



Lanark, Leeds and Grenville Long-Term Care Working Group

A Best Practice Approach to Intimacy and Sexuality

A guide to practice and resource tools for assessment and documentation

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Intimacy and Sexuality Practice Guidelines

Draft # 17 LLG LTCHs

September 2007

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 Values of this document are open for interpretation by each LTCH, but revisions to the contents of the guidelines will negate our endorsement and authorship.

Objectives: To develop a user-friendly guide that directs Homes in responding to issues of Intimacy and Sexuality while maintaining the dignity and autonomy of the resident, and 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.

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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, and sexual expression are a natural part of adult's lives. The ability to nurture is a key aspect of providing high quality care to all adults. 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 our LTCH's beliefs, 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}) and/or family should be involved in the development of a care plan that addresses the need for sexual expression if the resident is unable to make these decisions for her/himself in this regard;
- We accept that the population may include diversity in sexual orientation and gender identity (lesbian, gay, bisexual, transgender, transsexual: LGBT) and we do not discriminate on these grounds.
- We recognize that every resident has 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 the LTCH Advocate's Manual, ACE: Feb 2001).

- 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 to achieve a comfortable acceptance of sexual expressions 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).

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.

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.

- A description of the behaviour should be obtained, confirmed and validated with involved resident(s), partner, family member(s) and/or staff witnessing the event. 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
 - Is there potential harm or risk to the person(s) involved? What is the degree of risk?
1. What is the awareness of the resident(s) involved? **See Assessment of Awareness of Actions: Appendix C**
 - The results of the Awareness of Actions Assessment will determine next steps.
 2. 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 of the relationship?
 3. 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. It is important that staff observe, monitor situations, and assess level of sexual behaviour 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 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.**
- 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 policy.**
- 6. If the sexual behaviour gives rise for concern as to the resident's well-being, the Compliance Advisor (MOHLTC Regional Office) is to be contacted. The Compliance Advisor is always available to provide support and direction if concerns about the promotion of resident's rights exist (MOHLTC Regional Office, 2007).**
- 7. A LTCH incident form and a MOHLTC Unusual Occurrence (Critical Incident) Form may be required.**

Level of Sexual Behaviour	Description of Sexual Behaviour	Response
Level 1	Intimacy/ Courtship <ul style="list-style-type: none"> • kissing, hugging, handholding, fondling, cuddling (not inclusive) • consensual (implies awareness of actions) 	<p>No risk associated with this behaviour, if both persons consenting :</p> <p>Overall goal of staff response is to provide socially appropriate context for relationship that offers comfort and reassurance.</p> <ul style="list-style-type: none"> • This behaviour is viewed primarily as an intimacy relationship between two adults that are mutually consenting, implied by behaviour toward each other. • 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 <ul style="list-style-type: none"> • flirting, suggestive language, sexually laden language • not aggressive 	<p>Low level of risk associated with this behaviour:</p> <p>This behaviour may cause discomfort and reaction when directed toward staff; often occurring during personal care.</p> <ul style="list-style-type: none"> • 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, and 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, it sounds like you would like to have a conversation with me, so let’s talk. Why don’t you tell me about....”

<p>Level 3</p>	<p>Self-directed sexual behaviours</p> <ul style="list-style-type: none"> • masturbating • exposing oneself 	<p>Low level of risk. For self-stimulating behaviours the staff needs to observe and answer the following questions:</p> <ul style="list-style-type: none"> • For male: is there evidence of erection? Ejaculation? Skin irritation? • For female: is there evidence of injury as a result of masturbation? Is resident using a foreign object for stimulation? • Does the resident engage in this behaviour in the presence of others? How does this affect others? <p>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).</p>
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<p>Level 4</p>	<p>Physical Sexual Behaviours</p> <ul style="list-style-type: none"> Directed towards co-residents with agreement 	<p>Moderate level of risk associated with this behaviour.</p> <ul style="list-style-type: none"> 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 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 one partner in the pairing look distressed, upset, worried? 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? <p>If the resident is distressed or non-consenting move to Level 5.</p> <ul style="list-style-type: none"> If resident(s) are incapable to make decisions regarding their sexual expression it is critical to have POA_{PC}/SDM involvement to establish resident values, beliefs and level of comfort, and ultimately make 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.
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Level 5	<p>Non-consensual, overt physical sexual behaviours directed towards others that are a source of distress.</p> <ul style="list-style-type: none"> • Aggressive or repeated sexual overtures that are unwanted and rejected by others in the environment 	<p>A HIGH risk is associated with this series of behaviours:</p> <ul style="list-style-type: none"> • 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. • Are staff aware of the extent of sexual behaviours: one-on-one contact with the intent to kiss and caress, disrobing, oral sex or an attempt to engage in penetrative intercourse? <p>For this type of sexual behaviour there MUST be:</p> <ol style="list-style-type: none"> 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 Team. 3. An assessment of resident(s) Awareness of Actions: Appendix C, is required. 4. 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
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		<p>and education. Other parties may need to be consulted including extended family, volunteers, ministry, etc... Additional interventions will be identified through open dialogue.</p> <ol style="list-style-type: none"> 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 policy 7. The Compliance Advisor (MOHLTC Regional Office) is to be contacted for all Level 5: High risk incidents. More specifically if aggression is a factor and/or if the sexual behaviour gives rise for concern for the resident’s well-being, or that of the LTCH population. A LTCH incident form and a MOHLTC Unusual Occurrence (Critical Incident) Form is to be completed as per policy. 8. Police services are to be contacted by the staff directly, if the act or behaviour is deemed as “sexual abuse” or “sexual assault” (see MOHLTC definitions in Glossary, p. 13) as reported by the resident, or intervening staff. <p>*Note the Criminal Code of Canada does not discriminate “sexual abuse” from “sexual assault”.</p>
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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.
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.

MOHLTC Policy Draft: Prevention, Reporting, and Elimination of Abuse of Residents of Long-Term Care Homes (Document # 0808-01 Nov 2004)

Excerpts:

Definition of “**Abuse**”: Abuse of a resident means any action or inaction or power and/or betrayal of trust or respect by a person against a resident, that the person knew or ought to have known, would cause (or could reasonably be expected to cause) harm to the resident’s safety or well-being.

Abuse includes, but is not limited to:

- Physical abuse
- Sexual Abuse and Sexual Assault
- Emotional Abuse
- Verbal Abuse
- Financial Abuse

- Exploitation of a resident's Property or Person
- Neglect
- Prohibited use of restraints
- Measures Used to Discipline a Resident

Definition of "**Assault**":

- Assault is defined as attempting to apply force to a resident, or threatening (by act or gesture) to apply force to a resident in such a way that the resident can "reasonably" expect the threat or action to be carried out.
- Intentionally applying force to the resident, directly or indirectly, without the resident's consent.
- A physical attack on the resident.

Definition of "**Sexual Abuse**":

- Any non-consensual sexual intercourse, or other form of non-consensual physical sexual relations, with a resident
- Any non-consensual touching of a resident that is of a sexual nature. This does not include touching, remarks or behaviour of a clinical nature that is appropriate to the provision of care.
- Behaviour or remarks of a sexual nature towards the resident that are unwanted by the resident, including remarks that are sexually demeaning, humiliating, exploitive or derogatory.
- Any situation in which a staff member begins a sexual relationship with a resident.
- Sexual assault of a resident.

Definition of "**Sexual Assault**":

- "Sexual Assault" of a resident is an assault that is committed under circumstances of a sexual nature, such that the sexual integrity of the resident is violated.

Definition of "**Staff**": Staff of the LTC Operator includes, for the purposes of this policy, except where otherwise indicated, any permanent and contract, full-time, part-time and casual:

- Employees
- Physicians
- Agency staff
- Contracted health-care professionals
- Paid trainees
- Students under clinical placements

- Paid companions (paid by resident, family member or substitute decision maker)
 - Volunteers.
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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.terrano.org. Check availability with local Psychogeriatric Resource Consultant.

Web site Resources:

Advocacy Centre for the Elderly <http://www.advocacycentreelderly.org/>

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