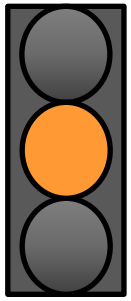
Love and Belonging Observation Tool

Expression of Need	Description of Resident Need	Care Approach	Things to Consider
Level 1	Love & Belonging; • Friendships, intimacy and sense of connection; • Kissing, hugging, cuddling, handholding, flirting, dancing • Masturbation/fondling oneself in private i.e. own room ******Reminder:*** ***Sexuality & Intimacy;*** *is a basic fundamental need, instrumental in overall health and well-being*	Provide and support a socially appropriate context for the relationship that offers comfort and reassurance by; • Ensure privacy • Ongoing monitoring of each resident's ability to consent to the need for intimacy/courtship • Update the Care Plan under "Love and Belonging" to reflect the current relationship status of both resident's • Discussion with the team around the organization of a team care conference to educate family on the identified need *******Reminder:*** ***Be aware of your own morals, values and beliefs, and how they may influence your response and actions. It is important to remain objective.***	• A person living with dementia is very much living in the moment, how can their need be supported in that moment? • How can we support individuals to form healthy relationships? • Be respectful; understand that it is normal for resident's to seek companionship, relationships and a means of pleasure. • Is there any intent to harm by one resident towards another? • Resident Bill of Rights with respect to forming relationships/ companionships as follows; **Resident Bill of Rights-LTCH's ACT 2007 S.O 2007, c.8 3(1)** • Persons with Dementia Have Needs, just like all of us; **(GPA 4e, adopted from Bell & Troxel, 2001)** • **Dementia Bill of Rights- (Adopted from Bell & Troxel, The Best Friends Approach to Alzheimer's Care, 2013)**



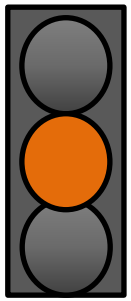
Love and Belonging Observation Tool

Level 2	Verbal/Non-Verbal Sexual Expression of Needs towards others; (i.e. co-residents, staff and/or visitors) • Suggestive language; Pointing to groin, reaching for a breast, buttock • Verbalizations such as; "Come here and give me a kiss"	These expressions may cause you as a care provider to feel uncomfortable. It is important to recognize that the resident may be misinterpreting their environment, who you are and what you are trying to do. • A resident response of this nature can often occur during personal care. • Promote the resident's independence as much as possible i.e. providing them with a face cloth to wash their groins etc. • The approach by the care provider is to be respectful, recognizing their feelings of unease related to their own personal values and beliefs. **Quick Tips for suggested care approaches;** • Avoid punitive language that could be seen as belittling and/or shaming the resident. • If suggestive language is directed towards a visitor, introduce the visitor, who they are and what they are there for. • If suggestive language is directed towards staff, step back, ensure you are within the resident's visual field, and introduce yourself, your role and what you are there to do. • If contact is unwanted by one resident, support that resident in introducing themselves and assist to another area of the home. • Engage in activities of interest • Use BSO-DOS to determine the time of day and schedule routine activities at this time.	A person with dementia is experiencing changes within their peripheral vision. What can the resident see versus what they can't see? As a care provider am I triggering a response based on my physical position? A person with dementia is also continuously trying to make sense of their environment. • Does it make sense to them that you are providing personal care? Do they understand they need help having a bath? • Are they simply misinterpreting your intentions as a care provider? • Are you misinterpreting their intentions as the resident? • Do they feel threatened? • Do they feel as though they have no other choice but to protect/defend themselves in that moment? ****** Remember: The resident's reality is not your reality as the care provider*** • Support Resident Rights being met as per Resident Bill of Rights, Dementia Bill of Rights **Resident Bill of Rights-LTCH's ACT 2007 S.O 2007, c.8 3(1), Dementia Bill of Rights***** ***See Above***

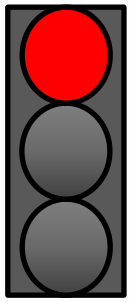


Love and Belonging Observation Tool

Level 3	Sexual behaviours/Unwanted Sexual Advances • Public masturbation • Fondling breasts, buttocks, groin, genitals of others • Risk of harming self	• Redirect to a more private area • Redirect and dissuade person from action • Ensure resident is covered and not exposed • Avoid punitive language Additional Tools; • P.I.E.C.E.S Assessment • Referral to MRT • Referral to Psychogeriatric Resource Consultant (PRC) • Referral to Geriatric Psychiatry • Community Adult Mental Health	• Consider the residents misinterpretation of their environment and their actions as a result of this perception • How are both resident's interacting with one another? Is one resident indicating either through words, or actions that they are not ok with the interaction? • Are one or both resident's doing something that indicates they are no longer agreeing with the interaction that has already started? • Assess for unmet needs (e.g. pain, infection, incontinence/toileting) • Has there been a marked change in the resident? • Is the person misinterpreting their environment? • Is the resident enjoying themselves? Is the resident unable to stop, or is it pleasurable? • Given your understanding of the resident's interpretation of their environment and the moment they are living in, is there evidence of any intent of harm?



Love and Belonging Observation Tool



Level 4	Unwanted or forceful Sexual Acts • Taking advantage of someone else • Forcing someone to perform unwanted sexual acts • Involuntary confinement, entrapment ******Reminder:*** ***Abuse:*** Abuse is defined as any action that ***intentionally*** harms or injures another person. ***Sexual Abuse:*** Is defined by the forcing of undesired sexual acts by one person to another ***Sexual Assault:*** Is defined as any form of sexual contact without the consent of both parties, and includes intercourse as well as unwanted touching or fondling ***S.271 of the Criminal Code**	• Refer to LTC homes internal process and policy on Sexual Abuse. Refer to the MOH Algorithm on Sexual Abuse	• Follow LTCH's internal policy regarding documentation, Care Plan, MOH reporting (CIS), contacting police, if deemed appropriate, notify POA. • Team debrief concerning strategies to prevent a reoccurrence, acknowledge feelings & emotions of resident(s), co-residents, staff, POA's, visitors

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Question #8

The Outcome

- Dorothy can consent, Serge cannot
- Interaction has some risk – between levels 2&3

Final Thoughts

- Person-centred care is paramount
- Proactive instead of reactive approach
- Care planning avoids pre-conceived notions of needs being wrong
- Avoid imposing staff's morals/values/beliefs/culture/attitudes on residents

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Poll Questions

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Slide 36 – Why Families should be included in love and belonging care planning

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Questions?