POLICY

All residents are supported in their right to consent to and enjoy consensual intimacy and or sexual intimacy with other residents. The object of this policy is to balance the individual resident’s right to privacy, dignity and emotional fulfillment with safety and health concerns arising from intimacy and sexual connection.

Staff will use a consistent process for determining residents’ capacity to consent to intimate sexual relationships.

All employees are responsible to report suspected events of sexual abuse or assault to the licensed nurse, Executive Director, adult protective services and law enforcement.

A health care provider shall not engage, or attempt to engage, in sexual misconduct with a current resident, client, or a resident’s key party, inside or outside the health care setting. Sexual misconduct shall constitute grounds for disciplinary action.

OBJECTIVES

1. To support residents in their need for intimacy, and/or sexual intimacy.
2. To provide a consistent approach and process for staff to follow when residents express a desire for intimacy, and/or sexual intimacy.
3. To prevent sexual assault and/or sexual abuse and exploitation of vulnerable residents.

DEFINITIONS

Intimacy
An act or an expression that serves as a token of familiarity, affection or the like. There are many types of intimacy:

- Cognitive or intellectual where individuals enjoy exchanging thoughts and ideas;
- Experiential, where individuals experience similar things together (can be work, play, or any activity);
- Emotional, where individuals provide each other with emotional support and share feelings; and
- Physical, which may include a wide range of activities such as touching, hugging, and holding hands in addition to sexual intimacy.
There are times when an intimate relationship can become sexual as the bonds of the relationship grow and the individuals become more familiar.

**Sexual Intimacy**
A form of sensual expression between individuals that may include hugging, kissing, laying down together, touching the body in intimate places, intercourse, or other sensual activities.

**Sexual Abuse**
Any form of non-consensual contact including but not limited to unwanted or inappropriate touching, rape, sodomy, sexual coercion, sexually explicit photographing and sexual harassment. Includes any sexual contact between a staff person and a resident, whether or not it is consensual.

**Acute Sexual Assault**
Any non-consensual or unwanted sexual contact that warrants medical treatment or forensic collection. Any acute sexual assault event must be reported to law enforcement immediately. Any injury resulting from an incident or event in which acute sexual assault cannot be definitively ruled out as a cause must be immediately reported to law enforcement.

**Sexual misconduct (Any sexual contact between a resident and a staff member).**
Sexual misconduct includes but is not limited to:
- Sexual intercourse;
- Touching the breasts, genitals, anus or any sexualized body part except as consistent with accepted community standards of practice for examination, diagnosis and treatment and within the health care practitioner’s scope of practice;
- Rubbing against a patient or client or key party for sexual gratification;
- Kissing;
- Hugging, touching, fondling or caressing of a romantic or sexual nature;
- Examination of or touching genitals without using gloves;
- Not allowing a patient or client privacy to dress or undress except as may be necessary in emergencies or custodial situations;
- Not providing the patient or client a gown or draping except as may be necessary in emergencies;
- Dressing or undressing in the presence of the patient, client or key party;
- Removing patient or client’s clothing or gown or draping without consent, emergent medical necessity or being in a custodial setting;
- Encouraging masturbation or other sex act in the presence of the health care provider;
• Masturbation or other sex act by the health care provider in the presence of the patient, client or key party;
• Suggesting or discussing the possibility of a dating, sexual or romantic relationship after the professional relationship ends;
• Terminating a professional relationship for the purpose of dating or pursuing a romantic or sexual relationship;
• Soliciting a date with a patient, client or key party;
• Discussing the sexual history, preferences or fantasies of the health care provider;
• Any behavior, gestures, or expressions that may reasonably be interpreted as seductive or sexual;
• Making statements regarding the patient, client or key party's body, appearance, sexual history, or sexual orientation other than for legitimate health care purposes;
• Sexually demeaning behavior including any verbal or physical contact which may reasonably be interpreted as demeaning, humiliating, embarrassing, threatening or harming a patient, client or key party;
• Photographing or filming the body or any body part or pose of a patient, client, or key party, other than for legitimate health care purposes; and
• Showing a patient, client or key party sexually explicit photographs, other than for legitimate health care purposes.

Sexual misconduct also includes sexual contact with any person involving force; intimidation or lack of consent; or a conviction of sex offence as defined in RCW 9.94A.030.

PROCEDURES

I. Initial Interventions:

If acute sexual assault and/or sexual abuse is suspected, the following procedure shall be initiated. For the purpose of this section, “acute sexual assault or abuse” includes, but is not limited to, any physical injury for which sexual assault or abuse cannot be immediately ruled out:

1. Ensure the immediate safety of the suspected victim and preservation of evidence.
   a. If a perpetrator is suspected, ensure resident is in a secure location that cannot be accessed by the perpetrator.
   b. Assign a staff member to remain with the resident until authorities arrive.
   c. Preserve evidence such as bedding, clothing, pads. Do NOT bathe or brush teeth of victim.
3. Notify Executive Director and licensed nurse. The Executive Director or designee shall report the suspicion to Adult Protective Services (APS).
4. Contact resident’s physician and family or responsible party as indicated.
5. Follow the usual procedures for changes and incidents by completing an Incident Report, and documentation in the 24 Hour Book.
6. Local County Crisis Centers are:

**Lane County:**

Sexual Assault Support Services  
24-Hour crisis line: 541-343-7277  
24-Hour Toll Free: 1-800-788-4727 (in Oregon)  
Office: 541-484-9791  
591 West 19th Avenue (corner of 19th & Jefferson)  
Eugene, Oregon 97401  

Hours: 9:00 AM- 4:00PM, Monday-Friday  

**Grant County:**

Heart of Grant County  
24-Hour Hotline: 541-620-1342  
Office: 541-575-4335  
Fax: 541-575-4336

**Columbia County:**

Columbia County Women’s Resource Center  
24-hour Crisis Line: 503-397-6161  
24-Hour Toll Free: 1-866-397-6161 (in Oregon)  
Office: 503-397-7110
When residents express a desire to have an intimate/sexual relationship, the facility Executive Director and the facility RN will be notified and immediate steps taken to determine appropriateness related to the residents’ intimacy and sexual needs.

1. The residents’ service plans will be reviewed in order to determine whether there is already an identified relationship established. If not established, the five step evaluation and planning process must be completed and documented.

2. If there is no identified relationship, the Executive Director and facility RN will work with the community, resident, medical provider and family to determine whether sexual intimacy is appropriate and if interventions will be called for.
3. If abuse is alleged or suspected, follow the processes described in the Abuse Policies and/or the sexual assault process above.

**II. Evaluation and Planning**

Recognizing behaviors and identifying appropriate interventions involves five steps:

1. **Determine Capacity**

Capacity must be determined in order to establish the validity of any resident consent. Having *Capacity* means that the person has:

- Sufficient memory to evaluate and make a choice.
- Sufficient judgment regarding the consequences of the choice, and
- Ability to decide freely

To help determine capacity staff must:

I. Initially discuss the relationship with the residents themselves.

Questions pertinent to this inquiry should determine:

(a) Is the resident aware of who is initiating the sexual contact? If not, actual consent is impossible.
(b) Does the resident believe the person initiating the sexual contact is a spouse, and is acquiescence a product of delusional belief?
(c) Is the resident therefore cognizant of the other’s identity and intent? (Without this awareness valid consent is impossible).
(d) Can the resident articulate the level of intimacy they would be comfortable with?
(e) Is the initiation of or acquiescence to sexual contact consistent with resident’s prior stated or demonstrated beliefs?
(f) Can the resident resist compulsion, coercion or pressure in order to decline sexual contact (i.e. to say "No")? (Without this capacity, valid consent is impossible).
(g) Does the resident understand that the relationship may be temporary (e.g. residency in the unit may be limited).
(h) Can the resident identify how they will feel/act when the relationship ends?
II. Collect data by questioning staff who are familiar with the residents and how they live their life in the community. The same questions listed above would be pertinent.

III. Collect data from family members or others who know the residents well. This process is informational. We are not soliciting opinions as to whether family members approve or disapprove; rather we are seeking data and factual information specifically relevant to the capacity determination.

IV. Review the record and evaluations related to the residents’ capacity to make decisions, including medical records, psychiatric or counseling records, assessments, and court or contract documents setting forth any relevant data, if available.

V. Check the residents’ record to see if the physician has deemed the resident to be capable of choice and/or involve the physician in this step as appropriate.

VI. If one or both of the involved residents have a cognitive impairment or dementia, then it should be considered whether the residents’ remaining abilities are sufficient to allow them to choose to be sexually intimate with another person.

VII. If a clear determination cannot be made based on available data, an assessment by a qualified mental health professional should be sought to determine the ability of either involved resident to form and articulate consent.

2. Consent

Consent means to voluntarily agree to make a choice to do something proposed by another, after considering the risks and benefits. Agreement cannot be considered voluntary if the individual is forced, threatened, coerced or under duress. A resident must have capacity in order to consent. Once capacity is determined:

- Continue conversations with residents and family to determine the parameters of consent including the type(s) of sexual intimacy.
- Document all such conversations in the resident record.

3. Involving Children, Spouse, Legal Representatives or Others (such as friends, Ombudsman or others)

It is important for residents, family and other appropriate persons to be involved in the process:

- Check for appropriate decision-making documents such as guardianship and/or healthcare Power of Attorney
- Conference with the family regarding:
4. Coupling

Coupling is when residents seek ways and locations for sexual intimacy. Identifying coupling behaviors is a means of determining that a relationship may exist between two individuals. Being aware of residents’ coupling behaviors can help staff evaluate potential health and safety risks and develop appropriate interventions as indicated.

- If coupling is observed, involved residents and families should be made aware of health and safety risks associated with sexual intimacy including injuries, UTI’s, incontinence, and sexually transmitted diseases such as HIV and Hepatitis
- Staff should report if they observe any residents in a documented relationship begin a new relationship with another resident
  - Coupling is a means of determining that a relationship exists between two individuals
  - Coupling means finding ways and locations for intimacy and sexual contact

5. Care Planning/Service Planning

Care/Service planning should include interventions agreed to by the resident, family, and/or legal representative; and interventions related to the residents’ relationship so that the interventions are communicated to staff.

- Interventions are reviewed in care conferences with the appropriate residents and/or family members quarterly and with any condition changes.
- Document all steps of the process in the clinical records.

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• If changes in the relationship are noticed, or if either resident forms a new relationship with another resident, the five step evaluation and planning process above will be completed and the care/service plans for all involved residents updated.

• Caregiver observations of the coupled relationship and resident health and status should be both periodic (i.e. every 90 days) or episodic as observed status changes occur. These changes should be documented and incorporated as changes to care and service plans where necessary.

### III. TRAINING AND COMMUNICATION

1. All staff shall be trained on hire on acute sexual assault. Training shall include:
   a. Detection and examples of sexual assault:
   b. What constitutes sexual assault vs. sexual abuse vs. intimacy:
   c. Victim’s right to refuse sexual assault exam:
   d. Only a trained Sexual Assault Examiner (SAE) should perform a Sexual Assault Forensic Exam (SAFE kit):
   e. Exam can detect evidence up to 86 hours after incident;
   f. A partial exam can be done after 86 hours; and,
   g. Victim care, including preserving evidence:
      i. Save bedding/clothing/pads
      ii. Do not bathe or brush teeth of victim