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

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

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Consider RISKS:
R: Roaming/Wandering: ____
I: Imminent Physical Danger: (frailty, falls, fire)____________________________
S: Suicidal ideation:____
K: Kinship: harm to or from resident____________________________________
S: Sexual abuse/assault, substance use/misuse, self-neglect, safe driving:
____
____
____

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, sensory loss, sleep disturbance, elimination..
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Intellectual (cognitive impairment, dementia, impaired judgment, aphasia, altered perceptions, misinterpretation, impulsivity)
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Emotional: (fear, adjustment, anxiety, depression, bereavement, recent losses, psychosis, …):
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____
____

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

Social/Cultural/Spiritual: (see Life Story):_____________________________________
____
____

Staff witnessing the event:___________________________

Other witnesses:____

Nurse In Charge:_______________________________ Date:________________

Adapted from: Putting the PIECES Together, 2006

Sexual Behaviour Assessment: Part Two Appendix B

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

If Admission Intimacy History 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? e.g. past traumas of sexual nature, passivity

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

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

3. Is there a POAPC /SDM who should be consulted/contacted about the behaviour?________________________ Contacted on :_________________
Response: ____
____
____
____

4. Does the Compliance Advisor need to be contacted? Yes___ No___
Contacted on:_____________ By:______________________________
Name of compliance advisor and the recommendations received:
____
____
____

5. Do the Police Services need to be contacted? Yes____ No____
Contacted on:_____________ By:_______________________________
Name of investigating officer:____________________________________
What was the outcome of this contact:
____
____
____

Adapted from: Putting the PIECES Together, 2006

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 POApc/SDM who interprets the last capable wishes of the resident, if unknown then the POApc/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:_____________