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**THE WELLNESS PROJECT:  
PROMOTING OLDER PEOPLES'  
SEXUAL HEALTH**

**Final Report**

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# **THE WELLNESS PROJECT: PROMOTING OLDER PEOPLES' SEXUAL HEALTH**

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## **PARTNER ORGANISATIONS**

### *The National Ageing Research Institute (NARI)*

The National Ageing Research Institute has developed a strong track record for a range of projects conducted in the biological, clinical, public health and education / workforce training areas associated with key health problems related to ageing. The Public Health Division of the National Ageing Research Institute has an established program of health services research in aged and community care. NARI Public Health Division has used action research as an approach to workforce training, an example being the ‘Well for Life’ Project. This approach supported the development of organisational policy and practice to enhance the social and physical health and well-being of the residents of aged care settings. NARI has used action research in multi-disciplinary, multi-factorial falls prevention projects for in-patients in the sub-acute setting of the Melbourne Extended Care & Rehabilitation Service. NARI is actively involved in research and workforce training for medical and health practitioners focusing on the translation of research evidence into clinical practice.

### *Melbourne Extended Care and Rehabilitation Service (MECRS)*

Melbourne Extended Care and Rehabilitation Service provides health care services predominantly to older people who live in the northern and western metropolitan regions of Melbourne. As the hub of the Aged Care and Rehabilitation Program of Melbourne Health, its services include rehabilitation, geriatric evaluation and management, specialist community based programs, mental health services and various forms of residential care. MECRS also endeavours to cater for the needs of diverse cultural and linguistic groups.

Melbourne Extended Care and Rehabilitation Service aims to be a centre of excellence in the provision of aged care and rehabilitation services. There are around 150 in-patient beds at MECRS, which are located in six wards, including three Geriatric Evaluation and Management (GEM) wards, a rehabilitation ward (primarily amputee and neurological patients), an Aged Transitional Care Unit, and a complex residential care unit (caring for residents with acquired brain injuries). MECRS acts as the base for Aged Care Assessment Services, a community rehabilitation centre, a day activities centre and Community Support Services. It has specialist medical outpatient clinics which deal with pain, falls and balance, memory, continence and wounds.

MECRS is involved in teaching current and future health care professionals from all disciplines, and has strong links with the National Ageing Research Institute.

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# Executive Summary

## Introduction

Sexual and sensual health are important for health and wellbeing for people of all ages. Despite this, there are attitudes and practices in society generally, which often carry over to those involved in the care of older people in hospital and residential aged care settings, that tend to minimise or ignore these needs for older people. The Wellness Project was developed in response to an identified need within a sub-acute and residential aged care setting (Melbourne Extended Care and Rehabilitation Service - MECRS). It was recognised that older people do have sexual health needs. Further, that targeted processes to support staff in the area of sexual health may facilitate improved holistic client care. It also built on previous activities by two members of the project team (Barrett and Hetzel) which included development of an organisation wide policy to promote sexual health at MECRS. Funding for implementation of the Wellness Project was received from the Veteran Substitution Fund, established by the Department of Veterans' Affairs, and administered by the Department of Human Services.

The broad definition of sexuality used in the project incorporates biological, socio-cultural, psychological and ethical components. It includes sexual behaviour (such as intercourse) but is a much broader concept encompassing body image, self-esteem, romance, touch, cuddling, physical intimacy and social relationships; the sensual expression of identity through the use of grooming, clothing, make-up, after shave and perfumes; and generally being and feeling masculine and feminine (Nay, Barrett et al. 1998). Feeling masculine or feminine also embraces individuals who are transgender or transsexual. Sexual health promotion aims to reduce the inequities that older people experience when their sexuality is not considered as a normal part of their health status. It involves the pro-active process of enabling older people to have the right to identify and realise their unique sexual and sensual preferences and needs without infringing on the right of others. Integral to the process is the development of sexual health policy within supportive geriatric services which are equipped and resourced to assist older individuals realise their sexual health aspirations (including sensual well-being). It is underpinned by the WHO definition of health, 'Health is a complete state of physical, mental and social well-being, not merely the absence of disease', and the principles for health promotion outlined in the Ottawa Charter (cited p30, Dines & Cribb, 1993). This operational definition emphasises the importance of an individual's sexuality and sensuality to his or her identity, and influences all aspects of an individual, including behaviour and relationships, and orientation.

### **Project aim**

To support the development of organisational practices designed to enhance the health and well-being of clients at MECRS through the promotion of clients' sexual health.

### **Settings**

The Wellness Project was conducted in two Geriatric Evaluation and Management (GEM) units and one low level care residential facility at MECRS, part of Melbourne Health. One of the GEM units was a secure, sub-acute complex care ward providing care for people with dementia.

## Research methods

A multi-method approach was undertaken to meet the project objectives:

- Baseline data collection employed self-report surveys of staff and audits of incident reports and medical records to inform the project. The surveys explored three key areas: knowledge on ageing; sexuality and older people; and organisational culture and health. Survey and audit information was used to identify current staff knowledge and practices relevant to clients' sexual and sensual health; to identify potential enablers and barriers to improved practice in these areas; and to contribute to the project evaluation.
- A Participatory Action Research (PAR) provided qualitative information and a framework for activities within the settings to address identified issues associated with sexual and sensual health for clients. During the PAR component of the project, facilitators and sexual health consultants from the project team worked with staff participants to:
  - a) explore issues related to the promotion of sexual and sensual health relevant to the particular unit;
  - b) seek agreement on key issues to be addressed;
  - c) explore the range of suitable actions to address the identified key issues;
  - d) seek agreement on a plan of action;
  - e) implement the actions;
  - f) reflect on the implemented actions; and
  - g) evaluate the outcomes and refine actions and / or identifying new or modified actions as needed.

Action research groups met regularly over a four to six month period.

- Follow-up data collection was conducted after the PAR was completed. A feedback questionnaire was designed to tap staff knowledge and opinions, exposure to, and experience with the Wellness Project. The feedback survey was sent to all staff in the participating units. Audits of incident reports and medical records were repeated for each unit on completion of the PAR.

## Findings

### Survey results

One of the strengths of the Project was the survey responses were able to be compared with larger reference samples of health professionals (Foreman, Wells et al. 2000; Lindeman, Gough et al. 2000). The responses from the Wellness Project sample were similar to the comparison samples of health professionals across Victoria, and residential care workers, suggesting that findings may be generalisable to a wider group of health professionals.

Ageism was investigated with a survey of knowledge on ageing. Overall, the sample across the three units scored an average of 57%, when ageism was defined as the false assumptions people hold about older people. This finding indicates that there is potential for improving staff knowledge about ageing. However, there was also high agreement with the practice rewards items, with over 90% of staff indicating that 'care of older people is gratifying' and that 'older people are a joy to

talk to'. Further, the Wellness sample scored significantly higher on these two items than the reference sample of health care professionals indicating the commitment that staff have for their work in caring for older patients and the rewards they experience. Similarly, staff knowledge about age-related changes in sexual functioning, and attitudinal aspects of sexuality indicated potential for improvement. The significant correlation between knowledge and attitude scores ( $r=0.38$   $p<0.05$ ) indicated the knowledge-attitude relationship which suggests the presence of an opportunity for people to learn about sexuality and older people, and to achieve positive changes in attitudes and practice.

The survey questions on organisational culture were developed to assess the context in which the project was being implemented, and how open the facilities were to changing practice. The survey results indicated some barriers to changing work practices. One item, in particular, stood out, staff perceived that 'work constraints' such as time and workplace procedures hampered them in their ability to do a better job at promoting individual care. However, staff were also more likely than the comparison sample to perceive that they received recognition for their work, received constructive feedback, felt valued by management and were promptly notified of changes in workplace procedures.

### **Results: Medical Record Audits**

The majority of the documentation revealed that records tended to be focused on managing symptoms with little exploration of underlying causes that may have been contributing to behaviours or outcomes for clients. Labelling and categorising of 'problem behaviours' was apparent. In one of the units, the low care residential facility, there appeared to be a systematic assessment process in place, however there was limited exploration of underlying issues, such as specific sexual and sensual health needs of clients. In the post intervention audit a trend to include a more systematic management plan within the medical records was identified. Overall, there appeared potential for greater exploration of sexual and sensual health issues.

### **Results: Participatory Action Research Discussions**

While the project involved direct contact with staff, not clients, the action research discussions provided indirect information on clients' sexual issues. The key findings from the action research meetings were:

- *Clients are sexual.* Staff participants reported a range of diverse sexual expression by clients including: flirting, cuddling, holding hands, masturbation, intercourse, sexually explicit language, sadomasochism, sexual identity and orientation and accessing sexual services and material.
- *Issues of privacy, dignity and choice.* These issues impacted on clients' opportunities for appropriate sexual expression.
- *Sexual expression by clients was challenging to staff.* In the absence of formal training some staff did not perceive clients to be sexual. This aspect, coupled with embarrassment in dealing with such sensitive issues, meant that not all staff provided sexual health promotion as a routine part of their practice. The Project enabled discussion and reflection of current practice issues.
- *The client's story.* Psychosocial context can be important in understanding the unique experience of each client and promoting sexual health. The Project found that psychosocial information about clients was valuable in exploring underlying issues and promoting the

sexual health of clients. This information was identified as being difficult to retrieve from the medical records.

- *Staff identified a need for consistency in the management of sexual health issues.* The knowledge and attitudes of staff reflected individual and societal attitudes, and expectations of staff, carers and clients. Factors influencing responses to sexual health expression included: age and gender of client(s); time of day or night; level of cognition of clients; resources available; staff attitudes (extent of ageist and gender biases); and staff experience.
- *Resources.* Resources are required to ensure education of staff, clients and families initially, and to support ongoing training for staff in the area of sexual health promotion.
- *Multidisciplinary teamwork.* Participants in the Project identified potential for better communication across professional teams (for example, medical nurses and allied health workers) as a strategy towards sustainable practice improvement.
- *Time.* Time was perceived as a major barrier to practice change. Staff perceptions that time constraints impacted on their ability to attend ARG meetings can be a barrier towards practice improvement. The project highlighted that a health promotion approach to sexuality had the potential to be more time efficient.
- *Sexual health – making links.* The project found that many staff were unaware that they were already implementing strategies to promote the sexual health of clients. Over the course of the project staff participants realised that their actions, for example in promoting client centred care, such as grooming, had the potential to bolster clients' self-esteem and general well-being. As a result of the experiential learning process and by modelling to staff the benefits of promoting sensual well-being, staff gained more insight on ways to promote clients' well-being.

Overall, the actions resulting from the PAR process produced practical and useful resources, such as a sexual health policy contextualised for the particular setting, guidelines and helpsheets, and client behaviour profile proformas for documentation of psychosocial profile. These resources were sought and valued by staff for sexual health promotion. The approach empowers staff and leads to an owning of the process. It initiates critical reflection of current practice which is a crucial step in practice change.

### **Major influences**

The organisational culture and macro policy were identified as major dominating influences on the successfulness of the PAR process in achieving practice change towards the promotion of sexual health of clients. A supportive organisational environment coupled with a suitable framework (such as the Accreditation Standards) and policy are crucial enablers for sexual health promotion.

### **Limitations of the study**

The participatory action process, although highly effective at facilitating discussion of a sensitive area and influencing practice, was conducted over a relatively short period (3-4 months), which meant that not all planned actions could be implemented during the time period of the Project.

## Recommendations

1. The achievement of sexual health promotion requires active facilitation and collaboration with staff to explore the issues in practical contexts and develop solutions to improve practice.
2. Sexual health policy and educational resources, such as guidelines, helpsheets and other resources for meeting sensual needs of clients, together with an organisational environment that supports professional staff development are crucial enablers of practice change in promoting client sexual health.
3. Sexual health assessments can form an important part of holistic assessment. Psychosocial information including aspects relating to sexuality may help to identify the nature and diversity of clients' cultural, sexual and sensual health needs.
4. Aspects of the built environment can impact on client privacy and therefore impact on the opportunities for sexual health promotion. These structural barriers should be addressed to implement best practice.
5. Perceived barriers need to be addressed. These include the attitudes towards sexuality and older people. Traditional education alone is unlikely to solve this. Experiential learning together with a supportive organisational environment, including leadership, are required.
6. Opportunities for further research be explored, including:
  - Further evaluation and development of the outcomes of participatory action research.
  - Further exploration of the long-term sustainability of practice change.
  - Exploration of the impact of practice change on health outcomes for clients.

## Summary

Overall the Project has achieved the original aim – to support the development of organisational practice designed to enhance the health and well-being of clients through the promotion of sexual health. Through the PAR process participants identified that they had begun to more fully appreciate the importance of sexual and sensual expression for the clients. Participants made two paradigm shifts. Initially, realising the way in which staff delivered clinical and personal care could impact positively or adversely on the client's sexual or sensual well-being. Further, they identified that in their current practices they frequently unconsciously incorporated sensitivity to sexual and sensual health preferences but did not always consciously and consistently communicate these practices across the units. As a result of the PAR process, a range of processes and resources that can facilitate sexual health promotion were developed.

The project has explored approaches that are likely to facilitate sustainable change. Further research is required to clearly establish the level and intensity of resources required to produce sustainable practice improvement. Further research is also required to investigate the impact of practice change on the health and well-being of clients.

The experience of the project indicated that participants were committed to improving their practice. Factors such as the high incidence of sexually challenging behaviour, perceived relevance of the topic area, and support and endorsement of management impacted on practice change. The challenge remains to ensure the potential for practice change towards sexual health promotion is achieved and sustained to promote the health and well-being of clients in hospital and residential care settings.

## **Glossary of Terms**

ACAS	Aged Care Assessment Services
ACHS	Australian Council on Healthcare Standards
ADL	Activity of Daily Living
ALOS	Average Length of Stay
ARG	Action Research Group
CRC	Community Rehabilitation Centre
DHS	Department of Human Services
DVA	Department of Veterans' Affairs
EBA	Enterprise Bargaining Agreements
EQuIP	Evaluation and Quality Improvement Program
FAQ	Facts on Ageing Quiz
GEM	Geriatric Evaluation and Management
HSOP	Health Status of Older People Project
MECRS	Melbourne Extended Care and Rehabilitation Service
NARI	National Ageing Research Institute
PAR	Participatory Action Research
RND1	Registered Nurse Division 1
RND2	Registered Nurse Division 2
SHKB	Sexual Health Knowledge and Beliefs
WHO	World Health Organisation

# 1. Introduction

Melbourne Extended Care and Rehabilitation Service (MECRS), formerly North West Hospital, is a health service providing sub-acute, residential and outpatient care as well as community based programs primarily to older people in the inner North Western Metropolitan area of Melbourne. In 1995, staff at MECRS identified the need to change practice to promote the sexual health needs of its clients. While sexual health is often not recognised as a need for older clients the staff and management from a number of units at MECRS identified clients were sexual in a variety of ways. Furthermore, staff reported difficulty in responding to sexual behaviours and promoting sexual health. Two practitioners in this environment, Barrett and Hetzel, members of the research team for the Wellness Project, identified the need to develop an organisation wide policy to promote sexual health. Drawing on clinical experience and current literature, the researchers believed that practice change would not occur without systemic processes endorsed by management. A policy was later developed after interviews with staff, clients and families to explore the experiences of sexuality (Nay, Barrett et al. 1998). Despite the involvement of staff in the policy development, a staff survey identified a number of barriers to the implementation of the policy (Nay, Barrett et al. 1998). In particular staff identified the need for education, training, support and resources.

Responding to these issues, staff from MECRS and the National Ageing Research Institute (NARI) met to explore options for a project which would seek to support practice change. Funding was secured from the Veteran Quality and Substitution Fund, established by the Department of Veterans' Affairs (DVA) and administered by the Department of Human Services (DHS) under the hospital services arrangement. The DVA has demonstrated a commitment to promote the psychosocial well-being of veterans and war widow(er)s through a range of activities including Gardner's (1998) study *Improving Social Networks*.

The Wellness Project employed an action research process to explore the relationship between attitudes and practices and to gain insight into how the rhetoric of policy can translate into practice (Meyer 2000). The action research process was conducted between November 2001 and April 2002 in three units of MECRS. During this period, facilitators and sexual health consultants from the project team worked with staff participants from the units to explore the relevant issues. Audits of documentation and staff self-report surveys were conducted prior to the action research and again at the end of the project. Audit and survey information was used in three ways: first to identify current knowledge and practices; second to identify potential enablers and barriers to improve practice in the area of sexual health for clients; and third to contribute to the evaluation of the research.

## ***1.1 Research aim and key objectives***

### **1.1.1 Aim**

The global aim of the Project was to support the development of organisational practice designed to enhance the health and well-being of clients through the promotion of clients' sexual health.

### **1.1.2 Key objectives**

The key objectives for the action research process were to:

1. explore the relationship between staff attitudes and practices in relation to older people's sexual health;
2. identify barriers to the promotion of older people's sexual health;
3. explore and develop targeted strategies to address issues and overcome the barriers;
4. implement interventions arising out of the action research phase; and
5. better equip staff to deal with this area of psychosocial health.

The audits of documentation and staff self-report surveys, conducted prior to the action research and again at the end of the project, were designed to:

1. examine staff perceptions of organisational culture and health using some key measures;
2. document staff perceptions of the factors that facilitate or impede practice change;
3. identify the extent to which ageist attitudes towards sexuality are perceived and/or internalised by health professionals;
4. review documentation in medical reports related to the key issues under study, such as staff ability to identify the appropriateness, frequency and nature of clients' sexual and sensual health issues, for example, body image, self esteem and social relationships;
5. compare the pre and post audit documentation addressing key issues (in 4 above); and
6. document feedback from staff on the action research process.

## ***1.2 Outline of the report***

This report describes the research project which aims to promote older people's sexual health. The research takes into account three main areas: societal views about sexuality and older people; quality care frameworks for the provision of aged care in hospital and residential settings; and the role of organisational culture in shaping practice change. Chapter 2 outlines an operational definition of sexual health; reviews the literature on key aspects of sexuality; describes societal influences on clinicians' knowledge and attitudes towards sexuality and older people; identifies elements of best practice and aspects of organisational culture in relation to practice change. Chapter 3 addresses the setting, including contextual information and the quality care frameworks for the provision of aged care. The research design and methodology is outlined in Chapter 4.

Chapter 5 presents the results of the staff self-report surveys. Chapter 6 outlines the findings from the audit of documentation. The key themes from the analyses of the action research process in the three research settings, an overview of the action research cycles and feedback from staff are presented in Chapters 7, 8 and 9. Chapter 10 presents results of follow up data collection. The final chapter brings together the research findings and their implications for promoting sexual health. It provides an overview of the findings from the perspectives of the clients and the staff (health care providers). It leads on to discussion of the enablers and barriers to practice change, and focuses on options for future directions responsive to the issues identified in the Project.

## 2. Review of the literature and best practice

### 2.1 *Defining sexuality and sexual health*

‘Prior to this century, individuals did not live beyond the reproductive years: thus sexuality of the older adult was not an issue’ (Glass, Mustian et al. 1986). The population of Australia is ageing rapidly, due in part to an increase in life expectancy, with the current proportion of people aged 65 and over being 12.2 % and expected to double by 2051 (Australian Bureau of Statistics 2002). Developing an operational definition for work in the area of older people and sexuality is of value given there are few studies and little policy development in the area (see Section 2.7).

In 1975 the World Health Organisation (WHO) defined holistic sexuality as:

“... the integration of the somatic, emotional, intellectual, and social aspects of sexual beings in ways that enhance personality, communication and love....Every person has a right to consider accepting sexual relationships for pleasure as well as for procreation” (World Health Organisation 1975).

The broad definition of sexuality used in this Project incorporates biological, sociocultural, psychological and ethical components. It includes sexual behaviour (such as intercourse) but is a much broader concept encompassing body image, self-esteem, romance, touch, cuddling, physical intimacy and social relationships; the sensual expression of identity through the use of grooming, clothing, make-up, after shave and perfumes; and generally being and feeling masculine and feminine (Nay, Barrett et al. 1998). Feeling masculine or feminine also embraces individuals who are transgender or transsexual. Sexual health promotion aims to reduce the inequities that older people experience when their sexuality is not considered as a normal part of their health status. It involves the pro-active process of enabling older people to have the right to identify and realise their unique sexual and sensual preferences and needs without infringing on the right of others. Integral to the process is the development of sexual health policy within supportive geriatric services which are equipped and resourced to assist older individuals realise their sexual health aspirations (including sensual well-being). It is underpinned by the WHO definition of health, ‘Health is a complete state of physical, mental and social well-being, not merely the absence of disease’, and the principles for health promotion outlined in the Ottawa Charter (cited p30, Dines & Cribb, 1993). Psychological and sociological perspectives are integrated within the operational definition of sexual health. Sexual and sensual expression enhance quality of life and wellness (Kaplan 1996). This operational definition emphasises the importance of an individual’s sexuality and sensuality to his or her identity and influences all aspects of an individual, including behaviour and relationships.

In the following sections literature is reviewed on the key aspects of sexuality: self esteem, body image and social relationships. The importance of each of these aspects to a sense of identity is discussed.

## **2.2 *Self-esteem***

Sexuality is life long, encompassing a mix of physical and emotional behaviour extending well beyond the reproductive years (Brogan 1996; Brogan 1996). A positive self-image and self-concept (the cognitive aspects of self-perception) is important in maintaining self-esteem (a sense of self worth). Therefore sexuality is an integral part of the whole person as it feeds self-esteem, self-concept and identity. The preservation of identity may be one of the most important needs of older people, particularly those who are institutionalised. Moreover, self-esteem may even affect the onset, duration and severity of chronic illness. It has been identified as a determinant of self-rated health (Cott, Gignac et al. 1999), and self-rated health is a powerful predictor of subsequent physical health and health care utilisation (Idler and Kasl 1995; Bath 1999). Increased self-esteem may impact positively on the health outcomes of older people institutionalised in hospitals or in residential aged care.

## **2.3 *Body image***

Body image is a complex concept. Body image can be defined as the way individuals see themselves, and how they perceive they are seen by others. It has been conceptualised as a mental picture of one's own body (Norris 1978). It is created by society and therefore determined by socio-cultural norms. Approval and acceptance from society are key influences on the way individuals construct their body image. Personality, ego, self-image and identity are central to the concept. In understanding body image it is important to appreciate that input from the senses, such as visual information, as well as input from physical movement and posture impact on an individual's self image and identity (Schilder 1950).

Physical appearance is an important part of body image. Grooming, clothes, make-up, jewellery, after-shave and perfumes as well as aids such as walking sticks and wheelchairs are integrated into body image (Salter 1997). As people age their body image is vulnerable to deterioration, as they increasingly incorporate chronic illness and disability into the image of their body. Popular culture places a high social value on being young, attractive and able-bodied. Surgery, such as loss of limbs and the use of aids, may negatively impact on a client's perception of their body image. Other influences that can disturb clients' body image can include a lack of touching or lack of opportunities for sexual expression.

## **2.4 *Social relationships***

Social relationships are central to a sense of identity and the means by which people define their existence and sense of control over their world (Swan and Brown 1990). Social relationships influence physical health and well-being and are considered to be predictors of mortality (Berkman and Syme 1979; Kawachi and Berkman 2001). Aspects of social relationships include the giving and receiving of emotional support (positive feedback), identity support (self-verifying feedback), and companionship, as well as providing information and tangible help. Receiving emotional support (positive feedback) is one of the most widely accepted examples of the beneficial effect of social relationships. However, research evidence suggests that the influence of social relationships on health is complex. For example, emotional support is beneficial only if it is generally consistent

with people's self-views. If feedback is given that is inconsistent with people's self-views then bewilderment and anxiety may result. People do not just require positive feedback but feedback that is consistent with their view of themselves (self-verifying feedback, ie, feedback that confirms their identity). Major life events, such as transitions into residential care, are often precipitated by poor health or health crises. The transition involves substantial change in surroundings, and often involves changes in social networks, leaving people vulnerable to identity disruption and the consequent impact on health. Meaningful social relationships may play an integral role in stabilising clients' self views and alleviating the impact of identity disruption on health.

## ***2.5 Clinicians' Knowledge and Attitudes: Societal influences***

Older people are often regarded as asexual despite evidence to the contrary (Minichiello, Plummer et al. 1996). There is a need for attitudes to change if society is going to more fully accept sexuality in individuals in later life. The situation is exacerbated in residential and health care settings where care provision may not accommodate the privacy and support necessary for sensual and sexual expression. In addition, societal and staff attitudes may reinforce the 'taboos' against sexual activity and perpetuate the myth of the asexual older person by failing to recognise sexual expression as legitimate or appropriate (Brown 1989; Nay and Gorman 1999). Older people whose behaviour is outside these perceived norms may even be the focus of derision. As a consequence of these restrictive attitudes, older people may repress their sexual and sensual expression rather than place themselves in a position of judgmental responses from staff (Butler, Lewis et al. 1994). Restricting the emotional and sexual expression of clients may result in difficulties in the maintenance of a sense of identity. Clients already face multiple challenges including, for example, coping with multiple medical problems, progressive dementia, functional limitations, such as the reduction in ability to carry out personal care; feelings of isolation, loss, anxiety, and lack of control. With any of these factors together with limited coping skills and challenging environments, people can experience depression, anxiety, agitation and aggression (Hall, Gerdner et al. 1995; Lantz, Buchalter et al. 1997). If staff can learn to promote autonomy and a sense of identity in those for whom they provide care, a reduction in anxiety and depression for older people in hospitals or residential care can result (Brane, Karlsson et al. 1989).

Given that older people are greatly influenced by the attitudes of health professionals, staff in residential and health care settings are in a good position to impart knowledge, alter attitudes and play an important role in helping older clients cope with the changes that accompany ageing, including sexual adjustment (Smedley 1991). Understandably however, for many health professionals discussing the sexual health goals of older clients may be beyond their comfort zone. The limited attention to older people's sexual health may stem from a number of areas: issues of privacy; insufficient knowledge and skills; few opportunities to explore their own sexual health; knowledge and attitudes; organisation culture and societal norms; or simply limited time and a focus on measurable tasks rather than holistic care. Education and training for staff are important key areas to consider when promoting sexual health. In 1987, Tarbox, Connors et al. (1987) have identified that health professionals demonstrate more positive attitudes towards the sexuality of older people after increased education.

## **2.6 *Sexual health assessment***

A sexual health assessment is the process that makes the broad conceptualisation of sexuality become meaningful and operational. However sexual health is frequently overlooked in the assessment of older clients. This is hardly surprising given the myth that older people are asexual (Arluke, Levin et al. 1984; Karlen 1992), the lack of sexual education for clinicians (Roughan, Kiaiser et al. 1993) and the belief that sexual health assessment is intrusive. When sexual health assessment occurs it is generally in response to sexually ‘inappropriate’ behaviour, however, the focus is often on containing the problem rather than promoting sexual health (Lichenberg and Strzepek 1990; Sloane 1993).

Wherever possible, clients’ input should be encouraged as part of the assessment to identify their perception of their overall health, views, knowledge and interest in sexuality (Johnson 1996) and level of sexual function (Roughan, Kiaiser et al. 1993; Brogan 1996). Cultural values, prejudices, family dynamics and relationships may all be important to take into account when laying the foundation for understanding and supporting clients. In the assessment process the most useful attitude for health professionals to take is to be accepting and supportive rather than labeling clients as ‘sexually inappropriate’ or ‘crazy’ (Norris 1978). Sexual health assessment does not operate in a vacuum. It requires health professionals to understand the impact of ageing and disease on sexual health, to provide continuing client education and to develop a care plan that incorporates sexual health. This cannot be achieved without adequate education of health professionals together with management support.

## **2.7 *Sexual Health Policy***

There is a paucity of published literature on sexual health policies. A literature search and contact with numerous health facilities Australia wide and internationally, conducted in 1996, failed to identify any facilities with a written sexual health policy for aged care. While no aged care specific policies were identified it was noted that a policy developed by the Department of Human Services NSW, for Intellectual Disabilities had some relevance to aged care. A further literature search in 2002 identified a ‘Sexuality and Individuality Policy’ developed for the Cosgrove Park Aged Care Facility in Launceston (Ford 2002). This policy highlights the obligation of staff to respect residents’ rights to form friendships and the right to sexual privacy.

Although the WHO recognises that everyone has the right to sexual health, few hospital and residential care facilities have policies to promote sexual health (Nay and Gorman 1999; Ford 2002). Guidelines, generally designed to manage and control behaviours rather than promote sexual health, have been developed by health professionals to manage clients challenging sexual behaviour. The absence of policies may have contributed to the myth that older people are asexual (Nay and Gorman 1999). This myth further highlights the need for a sexual health policy to guide practice.

The most significant function of a sexual health policy is to send the message to health care providers and clients that sexual health is recognised as a normal part of ageing. It sends a strong message to staff that sexual expression should be seen as a right rather than a problem. A policy reflects a ‘whole of organisation’ position and provides a foundation on which units and services can determine and implement practices which are consistent with the intent of the policy. A clear and comprehensive sexual health policy articulates the organisation’s position on this issue, it specifies how the organisation achieves the goals of the policy, it offers direction to health care providers and it recognises and incorporates clients as core to the policy’s objectives.

A policy defines boundaries for staff and clients. Boundaries act to include certain practices and behaviours and exclude others, for example it may be necessary to clearly state that staff are not expected to engage in sexual activity with clients. Once a policy is endorsed, it must follow that resources be allocated to ensure the policy is enacted. These resources should be channelled into education of staff, which is pivotal to practice development. Staff practices are often based on staff attitudes and beliefs. This is problematic if the staff member’s frame of reference is limited. For example, a staff member may never have encountered sexual diversity or be aware that many older men and women masturbate.

As mentioned in the Introduction, two of the current researchers (Barrett and Hetzel) identified the need to develop an organisation wide policy to promote sexual health. Staff of MECRS, who reported difficulty in both responding to sexual behaviours of clients and promoting sexual health, endorsed this need. Drawing on clinical experience and current literature the researchers believed that practice change would not occur without systemic processes endorsed by management. The MECRS Sexual Health Policy (Appendix 1) was developed after interviews to explore the experiences of sexuality with staff, clients and families (Nay, Barrett et al. 1998).

The sexual health policy developed at MECRS was a significant development in the promotion of sexual health for older clients. The policy recognised that the experiences of clients, relatives and staff as identified in the interviews (Nay et al 1998) were crucial to inform practice. The policy highlights the plethora of issues that surround sexual health promotion within health care facilities, such as boundaries, sexual identity, sexual orientation and the rights and responsibilities of staff, clients and the organisation. While the development of a sexual health policy is an important part of sexual health promotion, it was recognised that resources are required to assist staff to change practice associated with a new policy.

Objectives for the Wellness Project included exploring barriers to the promotion of older people’s sexual health, as well as to exploring and developing strategies to overcome these barriers, and resourcing staff to undertake practice change.

## ***2.8 Organisational culture and practice change***

Organisational culture is a term used to describe the social structure and characteristics of an organisation. It can be defined as a “system of shared meanings held by members that distinguishes the organisation from other organisations” (Robbins 1986, p431). Generally, an organisation’s culture is said to be stable and resistant to change, is taken for granted and involves a set of shared understandings and accepted behaviours (Langan-Fox and Tan 1997). To promote change within an organisation, Robbins (1986) suggests that a number of factors need to be addressed. Central to

these is the need for management to promote the new culture, support and encourage staff who adopt changes, and involve staff in the process to develop consensus and trust.

A number of features have been identified that are likely to impact on the organisational culture in health care facilities. For example, the provision of twenty four hour care impacts on communication and can lead to the development of subcultures (Thomas, Ward et al. 1990) and ageist attitudes lead to lower prestige and poorer working conditions in aged care facilities (Carr and Kazanowski 1994). High staff turnover and use of agency staff can limit communication of desired practices. Time pressures on staff means that life and death decisions become the priority and less life threatening factors (such as sexual health) are not considered a high priority for action or change (Smith 1998). Smith (1998) argues that strengths in facilities that have successfully implemented practice change should be applied to other facilities trying to implement changes. Some strengths include: goals agreed as a team, adequate staffing, clear and open communication, adequate education and resources, rewards, competition and fun in programs, leadership modelled from top and encouraged among staff, and a team approach with individual responsibility.

A number of studies have considered the impact of organisational culture on resident satisfaction in residential care. They have found that organisations that foster open communication between clients, their families, and staff, that value staff at all levels and promote resident independence and control over day to day decisions, leads to increased client satisfaction and quality of life (Langer and Rodin 1976; Grau and Wellin 1992).

Nazarko (1997) explains that staff need to be involved in the decision making process to help them 'own' changes and internalise them. Staff may offer suggestions and limitations that management have not considered. Staff have several options when faced with change, they can accept it, reject it, ignore it or rebel. When accepting change, staff can comply, identify or internalise the changes. The likely outcomes of each approach are outlined:

- With *compliance* comes a certain degree of coercion and acceptance because staff believe they have to. When staff are performing tasks through compliance, they will generally revert to the old methods when the person enforcing the task is absent.
- *Identification* requires that the manager has charisma so staff will follow their orders. This method also has problems as it is usually the manager that staff believe in and not necessarily the changes they are introducing.
- When staff *internalise* new practice, the changes become long lasting. Staff can own these changes and understand why they need to occur. When this happens, staff will tend to actively promote and perform the necessary changes.

Change can be threatening and can imply to staff that what they did before was not appropriate or good enough. Helping staff internalise changes by involving them in the decision making practice can benefit the staff, the health care facility and the residents/patients. The Participatory Action Research (PAR) approach used in this Project, is one approach to facilitate staff to internalise change.

The need to internalise change in practice was shown by Saltmarche, Kolodny & Mitchell (1998) who described the process and impact of a continuing education course for nurses working with older adults in an acute medical unit. The aim of the course was to help nurses provide patient

focused care where patients define their own problems and goals. “Caregivers are challenged to view patients as human beings with healthcare needs rather than as diagnoses or problems, and patient and family perspectives are sought, valued, and integrated into plans of care” (Saltmarche, Kolodny et al. 1998, p81). An ‘open learning’ approach was used where nurses were encouraged to share their views in a caring and non-judgmental environment. Although the nurses initially experienced discomfort when handing over control to patients, they later experienced many positive outcomes. They reported less pressure to solve problems, allowing more time to spend talking with patients. Nurses also reported that they began to question their motives and their previous assumptions, that they always knew what was best for the patient. The nurses involved in the process also reported frustration for two reasons: other staff did not share their new approach to care, and organisational structures presented obstacles. To try to remedy this, the organisation began the education sessions with more groups of staff to broaden the promotion of the desired new norms and behaviours.

In practice however, there is often little attention actually paid to an organisation’s culture when practice changes are designed. People, management and organisational culture therefore became important contextual issues to be addressed in the Wellness Project.

## **2.9 Conclusion**

The review of the literature identified that sexuality is integral to identity and contributes to psychological well-being throughout the course of our lives, for older people as well as younger people. It is likely to gain increasing recognition as a key issue in the promotion of older people’s health in the future. However, the sexual needs of older clients are often not recognised, with a negative effect on physical and psychological well-being. The review of the literature and best practice reinforces the need for a project which seeks to change practice to ensure the promotion of sexual health for older clients.

## **3. The Context**

### ***3.1 The Research Setting - Melbourne Extended Care and Rehabilitation Service***

Melbourne Extended Care and Rehabilitation Service (MECRS), provides health care services predominantly to older people who live in the northern and western metropolitan regions of Melbourne. Services provided by MECRS are described in earlier sections of the report (see p.i)

As of July 2002, MECRS employed 565 effective full-time staff across this range of services including residential care. Of those, 40% are nurses.

The three units of MECRS that participated in the study, a residential care facility, and two GEM units, one which is a secure sub-acute complex care unit, are described in more detail in Chapter 4 and in Chapters 7, 8, and 9.

#### **3.1.1 Organisational changes and their impact on the Project**

In Metropolitan Melbourne there has been ongoing change within the health care system as the Health Care Networks established in the late 1990s have been re-configured into Health Services. The new Health Service groupings are generally smaller, with fewer participating hospitals in each group. This has resulted in further restructuring and development as services have de-aggregated and regrouped.

MECRS is a part of the Melbourne Health Service, a leading health care provider serving metropolitan and country Victorians through the provision of acute, sub-acute and community based programs. During the period of the Project, the Melbourne Health Service has been re-structured so that programs are now structured across the health service, rather than campus based. This change has resulted in the dissolution of the MECRS Executive, and the devolution of some executive responsibilities to Health Service wide roles. The effect of these changes on the Project has been significant. The Project commenced with four MECRS Executive members on the Project Reference Group, which included the Chief Nursing Officer and Quality Manager. The dissolution of these positions at MECRS and the consequent reduction in MECRS representation on the Project Reference Group created additional challenges for the Project team to feedback Project findings to senior management.

Structural changes have also occurred at the unit management level in most units participating in the project and in some program areas, such as allied health. One of the GEM units has undergone some structural changes, which resulted in staff reduction and the loss of the Unit Manager prior to the commencement of the Project. A new unit manager was appointed in February 2002. Staff in the residential care facility have experienced significant organisational and managerial changes.

Nursing shortages have been identified and addressed through the negotiation of new Enterprise Bargaining Agreements (EBA) during 2001. There has been a substantial focus by the current government on attracting nurses back into the public health system. This included incentive payments, refresher training, and specified time available for professional development introduced as part of the EBA implementation. However staff members of units participating in the Project reported regular use of agency nurses to address staff shortages. High turnover of staff is likely to

impact on the quality of client care. Development of an EBA has also been in process for Allied Health staff during 2001/2002 – without resolution to date.

Along with redevelopment of the services there has been substantial redevelopment of the physical environment at the MECRS campus to include a new rehabilitation facility, new outpatient clinics and Community Rehabilitation Clinic, new cafeteria, new residential care facility for complex care, changes to the roads and reduction of the gardens on campus. Whilst the redevelopment has improved the physical conditions on the campus the process has involved significant changes and required flexibility and readjustment on the part of the staff.

### ***3.2 Quality Care Frameworks for Aged Care***

The Wellness Project spanned both residential care and sub acute hospital settings. As such it operated within the quality care frameworks of each of these settings, the Standards and Guidelines for Residential Aged Care and the Evaluation and Quality Improvement Program (EQuIP) in the sub acute hospital setting.

#### **3.2.1 Aged Care Reform and the Accreditation Standards**

Aged care reform was initiated in 1997 when the Aged Care Act was introduced into Federal Parliament. The framework for the assessment and improvement of residential care services includes the Accreditation Standards, which describe guidelines for care, management and organisational practice conducive to the provision of quality care, as well as compliance with building certification requirements. Central to the Accreditation Standards is the philosophy of continuous improvement. In December 2001, modifications to Accreditation have emphasised responsiveness to residents and their needs. Similar to any major reform process, the Accreditation process has been challenging for residential care providers.

The Standards and Guidelines for Residential Aged Care developed by the Department of Health and Family Services (1998) provide an excellent framework for incorporating sexual health promotion in practice. The standards require that staff must put in place strategies to foster family, friendship and social networks, provide privacy to enable residents to maintain intimate relationships and to ensure residents are able to exercise control and choice over their lifestyle while not infringing on the rights of others.

The philosophy of continuous quality improvement and individual care, the action research methodology and principles of workplace learning constitute the underlying framework for the Wellness Project, and are very relevant to the expectations set by the Aged Care Reform agenda in Australia.

### **3.2.2 Evaluation and Quality Improvement Program (EQuIP)**

The framework for the promotion and achievement of quality care within health care facilities is provided by EQuIP designed by the Australian Council on Healthcare Standards (ACHS). MECRS is a member of EQuIP and incorporates key elements in its approach to promote and facilitate continuous quality improvement. Accreditation is assessed in six main areas: continuum of care; leadership and management; human resource management; safe practice and environment; information management and improving performance.

## 4. Research Design and Method

### 4.1 *The setting*

Three units of MECRS participated in the Wellness Project. These were:

- 1) a 24 bed GEM unit incorporating a secure sub-acute complex care ward caring for people with dementia (Unit X)
- 2) a 24 bed standard GEM unit (Unit Y)
- 3) a 98 bed low care residential facility (Unit Z)

GEM Units involve the care of chronic or complex conditions associated with ageing, cognitive dysfunction, chronic illness or disability. Patients are admitted for review, treatment and management by a geriatrician and multi-disciplinary team for a defined episode of care. The GEM client group generally have complex, chronic or multiple health care conditions requiring treatment and stabilisation and/or medical review for future treatment options or service planning.

#### **The clients**

For the period November 2001 to April 2002, the client profile for the two GEM Units participating in the Wellness Project, Unit X and Unit Y, shared some common characteristics: the average age of clients was 82 years and both had a similar ratio of Australian born clients to overseas born (57:43 in Unit X, 53:47 in Unit Y). The two units differed in their ratio of male to female (50:50 in Unit X and 35:65 in Unit Y), and in their average length of stay (ALOS), 55 days for Unit X and 39 days for Unit Y.

For July 2002, the average age of residents for Unit Z was 79 years, the ratio of Australian born clients to overseas born was 80:20 and the ratio of males to females was 35:65.

#### **The staff**

The ratio of nursing staff to clients in the GEM Units (Units X and Y) is: 1:5 during the day; 1:6 in the evening and 1:10 at night. Resource wise, Unit Z, a low care facility, had the lowest staff to client ratios of the three settings. Effective full time staff for Unit Z comprised of 1.6 RND1, 1.6 RND2, and 16.7 other staff which include personal care assistants and kitchen staff.

Allied health services available to the GEM units include: occupational therapy, physiotherapy, speech therapy, dietician, podiatry, social work, clinical psychology and neuropsychology. Hand-overs between nursing staff occur daily between shifts. Multi-disciplinary team meetings (including nursing staff and allied health staff) are held in the hospital units each week.

### 4.2 *Ethical Issues and Ethics Approval*

Ethical issues surrounding dealing with such sensitive areas like sexual health, confidentiality of personal information, disclosure of information from medical records and security of records, required consideration. Processes for auditing documentation needed to take account of new privacy legislation and its attendant ramifications for information sharing in health care and residential care settings.

The Project team applied for ethics approval from the Royal Melbourne Hospital Research Foundation, Behavioural and Psychiatric Research and Ethics Committee. Ethics approval was granted on 14<sup>th</sup> November 2001, Protocol reference E/01/036.

### **4.3 *Groundwork for setting up the project***

#### **4.3.1 Establishing a Project Reference Group**

A Reference Group was considered essential to the Wellness Project to provide advice, comments and feedback. Part of the process for establishing the Reference Group involved the identification of the Project's key stakeholders. Key stakeholders are those with an interest in a project, and can significantly influence, or are important to the success of a project (Social Development Department 1995). Both internal and external stakeholders were identified. Internal stakeholders comprised people from within the hospital, for example, MECRS Executive, Heads of Divisions, Nurse Unit Managers, and staff. External stakeholders included representatives of key organisations that were interested in the project and could influence the success of the project, such as, government departments, industry and consumer peak bodies, and research organisations. Key stakeholders were identified and invited to participate in the Reference Group (see Acknowledgements).

The next step in the stakeholder analysis was to assess stakeholders' attitudes to the Project, and identify any opportunities for facilitation of project deliverables including dissemination, in accordance with the terms of reference developed for the Project Reference Group (see Appendix 2).

#### **4.3.2 Building management support**

In setting up the project, the importance of building management support was recognised as an essential step in the process. Management support has been identified as central to instigating change in clinical practice (Silver 1986). Members of the project team had meetings with the General Manager, the Executive, Heads of Divisions and Nurse Unit Managers at MECRS to explain the rationale, aims and methodology of the project. As collaborators, the executive members also contributed to the rationale, based on their clinical experience within the hospital and residential care facilities. For example, management had previously experienced a demand for expertise, knowledge and training, from the Project consultants, during a crisis in dealing with sexually challenging client behaviour. Key management personnel were invited as internal stakeholders to the Reference group for the Project.

### **4.4 *Research Design***

A multi-method approach was devised to pursue the Project objectives. The baseline data collection employed self-report surveys and medical audits to inform the Project. The Participatory Action Research (PAR) provided qualitative information and an evolutionary framework for activities within each of the Unit settings to address identified issues associated with sexual health of older people. The follow-up data collection was designed to contribute to the evaluation of the Project. It comprised a feedback survey on the Action Research process, and a repeat of the medical audits.

## **4.5 Baseline data collection: Self-report surveys and Audits**

### **4.5.1 Sample**

#### **Self-report surveys**

Staff lists for units X, Y and Z were obtained from the managers of each unit. The sample included **all** staff working in the units during November 2001. The sample comprised RND1 and RND2 nurses, allied health staff, medical staff, personal care assistants, personal service assistants, unit managers and kitchen assistants.

#### **Audits**

Audits of the incident forms and client medical records from the three participating units were conducted before the start of the Action Research Groups (ARG) in October 2001. All incident report forms from each unit were reviewed for the period of 6 months, April-September 2001. Any incident report that had a reference to an incident of a sexual nature was reported and the medical record of the client concerned in the incident was extracted and reviewed. Additional medical records from each of the GEM units were selected randomly from a list of separations (discharged patients) during September 2001 to obtain a sample of 15 per unit. These medical records were audited for the episodes of care that pertained to the separation in September. In Unit Z, the long term low care residential care facility, a slightly different approach was taken because there were too few separations (discharges) over the period. Care plans and medical records of 15 clients were randomly selected from a list of clients who were resident in the unit during September 2001.

### **4.5.2 Instruments for data collection**

#### **Self-report surveys**

The questionnaires comprised self-report questions covering knowledge and attitudes in three main topic areas: ageism, knowledge and attitudes towards sexuality and older people, and organisational culture. The questionnaires are included in Appendix 3. Where possible, relevant comparison groups were included to see whether there were any significant differences between the sample for the Wellness Project (see 4.5.1) and other samples of service providers or older people themselves.

#### ***Ageism***

Ageism by definition comprises negative stereotyping of older people. One way of measuring ageism is examining the false assumptions that individuals hold about older people. This underpins Palmore's (1988) facts on ageing quiz (FAQ). Palmore classified each item as indicating negative bias, positive bias or no bias. For example, for the two sample questions given below, respondents were asked to say which of the following were true or false:

*The majority of old people (aged 65+) are senile (have defective memory, are disoriented, or demented).*

*Physical strength tends to weaken in old age.*

For question (1) the correct answer is 'false'. If respondents answered 'true' their answer was categorised as indicating negative bias. For question (2) the correct answer is 'true'. If respondents

answered 'false' their answer was categorised as indicating positive bias. Nineteen questions from Palmore's (1977) FAQ were incorporated into the self-report questionnaire.

Another way of examining ageism is to examine the rewards and costs of working with older people. These concepts are included in Le Couteur's (1997) scale on attitudes of medical students towards careers in geriatric medicine. Nine items were adapted from the original scale. Two subscales were derived, one labelled Practice Rewards which included items on positive aspects such as, a joy talking to older people, care of elderly can be gratifying, and students need instruction on the positive aspects of growing old. The other sub-scale, labelled Practice Costs taps negative aspects of growing old.

### ***Sexual Knowledge and attitudes***

Knowledge of, and attitudes towards, older people's sexuality are assessed in the Aging and Sexual Knowledge and Attitudes Scale developed by White (1982). This is one of the most widely used instruments in the field, and includes 61 items addressing older peoples' sexuality. Two subscales can be derived from the instrument. The first is related to knowledge and assesses factual information related to older peoples' sexuality. The second scale examines attitudes by assessing the extent of a positive tolerant outlook based on beliefs that sexual behaviour among older people varies just as it does for younger people, and is underpinned by information about how older people feel about sexuality. Further, six of the items from the knowledge subscale form a Sexual Health Knowledge and Beliefs (SHKB) Index (Minichiello, Plummer et al. 2000). This index was used in another project to examine what a representative sample of older people themselves believe about sexuality (Kendig, Helme et al. 1996).

The consultants noted that White's Sexual Knowledge and Attitudes Scales (1982) did not adequately reflect contemporary sexual health issues. For example, the issues of HIV, safe sex, gender orientation and identity and same sex relationships were not included. This concern was confirmed in a small pilot of the original scale, with feedback from reviewers that the scale had a heterosexual bias. Furthermore, the scale did not reflect contemporary research, for example acknowledging the sexual health issues associated with incontinence. However, as there were no other suitable tools identified, a decision was made to modify the scale by adding the following questions:

- Some people over 65 engage in same sex relationships;
- Incontinence can affect an older person's sexuality;
- People over 65 should practice safe sex;
- Older people do not have more than one sexual partner.

The researchers recognise that the internal validity of these questions have not been established. However due consideration was given to present the questions in a way consistent with the White (1982) format.

### ***Organisational culture***

The third topic area of interest was organisational culture (see Section 3.3). Simply, organisational culture can describe "how we do things around here" (Clancy and Webber 1995). Twenty-four items from an index developed as a component of the Well For Life project conducted by NARI (Lindeman, Black et al. 2000; Lindeman, Gough et al. 2000) tapping workplace perceptions within

residential care settings were incorporated into the survey. The questions examined organisational context and how open facilities were to changing practice, and included one open-ended question relating to barriers and enablers to changing practice. Six subscales can be derived from the index.

### **Audits**

A proforma for data retrieval from incident forms and medical records was developed by the project team (see Appendix 4). The proforma was used to standardise the retrieval of information.

## **4.5.3 Data collection and analyses**

### **Self-report surveys**

The project team provided named packages, consisting of an anonymous questionnaire and a heart shaped chocolate as an incentive to fill in the questionnaire. The packages also contained a return envelope addressed to the project team. An alternative destination for completed questionnaires was a confidential box placed on each unit, which was collected after a three-week period. Data analyses by unit comprised descriptive statistics examining knowledge and ageist perceptions of sexuality and key aspects of organisational culture.

Where possible, survey responses were compared with relevant comparison groups to identify any significant differences between the sample in the Wellness Project and other samples of service providers or older people themselves. Survey responses tapping ageism were compared with responses from a large sample of service providers in Victoria that included agency nurses, ACAS (Aged Care Assessment Services) teams, and three major service providers of residential care staff (n=331) (Foreman, Wells et al. 2000). Survey responses, to the modified SHKB Index were compared with older peoples' responses from a representative survey of older community dwelling Australians (aged 65 and over), living in Melbourne and sampled in 1994 (Kendig, Helme et al. 1996). Responses to organisational culture questions were compared with a larger sample of service providers working within residential care establishments recruited for the Well for Life project conducted by NARI (Lindeman, Black et al. 2000; Lindeman, Gough et al. 2000).

### **Audits**

An audit was undertaken of incident reports and clients' medical records in the participating units for the period described in Section 4.5.1 Audits.

Incident reports are completed for adverse events, i.e. events that are not consistent with routine delivery of client care. By far, the majority of incident reports are related to falls (67% of incident reports within MECRS). Adverse events, such as aggressive behaviour, absconding and sexual behaviour, were all types of incidents that were included in the Project's audit procedures. Sexual behaviour included (but was not limited to) the use of sexually explicit language, verbal harassment of a sexual nature, exposing genitals, and sexually touching another client or staff member.

Medical records are essential components in the effective management of client health care. The WHO describes a medical record as "a collection of data compiled on a patient to assist in the clinical care of present and future illness. The term clinical care encompasses treatment given by doctors, nurses and others in the health team in a hospital, an outpatient clinic or primary care by a doctor" (Melbourne Extended Care and Rehabilitation Service 1999). The main purpose of a medical record is to serve as a basis for planning individual client care, to provide a means of

communication between doctors and other health professionals contributing to a client's care and to furnish documentary evidence of the course of a client's illness and treatment during each hospital episode of care.

Criteria for auditing of medical records were developed by the research project team. Any documentation related to the broad definition of sexuality, such as preferences for individual care including preferred gender of personal carer, preferences for grooming, clothing, romance, social relationships, as well as other sexuality and sensuality issues were noted from the medical records and care plans for clients.

A requirement of the Ethics Committee approval for the Project was that clinical staff undertook the auditing. Managers from the three units were asked to identify a clinical staff member to carry out the audits. Clinical staff who agreed to perform the auditing undertook an hour training session on medical auditing for the project. Audit guidelines and proformas were provided (see Appendix 4).

The approach used for the audits was designed to identify and consider the documentation of sexual health assessment, management and promotion. It was hoped that the process of training a staff reviewer would lead to future opportunities to conduct similar audits as part of the routine quality improvement practices of the organisation. This approach has many strengths that relate to sustainability of practice and also to increasing the ownership of the process. In turn, this was expected to lead to a stronger motivation to change practices where required and to provide positive reinforcement for practices that were at an appropriate standard. The analyses of the audit data involved descriptive analyses of the content and consideration of auditors' comments where appropriate. The data from the audits were interpreted and summarised for presentation in the report.

#### ***4.6 Participatory Action Research (PAR)***

PAR is an approach that is particularly suited to problem solving in the health care workplace. It relies on participants working together to identify problems in clinical practice and generating solutions to improve practice. It is an approach that can overcome the well-documented barriers to the inclusion of research findings into practice (Hicks and Hennesy 1997). The development of trust and investment is required to build active participation in the PAR process.

#### ***4.7 The PAR approach in the Wellness Project***

The PAR approach in this context refers to:

- outlining the PAR process;
- reviewing and exploring the taken-for-granted assumptions, beliefs, attitudes and experiences related to older clients' rights and responsibilities, as well as freedom of sexual and sensual expression;
- identifying current clinical practice; and
- generating informed critical discussion.

### 4.7.1 Sample

The PAR process involved members of the Project team working collaboratively with a voluntary group of multi-disciplinary staff from each unit to examine the way in which sexual health issues are routinely managed and to stimulate critical discussion about the reasons for maintaining or changing current clinical practice.

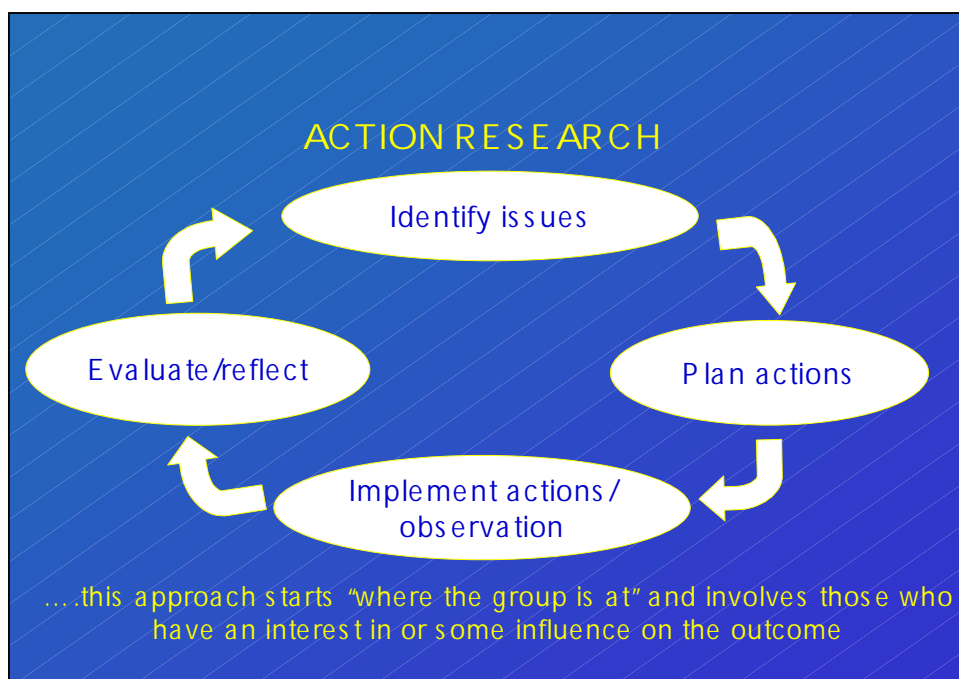
### 4.7.2 Process

To facilitate staff involvement, the first stage involved an information session. The project team was introduced, including the group facilitator and content experts: Consultant Nurse and Consultant Psychologist. The purpose of the information session was to identify and discuss:

- the broad concept of sexuality;
- myths about older people's sexuality;
- how sexuality is described and experienced by older people and the clinical implications for staff;
- an overview of the research project;
- how staff participation in ARG meetings could work; and
- guidelines for protection of privacy and maintaining confidentiality.

The action research methodology was introduced using Figure 1, an explanation of the action research method, and how it could work in practice was discussed with staff from each unit.

**Figure 1. Action research methodology**



It was explained that initial meetings would focus on:

- exploring issues related to the promotion of sexual health relevant to the particular unit;
- seeking agreement on key issues requiring attention;
- exploring the range of suitable actions to address identified key issues; and
- seeking agreement on a plan of action.

Expectations and ground rules for the ARG meetings were discussed with staff in the information sessions. These included:

- provision for counselling and debriefing if required;
- input from all participants was encouraged and balanced with a respect for people's rights to privacy and confidentiality;
- outlining guidelines for respectful communication; and
- the importance of privacy and maintaining confidentiality.

It was explained to staff that a core of 6 to 8 staff volunteers were sought to take part in the ARG meetings. Agreement to participate in the project according to the above conditions was sought from those who volunteered.

The ARG meetings occurred at regular intervals during a 4-6 month period from December 2001 to April 2002 on each of the three units. The frequency and timing of meetings was determined by staff from each unit who volunteered to participate (hereafter referred to as participants). Generally the ARG meetings occurred every two weeks during the *'between shifts daytime hand-over'* time to ensure maximum participation.

The strategies employed by the ARG facilitator team to build participation and broaden understanding as well as to empower participants with a sense of ownership included:

- facilitating interactive experiential sessions tailored to the ARG groups' needs, incorporating:
  - discussions of the nature and prevalence of incidents of a sexual nature identified by participants;
  - participants' capacity and level of comfort in managing incidents of a sexual nature; and
  - the level of support felt by participants in responding to clients' sexual expression .

The ARG group participants were given opportunities to:

- reflect on previous discussions, for example:
  - the nature and prevalence of incidents of clients' sexual expression and participants' level of comfort ;
  - identifying issues or incidents that generated feelings of discomfort from a high proportion of participants;
  - the relevance of the scenarios presented in the experiential learning sessions to clinical practice ; and
  - identifying clinical issues raised since the previous session.

- explore factors contributing to feelings of comfort and discomfort when promoting sexual health, such as values, attitudes, knowledge, experience and degree of support provided by peers and management.
- explore issues related to organisational culture, for example:
  - how supported staff felt in identifying sexual health issues and developing strategies within their unit;
  - the type of orientation that staff may require to develop skills and to provide consistent management strategies within the unit; and
  - how representative the ARG groups' understandings, opinions and insights were, in comparison with the rest of the staff in the unit.
- participate in experiential learning workshops, open to all unit staff, so that the broad aims of the Wellness Project and the breadth of the definition of sexual health were transferred across the unit. For example, a session on sensuality and well-being included:
  - role playing sensory deprivation; and
  - examples of stimulating the five senses.
- record ongoing learning and insights from the ARG meetings into a journal so that the participants could monitor the process and map their journey.
- reflect on the complexity of their different roles, such as acute care, rehabilitation, residential care and palliative care, and identify how these roles impact on the type of sensual and sexual health issues for clients.
- feedback on the issues raised in prior sessions, for clarification, and to prioritise which issues could be turned into actions.
- reflect on actions, modify actions and re-implement as required.

Overall, the strategies employed by the ARG facilitator team were developed to facilitate discussion of potentially difficult and sensitive issues and to set priorities for actions. It was important to take into account the context and culture of the unit, so that the priority issues fell out naturally into relevant actions for the unit. Further, the strategies needed to work through resistance associated with different world views and experiences, and to negotiate any difficulties with comprehension, to ensure all staff could grasp the issues. This involved a sharing of perspectives about the nature of the issues or problems; incorporating different understandings about causes and strategies; as well as acquiring a sense of ownership and a sense of confidence in handling these sensitive issues that recognised the diversity of individuals. The process required sensitive, skilled and knowledgeable facilitation to be aware of, and appropriately manage the particular sensitivities of the individual and organisational culture factors within the settings.

### **Data collection and analysis**

The primary data source consisted of detailed minutes and notes taken at the ARG meetings. A collaborative analysis was used to identify and organise meanings emerging from the data. Both manifest (face value) and underlying (hidden) meanings were identified to describe, interpret and explain the data.

The PAR process involved an ongoing procedure of clarifying the accuracy of the Project team's observations with the participants in the ARG meetings. Written feedback to participants in each setting was provided through a journal which provided a cumulative record of observations and interpretation from each meeting. To facilitate shared knowledge of the action research process and to bring other staff in the unit on board, the journal was located in the unit ensuring availability for access by all unit staff.

### **4.8 Follow-up data collection: Self-report survey and Audits**

The follow up data collection was conducted after the action research meetings had finished. A similar methodology to that used in the baseline data collection was used in the follow-up data collection. In the two GEM units (Units X and Y) the follow-up data collection was conducted in April 2002. However in Unit Z, the action research process continued until May 2002. The late finish, coupled with meeting the demands of the accreditation process, have resulted in delaying the follow-up data collection for Unit Z.

#### **4.8.1 Sample**

##### **Surveys**

Staff lists for each unit were obtained from the respective unit managers. The sample included all staff working on each unit during April 2002. The sample comprised of RND1 and RND2 nurses, allied health staff, medical staff, personal care assistants, personal service assistants, unit managers and kitchen assistants.

##### **Audits**

All incident report forms from each unit were reviewed for the period of 6 months, November 2001-April 2002. Any incident report that had a reference to an incident of a sexual nature was reported and the medical record of the patient concerned in the incident was extracted and reviewed. Additional medical records from each of the hospital units were selected randomly from a list of separations (discharged patients) during April 2002 to achieve a sample size of 15 per unit. These medical records were audited for the episodes of care that pertained to the separation in April.

#### **4.8.2 Data Collection Instruments**

##### **Surveys**

The feedback questionnaire comprised self-report questions designed to identify knowledge, opinions, and experience of the Wellness Project. Twenty-three evaluation items were developed to gain information about project reach, staff awareness of the Project, knowledge gained from the Project, staff experience of the Project, and the perceived relevance of the Project to their particular setting. The feedback questionnaire included open-ended questions on barriers and enablers to workplace practice change in the specific settings. The questionnaire is included in Appendix 3.

### **Audits**

The same proforma employed in the baseline audit was used in the follow-up audit (see Appendix 4).

## **4.8.3 Data Collection and Analysis**

### **Surveys**

The survey was administered using the same methodology as in the baseline data collection. Data analysis comprised descriptive statistics.

### **Audits**

The audits were repeated at the end of the action research process. The same methodology was employed as in the pre-action research group audit. Pre and post action research audits were compared.

## 5. Results of the Baseline Data Collection: Staff Survey

### 5.1 *Response Rates*

The overall response rate is the number of questionnaires returned as a percentage of those sent to staff on each unit. The overall response rate was **39%** (49/126). Response rates for each of the participating units were:

- Unit X (a secure sub-acute complex care ward caring for people with dementia) was **45%** (18/40).
- Unit Y (a GEM unit) was **63%** (25/40).
- Unit Z (a 98 bed low level care facility) was **13%** (6/46).

The low response rate for Unit Z means that the results cannot be generalised to all the staff from that unit. Therefore responses from Unit Z participants were included in overall figures but not in the separate comparison of the units.

### 5.2 *Ageism*

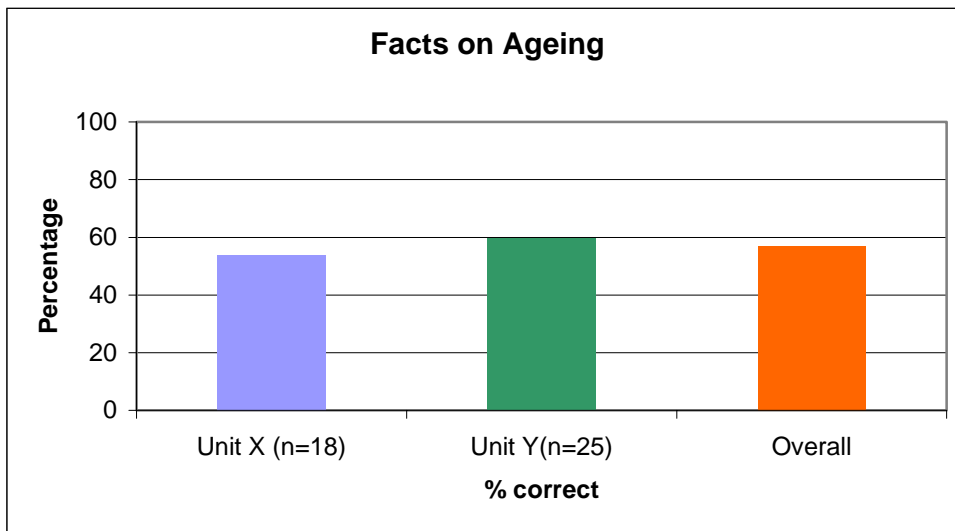
Although it has been recognised that older people may encounter stereotypical thinking, such as ageism or myths denying their sexuality when in contact with health professionals, little attention has been given to assessing the attitudes and knowledge of staff working in long term care facilities. Staff in residential care and health care settings are ideally placed to promote healthy sensual and sexual expression but may need barriers removed, for example, lack of education, training or guidelines, before they can manage the intricate issues surrounding older people's sexual health.

One of the tasks of this Project was to determine whether staff on the participating units who work with older people hold attitudes that may affect their practice with older people. It is not easy to measure attitudes or the degree to which they translate into behaviour. Self-report measures of attitudes can be regarded only as indicative of how an individual may behave in a given situation. One of the strengths of the Wellness Project is that we investigate health professionals' attitudes towards their older clients in two main ways: 1) as self-report surveys and 2) as part of the action research methodology (see Figure 1).

#### 5.2.1 **Facts on Ageing**

Figure 2 compares two of the units on summary measures from Palmore's FAQ. Overall, the average percentage of correct answers was 57%. The average percentage of correct answers from Unit Y (the GEM unit) was 60%, while Unit X (the complex care ward) was 54%. The difference between the units was not statistically significant ( $p=0.14$ ). The overall average score of 57% correct shows that although respondents answered the majority questions correctly there is still potential for improvement.

**Figure 2. Results from two groups and the overall mean for all participants on Facts on Ageing.**

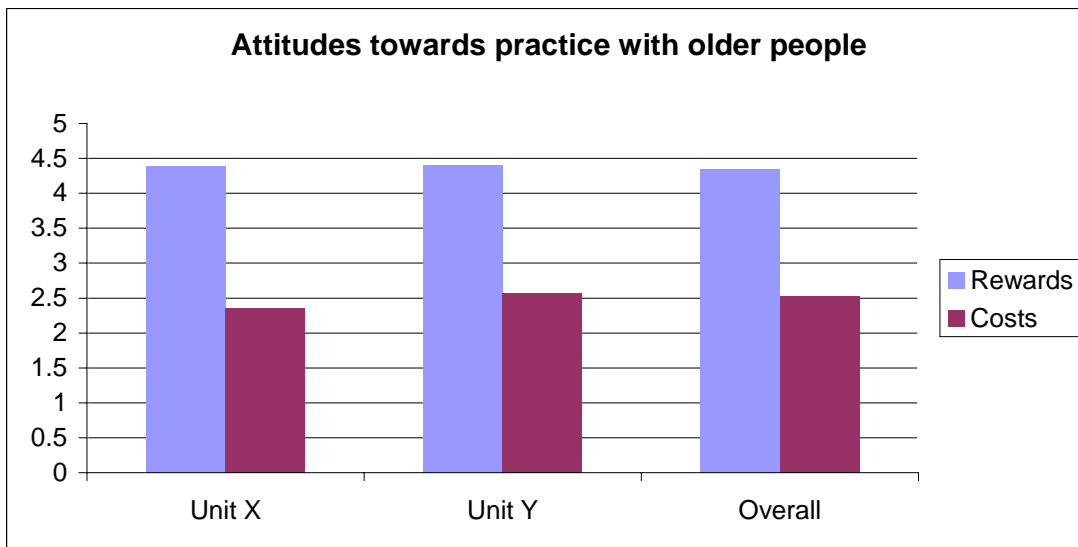


Each error could be classified as indicating positive bias, negative bias or no bias. Most of the errors were in a negative direction. This indicates that a significant proportion of staff hold some attitudes that may impact negatively on the quality of their work with older patients. T-tests were conducted comparing the degree of bias for respondents from Units X and Y. Respondents from Unit X (complex care ward caring for people with dementia) were more likely than respondents from Unit Y to make errors in a positive direction ( $t=2.017$   $p=0.055$ ). The difference was of borderline significance. Respondents from Unit X were more likely to overestimate the physical capacities of older people, whereas respondents from Unit Y were more likely to have correct knowledge about the relationship between age and decline in physical capacity, taking longer to learn something new, and slower reaction times. Accurate knowledge about normative age-related changes in functioning is important for clinical staff working with older patients. The finding that respondents from Unit X were more likely to demonstrate positive bias and overestimate the physical capacities of older people may reflect the type of patients under their care. People with dementia may be physically strong unlike other older patients in hospital who are inpatients because of physical health problems and may be very frail.

### 5.2.2 Practice with Older People

This section of the questionnaire contained items relating to clinical practice with older people. Two subscales could be discerned from this set of questions; one relating to Practice Rewards (items relate to rewards experienced with older patients), and one relating to Practice Costs (potential costs of working with older patients). Scores on items were rated from 1 (strongly disagree), 2 (disagree), 3 (undecided), 4 (agree) or 5 (strongly agree). Figure 3 shows how the two units scored on the related rewards and costs.

**Figure 3. Attitudes towards practice with older people**



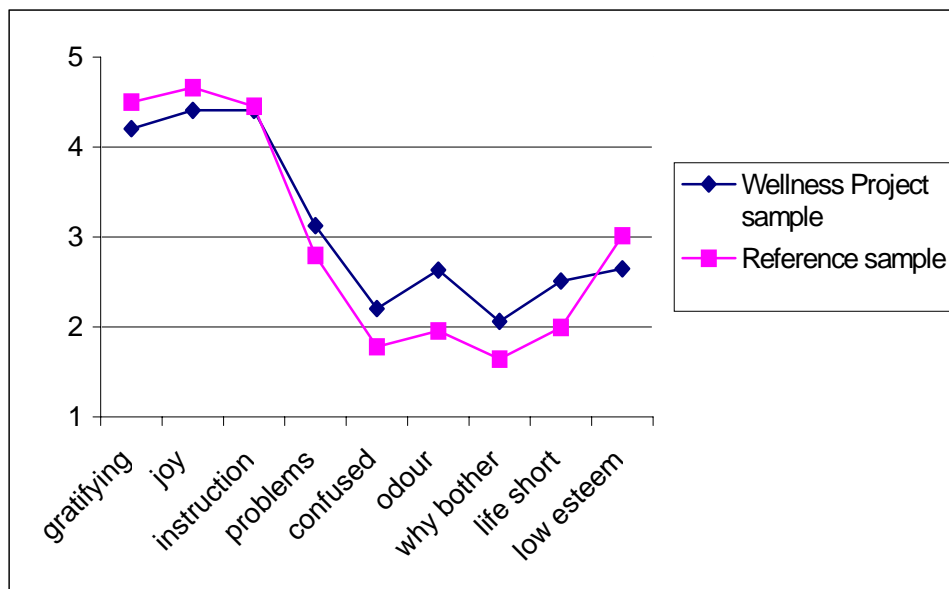
The units did not significantly differ in their summary scores on 'Practice Rewards' or 'Practice Costs'. There was high overall agreement with the Practice Rewards items (maximum score 5), and higher endorsement of rewards than costs, indicating that the majority of staff on both units felt that work with older people was rewarding. Perhaps of more interest is the Practice costs subscale, the items in this subscale tap against attitudes that manifest as either a dislike of work with older patients or beliefs that work with older people is of little value. The average score of approximately 2.5 indicated indecision overall about agreement or disagreement with the items.

All the items relating to practice with older people were compared against a much larger sample of Victorian health professionals to investigate any major differences between the Wellness Project sample and the larger sample of similar health professionals (Foreman, Wells et al. 2000) (see Figure 4). The reference sample (n=331) comprised nurses, ACAS staff, and residential care staff. For two out of three Practice Rewards items (left side of Figure 4: care of older people can be very gratifying; a joy to talk to older people) there were some significant differences between the Wellness Project sample and the reference sample. The Wellness Project sample were more likely to perceive that older patients were a joy to talk to ( $t=-2.637$   $p=0.042$ ) and that care of older patients can be gratifying ( $t=-2.28$   $p=0.023$ ). These findings may indicate that the Wellness Project sample is more positive in their attitudes towards older people than the reference sample or they may reflect a selection effect. The Wellness Project sample have chosen to work predominantly with older people, whereas the reference sample included agency nurses of whom one third worked mainly with younger people. Overall, the findings indicate that the results from Wellness Project sample are similar to the comparison sample.

There were no significant differences in the summary score for Practice Costs between the two samples, but on individual items some significant differences were detected. The Wellness Project sample scored significantly higher on three of the five Practice Costs items. They were more likely to perceive that older people are confused ( $t=2.371$   $p=0.021$ ), have body odour ( $t=3.721$   $p=0.000$ ), and have so many serious conditions and a short life expectancy that they are not worth the effort of bothering ( $t=2.895$   $p=0.004$ ), although in real terms the differences between the groups were minimal. These findings may indicate that the Wellness Project sample has slightly more ageist attitudes than those in the reference sample, which may affect their clinical practice. Alternatively,

the findings may reflect the client group that the Wellness Project sample work with. For example, the Wellness Project sample may be more likely to work with older people who have dementia, continence problems and other chronic illnesses. Interestingly, for the last item 'Care for older people is a low tech speciality held in low esteem by aged care staff and the public', the reference sample scored higher than the Wellness Project sample ( $t=-1.934$   $p=0.054$ ). This item is an example of therapeutic nihilism, people who answer positively to this statement may believe their work with older people to be of little value. The comparison sample was more likely to agree with the item, while the Wellness Project sample did not endorse the lack of self-esteem associated with working with older people. The difference between the two samples on this item was of borderline statistical significance. This finding may reflect that the organisational culture within MECRS values work with older patients.

**Figure 4. Responses of the Wellness Project sample and a reference sample to each item of Practice with older patients**



### 5.3 Sexual Knowledge and Attitudes

Two summary scores were derived from White's 1982 survey, one for knowledge and one for attitudes towards sexuality in older people. The original scores on the knowledge scale have been converted to a percentage and reversed so that a higher score indicates higher knowledge for representation in the Figures. Figure 5 shows the mean percentage scores for knowledge of sexuality in older people for Units X and Y, and an overall score for the total sample. Unit Y (GEM unit) had a higher score than Unit X (complex care ward) indicating higher knowledge about sexuality and older people, although the difference between the mean scores did not reach statistical significance.

**Figure 5. Mean percentage scores on White’s Knowledge about sexuality and older people**

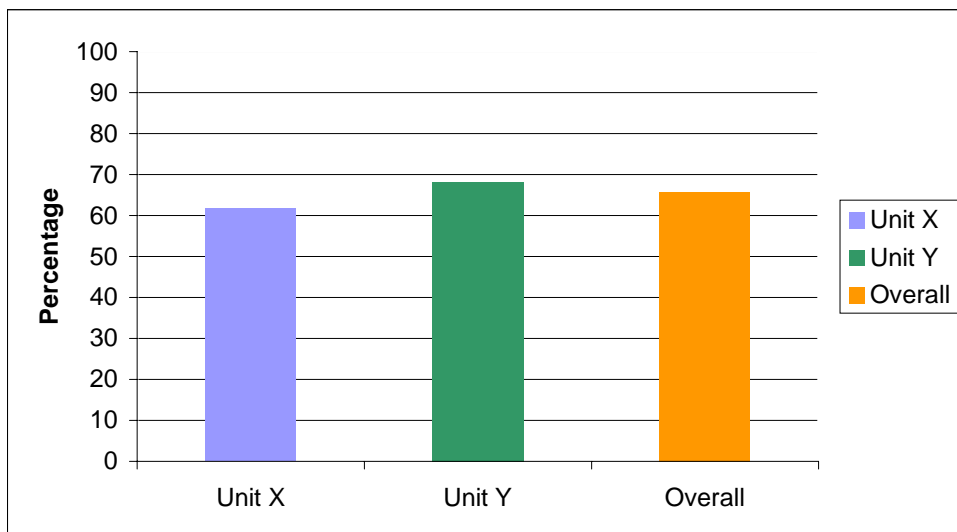
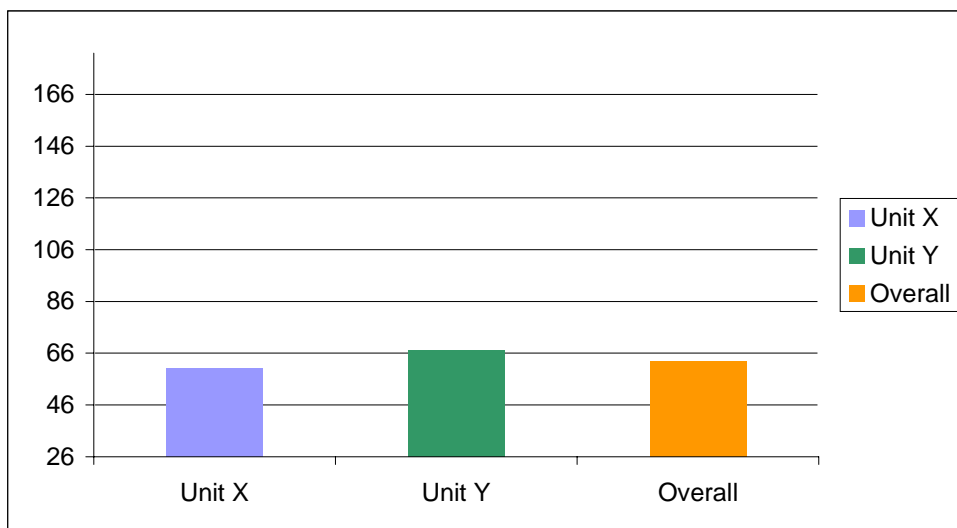


Figure 6 shows the summary scores for attitudes towards sexuality and older people. The original scoring from White (1982) had a possible range from 26-182 with a lower score indicating more permissive attitude. The scores were reversed for representation in Figure 6, to facilitate comparison with the knowledge scale. In Figure 6 a higher score indicates a more permissive attitude.

**Figure 6. Attitudes towards sexuality and older people**



The respondents from Unit Y had a higher mean score than the respondents from Unit X indicating a more permissive attitude towards sexuality and older people. Unit Y scored higher on the knowledge scale (indicating higher knowledge) and also scored more positively on the attitudes scale indicating a more permissive attitude, although this difference did not reach statistical significance. Because the difference between the two units is small we can conclude that, overall the two units are similar. The research literature indicates that greater knowledge about sexuality and older people is associated with more permissive attitudes (Wasow and Loeb 1979). The relationship between knowledge and attitudes is of interest to educational researchers. For this

sample, the correlation coefficient between knowledge and attitudes was 0.38 ( $p < 0.05$ ) indicating a moderate correlation between the two summary scores, indicating that knowledge and attitudes towards sexuality and older people are related. This finding suggests the presence of an opportunity for further educational opportunities to learn more about sexuality and older people, which has potential to also result in positive changes to attitudes.

Table 1 shows the four questions which were developed to supplement White's scale, and the percentage of respondents answering these in the affirmative.

**Table 1. Percentage answering in the affirmative to derived items on sexuality**

<b>Questionnaire items derived by C. Barrett, C. Hetzel</b>	<b>Unit X</b>	<b>Unit Y</b>	<b>Total sample for the Wellness Project</b>
Some people over 65 engage in same sex relationships	72	68	67
Incontinence can affect an older person's sexuality	83	96	90
People over 65 should practice safe sex	72	80	76
Older people do not have more than one sexual partner	0	8	6

Caution needs to be used when drawing inferences from Table 1 findings, as internal validation checks have not been applied to these additional statements. However the responses invite consideration. It appears that in the surveys that at an intellectual level many staff acknowledged sexual diversity among older people, but that this may not automatically translate to emotional or professional acceptance of clients expressing their sexuality within the settings.

The table reveals that that 2/3 of the respondents recognised that older people can engage in same sex relationships, should practice safe sex and that incontinence can impact on sexuality. It is concerning that very few respondents appear to have answered that older people do not have more than one sexual partner. This is particularly significant when reflecting on the disturbing trend noted in the literature, that notes an increase in the diagnosis of AIDS, in the 50+ age group (Wooten-Bielski 1999). It is reported that the difficulty for older people either engaging in unprotected sex or having multiple partners if presenting with symptoms that are consistent with HIV, health practitioners who perceive the older patient as asexual, may not screen for sexually transmitted diseases until much later in the disease course. The findings suggest that staff would benefit from experiential educational sessions that firstly, de-mystify sexual diversity and secondly address the associated clinical and professional issues of duty of care.

The six questions that comprise a modified Minichiello's SHKB index are shown in Table 2. The responses given by the Wellness Project sample are compared with responses from a representative sample of older people from the Health Status of Older People Project (HSOP) surveyed in 1994 (Kendig, Helme et al. 1996; Minichiello, Plummer et al. 2000).

**Table 2. Percentage answering in the affirmative to modified items from the Sexual Health Knowledge and Belief Index**

Items	Wellness sample %	HSOP <sup>1</sup> sample %
Sexuality is typically a life-long need	76	50
The relatively most sexually active younger people tend to become the most sexually active older people	25	17
There is evidence that sexual activity in older people has beneficial physical effects on participants	69	43
Sexual activity may be psychologically beneficial to older people <sup>2</sup>	86	50
Prescription drugs may alter a person's sex drive	92	41
Sexual disinterest in older people may be a reflection of a psychological state of depression	69	42

Interestingly, a higher proportion of respondents from the Wellness Project sample, comprising staff working with older people, answered in the affirmative, compared with the representative sample of older people. This suggests that staff working with older people had more knowledge than the older people themselves. The wording in the SHKB index differs from that used in the Wellness Project. For example, in the fourth statement 'sexual activity **may be** psychologically beneficial to older people' was the wording used in the Wellness Project whilst 'sexual activity **is** psychologically beneficial to older people' was the wording in the SHKB Index. Possible explanations for why the respondents answered these questions more positively than the sample of older people may include: the respondents are younger, better educated and come into contact with these issues in the course of their work so they have a better knowledge. Also, older people may be more influenced by stereotypical thinking and believe the myths surrounding the asexuality of older people because of the lack of public discussion among older cohorts. However, the difference in wording of the questions may also have contributed, at least in part to the difference, so caution needs to be used in the interpretation of these comparisons.

<sup>1</sup> Source (Kendig, Helme et al. 1996; Minichiello, Plummer et al. 2000)

<sup>2</sup> The wording in the SHKB index is 'Sexual activity is psychologically beneficial to older persons'.

## **5.4 *Organisational Culture***

One of the tasks of the Wellness Project was to evaluate how predisposed the culture of the organisation was to promote individual care. Aspects of organisational culture, such as leadership style, shared vision and values for promoting individual care, effective management, teamwork, opportunities for professional development, and work constraints, may all play a significant part in predisposing an organisation to changing practice towards the promotion of individual care of patients or residents (clients). A factor analysis was applied to the responses to the organisational culture survey in order to identify grouping of survey items that are looking at a common underlying structure. As displayed in Table 3, the results indicate that there appear to be six underlying key constructs that contribute to the overall understanding of organisational culture within the participating units.

**Table 3. Factor analysis results of organisation culture survey**

FACTORS	Survey questions
<p>Factor 1 Strong leadership with shared values for the promotion of individual care</p>	<p>Current systems promote resident well-being I am happy with the level of control I have over day to day decisions I have an opportunity to adapt practice to meet individual needs of clients My manager listens to my suggestions I am promptly notified of any changes in workplace procedures There are regular opportunities to discuss individual clients needs I am given constructive feedback about my work My supervisor understands the issues and problems that I face in my work My opinions about individual client needs are valued by my supervisor Management values staff</p>
<p>Factor 2 Team work</p>	<p>My co-workers do not value my judgement<sup>R</sup> I enjoy working with my co-workers The staff in my area work together as a team I find the work I do satisfying</p>
<p>Factor 3 Work constraints</p>	<p>Time constraints make it difficult to promote individual care<sup>R</sup> My opinions about individual client's needs are valued by my supervisor<sup>-ve</sup> Current workplace procedures restrict me from doing a better job My supervisor compliments me for a job well done<sup>-ve</sup></p>
<p>Factor 4 Job expectations and potential to promote individual care</p>	<p>There is little potential to improve client well-being through individual care<sup>R</sup> I am unclear as to what is expected of me in my job<sup>R</sup> I rarely have opportunities to be involved in further training<sup>R</sup> Current workplace procedures restrict me from doing a better job<sup>R</sup> My supervisor compliments me for a job well done My opinions about individual client's needs are valued by my supervisor</p>
<p>Factor 5 Effective management</p>	<p>I do not receive recognition for the work I do<sup>R</sup> I feel that my work is not valued Management values staff<sup>R</sup> I am given constructive feedback about my work My supervisor compliments me for a job well done I am promptly notified of any change in workplace procedures</p>
<p>Factor 6 Lack of opportunities for professional development</p>	<p>I need more opportunities to develop my skills I rarely have opportunities to be involved in further training at work<sup>R -ve</sup> I have opportunities to take on new roles if I want to<sup>-ve</sup> The staff in my area work together as a team</p>

<sup>R</sup> indicates statement is reversed in loading on factor score

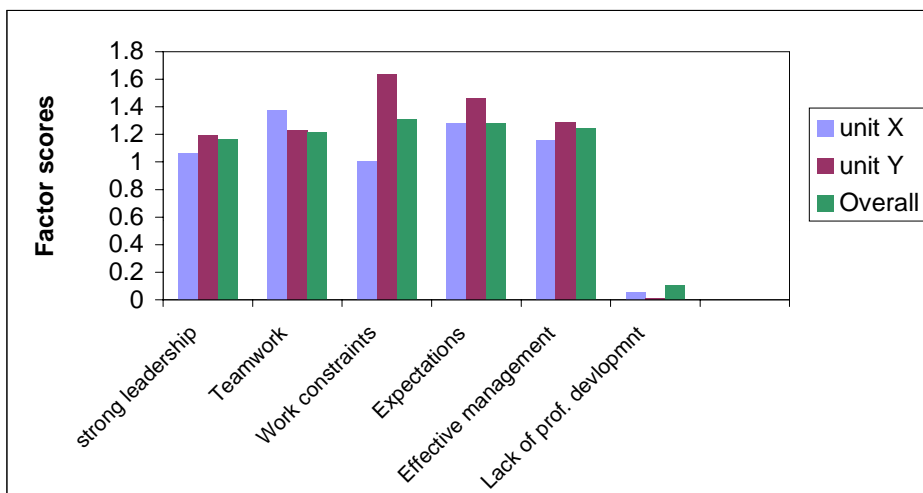
<sup>-ve</sup> indicates the statement negatively loads on factor score

The directionality of the factor scores is shown below:

- strong leadership with shared values for promoting individual care of clients (a higher score indicates strong leadership);
- teamwork (higher score indicates better teamwork);
- work constraints (higher score indicates more work constraints);
- job expectations and promotion of individual care (higher score indicates clearer expectations);
- effective management (higher score indicates effective management);
- lack of professional development opportunities (higher score indicates lack of opportunities).

Figure 7 shows the mean factor scores for the two units and the overall mean score for the total sample.

**Figure 7. Mean Factor scores for the organisational culture items for two units and overall**

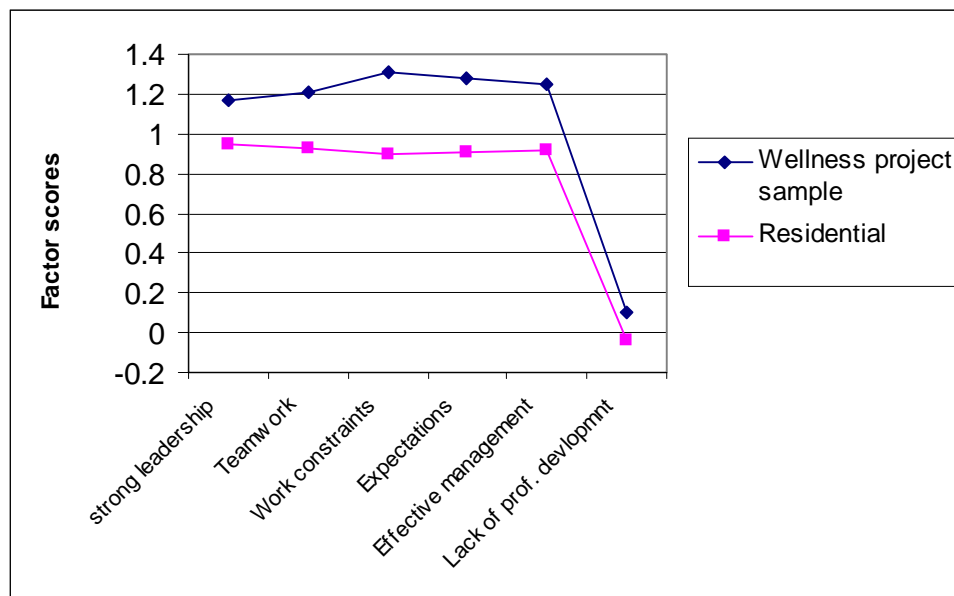


Overall, survey responses between the two units were very similar. The largest difference between the two units was related to work constraints. The respondents from Unit Y appear to be more hampered by work constraints than the respondents from Unit X ( $t=-2.106$   $p=0.045$ ). No other differences between those two units reached statistical significance. Interestingly, the score for the whole sample on ‘lack of professional development opportunities’ was higher than the scores for the two individual Units, X and Y. This finding may indicate that the scores from Unit Z inflated the overall score, and that the respondents on Unit Z perceive a lack of professional development opportunities. The response rate for Unit Z was too low at 13% to warrant a separate analysis.

The scores on the six factors for the Wellness Project sample were compared with a much larger sample of residential care workers ( $n=134$ ) surveyed as part of a project promoting physical activity and nutrition (Lindeman, Black et al. 2000). The factor scores are illustrated in Figure 8. The vertical axis shows the average score of the two samples (Wellness Project sample and comparison Residential Care Sample). The graph shows that the Wellness Project sample scored higher on all factors. Significance testing showed differences between the samples for three of the factors. The

Wellness Project sample reported more work constraints, had higher job expectations and potential for promoting individual care of patients, and scored higher on effective management. The Wellness Project sample were more likely than those from the Residential Care sample to perceive that they received recognition for their work, received constructive feedback, felt valued by management and were notified of changes in workplace procedures promptly. Interestingly, the Wellness Project sample was more likely than the comparison sample to have expressed a concern about a lack of professional development opportunities, but this trend did not reach statistical significance.

**Figure 8. Organisation culture factor scores for the Wellness project sample and a reference sample of residential care staff**



Responses to the open-ended question ‘What are the things about your unit that influence the chance of changing practice?’ elicited information about enablers and barriers to workplace change. Responses from both of the hospital Units, X and Y, indicated that environmental/physical layout problems are a barrier to clients’ privacy. Respondents from Unit X perceived problematic issues about legality and confidentiality, as well as difficulties when carers’ and clients’ views do not concur. The lack of meeting together, other than at case conferences, was also mentioned. Respondents from Unit Y perceived a lack of consistency in managing issues, as well as some limitations in communication between medical and nursing staff. Respondents from Unit Z were concerned about the time required to complete paperwork and how it encroaches on time spent with clients. Respondents from all units agreed that management is integral in effecting major changes in practice.

## 5.5 Summary

The extent of ageism depends to some extent on how it is defined. The overall sample in the Wellness Project scored an average of 57% when ageism was defined as ‘the false assumptions held about older people’. This finding indicates that there is potential for improving staff’s knowledge about ageing. However, there was also high agreement with the practice rewards items, with over 90% of respondents indicating that ‘care of older people is gratifying’ and that ‘older people are a joy to talk to’. Further, the Wellness Project sample scored significantly higher on these two items than the reference sample of health care professionals. This indicates the commitment that respondents have for their work in caring for older clients and the rewards they experience. Similarly, respondents knowledge about age-related changes in sexual functioning, and attitudinal aspects of sexuality indicate potential for improvement in order for staff to respond most appropriately to clients’ needs. The significant correlation between knowledge and attitude scores ( $r=0.38$ ,  $p<0.05$ ) indicates the knowledge-attitude relationship which is of interest to educational gerontology and suggests an opportunity for staff to learn more about sexuality and older people, as well as the potential for this to change attitudes and practice.

The survey questions on organisational culture were developed to assess the context in which the project was being implemented and how open the facilities were to changing practice. The survey results indicated some barriers to changing work practices. One item in particular that stood out was that respondents perceived ‘work constraints’, such as time and workplace procedures, hampered them in their ability to do a better job at promoting individual care. However, respondents were also more likely than the comparison sample to perceive that they received recognition for their work, received constructive feedback, felt valued by management and were notified of changes in workplace procedures promptly. These are all positive aspects of organisation culture, and indicate a reasonable framework on which to build additional activities targeting improved attitudes and practice in sexual health.

Overall, the responses from the Wellness Project sample were similar to the comparison sample of health professionals across Victoria, and residential care workers indicating that findings may be generalisable to a wider group of health professionals (Foreman, Wells et al. 2000; Lindeman, Gough et al. 2000).

## 6. Results of the Baseline Data Collection: Audits

As outlined in the methodology chapter, audits of incident reports and medical records were conducted in relation to the documentation of clients' sexual health. Data on the types of incidents reported over a 12-month period, January 2001 to January 2002 for the three units indicated that the majority of incidents related to falls (67.4%). Sexual issues were coded under 'other'. This category comprised 10% (79/788) of the total incidents over the 12 month period. In addition to sexual issues, the category of 'other' comprised of such issues like minor accidents and allegations of theft.

Incidents coded as 'other' in the two hospital units (Unit X and Y) comprised 8.2% (43/524) of the total incident reports raised during the 12 month period. Of those 43 incidents, the majority 84% (36/43) occurred in Unit X, and only 16% (7/43) in Unit Y. Incidents coded under 'other' in the residential care unit (Unit Z) comprised 13.6% (36/264) of the total incident reports over the 12 month period.

### 6.1 Unit X: Pre-Action Research Audit (September 2001)

Eight incident reports related to sexual issues were made during the period audited. Of these incident reports, 6 related to one client. In total, 5 medical records were selected as a result of linking to the incident reports and a further 10 records were randomly selected from 15 separations for the month of September 2001.

There were substantially more references to the sexual and sensual health of clients identified in the audits from Unit X compared to the other units. Interestingly, the main documentation identified through the audits related to 'problem behaviour' of a sexual nature and showed an approach to assessment and management that was problem driven rather than reflecting a philosophy of sexual and sensual health promotion. Issues of labelling and stereotyping were identified in the audit data. For example, one male client, with a history of aggression, repeatedly asked for a mirror so that he could see his reflection whilst he masturbated. Furthermore, this client was found in other (female) clients' rooms exposing himself or attempting to masturbate. A psychiatric assessment recommended the client be medicated and 'specialled' (one to one nursing supervision) to address the issue of his 'sexually inappropriate' behaviour. However, there is no evidence of a sexual health assessment or management plan being developed to identify the underlying issue for this client. Staff did not appear to explore the option of giving the client a mirror and ensuring a private space was available for him to masturbate. Perhaps as a consequence, this client was transferred to a psychogeriatric unit for further assessment and management due to what was perceived as increasingly problematic behaviour.

Other audits revealed differences in the interpretations of behaviour by medical and nursing staff. For example, the entry by medical staff in the discharge notes indicated a client's behaviour was, "*sexually and verbally inappropriate...Has a doll that she thinks is her son*". Nursing staff included the following comments in the medical record: "*Mrs A likes to carry her doll around with her and constantly, spends time wandering into other clients' rooms, constantly talking to herself and doll.*" Management of this client was not entirely problem focused as evidenced by the following entry in her care plan, "*Allow Mrs A to go about her business of caring for the 'child'.*"

*Meet Mrs A in her reality - do not try to orient her to our reality". "May be useful in transition to discharge"* was the comment by the Registered Nurse (ACAS).

However, the majority of the documentation revealed that records focused on managing symptoms rather than exploring the underlying causes that may have been contributing to behaviours or outcomes for clients. Labelling and categorising of 'problem behaviours' was apparent. This was further reinforced by the finding that in 8 of the 15 records selected for review, the auditor reported no positively framed comments relevant to sexual or sensual health of clients.

## **6.2 Unit Y: Pre-intervention Audit (September 2001)**

No incident reports relating to issues of challenging behaviour or sexual health of clients were identified during the audit period. Only one of the Unit Y clients audited had anything recorded in medical records related to sexual and sensual health that was retrieved through the audit process. One of the 15 records audited identified a client's refusal to shower and to change clothes, but paradoxically the client would apply lipstick and do her hair several times a day. On this unit, the staff reported they were providing holistic care and there were relatively few issues relating to sexual health of the unit's clients.

Possible explanations for the different levels of relevant incidents in this unit compared to Unit X include the differences in the client mix (see section 4.1) or differences in consideration of what constituted relevant issues for audit documentation. However, it is unlikely that incidents were missed as the training provided for auditors was comprehensive and emphasised the broad range of issues and areas that could be considered under the umbrella of sexual and sensual health.

## **6.3 Unit Z: Pre-Action Research Audit (September 2001)**

One incident report and medical record progress notes referred to a male client wandering into other clients' rooms who was aggressive and abusive to staff when asked to return to his room. Progress notes for this client, revealed problems with faecal and urinary continence and disturbance, for example, using charts as toilets and smearing faeces over the floor.

As part of the standard assessment process within this unit, staff are prompted to consider client preferences, cultural and spiritual issues as well as social activities and abilities. Within this framework, nine out of the fifteen records reviewed provided some detail about client preferences and needs in these areas. The cultural and spiritual assessment of three female clients indicated that they preferred female staff caring for them and refused to be showered by male staff, unless the male staff were known to the clients and had gained their trust. The records of five clients revealed some degree of social isolation either because of preference (four) or because of low self-esteem and requiring encouragement to join in (one). One record revealed a degree of harassment of a female client by a male client (for example, following her to the toilet).

The auditor expressed some useful insights into ways of improving documentation that may have a positive impact on the care provided. For example, encouraging more detailed exploration of the contextual and precipitating circumstances when a client becomes aggressive or refuses care. The gender of the staff member or client who was on the receiving end of any disruptive or abusive

behaviour was not usually recorded and the auditor suggested this may be useful in preventing further episodes, particularly in identifying triggers to the behaviour.

The information that was retrieved from the audit tended to simply state observed behaviour or preferences, coupled with limited evidence of further assessment or exploration of the underlying related issues. As with Unit X, it was common to identify documentation that related to problems encountered rather than the identification of goals or interventions that may have a sexual health promotion focus. Nevertheless, Unit Z had the most documented evidence that the broader sensual and sexual needs of the older person were being taken into consideration. For example, goals related to improving self-esteem and social interaction as well as references to clothing and emotional well-being derived from expressing sensuality, illustrated this focus.

These goals reflected a greater exploration of sexual and sensual health issues which is consistent with the Quality of Care Principles in the Standards. Whilst there is still a tendency towards reporting 'problem behaviours', the staff of this unit appear to be practising assessment that is more closely aligned with the goals of sexual and sensual health promotion.

#### ***6.4 Summary or Pre-Action Research Audit on the 3 Units***

Overall, there was limited systematic application of a holistic assessment (including sexual and sensual health issues) in routine clinical practice. Records tended to be problem focussed with little contribution to assessment and care planning or exploration of underlying causes or triggers of challenging behaviour. Labelling of challenging behaviour as 'sexually inappropriate' was a common practice. In Unit Z, there was a more systematic assessment process in place, however, there appeared to be limited exploration of specific sexual or sensual health needs of clients. Documentation was somewhat limited and still tended to focus on 'problem behaviours'.

#### ***6.5 Introduction to Results of Action Research***

The next three chapters present the key themes and actions from the action research in the three units relating to the promotion of older people's sexual health in each of the three settings. The themes highlight the knowledge, beliefs, attitudes and experiences that surfaced through the ARG discussions, which tend to characterise and shape current practice.

Each setting is addressed separately in the following chapters. Each series of themes is preceded by background information on the individual setting, details of the ARG participants, and the frequency and number of action research meetings. Articulating the key themes represents the first step in the action research process. Planning and deciding on action, the application of certain actions, and the outcomes of these actions are further steps in the action research process. These aspects of the process are also considered for each individual setting.

## **7. RESULTS UNIT X Action Research**

### **7.1 Background**

#### **7.1.1 The setting**

Unit X is a secure sub acute complex care ward. This unit cares for clients who have been diagnosed with dementia or who have a cognitive impairment and behavioural problems which necessitate a secure environment.

The Unit has undergone some structural changes, which resulted in staff reduction and the loss of the Unit Manager. A new unit manager was appointed on February 4<sup>th</sup>, 2002.

Details of staff and clients are described in Chapter 4: Research Design and Method, section 4.1.

#### **7.1.2 Participants, frequency and number of ARG meetings.**

Information sessions conducted by the project team to outline the project were attended by 20 multidisciplinary unit staff. Volunteers were requested to make up a smaller group, who would participate in the project and have an ongoing role.

Over the duration of the project a total of 22 unit staff attended the ARG meetings. Of this total 6 staff attended more than half the sessions and constituted a core group. This group was comprised of three allied health staff (occupational therapist, allied health assistant, and social worker) and nursing staff (RND1 and RND2). Nursing staff attendance fluctuated ranging from 2 to 6 staff per meeting. The average size of the ARG was 6.

The Acting Nurse Unit Manager encouraged staff participation in the ARG meetings. The new Nurse Unit Manager, appointed in early February 2002, also endorsed this participation. Her attendance at the groups attracted higher rates of participation by nursing staff in the latter stages of the project.

A total of 14 meetings were conducted during the action research period. This included an experiential education session open to all staff and attended by 13 Unit X staff, which comprised of three allied health staff, and ten nursing staff, including the Nurse Unit Manager. This education session represents one of the actions determined by the action research participants and is discussed under section 7.3.

### **7.2 Key Themes**

#### **Client sexual expression – ‘problem behaviour’**

Relative to staff from other settings who participated in the project, the staff from Unit X experienced more overt expressions of client sexual and sensual behaviour. For example, clients expressed sexually explicit language; got into bed with other clients; masturbated or exposed their genitals in public areas of the unit and clients inappropriately touched other clients or staff. Staff welcomed the opportunity to participate in the Project and discuss these issues.

*“We have so many sexual behaviours in this ward, and we have been tip-toeing around them for so long - I don’t know why. We have such a need for this project. I don’t know why we didn’t do it ages ago.”*

*“Great thing about this group is that it puts out the issues for this ward on the table.”*

Many of the reports of sexual expression were related to sexually challenging behaviour. Consequently some staff in the unit had difficulty understanding why the project team wanted to discuss strategies to promote sexual health, rather than simply respond to the ‘problem’ behaviours.

*“You’re only talking about the good stuff, what about the problems?”*

However many of the ARG participants recognised that the promotion of appropriate sexual expression was the most appropriate way to manage sexually challenging behaviour.

### **Staff Attitudes and Knowledge**

While staff in Unit X reported frequent sexual expression by clients, some staff believe it was inappropriate for older people to be sexual.

*“Some staff members who have been to these (project) sessions won’t come back – they think we should not be talking about sexual health, they think older people should not be sexual – they know sexual behaviour happens but they think it is wrong, so they won’t come to these sessions.”*

Others believed it was counterproductive to allow clients to express their sexuality.

*“I’ve done legal nursing...They gave us real cases. You have to divert the (client) because when they put thoughts into action they go manic or psychotic or depressed. You have to get them to think about something else.”*

The ARG participants in this unit identified that they faced a significant challenge to change the attitudes of some staff in the unit. However, as a core group of staff who understood sexual health, the group hoped that they could slowly work towards changing practices in the unit.

### **Cognitive function**

Participants’ responses to expressions of clients’ sexual behaviour were influenced by clients’ level of cognitive impairment.

*“The higher the level of cognitive degeneration the less notice you’re likely to take, but probably would mention to the team to make sure the situation is monitored.”*

*“ Does he (the client) know what he is doing (is cognitively aware)?...we have to be careful not to over dramatise or sensationalise the situation”.*

While strategies to promote sexually appropriate behaviour required consideration of the clients’ cognitive function, the facilitators encouraged the participants to move from ‘he knew what he was doing’ to ‘what was he trying to say’.

### **Male-Female differences**

Participants reported that some staff responded to sexual expression from male clients differently to female clients. Male clients are expected to express sexual behaviour, but females are not. For example, when a female client was allegedly harassing a male client, the situation was allowed to escalate before strategies were introduced to modify the female client's behaviour. In contrast when a male client harassed a female client, the male client was 'specialled' (that is, a specific nurse is employed to work one to one to use consistent strategies to respond to behaviour).

### **Sexual Preferences**

Some staff did not perceive that clients could be gay or lesbian. Participants reported that different strategies were developed for clients of the same sex in bed together. Staff did not expect clients to be gay/lesbian therefore this behaviour was not perceived as sexual. However if a male client was in bed with a female client this was viewed as problematic and immediately rectified. It appeared that the opportunity to recognise and support clients' sexual diversity was overlooked.

### **Teamwork**

The contribution each discipline could make to the development of care management strategies to promote sexual behaviour of clients was not well understood.

At a team meeting in the Unit an incident concerning a female client receiving unwanted sexual advances from a male client was raised incidentally. Participants commented that the situation was raised only incidentally rather than regarded as a crucial issue for all team members' consideration.

Some participants were frustrated that the incident had not been discussed with the multi-disciplinary team and therefore the opportunity for all team members to contribute to the development of management strategies was missed. The incident however was perceived by nursing staff as a nursing problem requiring nursing strategies.

Another participant felt that discussion with the team would only inflame the incident.

*"Don't make a big thing out of it...you'll make it explode"*

Participants identified that sexual health issues are responded to differently than other health issues.

*"...The fact that it was not a medical problem made it harder for people to discuss."*

*"We discuss medical issues and should be prepared to treat psycho social issues with the same importance. However the latter carry different emotions and if you have not had experience with any sexually challenging behaviour it may be more difficult to discuss."*

Exploration of the roles of various team members facilitated better understanding on how incidents of clients' sexual expression could affect the delivery of services by all team members. Some participants agreed that more frequent multi-disciplinary team communication was crucial in sharing experience and knowledge as well as identifying the most effective ways of managing client care.

### **Conflicting Responsibilities**

It was a challenge for staff to meet their dual responsibilities to clients, families and the organisation when issues around sexuality and communication arose. For example, a client's transfer to an aged care facility is likely to be jeopardised if it is known that the client has a history of sexually challenging behaviour. However, participants considered it was important to communicate all aspects of a client's history.

*“You are only able to comment on the persons observed behaviour while they are in your care.”*

Families were acknowledged as having an important role in assisting staff to understand the individual in their care, and their behaviour, through their life story. However, participants identified a tension between the needs of the client and the needs of the family.

Participants identified the need for guidance in assessing whether it is in the client's and the family's best interest to discuss the client's sexual behaviour with the family and in determining who should be responsible for liaising with the family. Most participants did not feel equipped to discuss the clients' sexual health needs with their families.

*“Don't know families well enough to know how they will take it – when do you tell them, what do you tell them... in relation to sexuality, intimacy and aggression. Some families won't even accept that that their relative has dementia.”*

*“More complex things to deal with in Unit X – a lot (families) have had to deal with a lot before their relative has had to come here. Ones that haven't been involved have more trouble with the issue as they haven't known the challenging nature of the behaviour.”*

Participants identified that increased awareness and knowledge of clients' sexual health needs would improve their understanding of the considerations to be taken into account in any communication required with families on clients' sexual needs. Actions to raise staffs' level of awareness of older people's sexual and sensual health needs was deemed by the participants to be a priority.

### **Resources**

Limited resources were available for providing clients with a choice of sensual experiences which would meet clients' needs for touch and intimacy, promoting their sexual and sensual expression. While sensual experiences, such as massage and music therapy, had been offered at different times, participants' comments highlighted the need for sustainable programs to become part of the practice of Unit X.

### **The Client's Story**

A client's psychosocial context or 'story' is a valuable resource for sexual health promotion. This information can inform strategies for diversion to minimise challenging client behaviour and provide opportunities to proactively engage with the client. However, this information, such as details of a client's family, the individual's previous occupation, personal interests, and sensory losses and gains, was difficult to access in the medical record. Participants' comments revealed that a significant amount of psychosocial information about a client is available in the client's medical records, however it is scattered through the file and takes a long time to retrieve.

*“Medical histories are not as thorough as they were in the past and we miss a lot of information about (clients).”*

Participants identified instances where client behavioral issues were being addressed separately by the medical and nursing staff in the absence of information on the sensual, sexual and other psychosocial needs of individuals. Participants recommended strategies be developed to communicate to the rest of the staff about the importance and breadth of sexuality and sensuality, for example, it's not just about sex, it's also about loneliness, grief and loss, relationships, personal identity, belonging, and social connections.

### **Consistent strategies**

Participants identified the need for communication strategies to create change across Unit X, to achieve consistency in strategies used by staff to promote clients' sexual and sensual health, and to keep the discussion open. Strategies also need to be developed “to link the work across the wards”.

*“Want to use this (opportunity for open dialogue) as broadly as possible – how can we use the themes across the wards. How to link the work across the wards – acknowledging people as whole persons”*

## **7.3 Action planning, implementation and outcomes.**

Through exploring their knowledge, beliefs, attitudes and experiences in relation to older people and sexual health, the ARG participants identified some key barriers to practice change in promoting older people's sexual and sensual health including actions to address these. Many themes were identified throughout the ARG meetings. The key barriers identified by the participants were those that they believed they could act upon as a group within the time constraints for the Project.

The key barriers and actions identified by participants are summarised below.

### **1) Limited opportunities for multi disciplinary team communication. (see 7.4 Action Research Cycle 1)**

It was apparent to some participants, that more frequent multi disciplinary team communication was crucial to share the experience and knowledge as well as to identify the most effective ways of managing clients' care.

### **Actions:**

- Enhance team communication to ensure a multi disciplinary approach to delivery of care. ARG participants identified the need to promote greater collaboration between nursing and allied health staff, such as the inclusion of allied health staff in nurse hand-overs. Participants presented to nursing staff a proposal that allied health staff be routinely invited to nurse hand-overs. Some nurses raised concern that this proposal would result in fewer opportunities to discuss freely the challenges they encountered on a daily basis on the Unit.
- Participants agreed to trial a case review or a case conferencing model to improve team communication in developing practical strategies for managing challenging client's behaviour (see point 2 next page 'raising awareness of client's perspective').

### **Outcomes:**

- The Nurse Unit Manager gave strong endorsement for the proposal to invite allied health to nurse hand-overs on a regular basis.

#### **2) Raising awareness about the client's perspective. (see 7.4 Action Research Cycle 2.1 – 2.3)**

Participants' comments revealed that client behavioural issues were sometimes being addressed in the absence of information on their sensual, sexual and other psychosocial needs. The lack of this contextual information was considered problematic in achieving best practice holistic health care.

### **Actions:**

- *Experiential learning.*  
ARG participants identified the need to communicate to the rest of the staff about the importance and breadth of sexuality and sensuality, for example, it's not just about sex, it's also about relationships, personal identity, belonging, and social connections. The provision of education sessions was identified as one way of reaching staff who were unable to or did not wish to participate in the ARG discussions. Through the use of role-play, this session aimed to increase staff awareness on the importance of understanding the client's psychosocial context. The session was conducted on the ward and was open to all Unit X staff to extend the reach of the project.
- *Present the client's story through a 'life book.'*  
ARG participants suggested a 'life book' be developed for clients. The aim of the life book was to concisely record the client's story to promote shared understanding of a client's likes, dislikes, sensory losses, past interests and activities.

### **Outcomes:**

- ARG participants reported that their participation in the project had brought about better understanding of the breadth and relevance of sexuality and sensuality of their clients.
- Feedback on the proposal to develop a "life book" for individual clients was that it may not be practical. Some staff perceived that it represented additional work when this assessment information was already in clients' files. In the process of 're planning', staff agreed to trial a case review or case conferencing model through which practical strategies for managing

challenging client behaviour could be further explored. The Nurse Unit Manager endorsed this initiative.

**Actions:**

- Case Review Model. The case review process initiated by participants involved:
  - Flagging challenging behaviour at ward team meeting;
  - Identifying staff to complete a client behaviour profile;
  - Presentation of the case review to the multidisciplinary team; and
  - Brainstorming management strategies.

A client (patient) behaviour profile proforma (Appendix 5) was developed by the project consultants and endorsed by the ARG participants. The case review process was piloted and endorsed by the team.

**Outcomes:**

- More work was needed on developing an efficient means of drawing together client psychosocial information to address the difficulties staff had in retrieving this information from the client's medical record.
- The case review process highlighted the importance of ongoing communication between staff on client management strategies to achieve consistency in the strategies they use to care for clients. This improvement in teamwork could lead to better health outcomes for clients.

**3) Client's sexual expression regarded as 'problem behaviour'. (see 7.4 Action Research Cycle 3)**

Approaches to assessment and management were often 'problem driven' rather than reflecting a philosophy of sexual and sensual health promotion.

**Actions:**

- *Develop guidelines for promoting clients' sexual health.*  
Participants identified a need to develop helpsheets in relation to four areas: clients using sexually explicit language with staff; exposing genitals; masturbating in public areas and inappropriately touching other clients and staff.

**Outcomes:**

Resources were developed by the Consultant Nurse and Consultant Psychologist for the Project to resource Unit staff in developing strategies to address challenging situations relating to clients' sensual and sexual needs. These included:

- A proforma for a Client (patient) Behaviour Profile
- A policy to promote the sexual health of patients contextualised to Unit X
- Core Principles for Managing Sexually Inappropriate Behaviours.
- Help sheets on behaviour management strategies on the following topics:

Client using sexually explicit language with staff;  
Client exposing genitals in public space;  
Client masturbating in public spaces; and

Client inappropriately touching other clients and staff.

The core management helpsheet was developed with direct involvement of the ARG participants. As a result of time constraints, the remaining helpsheets were developed by the project consultants and given to staff for feedback. These resources are shown in Appendix 5.

Initially the consultants were concerned that the helpsheets presented sexual expression as problematic. However, after discussion with participants, it was agreed that while the helpsheets were responses to problem behaviour, they allowed the opportunity to present to staff some strategies to promote sexual health.

**4) Limited resources for meeting sensual needs of clients. (see 7.4 Action Research Cycle 4)**

The ARG participants identified initiatives, such as music therapy and massage therapy, to provide choices for clients and to address their need for sensual well being and intimacy.

***Actions:***

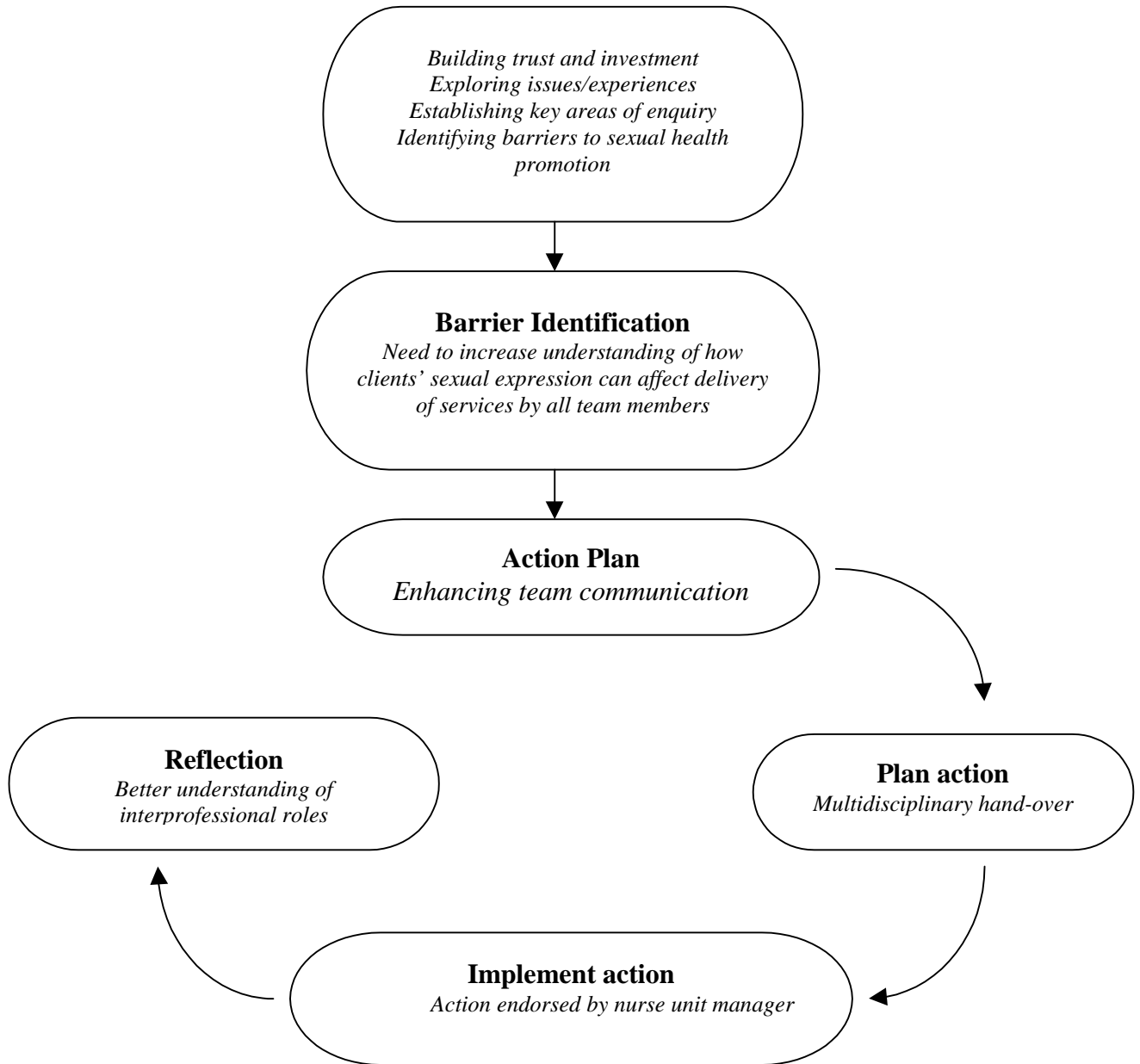
- Identify resources for developing therapy programs, such as music and massage, which can be sustained.

***Outcomes:***

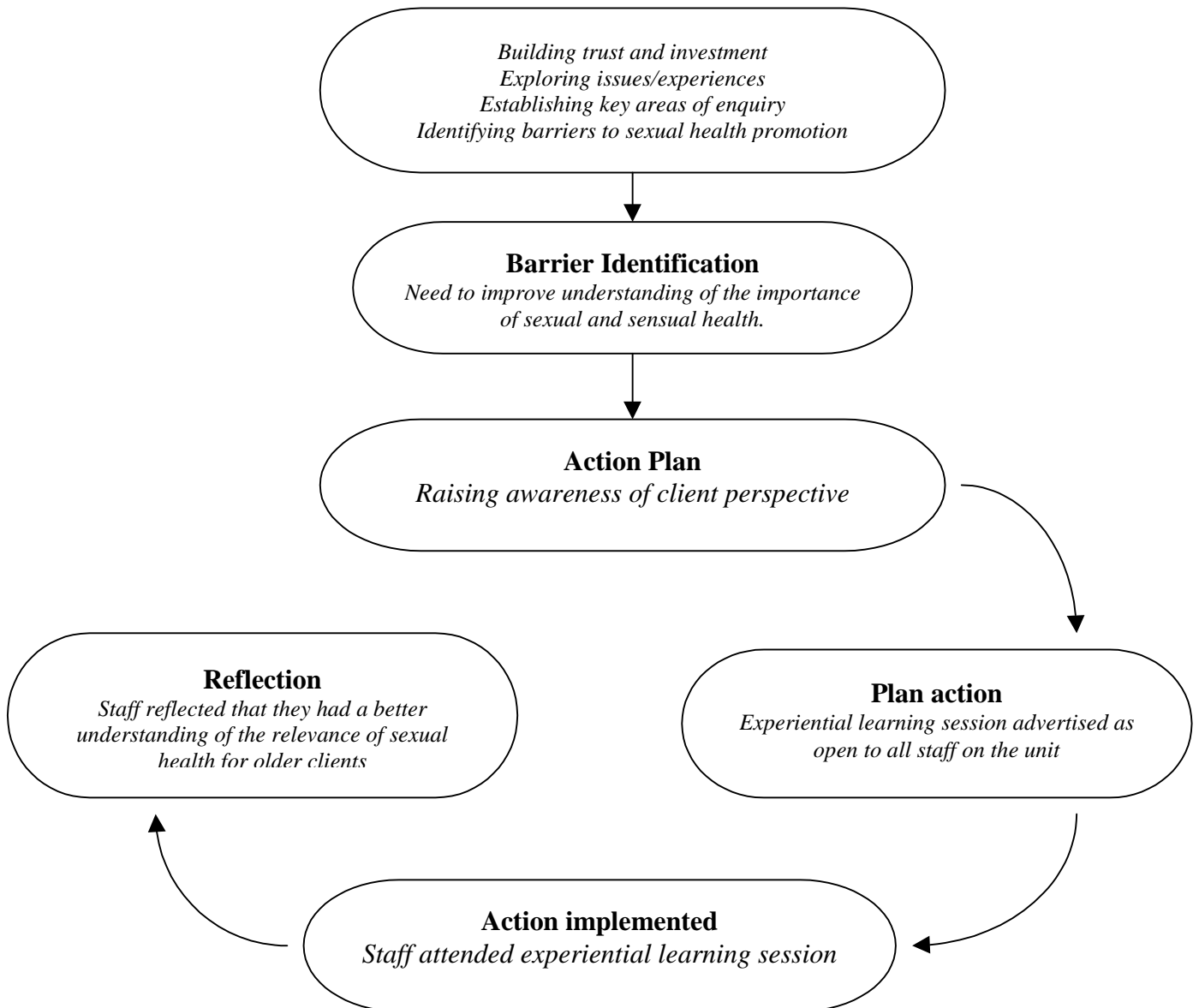
- This action was not implemented during the project. However participants highlighted that further resources for implementation of this action be identified in the recommendations from this research.

7.4 Diagrammatic Overview of Action Research Cycles

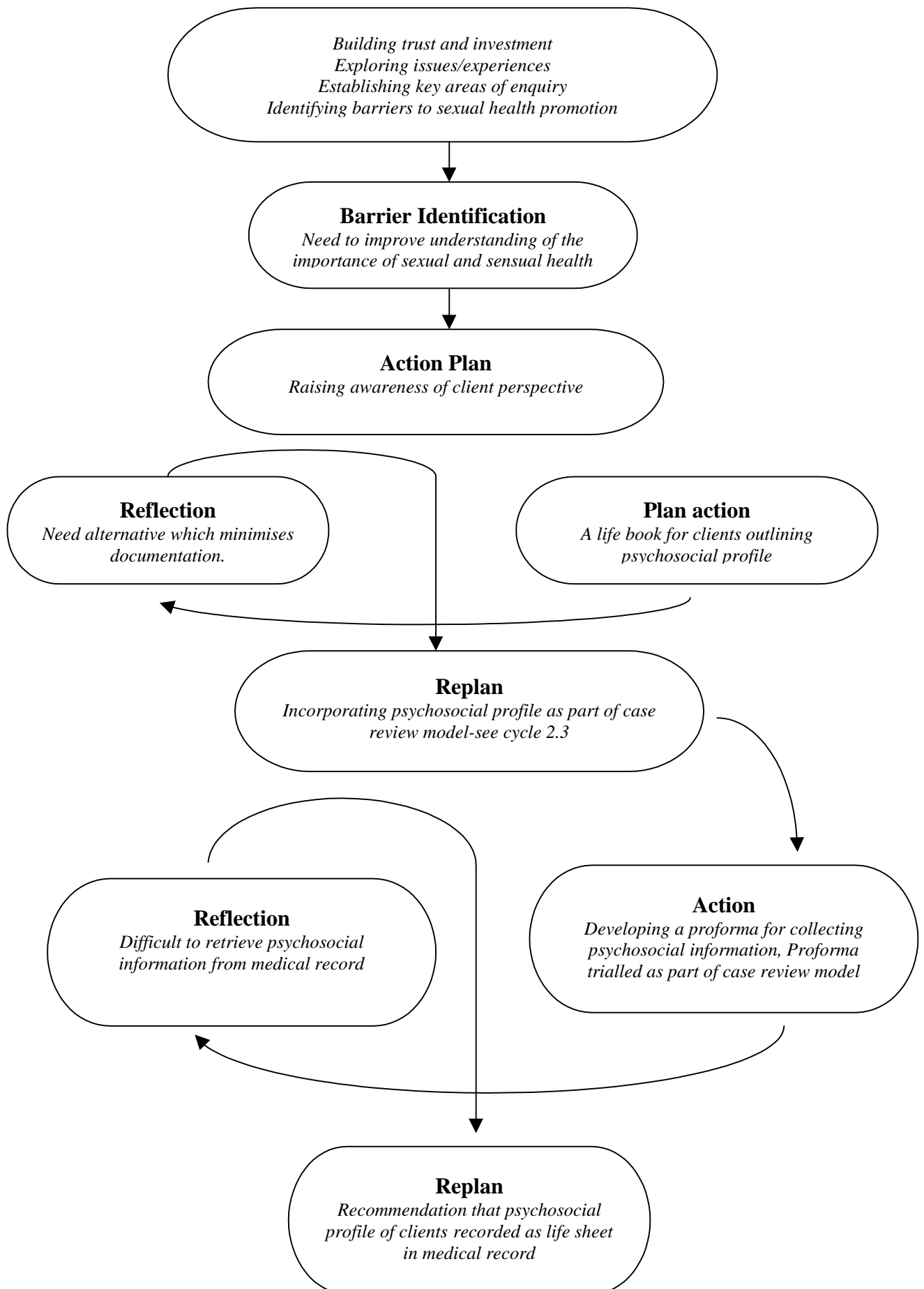
Figure 9. Unit X: Action Research Cycle 1



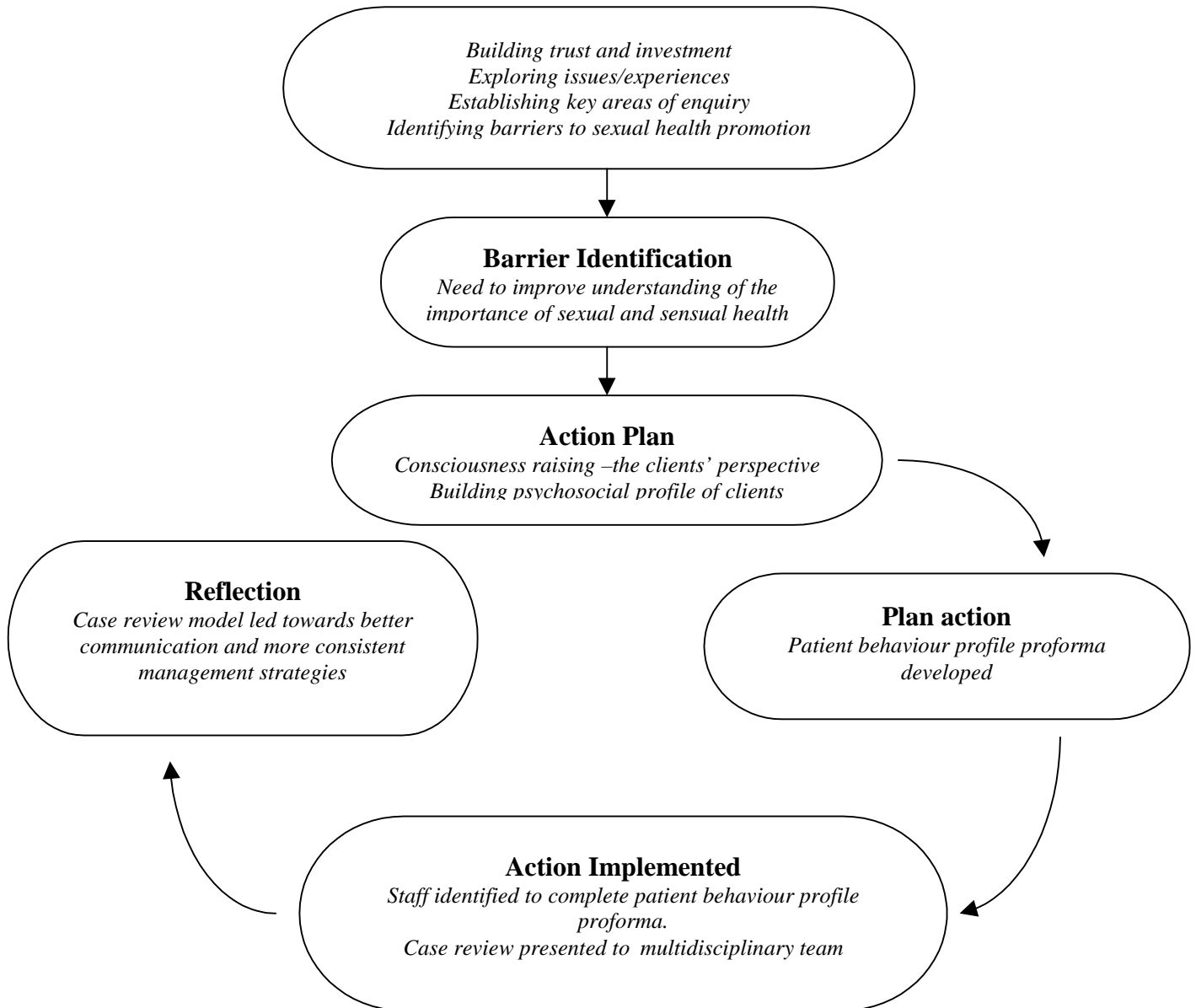
**Figure 10. Unit X: Action Research Cycle 2.1**



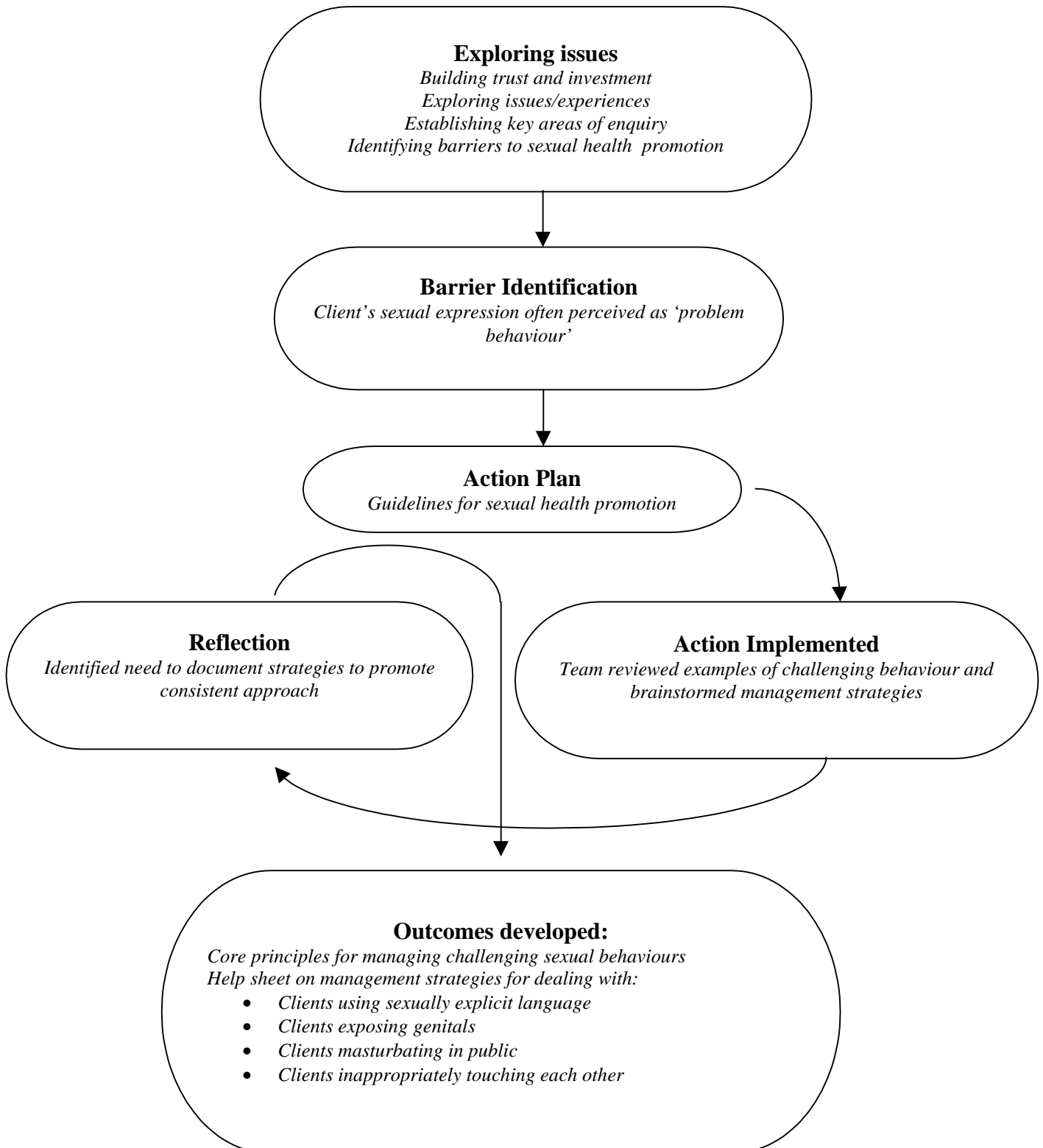
**Figure 11. Unit X: Action Research Cycle 2.2**



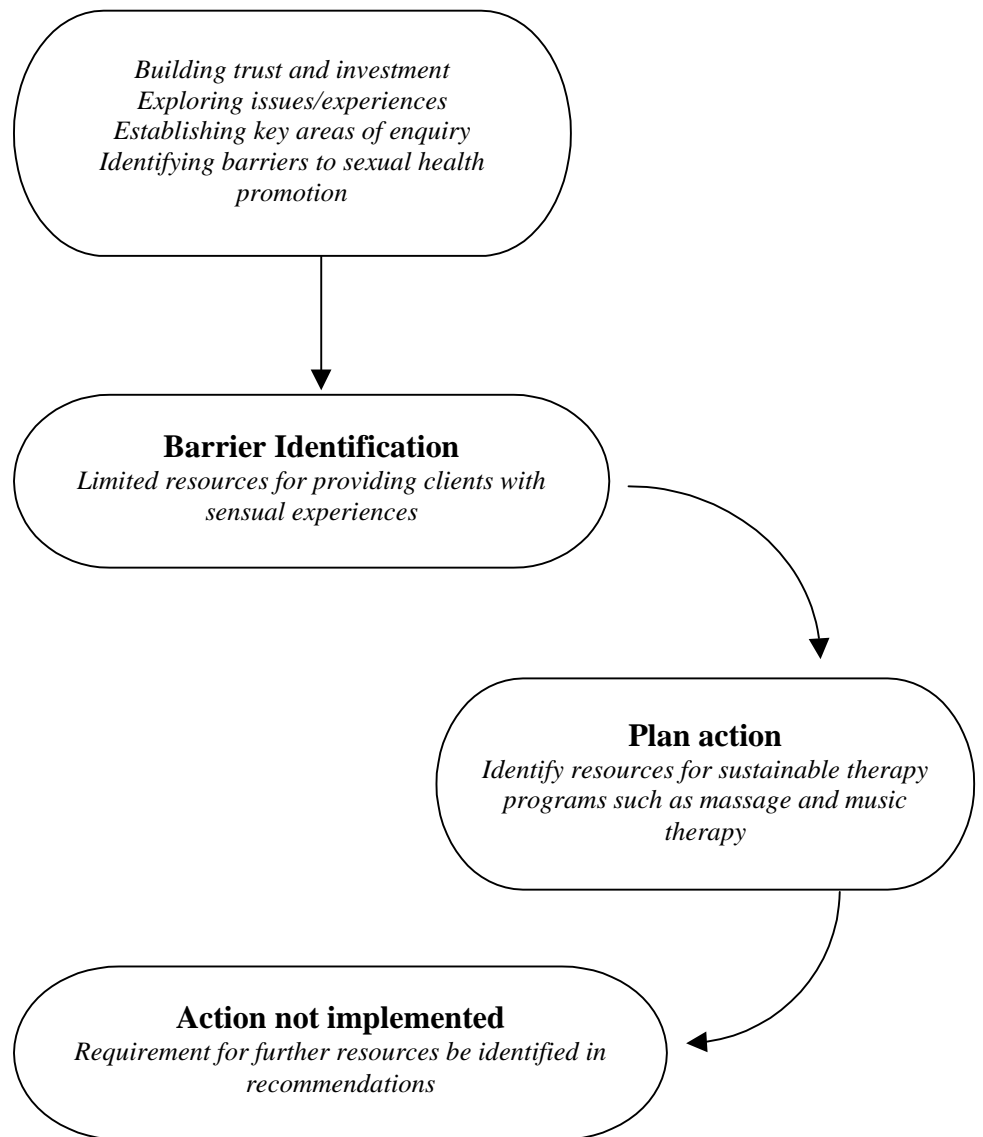
**Figure 12. Unit X: Action Research Cycle 2.3**



**Figure 13. Unit X: Action Research Cycle 3**



**Figure 14. Unit X: Action Research Cycle 4**



## **8. RESULTS Unit Y Action Research**

### ***8.1 Background***

#### **8.1.1 The setting**

Unit Y is a Geriatric Evaluation and Management Unit (GEM). The GEM client group is usually older people with complex, chronic or multiple health care conditions requiring treatment and stabilisation of those conditions and/or medical review for future treatment options or service planning.

Details of staff and clients are described in Chapter 4: Research Design and Method, section 4.1.

#### **8.1.2 Participants, frequency and number of ARG meetings**

The information session conducted by the project team to outline the project was attended by 18 multi-disciplinary staff (13 nursing staff and 5 allied health staff). Over the duration of the project a total of 17 Unit Y staff attended the ARG meetings. Six staff attended more than half the ARG meetings and constituted a core group. On average the size of the ARG meeting was 4-5, which consisted predominantly of nursing staff (RND1 and RND2). Allied health staff was represented on occasions by the occupational therapist (three occasions) and the dietician (one occasion).

Attendance fluctuated for the first few sessions. By the fourth session the core group of 4-5 staff was formed, all of whom were nursing staff.

Meetings for the ARG were held on the ward immediately following the nurses hand-over held at 2:00pm. Meetings were held weekly in the initial stages of the project with longer intervals between meetings as the project became established. A total of 8 meetings were held between the period, November 2001 to April 2002. This included an experiential education session open to all staff and attended by 6 Unit staff. This education session focussed on increasing awareness of the relevance of sexual and sensual health for older people.

### ***8.2 Key Themes***

#### **The meaning of sexuality**

At the commencement of the Wellness Project there was a general perception amongst staff in Unit Y that the project's focus was on 'sex' not 'wellness'. Participants of the ARG reported that their colleagues commented:

*"...you're on that sex project".*

Some staff perceived that clients' sexual needs were so unimportant that the project was not relevant. Furthermore, many staff believed that as the unit generally provided holistic care the project was not required.

Over the period of the ARG meetings participants developed an increased understanding of sexual health and its importance to the clients in the unit:

*“... it’s not just about sex – it is wellness, so it’s broader.”*

However, while the knowledge and attitudes of the ARG participants changed, a significant challenge for participants was to communicate this information to colleagues.

One of the key strategies of the facilitators was to support ARG participants to identify issues and change practices across the unit.

### **We must be doing something right**

After exploring the definition and importance of sexual health, participants reflected on their practice to identify how clients’ sexual health needs were met.

Participants were assisted to identify the links between basic care strategies and clients’ sexual and sensual health. For example participants recognised the importance of, but had not made the connection between, grooming and clients feeling good about themselves. The ability to make choices about hygiene and self care impact on clients’ sexual and sensual health.

*“I think we do some of these things automatically and don’t realise we are doing it, we are making a difference without realising.”*

*“We obviously do something, clients get used to us very quickly. One client here goes home on day leave and now doesn’t want to go home – what’s happening here – she must be used to the lack of privacy; or she likes the company; or the sense of security; or she worries she is a burden to her family at home. We’re sending her home on overnight leave now to build up her confidence.”*

### **Grooming**

Participants identified the importance of exercising choice about clothing, and personal routines for clients’ sexual health. Participants noted how a trip to the hairdresser could transform a client’s mood.

*" To-day is hairdressing day. Maybe 6 or 8 (clients) go, they come back smiling...such a transformation."*

Participants also recognised that as staff they had an important role to play in providing clients with the support they needed to make choices about their personal routines. For example, one participant recalled a female client who had small areas of broken skin on her face. Later it became apparent the client had facial hair and while trying to use tweezers to pluck out her facial hair was pulling off pieces of skin.

*“...she had no trouble asking for everything else but could not ask to pluck her chin.”*

Participants discussed the need to be aware that some aspects of grooming are very personal for clients and require a sensitive approach. Furthermore participants initially identified that they do not always have the resources to ensure the clients’ grooming needs are met.

*“...too under resourced ...often can't just get the basics done”*

However after exploration of the issues participants identified that the attitude of some staff was a greater obstacle to sexual health promotion than the under resourcing.

*“...the perception held by many nurses that ‘this is a hospital – not a hotel/ resort”*

Providing choices for clients in relation to personal hygiene routines, such as grooming, was recognised by participants as basic care, rather than an extra ‘hotel/resort’ type service that would be accommodated if the resources permitted.

### **Dressing with dignity.**

The issue of hospital gowns and pyjamas was raised by participants as compromising clients’ dignity and individuality.

*“It’s difficult when people don’t have their own clothes. Gowns are not appropriate if a client is walking around.”*

*“The men’s pyjamas are worse. The fly keeps on flapping open and exposing the penis”*

*“Yeah, they walk along the corridor with their butt hanging out. You try to hold the back of the gown together but it’s difficult if your hands are full with stuff”*

Participants felt that hospital issue clothing should cover private parts of the body. However while consideration was given to modifying this clothing it was agreed it was more appropriate to encourage clients to wear their own clothing.

*“A client has just come in aggressive and abusive. He wants to go home and get his own clothes, shoes and glasses. It’s a very reasonable request”*

While aggressive or abusive clients may be labelled without consideration for trigger factors, participants identified the trigger for this client was compromised sexual and sensual expression.

### **Privacy to undertake personal hygiene routines.**

Privacy for personal hygiene routines such as toileting was seen as important for clients. However participants recognised that clients’ privacy could be compromised in the current physical environment.

*“I couldn’t relax sitting on a toilet with a door that swings open. Really bad design.”*

However, the approach taken by some staff compensated for the physical and environmental limitations.

*“A client complained recently that staff wouldn’t let her use the toilet as an alternative to the commode by the bed - they want me to use the commode to clear bowels.”*

Participants identified a number of strategies that they use to ensure clients are provided with the privacy to undertake personal hygiene routines.

*“Usually we ask ‘do you want to use your bowels?’ and try and get them to use the bathroom.”*

While the physical environment is often viewed as an obstacle to the promotion of sexual health, participants demonstrated that staff awareness could at least partly negate the physical limitations.

### **Respectful engagement.**

Participants were able to identify that the language they use (both verbal and non-verbal) when assisting clients may significantly impact on the client’s self esteem.

Participants were assisted to explore the difficulty many clients would experience in having to accept another person touching their private parts and in some cases having to undertake very intimate actions on their behalf, such as wiping after elimination.

*“ God I'd hate some body to wipe my bottom when I'm young or old.”*

Participants were able to recognise the importance of how they engage clients when providing assistance with intimate activities for clients’ sexual health.

*“We see six nude people in front of us everyday. Maybe we go gently but sometimes not gently enough.”*

Another participant reflected on her frustration when, after spending considerable time assisting a client to shower and dress, the client was incontinent.

*“...and then we come along and go “Oh!” and don't realise we are doing it, but that must them feel worse.”*

The participants acknowledged that while this situation was frustrating for them, the incontinence and their response could devastate the client. Participants felt that while their frustration was reasonable there was a need to be more cognisant of how situations such as this affect the sexual health of clients.

### **Sensual Health**

An experiential learning session was facilitated to explore the importance of the five senses, ie: smell, touch, taste, hear and sight. Participants’ responses included passion for the smell of coffee, the taste of chocolate etc, listening to their favourite music and being in their favourite place in their garden watching their garden. Participants were assisted to identify how these sensual needs were accommodated for clients. Furthermore participants appeared profoundly affected when they reflected how they would respond if they were deprived of sensual choices they took for granted.

Participants were then assisted to describe how sensual needs are accommodated or overlooked in the unit.

*“One of the patients is a painter, now she is blind. She used to have regular exhibitions. She said ‘ you don’t know what it is like for me’...How awful.”*

Clients experience grief and frustration associated with the sensory losses. Participants were able to identify that they are in a position to offer clients access to familiar sensual experiences.

### **Staff Gender**

Participants examined the effect of gender on the relationship between the carer and the client. Participants identified that clients need to be able to exercise choices about the gender of the staff member assisting them to undertake intimate activities of daily living such as toileting, dressing or showering.

*“Some...older ladies (are) horrified by a male nurse showering or giving suppository.”*

*“Ladies have said it’s hard to get used to a male looking after them. Showering is a big thing.”*

While the mostly female participants acknowledged that the male nurses were sensitive to clients’ needs, some female clients found it difficult to have a male nurse assist them with intimate activities.

### **Relationships and belonging**

Participants further identified that clients’ relationships play an integral role in their sexuality expression. While a number of clients have spouses or children, others have significant loss of relationships.

*“One couple here are the last of their family and have no one. They are going into a nursing home.”*

For this couple to lose their family and then their home was a significant loss. Participants also noted that some clients did not lose their partner as such but lost the relationship they had:

*“...He was always the ‘man’ and now he (perceives he) is a burden.”*

For both husband and wife in this relationship there was significant change to the dynamics of the relationship. The group identified the impact that loneliness, grief and loss, relationships, personal identity, belonging and social connections have on individuals’ sexuality and sensual health.

### **Choice and autonomy.**

Clients’ choices relating to their daily living activities were greatly restricted during their hospital stay.

*“We dictate how they live.”*

Some participants identified that clients had reduced choice and autonomy and made attempts to provide choices for clients.

*“They are not in control with the physio, OT, doctor and ourselves dictating what they do for their day...there is an expectation that nurses will have clients up and out of bed and happy.”*

However the question was raised about the value of the choices clients were offered.

*“They get a choice between a wash or shower but not whether to have one or not.”*

Participants agreed there was the opportunity to rethink the choices clients are given to ensure they have as much autonomy as possible.

### **Individual Diversity**

While participants acknowledged that clients are diverse individuals they felt they had to work hard to maintain their focus on the client’s individuality.

*“It’s difficult not to lump everyone together...Have to strive to see the person as an individual.”*

Clients’ individual differences in sensual health routines need to be acknowledged and respected.

*“Sometimes you don’t have the time or the inclination and you try and try and don’t get anywhere so you just turn off, you don’t have time and with some others you can make a difference so you focus on them.”*

*“It’s not like you are compromising care – it’s just that you are providing the minimum, eg, ‘you’re just getting your shower today darling’”.*

Participants highlighted that barriers to promoting sexual health of clients included staff shortages and clients behaving in a challenging way.

### **Managing Sexually Challenging Behaviour**

Participants reported that they have experienced sexually challenging behaviour. They also identified that there is a need for skills and information to assist them to cope and respond better to challenging situations relating to sexual and sensual health.

*“It did happen to me (touched on the breast) and now I know what I’d do. I think role play is an important way of learning what to do – we should be able to practice what we would do.”*

The use of role-play in the sessions assisted participants to gain greater insights into clients’ feelings of frustration and identified that staff required further skills and knowledge.

### **8.3 Action planning, implementation and outcomes.**

The Unit Y staff who participated in the ARG meetings identified a number of relevant issues and future actions to further promote clients' sexual and sensual well-being. The recommended actions were not implemented within the time frame for the Project primarily due to staff and management perceptions that they already provided holistic care, taking into account the client's perspective, reflecting the dominance of organisational culture on the action research process. The description of the barriers and recommended actions is followed by some reflections by the facilitation team (see Section 8.5).

Many themes were identified throughout the ARG meetings. The key barriers identified by the participants were those that they believed were relevant to their setting and would improve practice in relation to client centred care.

#### **1) Sensual Health (see 8.4 Action Research Cycle 1)**

Clients experienced grief and frustration associated with the sensory losses. Participants were able to identify that they were in a position to offer clients access to familiar sensual experiences.

##### ***Recommended Actions:***

- Increase opportunities for communication between staff on clients issues, such as, coping with the impact that relationships, personal identity, belonging and social connections have on an individuals' sexuality and sensual health.
- Participants recommended the unit purchase hand held massage devices, electric oil burners, a foot spa and contract services of a clinical masseur to provide more sensual health opportunities for clients.
- The Unit Manager and ARG participants expressed an interest in developing a brochure for their unit highlighting the importance of sensual and sexual well-being for older clients. A draft of the brochure developed by the consultants is currently under consideration (see Appendix 5).

#### **2) Grooming (see 8.4 Action Research Cycle 2)**

Participants recognised that as staff they have an important role to play in providing clients with the support they need to make choices about their personal routines.

##### ***Recommended Actions:***

- Increase opportunities, within available resources, for choices that clients can make about personal hygiene routines, including grooming, on admission as part of the assessment and then as part of ongoing review.

#### **3) Managing sexually challenging behaviour (see 8.4 Action Research Cycle 3)**

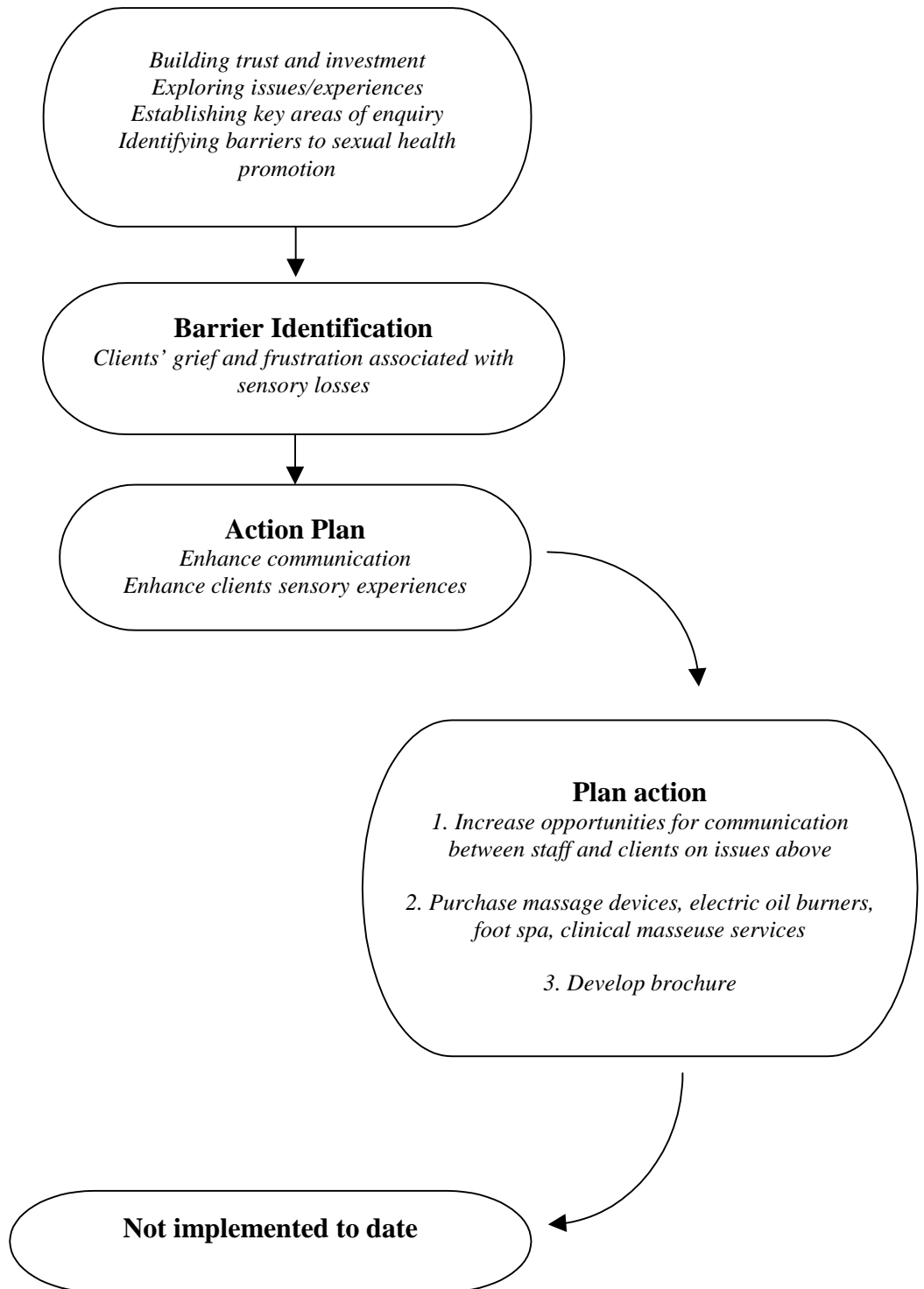
Participants identified a need for skills and information to assist them to cope and respond better to challenging situations relating to sexual and sensual health.

##### ***Recommended Actions:***

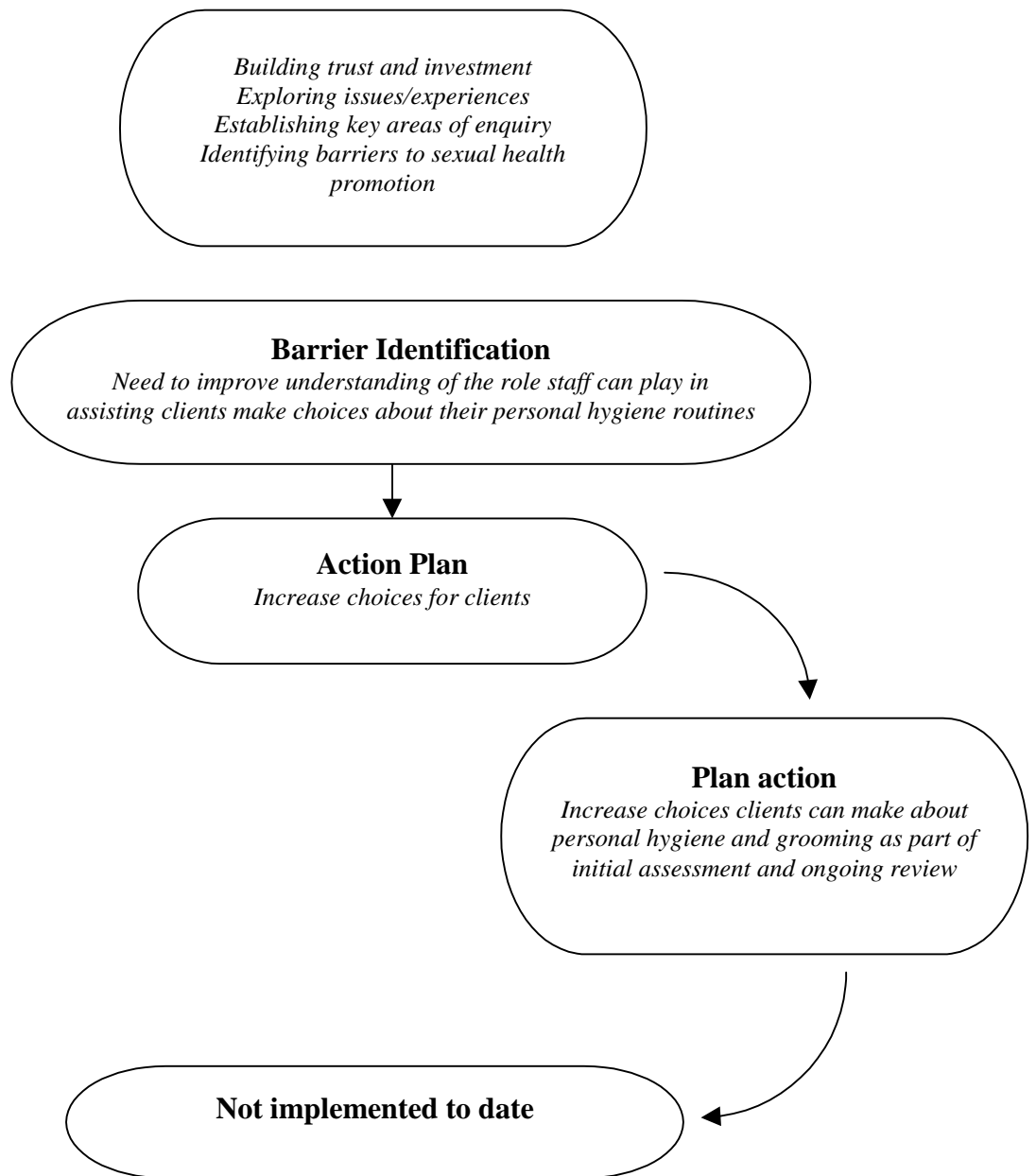
- Education and training to assist staff cope and respond better to challenging situations relating to sensual and sexual health.

8.4 Diagrammatic Overview of Action Research Cycles

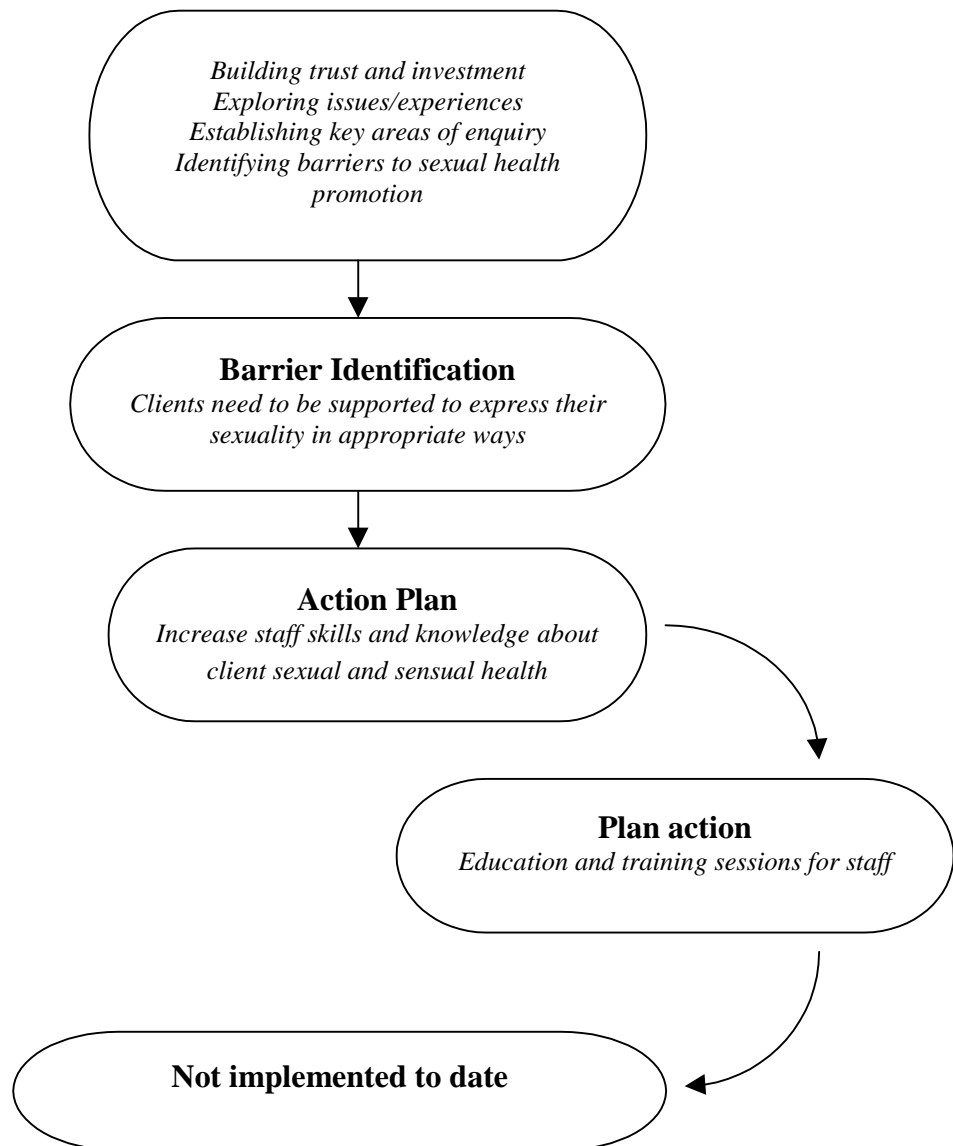
Figure 15. Unit Y: Action Research Cycle 1



**Figure 16. Unit Y: Action Research Cycle 2**



**Figure 17. Unit Y: Action Research Cycle 3**



## **8.5 Reflections on ARG**

In order to create practice change, the Unit Y staff and management and the MECRS organisation needed to be able to identify the status of current practice. The process included determining how the deficits in the existing culture created barriers to change and the strengths created conditions and opportunities for improvement.

The Unit Y ARG participants were presented with several dilemmas during the course of their involvement. Firstly, ARG participants articulated that they were not necessarily representative of the rest of the staff. Their preparedness to consider the role of sexual and sensual well being to older people including their clients, at times, set them apart from some of their colleagues.

Secondly, there did not appear to be a congruence of vision. The ARG participants indicated that there was not a shared vision or understanding that sexuality was integral to their client's well-being. The participants identified that through the experiential and ARG sessions they had begun to more fully appreciate the relevance and importance of sexual and sensual expression for their clients. Additionally, the ARG participants made two "paradigm shifts". Initially, realising that the way in which staff delivered health care through clinical and Activities of Daily Living (ADL) assistance could impact positively or adversely on the client's sexual or sensual well-being. Furthermore, they identified that in their current practices they frequently unconsciously incorporated sensitivity to sexual and sensual health preferences but did not always consciously and consistently communicate these practices across the unit.

Thirdly, they found that by being engaged in the ARG process and identifying areas for practice improvement they were becoming philosophically different from some of their colleagues and were presented with the challenge of how to engage the other staff. It appeared that the sensitivities which often surround the topic of sexuality may have contributed to the outcome.

At times, when commencing a new session, the facilitators were struck by the participants' sense of inertia or 'stuckness', particularly when at the completion of the previous session the participants had been eager to communicate their insights with their colleagues and to implement actions to improve or consolidate practices. Concomitant with this challenge, the ARG participants found that changes to staff-client ratios and regular use of agency staff presented further obstacles resulting in reduced opportunities for their attendance.

Consequently, although the participants generated many key issues and learnings identified through the ARG sessions they did not all fully translate into completed actions. The Unit Y staff who participated in the ARG meetings identified a number of key barriers to sexual health promotion that they believed were relevant to their setting and would improve practice in relation to client centred care. However, as mentioned in section 8.3 these recommended future actions were not implemented within the time frame for the Project.

## 9. RESULTS Unit Z Action Research

### 9.1 Background

#### 9.1.1 The setting

Unit Z is a low care residential facility with 98 beds.

Details of staff and clients are described in Chapter 4: Research Design and Method, section 4.1.

#### 9.1.2 Participants, frequency and number of meetings.

Twelve months prior to the project, the staff of Unit Z had experienced significant organisational transformation and frequent managerial changes. The three Unit Managers for the project's duration all perceived that the staff would experience difficulty participating due to the pressure placed upon them by the ongoing Accreditation process. At the commencement of the action research process in Unit Z attendance was low. Participants believed that many staff perceived the discussions were about sex and were too embarrassed to participate or perceived themselves as 'too old to talk about it'. The project team believed it would not be viable to support such a small group. The Unit Manager recommended restarting the ARG after a short break to allow staff time to meet the more pressing needs required to meet the Accreditation standards and guidelines. A small break was incorporated and the project then restarted with a new focus on supporting staff to look after their clients by looking after themselves. The flyer promoting the first session to re start the ARG process stated the following.

*Need to recharge the batteries?*

*Are you finding you are giving out so much, there's not a lot left over for you.*

*Who is looking after you? Looking after yourself is the key to looking after your clients.*

When sessions recommenced 8 staff attended, a significant improvement on the low attendance at the earlier sessions. Over the period from February 2002 to April 2002, 10 ARG meetings were held in Unit Z.

The following responses from participants highlight the low morale and challenges for the ARG facilitators.

*"There are staff here with lots of experience and ideas about running the place if they could express them. Is that expertise being tapped – sense of it "falling on deaf ears"*

*"We came to the job because we wanted to care for people. We get tense and take it out on people at home."*

*"It feels awful to go home and worry about the things you didn't get done."*

*"We are often working for nothing – we don't get paid for overtime – yet we can't get everything done while we are at work."*

After this initial contact with the staff it became apparent that the focus of the sessions would need to be two-fold.

Firstly, staff required opportunities to reflect on ways to look after themselves as they presented as stressed and under resourced. It was counter-productive to ask the staff to consider their clients' sensual and sexual well-being when the staffs' morale and well-being appeared impoverished. The staff needed to experience how sensuality intrinsically fed their self-esteem and wellbeing to gain insight into the needs of their clients.

Secondly, by modelling to staff the benefits of promoting sensual well-being, greater insights would be gained by the staff when reflecting on ways to promote and value client's sensual well-being.

Therefore, the themes, identified from the ARG discussions and clarified for their accuracy with the ARG participants, have a strong focus on the participants' experience of the culture of the unit and the organisational context.

In relation to sexual and sensual health, responses from participants demonstrated an understanding of sexuality as a broad concept and a diversity in client sexual expression. Key themes are highlighted as follows.

## **9.2 Key Themes**

### **Clients are sexual.**

Participants experienced sexuality being expressed by clients in a range of ways, including: flirting, cuddling, holding hands, kissing, masturbation, intercourse, using sexual language, grooming, sadomasochism, and accessing sexual services and material.

Participants' responses reflected on how their life and work experience impacted on their attitudes towards older people and sexuality. Some participants had worked at the unit for a long time. For example, one participant reflected on changes in her attitude over the period of time she had worked at the unit.

*“When I first came here I used to think sex stopped at 60 – what you see in the hostel – you don't stop being sexual.”*

### **Clients have sensual health needs.**

ARG participants identified issues related to sensual well-being, such as grooming, exercising choice about clothing and personal routines.

*“Some clients are very particular about clothing and appearance”*

Participants acknowledged how good grooming practices could boost a client's sense of well-being and sensual expression.

*“When I noticed that Mrs X had her wig on, done her nails and make-up...She asked me to tie a scarf in her hair. I said Gee Mrs X you look great! And she beamed and walked away kinda proud. I think she didn't go to the dining room because of her hair. I notice she is going to the dining room again.”*

### **Staff gender.**

Participants reported that some female clients expressed a preference for a male or female staff member.

*“If a (client) tells me that she wants only a lady (female staff) to help her I tell the morning staff that so she doesn't get a shock if a male carer walks in.”*

Where a client expresses a preference for a male or female staff member this choice is respected. In particular, participants accepted that some female clients are embarrassed to be seen naked in the shower by a male staff member. This was viewed by participants as a reasonable request and part of clients' sexual health and is accommodated wherever possible.

### **Clients' privacy: Staff responsibilities**

Participants acknowledged it is important to maintain clients' privacy by knocking on clients' room doors and waiting for permission before entering clients' rooms. Participants recalled a number of incidents when staff would knock on the client's door and then enter the room to find a client masturbating. Participants acknowledged that some of the clients felt anxious and embarrassed because they had been 'discovered' masturbating. Participants reflected that while it was respectful to knock it was just as important to wait for an invitation to enter the room before moving into it.

*“I felt uncomfortable, I should've waited...I know he was embarrassed”*

*“Sometimes it is difficult because I knock and wait for “yes come in” and nothing happens...I worry if I go away that the client could be slumped behind the door hurt or sick...if I don't go in I could be in trouble...so we need a way to fix it...”*

Participants identified a number of innovative strategies to ensure all clients were afforded the right to give staff permission to enter their room. Suggestions included door handle signs similar to hotel facilities.

### **Coping with clients' sexual expression.**

Not all participants were comfortable with clients expressing their sexual health needs. Participants reported that there were two different ways in which they became aware of client's sexual health needs.

1) Whilst providing assistance with daily living skills, participants reported that they frequently encounter clients expressing their sexuality. For example, participants reported a male client becoming aroused during assisted bathing/dressing or staff members interrupting a client who was masturbating.

In these circumstances some participants reported feelings of discomfort, being challenged, distressed or at a loss for words or appropriate response, even though the behaviour could be seen as healthy sexual expression.

2) Participants indicated considerable difficulty coping when a client touches a staff member in an intimate way inappropriately and without permission. For example, a client perceived to be cognitively aware and mindful of boundaries of appropriate behaviour, touched the backside of a female staff member. Participants also reported difficulty coping with intimate statements from clients, such as:

*“you’re just the right person for a cuddle”,  
“you’ve got a nice figure” and  
“you’ve got legs like...”.*

Although these statements may appear benign when taken out of context, the tone of the client’s voice, their body language and the frequency of these statements appeared to alter the intent. Participants reported that when they were alone with the client, and these statements were made, the experience was intimidating. Additionally, participants felt distressed when they were the recipients of very sexually explicit statements which signalled the client’s intent of sexual engagement/threat. For example, references to staff members genitalia shocked and disempowered female staff.

Participants reported that in these situations they are unsure how to respond to the client. Furthermore they are unsure how to communicate these incidents to management. A key concern was that staff would be seen to have said or done something to have triggered the explicit behaviour or language. Guidelines were developed for the management of each sexually challenging behaviour identified by the participants (see section 9.3).

### **Commitment to client needs.**

ARG participants expressed concerns about clients’ care and well-being.

*“...a lot of the clients have a high level of need – we don’t have the resources to look after them properly”*

*“We have clients with behavioural problems (dementia) – and medical problems. We can’t give the residents the care they need..”*

*“Since our meeting last week,...we were told our staff ratios will be cut to 15 residents to one staff – with the resident mix we have, that’s not practical”.*

*“Something has to give – it is the resident’s care that gives.”*

Given the level of staffing and demands placed on staff it was commendable that they continued to have their clients’ well-being as their primary concern. It was, therefore, not surprising that the project team found staff in this unit receptive to strategies to promote clients’ sexual and sensual health.

### **Managing Sexually Inappropriate Behaviour**

Participants reported incidents where clients had made sexually inappropriate comments to them. Participants needed to learn how to assertively communicate and manage when clients transgress sexual boundaries.

*“What should I do if I’m stuck in the (client’s) room and he does that again?”*

A session on assertive communication and basic ways to feel resourced in challenging situations was conducted for participants and enthusiastically received.

*“I really found that when I practised that at home, I felt stronger and more in control”.*

*Who would believe that just the way you stand can affect the way you think and talk.”*

However while strategies were developed to manage sexually inappropriate behaviour the focus of the sessions was primarily providing clients with the opportunity to express their sexuality in a positive way.

### **Choice and Decision Making**

Through the sessions, participants developed a better understanding that ADLs, such as showering/dressing etc, provided the client with opportunities for choice and self-determination. Participants were able to make the connection between these everyday activities and the sensual well-being and self esteem of clients.

*“ I didn’t realise how many choices are automatically taken for a (client), compared with when they are at home”. “It would be depressing and hard to adjust to...” “ No wonder some of the clients get depressed.”*

The unit already had systems in place for ensuring clients’ choices were identified, what appears to have changed for participants is an understanding of and a respect for these choices. Furthermore participants made links into the profound effects of choice and decision making on clients sense of worth, self-esteem and sexual well-being.

### **Sexual Health Promotion: Links to Accreditation.**

Staff were fatigued and disheartened by the additional demands that had been placed on them to pass the Accreditation process for the Standards and Guidelines for Residential Aged Care.

*“When we were assessed for accreditation we were told we had three years to achieve all the standards. When formal notice came through it was noted that we had only one year. That felt depressing”*

*“The Code of Practice for aged care facilities has standards that are up here (high)- What a joke- its propaganda. Resources and funding are not going to the right areas.”*

*“...we’ve been feeling frustrated for a long time...We came here last week, not knowing what to think and you sat here and listened - you didn’t condemn us”*

Participants saw the accreditation processes as series of never ending hurdles, with each hurdle a little harder than the last. Philosophically participants could see that the accreditation process was an important measure of quality of care. However, the dilemma the participants experienced was that the time taken to prove quality of care, through accreditation took them away from providing the care that clients needed. Initially, the project was viewed as another hurdle. Consequently, the first sessions focused on ‘mutualising’ or drawing parallels between the loss, grief and disempowerment participants experienced with those experienced by clients. Self-esteem becomes undermined when choice and decision making are diminished for staff and residents.

Further parallels were drawn when participants expressed uncertainty about the outcomes from the accreditation process and possible implications for the future of the unit.

*“Where is our future?– what will happen to the clients? It was like falling in a black hole.”*

ARG sessions explored how the same processes of loss and change can render the client depressed, confused and uncertain of where they belong and what is expected of them. Consequently, the facilitators demonstrated to participants that the strategies to overcome sense of loss and confusion involve the same processes for staff and clients.

### **The Burden of Documentation**

Participants reported substantial pressure related to the documentation requirements for care plans and resident classification index. The care plan was reported to be lengthy, complex and inappropriate for the resident mix.

*“The government can’t ask us to do all this paper work – There’s more paper work than we can manage, however, if we don’t do it we don’t get the money to look after the clients. More pressure on us doing the paperwork than caring for the clients properly.”*

*“It is very frustrating - one group of advisers sent us in one direction in developing a format for care plans and others have sent us in another direction – very confusing – have had three different inputs,(but) it feels right now!!”*

*“Our residents mix is different to other settings in MECRS - a 26 page care plan is not appropriate here.”*

*“Care plans used by other hostels are 11 pages long yet we are unable to use them.”*

Participants felt that the documentation was not only excessive and unrealistic but that it further reduced the time they had to meet client’s care. In the ensuing sessions, the participants identified the need to reduce documentation in order to free up more time and resources for promoting clients’ sexual and sensual health.

Since completing the ARG meetings in Unit Z staff have been involved in the development and the introduction of a ten page care plan for the Unit.

### **9.3 Action planning, implementation and outcomes.**

In response to identified key barriers to promotion of clients' sexual health the ARG participants developed a number of resources including; a policy to promote the sexual and sensual health of clients; recommendations to promote staff wellness; and guidelines for the management of sexually challenging behaviour. These identified key barriers and resources are described below.

#### **1) Sexual Health Policy (see 9.4 Action Research Cycle 1)**

Participants recognised that clients had sexual needs and that staff required guidelines to appropriately promote clients' sexual and sensual well-being.

Participants were unaware of a sexual health policy at MECRS, but felt all staff should be aware of how it relates to their particular setting and practice. On hearing about the policy participants asked:

*“Where is it? ,... what does it say?,.... would it work here?”*

#### **Actions:**

Over the period of the project and as a result of insights through the ARG sessions, participants developed their own sexual health policy (see Appendix 5).

#### **Outcomes:**

The sexual health policy starts with a definition of sexuality that incorporates the learning about clients' sexual health from the sessions.

‘For the purposes of implementation of this policy sexual health is defined as: People’s sexual health includes their sexual identity (maleness, femaleness), their sensuality (body image, grooming, touch, erotica, romance), their intimate relations and expressions of their sexuality (hugging, holding hands, flirting, masturbation, sexual intercourse). In the context of residential aged care, sexual health must include the rights of residents to express their sexuality in an appropriate place within a supportive environment with the assurance of privacy without infringing on the rights of others. The hostel policy addresses the rights and responsibilities of residents, staff, relatives and partners and management and considers the relationships between these groups.’

The policy then explores eight areas of client sexuality, identified by the participants, that staff can address. These include self-esteem, grooming, choices, individuality, sexual activity, privacy, loneliness, senses and sexually inappropriate behaviour. What was encouraging was the breadth and depth of the participants' understanding that sexuality underpinned so much of the care that they delivered. This was evidenced by the summarised key observations.

- Clients need to be affirmed about the way in which they act or look as it feeds their self-esteem;
- Clients' sense of well being can be boosted through good grooming practices;
- Clients need to have control over their lives and be able to exercise choices;
- Clients' individuality needs to be understood and celebrated;
- Clients have the right to express their sexuality without infringing on the rights of others;
- Clients have the right to privacy;
- Many clients grieve the loss of independence, relationships and belonging;
- Staff recognise the importance of social interactions for clients; and
- Staff recognise that the senses feed self esteem and sexual and sensual health.

Finally, the policy refers to a separate set of guidelines for the management of sexually inappropriate behaviour and policy to promote staff wellness. Both of these documents are discussed in the sections that follow.

## **2) Promoting staff wellness**

Participants acknowledged that it was not possible to value the sexual and sensual health of clients without valuing staff's sensual wellbeing.

### ***Actions:***

Participants identified through the ARG sessions actions to ensure that staff needs are met and developed these actions as recommendations for MECRS.

### ***Outcomes:***

Recommendations to promote staff wellness were developed by ARG participants with the support of the facilitators. While the recommendations outline strategies for staff wellness, for example, the portering of clients, staff communication and staff facilities, a dual purpose of the recommendations was to model behaviour that could be applied by staff to clients. These recommendations were specifically addressed to MECRS and have not been included as appendices.

## **3) Coping with clients' sexual expression and sexually challenging behaviour (see 9.4 Action Research Cycle 1).**

Not all participants were comfortable with clients expressing their sexual health needs, even when behaviour could be seen as healthy sexual expression. Additionally, clients felt distressed when they were recipients of sexually challenging behaviour such as a client making a very sexually explicit statement.

### ***Actions:***

Participants identified a need for guidelines to support practice development.

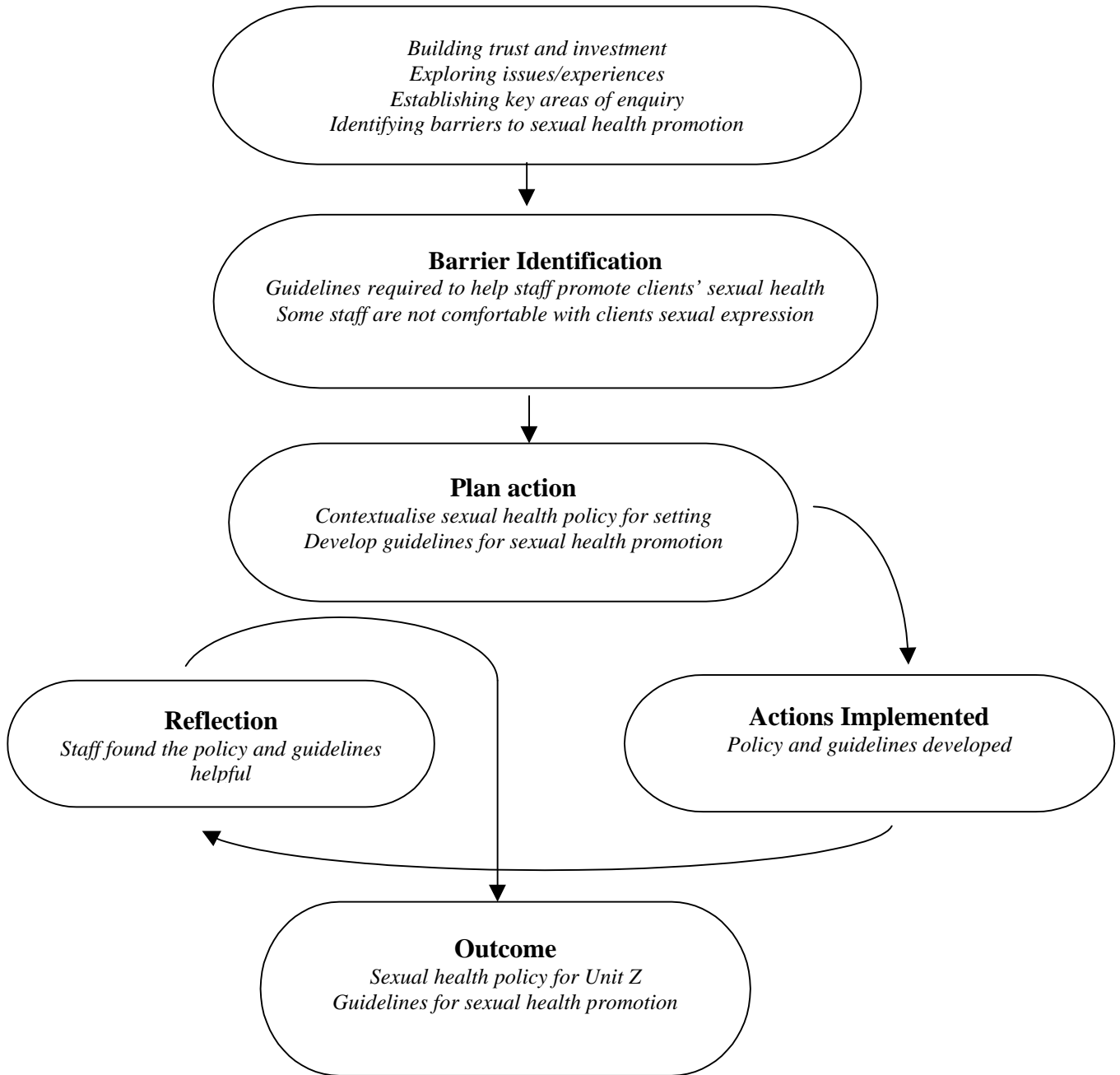
### ***Outcomes:***

Guidelines were developed specifically for Unit Z for the management of sexually challenging behaviour based on the helpsheets developed for Unit X. Management in Unit Z felt that tailoring these helpsheets to suit the needs of residential aged care would assist in ensuring sustainable practice change.

At first glance, these guidelines may be viewed as having a negative ‘sex is a problem approach’. However, core principles and individual management strategies emphasise that the best way to manage inappropriate sexual expression is to ensure clients have the opportunity to express themselves in a sexually appropriate way. The differences between these guidelines and the helpsheets for Unit X look small but are significant in terms of practice. One guideline is included in Appendix 5 to illustrate the difference.

9.4 Diagrammatic Overview of Action Research Cycles

Figure 18. Unit Z: Action Research Cycle 1



## 10. Follow-up Data Collection – Surveys and Audits

### 10.1 Results of Feedback Survey

#### 10.1.1 Response Rates

The response rate is the number of questionnaires returned as a percentage of those sent to staff members on each unit. The overall response rate was 17/80 = **21%**

Response rates for each of the participating units (Unit X and Unit Y) were:

- Unit X was **15%** (6/41)
- Unit Y was **28%** (11/39)

The low response rate for the two Units means that the results cannot be generalised to all the staff from that unit.

#### 10.1.2 Analysis and Discussion of Results

##### **Length of time staff had worked on the units**

Overall, 59% of the respondents to the survey had worked in the units for more than one year, but in the comparison by unit, a different story emerged. In Unit X, only 17% had worked for more than one year and 50% had worked on the unit for less than 6 months. In Unit Y, 82% had worked on the unit for more than one year.

##### **Knowledge and experience of the Wellness Project**

Overall, 82% (n=14) of the staff who responded to the feedback survey had heard about the Wellness Project. Sixty-seven percent (n=4) of those staff working in Unit X reported that they had heard about the Project, but only 1 staff member had taken part in the Action Research meetings. In Unit Y, 91% (n=10) had heard about the project and 55% (n=6) had participated in the Action Research meetings. Out of those who participated in the Action Research, the majority (n=5) attended more than one meeting

##### **Relevance of the Wellness Project**

Overall, 50% of staff found that the project was relevant to their work, one staff member reported that the Project hardly ever seemed relevant, and two staff members said they didn't know whether it was relevant.

##### **Definition of sexual health**

Overall, 47% (n=8) of staff reported all of the following aspects which were included within the Wellness Project's definition of sexual health: body image, romance, sensual well-being, touch, relationships, grooming, clothing, feeling masculine or feminine and intimacy, were included within the Wellness Project's definition of sexual health. It appeared that staff from Unit Y had better knowledge than staff from Unit X, with six staff from Unit Y reporting all nine aspects, in comparison to only two staff from Unit X.

## **Usefulness of the Wellness Project:**

### ***Communication***

Overall, 18% (n=3), all from Unit Y, thought that participating in the Wellness Project improved communication in their unit. The majority (41% n=7) remained neutral.

### ***Teamwork***

Overall, 18% (n=3) thought teamwork had improved as a result of the project. However, the majority (35%) remained neutral.

### ***Made no difference***

Overall, 35% (n=6) thought that the Wellness Project had made no difference to their work.

### ***Improved enjoyment***

Only 1 staff member reported that the project had improved enjoyment of his/her work.

### ***Improved understanding of the issues in dealing with sexuality and older people***

Overall, 41% (n=7) of staff reported a better understanding of the issues because of participation in the Project.

### ***More comfortable***

Thirty-five percent (n=6) of the whole sample reported that they felt more comfortable about managing challenging sexual behaviours. The majority of these responses (n=5) were from staff in Unit Y.

### ***Broadened attitudes***

The majority of staff (53%) reported that the Wellness Project had broadened their attitudes towards sexuality and older people. Most of the staff that reported a change in attitude were from Unit Y (n=6).

### ***More instruction***

Overall, 29% (n=5) of staff reported that participation in the Wellness Project had shown them that they needed more instruction in dealing with issues of sexuality. Most of the other responses were neutral (n=5).

### ***Enabled change in the workplace***

Overall, 18% (n=3) thought that participation in the Project had resulted in a change of practice on their unit, one affirmative response was from a staff member in Unit X and two affirmative responses were received from Unit Y. Interestingly two staff responses from Unit Y strongly disagreed with the statement, suggesting from a minority that there was some disagreement with the suggestion that the Wellness Project might have changed practice.

### ***Improved health and well-being of clients***

Overall, 24% (n=4) thought that their participation in the Wellness Project had improved the health and well-being of clients in their care. Only one respondent strongly disagreed with this statement.

One additional comment made about the Project was:

*“Communication via email notifying us of meeting times was timely and made us aware of the project.”*

### **10.1.3 Summary**

Overall, as response rates to the feedback survey were low the results may not be generalisable to all staff working in the units. However, feedback was generally favourable and suggested that staff knowledge and attitudes to sexual health improved as a result of participation in the Project. Twenty-nine percent of staff reported that they needed more instruction in dealing with these challenging issues. Issues relating to organisational culture, such as communication and teamwork, were deemed to improve by a minority of staff (18%). Also, changes in workplace practice as a result of participating in the Project, were perceived by a minority of staff. Importantly, about one quarter of staff perceived that the health and well-being of clients had improved as a result of their participation in the Wellness Project.

## ***10.2 Post Action Research Audits***

### **10.2.1 Unit X: Post-intervention Audit (April 2002)**

Four incident reports were made during the period audited. Of these incident reports, all related to different clients. A further 9 records were selected from the separations for the month of April 2002.

The incident reports and linked medical records described instances of overt sexual behaviour towards staff and clients. The incident report for one client described sexually challenging behaviour towards staff. The medical records described how the client was resistive towards nursing intervention, particularly disliking staff removing his clothes although he was doubly incontinent. The entry in the medical records indicated that this client may misunderstand staffs' intentions when they are removing his clothes, and interpret the actions as sexual. This entry indicates some exploration of underlying cause rather than simply labelling this individual's behaviour as "sexually inappropriate". Another two of the incident reports described clients' behaviour as sexually inappropriate and intrusive with some incidents involving other clients. The medical records described the actions taken which included: conversations with family members; explanations how the individuals may have some underlying sensual or physical needs which are not being addressed; monitoring of behaviour and emphasising the importance of consistency from staff in dealing with behaviours. The care plans asked staff to speak to the clients and to advise them if their behaviour was inappropriate.

Another medical record described the behaviour of a female client as inappropriate. No incident reports related to this client although sexually challenging behaviour was documented in the medical record. This may represent a change in practice in dealing with sexuality issues, rather than raise the incidents to a hospital wide issue (by raising an incident report), the staff in the unit managed the situation within the ward, involving the family and the carer group. The client was continually found naked, wandering at night as well as seeking out and making advances towards one male client. Staff discussed this behaviour with the client's daughter and agreement was reached that increased supervision would be undertaken to make sure that there was no physical contact with the male client. The female clients family was referred to a carer support group for counselling. As the behaviour persisted despite the increased supervision agreement was reached that relocation of the client from the unit was the most appropriate course of action. All the entries

in the records referred to her behaviour as 'sexually inappropriate'. There appeared to be little exploration of her sexual needs and her relationship with the other client.

Furthermore, another medical record showed evidence of a sexual health assessment to explore factors contributing to sexually challenging behaviour. A male client was reported as making inappropriate sexual remarks and was found with his hand on another client's breast. Discussions with family members revealed an alleged incident of sexual assault in the past and a more recent history of impotence. Management strategies identified by staff included liaising with a psychologist and speaking with the client regarding his behaviour.

In the additional seven records reviewed, the auditor reported further evidence of the awareness of clients sexual or sensual health with an entry indicating a client was "beautifully groomed".

According to the auditor's comments, there have been more sexual issues presenting in the unit in the latter few months. Therefore the drop in incident reports pre to post intervention from eight to four may indicate some change in practice on the unit. Staff may be endeavouring to deal with these issues within the unit rather than raise the profile hospital wide by filling in incident reports. There is some evidence of sexual health assessment and exploration of what may have triggered or precipitated behaviours, together with appropriate recommendations for actions from staff being incorporated in care plans.

### **10.2.2 Unit Y: Post-intervention Audit (April 2002)**

Again, no incident reports relating to issues of challenging behaviour or sexual health of clients were identified during the audit period. Further, there was no documentation of any sexual or sensual health issues in the 15 selected medical records relating to separations in April 2002.

In two reviews of 15 randomly selected case histories no examples of sexual health assessment, management or promotion were identified in case note documentation as identified by the auditor. One explanation, consistent with the literature in this area, may be the tendency by clinicians to view older clients as asexual. Other explanations could be that over the period of the project there were no occasions of overt client sexual expression or no change in documentation practices. The literature notes that often, the only time sexual health issues are noted within the clients case notes is when expression of sexuality by the older client is seen as a "problem " to the staff, co-residents and possibly the client. The concept of including sensual and sexual health issues within the framework of proactive assessment, promotion and management is not routine. This presents a challenge for an older client who continues to believe and act in a sensual and sexual manner as well as for the staff involved in their care.

### **10.3 Summary – 2 Units**

Over the length of the Wellness Project, it appears that practice may have changed in Unit X (the unit dealing with a higher prevalence of sexually challenging behaviours). The incident reports were reduced by a half, even though according to the clinical staff there were more challenging behaviours to manage. There appeared to be a trend to include more systematic management plans within the medical records in the post intervention audit. A notable change in the quality of documentation from nurses reflected a more holistic assessment of clients sexual and sensual health.

In Unit Y, there was little evidence of changes to the documentation of clients' sexual and sensual health. However participants in Unit Y demonstrated an increased awareness of clients' sexual health and reported changes to their practice (see Section 8.2).

# 11. Findings and Directions

## 11.1 Introduction

In this chapter we describe the major issues relating to clients, staff and the organisation that surfaced during the Wellness Project. The key findings relate to observations and practice that surfaced in the Action Research, together with findings from the surveys and audits. This is followed by key influences on the process, such as macro policy and organisational culture, and leads on to identify the key enablers for sexual health promotion. The chapter finishes with a focus on future directions

While the Project involved direct contact with staff and not with clients, Project activities indirectly provided the client's perspective on issues relating to their sexual health.

## 11.2 Findings

### 11.2.1 Clients Perspective

In this Project, findings were identified with regard to the broad definition of sexual health (Section 2.1). Staff participants provided information about clients' behaviour and psychosocial context that can be identified as related to the sexual and sensual needs of clients. These aspects can also be traced to significant changes in the life of individuals (losses such as functional limitation, bereavement, and change of residence) which in turn may affect their sexual and sensual needs.

#### **Sexuality**

Project findings are consistent with research evidence that suggests that older people are sexual. Through the staff surveys, medical record audits and the ARG meetings, a diverse range of sexual expression by clients was identified including: flirting, cuddling, holding hands, masturbation, intercourse, sexually explicit language, sadomasochism, sexual identity and accessing sexual services and material. Interestingly 67% of staff surveyed acknowledged that some older people engage in same sex relationships, although the Project team found that the opportunity to recognise and support clients' sexual diversity in these units was sometimes overlooked. However, in unit Z, the residential setting, some participants noted that same sex relationships existed and incorporated this information into their sexual health policy.

Clients were also noted to have sensual needs. During the course of the Project, specifically after experiential education sessions, staff gained some insight into how sensual stimulation involving taste, smell, sound, vision and touch could elicit important memories and provide identity anchors for clients. Further, staff recognised that the resources for providing clients with a choice of sensual experiences, such as music or massage therapy were limited. These therapies can address physical, psychological emotional, cognitive and social needs of clients within therapeutic relationships and impact positively on the client's sense of identity. Some staff participants recognised that clients' sexual and sensual expression also contributed to a robust sense of identity and well-being.

### **Opportunities for sexual expression**

As a consequence of the limitations of the physical environment and the view held by some staff that older clients are not sexual, clients had limited opportunities for sexual expression. It was therefore not surprising that some clients, particularly those with cognitive impairment expressed themselves in what were considered inappropriate ways. As a result of the Project, staff participants' recommendations include: the need to respect clients' need for privacy; and to afford appropriate respect to clients expressing their sexuality through language and behaviour.

### **Self-esteem**

As a result of participating in the Project, staff recognised that the self-esteem of clients was linked with clients' sexual health and overall well-being. As evidenced in the thematic analyses (Section 8.2) staff acknowledged that subtle changes to clients' sexual health (including sensual well-being) could have considerable impact on clients' self-esteem. This was evidenced by the boost to clients' confidence and social engagement elicited after clients were given opportunities to exercise choices regarding grooming and hygiene practices. Staff recognised that clients' opportunities to express sensual and sexual choices were currently limited and required further resources. Additionally some staff commented that it required all the staff in the units to understand the relevance of sexuality to older clients before consistent practice change would occur.

### **Loss**

Generally, bereavement, sensory loss and other losses such as illness leading to functional limitation, become increasingly common with advancing age. Further, transition into residential care can be considered to be a major life event, the change in surroundings can lead to profound changes in social networks, leaving clients vulnerable to loss, loneliness and identity disruption.

Project findings showed that loss was a major issue for clients. Through participating in the Project, staff identified that they were in a position to offer clients access to new and familiar sensual experiences, such as the use of electric oil burners, favourite food and music. These sensual experiences may help to recompense older clients for the losses they have experienced. Further, staff realised that it was important to respond to clients and to acknowledge the extent of clients' losses. Although staff acknowledged clients' issues of loss had a bearing on clients' health and well-being, they did not consistently make the connection.

### **Privacy**

Project findings from open-ended questions in surveys indicated that staff perceived problems with the built environment within their particular units, and further that these problems impacted on the chance of changing practice towards sexual health promotion. In the three units in the Project, problems relating to private spaces, individual rooms, and communal spaces, were identified. Staff identified problems related to limited physical space and doors that swung outward which affected clients seeking some privacy to go to the toilet.

Other aspects of the privacy issue were raised in the ARG meetings. Staff participants reflected that lack of privacy for clients to undertake intimate activities or to express their sexuality was a major issue. Clients who wished to masturbate, engage in intimate behaviour or have sexual intercourse needed to have a private space and had to rely on staff to respect their privacy and not enter the bedroom without permission. As a result of taking part in the Project, staff participants from the residential care setting identified a number of innovative strategies to ensure all clients were afforded the right to give staff permission to enter their room. An example was the use of door

handle signs such as a 'do not disturb' sign to remind staff that they needed to wait for permission to enter. Given that not all staff viewed clients as sexual some staff did not understand the client's need for a private space for sexual expression.

Privacy for intimate daily activities was also an issue. Staff participants recognised that, the lack of privacy to undertake toileting embarrassed some clients in the GEM wards. Some staff implemented strategies to recompense clients for the lack of privacy, for example by ensuring clients were provided with the opportunity to use a toilet rather than bedside commode where ever possible.

Many clients with cognitive impairment had difficulty identifying private spaces for sexual expression. For example, a number of clients masturbated in view of other clients and staff. Some staff recognised that clients needed to be shown a private space and reminded that their private behaviour infringed on the rights of others in a public space.

### **Dignity**

Staff participants in the ARG meetings reported that delays in providing clients with their own clothes resulted in both staff and clients' frustration regarding the necessity of wearing hospital gowns and pyjamas without adequate covering of private parts of the body. Through the ARG sessions staff also established that a clients' personal clothing provided sensual and social anchors which had the potential to boost a person's sexual health and general psychosocial well-being. Consequently staff highlighted that to strive for best practice, clients' families would be encouraged to bring in the clients personal clothing on admission. Consideration was given to the possibility of modifying the hospital gowns design to increase more reliable coverage, however this did not translate into an actionable goal during the Project's duration.

### **Choice**

During the ARG session, participants confirmed that sexual and sensual well being could be promoted by enabling clients to make choices about a range of personal hygiene practices. Although choice was important for clients if they were to maintain their dignity, self-esteem and individuality, staff participants indicated that maximising opportunities for clients' self determination did not always translate into routine practice. Furthermore staff participants noted that some clients had difficulty in maintaining personal hygiene and grooming without assistance from staff. However participants indicated, that although clients were asked about some of their personal hygiene preferences, the current assessment methods would not adequately elicit detailed information about the client's more intimate health routines and preferences.

Participants in some units also revealed that clients' decision making about hygiene choices was sometimes limited. In the GEM units participants reported that the time of shower was often influenced by staffing issues and clients did not usually get asked about whether they want to have a shower or not. Furthermore in these units, staff commented that clients were not usually in control of how they would spend their days because these decisions were usually made by staff, as they attempted to juggle the needs of all the clients. Through the ARG discussions, staff participants recognised that small changes in practice could provide greater choice for clients.

### **The client's story**

Individual history and life experience can be important factors in explaining current behavioural issues. The experiences of clients together with information about their social backgrounds are considered important factors in explaining medical and psychological status of clients, as well as their general outlook and expectations.

Prior to the Project, when a client expressed what was considered inappropriate sexual behaviour<sup>3</sup> the traditional responses from staff could include ignoring, medicating, or removing the client from the unit. There appeared to be potential for more consideration about how the client's pre-morbid psychosocial and cultural context (the client's story) could impact on their sexual expression.

Through the ARG meetings staff participants gained recognition that in most situations where a client had expressed themselves in an inappropriate sexual manner, understanding the client's story helped staff to better appreciate their behaviour. The client's story could help to explain behaviour and help staff respond to underlying needs and promote sexual and sensual health of the client.

### **Cognitive Function**

In all units there were clients who had impaired cognitive function. Frequently, the clients' level of cognitive function influenced their sexual expression. As previously discussed (under Privacy) participants identified some cognitively impaired clients had difficulty identifying a private space for private behaviour such as masturbation. Some clients experienced difficulty understanding their sexual advances were unwanted by other clients or staff. Some clients misinterpreted help with personal care, such as showering assistance by staff, as a sexual invitation. Understanding the client's cognitive impairment was an important component of understanding what they were doing and why.

### **Dependency on staff**

Staff participants reported that clients were dependent on staff for many aspects of their health and well-being. Unless staff were aware of clients' sexual and sensual health needs then clients experienced considerable difficulty maintaining pre-morbid intimate personal hygiene, sensual and grooming regimes.

Through the ARG process staff participants recognised the important role they played in assisting the client to complete more intimate procedures. Additionally staff participants increased their awareness that because of their health professional status they were involved in clients' very personal and intimate body spaces and health routines. For example, insertion of a suppository could be a routine procedure for staff, but for the client, had the potential to elicit a range of sexual and sensual responses and memories.

Staff participants discussed how the professional need to undertake these procedures came with the responsibility to do so in a manner respectful of the client's private body space and their sensual and sexual privacy.

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<sup>3</sup> As older people are usually viewed as 'asexual', sexual expression is viewed as abnormal, necessitating a challenge to staff or carers. Too frequently any type of sexual expression from an older person/client may be perceived as 'sexually inappropriate' and the person a deviant presenting a problem to be solved. For the purposes of the Project sexual behaviour conducted within 'appropriate' private spaces without violating the rights of others is deemed as healthy/appropriate sexual behaviour. Inappropriate sexual behaviour refers to sexual behaviour through action or word, which intentionally or inadvertently and without consent, undermines others' sexual well-being, safety and rights.

## **11.2.2 Staff Perspective**

### **Clients' sexual expression is challenging to staff**

Perceptions that older people are not sexual, and older peoples' sexual expression is not legitimate, make for obstacles to sexual health promotion. These perceptions reflect the attitudes of society at large – the asexual older Person (Minichiello, Plummer et al. 1996; Minichiello, Plummer et al. 2000). As a result of societal attitudes, and embarrassment talking about such a sensitive topic, staff may not promote the sexual health of clients as a routine part of practice. Further, research evidence indicates that clients would prefer staff to initiate discussion about sexual concerns, and that staff expect clients to introduce the topic (Waterhouse and Metcalf 1991).

The Project found that in the absence of formal training some staff did not perceive clients to be sexual and therefore did not promote sexual health as a routine part of their practice. In the absence of opportunities for appropriate sexual expression, and without cues from staff, clients sometimes expressed themselves in inappropriate ways. As a consequence of the frequency of inappropriate sexual expression some staff perceived that sexual expression was problematic.

What the ARG process assisted staff to do, was to see that sexual expression was broader than challenging behaviour and that staff could promote the sexual health of clients. Further, the Project identified that staffs' experience of clients' sexual issues was not routinely discussed and practice in dealing with the issues was frequently left 'unsaid'. Prior to the Project participants acknowledged that they frequently felt too inhibited, embarrassed, uncomfortable or ill-informed to formally and appropriately discuss clients' behaviour or language when it was of a sexual nature. The Project enabled staff to discuss and reflect on the issues and practice in a non-threatening way. The process of surfacing the issues was critical to improving practice.

### **Sexual health – making links**

Consciousness raising can be an important component of health promotion because it can lead to organisational learning in relation to best practice.

The Project found that many staff were unaware that they were already implementing strategies to promote the sexual health of clients. Staff participants were aware that: grooming was important to clients and had potential to boost self-esteem and well-being; that wearing hospital gowns and pyjamas which did not cover private parts of the body impacted on the dignity of clients; and that privacy for activities such as toileting needed respecting. However, while staff identified these issues as a part of promoting client centred care they were unaware that they were aspects of sexual health promotion. Involvement in the Project enabled staff to realise the extent of what they already do in the way of sexual health promotion.

### **Resources**

Established institutional resources and arrangements are critical structural pre-conditions for good practice in the promotion of sexual health. The accessibility of financial resources is an obvious pre-condition but important to note. Generally the availability of resources can be an indication of management's intent and position as supportive to the notion of sexual health promotion. Resources for education, training and funding for the provision of access to skilled sexual health consultants are required to facilitate best practice in this important area.

The Project found that adequate resources were needed for sexual health promotion. Staff participants identified that a unit wide and management commitment to a congruent sexual health promotion vision was mandatory. Integral to this vision was an understanding that proactive investment in sexual health promotion could prove more cost effective than a damage control process of responding to clients' sexual health only when clients exhibit inappropriate behaviour.

Participants recognised that resources are required to ensure education of staff, clients and families initially, and to support ongoing training for staff in the area of sexual health promotion. Resources for therapies, such as massage and music therapy are useful to support staff to promote sexual health of clients.

### **Time**

Time was identified as a major barrier to practice change. Specifically, the Project was sometimes hampered by the lack of a structured time slot for this activity. In the hospital units, there was a designated time slot 'between shifts hand-over' that could be used for staff participation in the ARG meetings. Staff may perceive that they cannot take time out of their routine work and may be expected to participate in their own time. This issue proved problematic in arranging the ARG meetings.

However another aspect of this issue is also important. Although staff perceived that time constraints were a major barrier to promoting clients' sexual health, the Project identified that attitudinal barriers may be more important. For example, prior exploration of psychosocial issues may reduce the prevalence of challenging sexual incidents leading to a more efficient use of staff time, rather than specialising clients (1:1 care) after the incidents have occurred.

### **Multidisciplinary Teamwork**

Alongside the concept of holistic health care in today's health care environment, sits the notion of effective multidisciplinary teamwork. Communication links across professional teams facilitate the development of a shared understanding, and are likely to lead to more robust and sustainable strategies for best practice.

Participants in the Project identified some potential for improved communication across professional teams (for example nurses, medical and allied health workers) to facilitate sustainable practice improvement. Communication across professional teams was identified as central to share experience, knowledge and to focus on the most effective ways of managing client care leading to sustainable practice improvement. In one of the units where the Project was implemented, the action research process fostered improved care practice across inter-professional boundaries.

### **Valuing staff**

Another aspect of consciousness raising identified during the Project relates to the insights gained by staff into the impact of sensual issues on their general well-being. The need for valuing staff was identified as a key facilitator to practice change, particularly for staff in the residential care setting, where morale was low. During the Project, staff were provided with opportunities to reflect on ways they could look after themselves because it was identified as counter-productive to ask staff to consider clients' sensual health, when their own was perceived as neglected and impoverished. As a result of the experiential learning process and by modelling to staff the benefits of promoting sensual well-being, staff gained more insight on ways to promote clients' well-being.

### **Psychosocial context (see also the client's story)**

The project found that psychosocial information about clients was identified as being difficult to retrieve from the medical records. The limited contextual information, which can provide the context for client behaviour, was problematic to both achieving and identifying best practice holistic health care. Psychosocial information is crucial in assessment and care planning and fundamental in changing practice from a symptom management approach, towards detailed exploration of underlying issues for clients. The staff identified that some psychosocial information was available within the medical records but it was scattered throughout and difficult and time consuming to retrieve it. Initially staff participants from one of the units considered the notion of a 'lifebook' for clients outlining the client's psychosocial profile. However during the course of the Action Research, this action was replanned into an alternative strategy that required less documentation. A proforma for collecting psychosocial information was trialled as part of a case review model, leading to a recommendation the psychosocial profile of clients to be recorded as a 'life sheet' in the medical records.

Further, staff identified that families' contribution, particularly in relation to gathering psychosocial information for the client's profile, was valuable in exploring sexual health issues. Findings from the post Action Research audits in Unit X showed that psychosocial profiles were being built using families' contributions through the carer groups. However, tensions can arise in the partnership between health professionals and families in the provision of client care, particularly in relation to sexual issues. Sharing information with families raises issues about whose well-being is more critical, client or family (where goals are not shared); and issues of privacy, particularly for people with dementia, where consent and capacity need to be considered.

### **Consistent management strategies**

Staff identified a need for consistency in the management of sexual health issues. This issue emerged through the action research process, and was also identified in the medical record audits. The inconsistency in responses to clients' behaviour largely reflected individual, cultural and societal attitudes, and expectations of staff, carers and clients.

Factors influencing responses to sexual health issues included: age and gender of clients (as shown in Section 7.2 it was more commonly expected for males to express sexual behaviour than females); time of day or night; level of cognition of clients; resources available; staff attitudes (extent of ageist and sexist biases); and staff experience.

### **Knowledge and attitudes**

Ageist attitudes towards sexuality and older people are demonstrated where there is a lack of acceptance that sexual behaviour among older people varies in the same way as it does for younger people. One of the strengths of the Project was survey responses from the Wellness sample were compared with much larger reference samples of health professionals (Foreman, Wells et al. 2000; Lindeman, Gough et al. 2000). Therefore findings may be generalised across a wider group of health professionals.

Project survey findings indicate that there is considerable scope for improvement in staff knowledge in the area of sexuality and older people. A significant finding is that knowledge and attitudes are related (see sections 5.1.2) suggesting the presence of an opportunity for education and potential to positively impact on attitudes.

Another of the strengths of the Project is that it investigated knowledge and attitudes in two ways. One was through the surveys, the other was through exploration in the Action Research. The action research process and experiential learning explored knowledge and attitudes towards sexuality and older people. As a result of participating in the project, staff participants developed a deeper “know how” about the breadth of the operational definition of sexuality and the relevance for older people (clients) in their care. This contributed to a broadening of staff attitudes towards sexuality and older people and for some staff it led towards a desire for more education on the topic (section 10.1.3).

### **Overall**

Action research is gaining increasing recognition as an approach that is particularly suited to identifying problems in practice and finding solutions or helping to develop solutions in order to improve practice (Meyer 2000). Throughout the Project, expert facilitators and content experts worked closely with staff to explore the sexual issues of clients in a practical context so that sexual health promotion of clients could be better translated into action.

It is interesting to compare the contexts of the units participating in the Wellness Project. Any differences between the units can help to explain any differences in the outcomes of action research in terms of producing practice change towards sexual health promotion. In a comparison of the two hospital units, the GEM unit that specialises in the care of clients with dementia, had a higher male:female ratio of clients. Further, over a 12 month period, more incidents categorised under ‘other’ (the category that included sexual incidents) were raised in this GEM unit (36) than the other GEM unit (7). All these factors may have contributed to important pre-conditions for action such as a shared understanding of the importance of sexuality, and perceived relevance of sexual health promotion. In turn these pre-conditions may have impacted on the staff participants’ ability to foster better practice in sexual health promotion and produce practical outcomes.

A question that arises out of the Project is the question of ‘reach’. Did the Project reach adequate numbers to enable sustainable practice change? The ARG process worked with small numbers of staff participants. Were adequate numbers of staff reached to achieve critical mass for practice change? It appears that in one of the units, a number of actions were implemented that are likely to have changed routine practice within the Unit. Therefore the small numbers of staff participants can be a sufficient critical mass to plan practice change given sufficient organisational support.

### **11.3 Key Influences**

It is important to set in context the key influences and enablers which will lead to the successful development and implementation of sexual health promotion in health care settings. This Project has identified current aspects of practice and organisation functioning which can form enablers in achieving sexual health promotion which forms part of optimum health care provision.

### **11.3.1 Macro-Policy Level**

Accreditation took place in the residential care facility during the course of the Project. While this process was the major focus and was on the one-hand stressful, it also represented an opportunity for the development of complementary work in advocating individualised client care.

Reform and restructuring on several levels influenced the successfulness of achieving practice change. Network changes (MECRS to Melbourne Health), Department of Human Services Policy, impact of turnover of staff, increasing proportions of agency staff and cuts in resources (cut-backs in double shifts enabling nursing staff to be released for professional development, impacted on the success of the project). The network changes resulted in a restructure of Executive positions with MECRS. This restructuring impacted on the Project. specifically all of the internal stakeholders invited to become part of the Reference group were restructured or resigned during the course of the Project.

### **11.3.2 Organisation Policy level**

Structural changes in management impacted on the strength and duration of management support for the Project

While the development of a sexual health policy at an organisational level did take place at MECRS, a major reason why the policy did not uniformly translate into practice change was the need for educational resources as highlighted in a previous study (Nay, Barrett et al. 1998).

After reflection on the outcomes of the ARG it was apparent that several factors contributed to the policy not being uniformly adopted. That sexual health promotion requires staff education and support including the development of educational resources, for example: guidelines and helpsheets. It is apparent that allocation of such resources was not implemented as the participants confirmed that they had insufficient sexual health resources and knowledge to undertake practice change. This is consistent with the principles for health promotion as outlined in the Ottawa Charter (cited p30, Dines & Cribb, 1993). Namely, that in order to achieve clear outcomes in the sexual health promotion all the following elements will be required to be supported by management and the organisation ie: building healthy sexual policy, creating supportive environments, strengthening community action within the organisation, developing the staff's personal skills and reorienting the health service from a problem orientated to a proactive focus.

### **11.3.3 A supportive organisation environment**

A supportive organisational environment emerged as an important pre-condition for implementing actions, reflection on actions, leading towards practice change and the promotion of sexual health of older clients during the action research process in the settings. With active management support, the core group of participants engaged in the action research found it possible to implement actions within their setting. While clients and their welfare are central to the Project, the group with the greatest ability to impact on clients' welfare is staff. The role of staff, including their understanding of clients needs, the support of their work by management and recognition by the organisation are vital components of healthy organisation functioning. Change in practice to further the promotion of sexual health also requires leadership and continued vision modelled from the top to constantly demonstrate and reinforce good practice.

Identifying the importance of these areas of practice from the differing perspectives of the clients, the staff and the organisation leads towards identifying the enablers of practice change. The next part of this chapter outlines the enablers of practice change towards sexual health promotion at different levels: clients and staff; organisation and macro-policy.

### ***Key Enablers of the promotion of sexual health***

#### **Clients and staff**

- Recognition that older clients are sexual.
- Respectful relationships between clients, carers and staff.
- Opportunities to increase knowledge about, sexuality and older people.
- Experiential learning about older people and sexuality leading to a change in consciousness (organisational learning) about the breadth and relevance of sexual health promotion in the setting.
- Organisational learning using action research approach. This approach empowers staff and leads to an owning of the process. The approach included a key element which emerged as important in practice change, critical reflection on current practice.
- External facilitators and content experts to enable critical informed discussion about practices concerning sexual health promotion.

#### **Macro policy level**

- Frameworks for quality care – specifically Accreditation and EQuIP.

#### **Organisational policy level**

- A policy, guidelines and other educational resources which can help to provide a framework for sexual health promotion.
- A supportive organisational environment which can facilitate the provision of infrastructure support, a shared vision, resources for education and training, and support for staff development, multidisciplinary communication and formal structures which support staff and client involvement in developing practice change.

## **11.4 Outcomes**

The educational resources from the PAR process in the three settings include:

- Unit X: Policy to Promote Clients Sexual and Sensual Health;
- Unit X Help Sheets 1-7;
- Unit X Patient Behaviour Profile (client assessment proforma);
- Unit Y Brochure for clients and relatives (draft under consideration);
- Unit Z Staff Rights and Responsibilities relating to the Promotion of Residents' Sexual Health;
- Unit Z Staff Recommendations for Promoting Staff Wellness;
- Unit Z Guidelines for the management of sexually challenging behaviour.

These resources are included in Appendix 5 with the exception of Unit Z Staff Recommendations for Promoting Staff Wellness.

## **11.5 Dissemination**

Findings from the Project were presented in the following forums and media contacts:

1. Barrett, C. 'Celebrating Sexuality in Aged Care' presented at the Australian Association of Gerontology Forum, March 2002.
2. Hetzel, C. 'Celebrating Older People's Sexuality' presented at the Family Planning Victoria, Lecture/experiential workshop as part of the Advanced Nurse Practitioner Course, February 2002 and May 2002.
3. Hetzel, C. 'Identification and Prevalence of Sexual Health Issues in a Residential Care Setting' presented at the Alexandra Private Nursing Home, Caulfield July 2002.
4. Hetzel, C. and Barrett, C. Health Dimensions, ABC, October 2001.
5. Hetzel, C. People Dimensions, ABC, May 2002; June 2002.

### ***Invited presentations:***

Hetzel, C. Invitation to present on 'Sexual and Sensual Health Issues for the Older Person: Considerations for Rehabilitation', Rehabaid Centre, Hong Kong, October 2002.

## **11.6 Future directions and further research**

Future directions relate to how the process of promoting sexual health could be disseminated into other settings. Given the insights resulting from the Project, the research team recommends:

### **Action research approach using facilitators and content experts**

The achievement of best practice requires active facilitation and involvement of content experts. Much of the early effort within the action research process was directed at building trust and investment in the process and uncovering unacknowledged attitudes and elements of practice towards sexuality and older clients. The involvement of facilitators and content experts to

encourage learning and facilitate discussion of issues relating to current practice practice is critical to the implementation of best practice of promoting sexual health.

### **Education, specifically experiential learning, contextualised for setting**

An understanding of the breadth of the operational definition of sexuality and sexual health is key to enabling discussion of the issues, and grounding discussions on current practice. The Project identified that more education was required to assist staff to respectfully communicate to clients about private sexual behaviour and appropriate private spaces and to positively manage the complexity surrounding sexual health. It was also recognised that education would be helpful for some clients regarding appropriate places where private behaviour can occur. Experiential learning assists staff to make the paradigm shift in attitude and also models appropriate management strategies.

### **Supportive policy and organisational issues**

Workforce issues and system-wide mechanisms for enabling the involvement of staff are important issues and need exploring in the context of any setting. Structural barriers such as space arrangements for privacy may need to be addressed. Organisational policy that supports staff development and provides infrastructure support will facilitate practice change. Guidelines and helpsheets are useful resources for sexual health promotion. Sexual health assessments that incorporate psychosocial information including sexual health information help to identify the nature and diversity of the clients' cultural, sexual and sensual health needs. This will enable the staff to better understand the client's needs and provide opportunities for clients' self-determination in relation to sexual health.

### **Opportunities for further research be explored including:**

- Further evaluation and development of the outcomes of participatory action research.
- Further exploration of the long-term sustainability of practice change.
- Exploration of the impact of practice change on health outcomes for clients.

## 12. References

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## **13. Appendices**

### ***13.1 Appendix 1. MECRS Sexual Health Policy.***







***13.2 Appendix 2. Terms of Reference for the Wellness Project Reference Group***



### ***13.3 Appendix 3. Self-Report Questionnaires and Feedback/Evaluation Form***

























**13.4 Appendix 4. Data Collection Guidelines and Proformas for Audits**













*13.5 Appendix 5. Resources Developed as a Result of Action Research Cycles*