

**What are the limiting or facilitating factors
for nurses in assisting elderly people
in aged residential care to express their
sexuality?**

An integrative literature review

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ABSTRACT

Objectives: This research sought to identify and explore the limiting or facilitating factors for nurses in assisting older people who are over 60 years of age and who are residing in aged residential care facilities (ARCFs) to express their sexuality. A secondary objective was to identify strategies and guidelines that assist nurses with facilitating the sexual needs or preferences of older people in ARCFs. For the purpose of this study nurses are defined as any nurse certified to practice by their respective national registration councils including enrolled nurses (ENs).

Methods: A integrative literature review methodology was utilised in this research. This method allowed the inclusion of extensive evidence from a range of articles and provided a comprehensive understanding of the research topic. The included articles included qualitative and quantitative studies. Quality appraisal and data extraction was undertaken using the Joanna Briggs Institute (JBI) appraisal and data extraction tools (Joanna Briggs Institute, 2014). A thematic approach was utilised to analyse and synthesise the findings (Braun & Clarke, 2006).

Results: Ten articles were selected for critical appraisal all of which met the inclusion criteria. One article published in 2004 was deemed seminal and was included in the study (Roach, 2004). The themes that emerged from the review of the literature were a lack of privacy, perceptions towards sexuality by older people residing in ARCFs, expression of sexuality as an inappropriate behaviour, roles and relationships and finally attitudes towards sexuality. Lack of privacy was attributed to poor physical environments, the daily routines and interactions that did not promote privacy between staff and residents such as knocking on doors and not waiting for an invitation before entering a resident's room. Most of the health care staff and residents considered the expression of sexuality by older people residing in

ARCFs as an appropriate human need and right that continues to be significant throughout life. In contrast some participants especially residents, found the expression of sexuality by older residents as inappropriate. Their peers considered the expression of sexuality as inappropriate due to perceptions of advanced age, poor health and not enough privacy to facilitate sexual activity.

Attitudes such as discomfort when discussing sexuality or addressing matters relating to the expression of sexuality of residents, embarrassment and shock were identified as barriers. Nurses' lack of knowledge and assessment skills to address sexual health concerns of residents and the expression of sexuality by older residents in ARCFs were found to contribute to their discomfort to discuss the sexuality of residents.

Conclusion

Sexuality continues to be important in older age. The expression of sexuality may shift from physical sexual activities to other forms such as showing of affection, loyalty, respect, the need to look and feel attractive and companionship. The expression of sexuality can be more challenging for older people residing in ARCFs particularly those affected by dementia. Nurses have a role to facilitate the expression of sexuality for older people in these settings. Adopting a person-centred approach ensures that the physiological, emotional, social and cultural aspects of care are addressed for the residents. Nurses need to be encouraged to gain knowledge and skills in assessing the sexuality of older adults.

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Abbreviations

ADLs	Activities of daily living
AIDS	Acquired immuno deficiency syndrome
ARCFs	Aged care residential facilities
DONs	Directors of Nursing
ED	Erectile dysfunction
ENs:	Enrolled nurses
HIV	Human immunodeficiency virus
IDC	Indwelling urinary catheter
IDT	Interdisciplinary team
IPA	Interpretive phenomenological analysis procedure
ISB	Inappropriate sexual behaviours
JBI	Joanna Briggs Institute
LGB	Lesbian, Gay and Bisexual
MMSE	Mini mental status examination
MoH	Ministry of Health
MSD	Ministry of Social Development
PCSLF	Patient-Centred Situation Leadership Framework
PLISSIT	Permission Limited Information Specific Suggestions Intensive Therapy
PICO	Population, Intervention, Comparison, Outcome

PICo	Population, Intervention, Context
QARI	Qualitative Assessment and Review Instrument
RNs	Registered nurses
SExAT	Sexuality Assessment Tool
STIs	Sexually transmitted infections
PVD	Peripheral vascular disease
QoL	Quality of life

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Chapter one

1.0 Introduction

This chapter gives a brief overview of sexuality in later life and some of the factors that affect the expression of sexuality for older people and particularly those residing in aged care facilities (ARCFs). Sexuality is a significant aspect of one's identity and well-being which remains present throughout the life span (Gott & Hinchcliffe, 2003; Langer, 2009; Rheume & Mitty, 2008). Sexuality influences one's self image, sense of identity and self-worth while social interactions and relationships can assist individuals with maintaining a sense of self-identity as well as providing support through life changes (Heath, 2011). The expression of sexuality for older people is viewed as taboo, with stereotypes having a huge influence towards perceptions that the expression of sexuality decreases and becomes irrelevant with age (Gott, Hinchliff & Galena, 2004; MacGabhann, 2015; Rheume & Mitty, 2008). This taboo is often more evident towards older adults who identify their sexual orientation as Lesbian, Gay and Bisexual (LGB) (Darnaud, Sirvain, Igier & Taiton, 2013; Norton & Tremayne, 2015). This can result in older adults in these population groups choosing not to disclose their sexual orientation out of fear of being rejected or being discriminated against by health professionals and this subsequently leads to isolation and poor well-being (Fish & Karban, 2015; Langer, 2009; Norton & Tremayne, 2015).

Despite the prevailing stereotypes, the expression of sexuality continues to be significant in later life, with the emphasis of the expression of sexuality shifting from intimate physical sexual activity to love, loyalty, closeness and companionship (Gott & Hinchcliff, 2003).

Moving into an ARCF is a major life change and is associated with the loss of usual supports, personal and financial independence (Bland, 2005; Calkins, 2018; Heath, 2011) and it is often associated with the loss of independence to express sexuality (Hajar & Kamel, 2003; Mahieu & Gastmans, 2015). Chronic conditions and progressive diseases for example, which result in

gradual cognitive decline, physical disability and incontinence, contribute to this loss of independence and makes the expression of sexuality challenging for older residents in ARCFs (Bowman, Whistler & Ellerby, 2004). In the United Kingdom more than 50% of residents in ARCFs had dementia, had been affected by a stroke or some form of neurodegenerative disease and 76 % of the residents were immobile and required assistance (Bowman et al., 2004).

Nurses are often the ones who have first contact with residents when they are admitted into ARCFs and the first to discuss their health concerns and preferences (Peate, 2004). While nurses may be aware of the physiological changes that affect sexuality (Garrett, 2014), sexuality is not widely discussed nor addressed sufficiently by health care staff in the care of the older person (Garrett, 2014; Maes & Louis, 2011). This can influence the assessing, planning and provision of individualised care that addresses patients' sexuality needs (Rheume & Mitty, 2008; Peate, 2004). Nurses may avoid addressing the expression of sexuality with residents because of their own discomfort to discuss the topic (Mahieu, Van Elssen & Gastmans, 2011; Saunamaki, Andersson & Engstrom, 2010). Nurses' personal beliefs, cultural values and level of knowledge about sexuality and ageing have been noted to influence their responses towards the expression of sexuality of older people residing in ARCFs (Bouman, Arcelus & Benbow, 2007; Mahieu et al., 2011; Salzman, 2006). It is important to gain insight into the factors that assist nurses to facilitate or limit the expression of sexuality for older people residing in ARCFs to improve care and quality of life for residents (Elias & Ryan, 2011).

1.1 Personal Statement

The researcher is a registered nurse (RN) who practices in a rehabilitation unit for older people affected by stroke. Some of the patients admitted to the unit are older men who

identify as gay and the researcher has observed that some nurses hold preconceived notions towards these patients and that these patients were open to disclosing their sexual orientation but were reluctant to discuss it with some members of the interdisciplinary team (IDT). The researcher also observed that the sexuality of patients undergoing rehabilitation did not appear to be given the same consideration and focus in the rehabilitation process when compared to other aspects such as regaining function, mobility and continence. Some patients were left with permanent physical and cognitive impairments which had an impact on their function, independence and self-image. Some patients were discharged from hospitals to their own homes or into ARCFs with newly inserted indwelling urinary catheters (IDCs) which they were meant to manage long term. The researcher observed that no education considerations were given to this group of patients regarding sexual intimacy with the IDC insitu. It seemed that the sexuality aspect of care was not given priority despite the physical and cognitive impairments that affected some patients which in turn may impact on the patients' quality of life including their expression of sexuality. It is in view of these observations and the researcher's perception that the sexuality of the older person was being ignored in the delivery of care that made this an area of interest for the researcher.

1.2 Dissertation Structure

Chapter one has provided an overview of the research topic. Chapter two provides further detail background to the topic of sexuality with reference to the expression of sexuality by older people in ARCFs, its relevance to human rights, relevant legislation and nursing practice. Chapter three discusses the integrative review methodology and outlines the rationale for choosing this method. The research question, the search strategy and the tools used to appraise the quality of data, to extract data and analyse data are also presented in this chapter. Chapter four presents the findings of the integrative review. A discussion of the findings of the integrative review is undertaken in chapter five. Findings from other studies,

relevant legislation and appropriate models of nursing care to support the expression of sexuality for older residents are also discussed in this chapter. The strengths and limitation of the study, implications for practice and research as well as recommendations are also presented in this chapter. Chapter six provides a summary of the study topic and a conclusion of the integrative review.

Chapter Two

Background

2.0 Introduction

Sexuality encompasses a wide range of aspects such as intimacy, gender and identity, sexual orientation, affection, reproduction, connection to self and others, self-image and self-pleasure (Aguilar, 2017; Maes & Louis, 2011; World Health Organisation, 2006). It is a significant aspect of one's physical, emotional and mental well-being which changes over time and remains important regardless of age (Hajjar & Kamel, 2003; Norton & Tremayne, 2015; Wallace, 2008; World Health Organisation, 2006).

Intimacy consists of significant components which are commitment, emotional intimacy, and physical intimacy, in the form of physical closeness and or sexual intercourse, mutuality and cognitive intimacy which can be represented by having shared values and thinking about one another (Rheaume & Mitty, 2008). The expression of sexuality is not only limited to intimate behaviours, it is also expressed through beliefs, values, behaviours, practices, companionship, attractiveness and roles and relationships (Hajjar & Kamel, 2003; Kamel & Hajjar, 2004; Tabernacle, Honey & Jinkins, 2009; World Health Organisation, 2006).

Sexuality promotes one's sense of identity, self-esteem and social relationships, all of which are fundamental aspects of physical, emotional and mental well-being (Heath, 2011; Wallace, 2003). There is a positive correlation between positive sexuality perceptions and higher self-esteem, better cognitive function and mental health. Due to their own perceptions about their sexuality individuals who identify as lesbian, gay and bisexual (LGB) are more likely to experience poorer mental health (D'Augelli, Grossman, Hershberger & O'Connell, 2001; McParland & Camic, 2016). The expression of sexuality is influenced and shaped by many factors including social, religious, economic, cultural, spiritual, biological, psychological,

political, ethical, legal and historical (Rheume & Mitty, 2008; World Health organisation, 2006).

2.1 Social perceptions about sexuality and aging

Before the year 1973, homosexuality was represented as a form of mental illness in the Diagnostic and Statistical Manual of Mental Disorders (McParland & Camic, 2016; MacGabhann, 2015.) Significant positive changes towards the acceptance of homosexuality have occurred since then, with the legislation of same sex marriage in Western countries, such as Australia, Canada, the United States (US), the United Kingdom (UK) including New Zealand (Fish & Karban, 2015; McParland & Camic, 2016). However, nonheterosexual relationships remain illegal and punishable by death in other countries (Carrol & Itaborahy, 2015; Fish & Karban, 2015).

Despite the growing acceptance and supportive legislation for same sex relationships, stereotypes regarding the sexuality of older people continues to be prevalent. Older adults are often viewed as asexual or their body image as unattractive (Gott et al., 2004; MacGabhann, 2015; Rheume & Mitty, 2008). These views are also influenced by the media images which portray sexuality and body image attractiveness as something that is mostly achieved by the young (Mahieu, Elssen & Gastmans, 2011; Norton & Tremayne, 2015). Some of the barriers towards an older person's sexuality are influenced by the values developed in the early 20th century which did not regard the personal expression of sexuality as important (Rheume & Mitty, 2008; MacGabhann, 2015). While these beliefs and values continue to influence the older person's view toward their own sexuality, Gott (2003) points out this may not apply to all older people as they are not a homogeneous group.

2.2 Health outcomes related to sexuality and aging

Despite the prevalence of the identified stereotypes, studies have shown that older adults including those residing in ARCFs continue to communicate their sexuality in various ways regardless of the physiological changes and sexual dysfunction brought on by disease or side effects of medication (Hajjar & Kamel, 2003; Maes & Louis, 2011; Norton & Tremayne, 2015; Wallace, 2008). Chronic conditions such as hypertension, diabetes, benign prostatic hyperplasia may inhibit sexual activity or lead to loss of sexual interest in men (Knight & Nigam, 2008; Rheume & Mitty, 2008) also, hypertension, diabetes, smoking and high cholesterol levels may cause blood vessels problems leading to erectile dysfunction (Knight & Nigam, 2008; Rheume & Mitty, 2008). Neurological problems such as Parkinson's disease, cerebrovascular accidents and spinal cord injuries may also cause erectile dysfunction (Rheume & Mitty, 2008). The incidence of erectile dysfunction increases with age, with 75 % of men experiencing it before 70 years of age (Rheume & Mitty, 2008). For women, genitourinary symptoms such as vaginal dryness, irritation, and pain associated with postmenopausal changes due to low levels of oestrogen all contribute to lessening sexual activity and pleasure. Body image changes, especially after a mastectomy for example, can cause feelings of loss of femininity for some women while reduced mobility and increased fatigue associated with medical conditions such as hypertension, arthritis, cardiovascular disease and diabetes can limit sexual activity (Norton & Tremayne, 2015; Parker, 2006; Rheume & Mitty, 2008). Some medications such as antihypertensives, antidepressants, antispasmodics and antipsychotics can sometimes adversely affect both men and women's sexual interest and function (Rheume & Mitty, 2008). The frequency and intensity of the physical act of sexual intercourse may reduce with age causing older adults to mostly focus on displays of affection, romance, touch, personal grooming, the desire to feel attractive and companionship (Hillman, 2008). Throughout this integrative review the term older people

refers to, female and male adults aged 60 years and over who reside in ARCFs. This is consistent with Erick Erickson's developmental life theory which identifies the age of 60 as the age adults reach old age (Humphrey, Lee & Green, 2011).

2.3 Expression of LGB sexuality in ARCFs

Despite the improvements in conditions for same sex relationships, individuals who identify their sexual orientation as LGB continue to experience prejudice and health inequalities because of ongoing assumptions that everyone is heterosexual in most social structures (Fish & Bewley, 2010; Langer, 2009; Stonewall, 2012). Sexual diversity is not recognised in ARCFs and individuals who identify their sexual orientation as LGB may not disclose their sexual orientation (Callan, 2006 ; Fish & Karban, 2015) for fear of experiencing prejudice, indirect discrimination, social exclusion and exclusion from access to healthcare services (Fannin & Fenge, 2008; Fish & Karban, 2015; Stonewall, 2012). Fannin and Fenge's (2008) study revealed that while older gay and lesbian men and women in ARCFs value personal identity, isolation and exclusion was the norm in ARCFs and there was a significant number of the gay and lesbian older population that were invisible in these settings. This has the potential to negatively impact on the LGB communities' sexual health and sexuality as their needs regarding this aspect of care could be neglected by policy makers in the formulation of health policies and by health providers in the delivery of care (Fish & Bewley, 2010; Rondahl, 2009).

Sexual orientation is regarded as one's ability to have profound affectional, emotional and sexual attraction to another person of any sex (Blondeel et al., 2018). Sexual orientation is rarely identified as a significant aspect in the personal identity of older people residing in ARCFs (Fannin & Fenge, 2008; Frankowski & Clark, 2009). According to Rondahl, (2009) it is apparent throughout care institutions that nursing staff hold assumptions of heterosexuality

as the norm. This is portrayed through the depictions of traditional families on posters and documentation that enquires about individual's marital status as opposed to relationship status (Rondahl, 2009). This may lead non-heterosexual older people in these settings to be fearful of experiencing discrimination, neglect, or abuse towards their sexual orientation by other residents (Frankowski & Clark, 2009). These fears may cause individuals who identify as LGB to be less open to disclosing their sexual orientation (Fish & Bewley, 2010; Fish & Karban, 2015; Stein, Beckerman & Sherman, 2010). Men who have sex with men but do not identify themselves as gay may not also disclose their sexual orientation out of fear of experiencing social and cultural stigma associated with same sex attraction (Ekstrand et al., 2017). It was revealed in Ekstrand et al. (2017)'s study that men who have sex with men were disproportionately impacted by HIV due to their limited awareness of HIV and sexual risk taking behaviours. This lack of disclosure may result in the sexuality needs of residents identifying as LGB and men who have sex with men to remain unmet (Ekstrand et al., 2017; MacGabhann, 2015).

Other than the assumptions of heterosexuality, homophobia in nursing has also been identified as a barrier in facilitating the sexuality of the older person. Homophobia can be defined as the innate fear of homosexuality that results in failure to provide holistic care to non-heterosexual individuals (Lyden, 2007). Nurses with homophobic tendencies may be reluctant to provide care to homosexuals, avoid them or treat them in a judgemental manner (MacGabhann, 2015) resulting in failure to provide adequate care to this group of clients (Lyden, 2007). The mental and physical health of the LGB community has been found to be poorer compared to that of their heterosexual counterparts (King & Nazareth, 2006).

2.4 Expression of sexuality in policy consideration

In their list of sexual rights, the World Health Organisation (2010) has stipulated that every individual has the right to choose to participate in consensual sexual relations, the right to be fully informed on sexuality matters and the right to attain a safe and satisfying sexual life (Heath, 2011). Therefore, organisations and health professionals have the mandate to create policies and environments that support the achievement of these rights for older people living in ARCFs (Heath, 2011). The Australian and New Zealand health systems have developed standards to guide health professionals in the provision of the best possible care for consumers (Australian Commission, 2017; Ministry of Health, [MoH] 2008). Midwives and registered nurses in Australia are expected to provide comprehensive care that is aligned with the consumer's desired health outcomes and preferences. This comprehensive care should be provided based on the consumer, their families, carers and the interdisciplinary team (Australian commission, 2017). The health and disability core standard service of safe and appropriate environment stipulates that facilities should provide consumers with physically accessible environments, adequate personal space and bed areas to meet the needs of the group (MoH, 2008).

Stereotypes that sexuality of the older person diminishes with age remain prevalent and continue to influence the formation of health policies (Gott & Hinchcliff, 2003; MacGabhann, 2015; Mahieu & Gastmans, 2015; Norton & Tremayne, 2015). It is apparent that the sexuality of the older person receives limited attention within policy consideration and formulation (Andrews, 2001; MoH, 2001, 2002, 2016; Ministry of Social Development, 2015; United Kingdom Department of Health, 2014).

The lack of focus on sexuality of the older person is surprising given that statistical projections by the American Hospital Association indicated that by the year 2030 approximately 58 million people living in the United States of America will be aged between 66 and 84 years and 35 million of whom will be living with multiple chronic conditions. This

forecasts a future need for an increase in aged care facilities (Aguilar, 2017). In 2011, there was an increase of almost one million people aged 65 years from 2001 in England and Wales with four and a half percent of that population living in communal homes (Office for National Statistics, 2013).

In comparison to other European Union countries England and Wales had a lower aged population than the European Union average of 18 % while Germany and Italy had the highest percentages of 21% and 20% respectively of people aged 65 and over in 2001 (Office for National Statistics, 2013). In Australia, the population of people aged 65 and over increased from 14 % in 2011 to 16 % in 2016. In 2016 5.7 % of those aged 65 and over lived in communal or short-term accommodation, with 91% of those living in communal accommodation lived in ARCFs (Trewin & Madden, 2017). The probability of living in ARCFs increased by 1% for people aged over 65 to 74 years and rose sharply to 24 % for those aged 85 and above (Trewin & Madden, 2017). In 2013, 88.8% of the people aged over 65 in New Zealand who lived in non-dwellings resided in ARCFs (Statistics New Zealand, 2015). The median age of population is expected to rise to 43.1 years by the year 2050 while the number of older people aged over 85 years is projected to rise to 322 000 by the year 2051 (Statistics New Zealand 2015).

For the purposes of this study, ARCFs refers to institutions that provide residential accommodation and offer assisted living to older people (Mahieu & Gastmans, 2015). Following admission, these ARCFs become home for the older people and hence these facilities should facilitate an environment that promotes older people to continue with their existing activities of daily living (Mahieu & Gastmans, 2015). A lack of physical and information privacy, lack of communication or assessment about sexuality, negative staff attitudes, the profiling of residents for example, widowed, single or divorced status and poor health have been identified by staff and residents as barriers to older people in ARCFs

expressing their sexuality (Bauer et al., 2013; Hajjar & Kamel, 2003; Kamel & Hajjar, 2004; Langer, 2009). Despite the enforcement of legislative regulations which mandates that privacy is a right of patients, the design and environment of ARCFs do not promote residents' privacy (Hajjar & Kamel, 2003). Most ARCFs are designed with the focus of meeting the safety needs of residents and creating therapeutic environments compromising the residents' personal aspects of their lives (Bauer, 1999; Hajjar & Kamel, 2003).

The delivery of nursing care is mostly focused on safety and meeting older residents' physical care needs while the sexuality aspect of care is commonly ignored (Bauer 1999; Hajjar & Kamel, 2003). The focus towards meeting physical and safety needs was found to be driven by the prevailing medical model which places emphasis on maintaining safety and the physical health of residents with little consideration to the expression of the older person's sexuality (Bauer, 1999). The confidentiality of medical information is well practiced in most ARCFs however staff are sometimes prone to breaches of privacy and discuss residents' personal information with their peers around other residents and this may make older people more reluctant to be open to discussions regarding sexuality (Hajjar & Kamel, 2003).

2.5 Expression of sexuality and dementia

The expression of sexuality may be more challenging to older people affected by dementia or with cognitive impairment residing in ARCFs (Hajjar & Kamel, 2003; Langer, 2009; Maes & Louis, 2011). Despite the cognitive and physical changes brought about by the progression of the disease, sexuality does not cease to exist in the presence of dementia (Higgins, Barker, & Begley, 2005). For older individuals with dementia it may be difficult for them to express their sexuality (Hajjar & Kamel, 2003; Langer, 2009; Maes & Louis, 2011; Rheaume & Mitty, 2008; Wallace, 2008) as their cognitive status, ability to communicate and memory

decline (Tarzia, Fetherstonhaugh & Bauer, 2012). This may make it more challenging for nurses to ascertain the presence of consent in the event of physical intimacy among older residents with dementia (Hajjar & Kamel, 2003; Langer, 2009; Maes & Louis, 2011; Rheume & Mitty, 2008; Wallace, 2008). Impaired judgement may also cause older residents to inappropriately direct their sexual activity to other residents or staff (Hajjar & Kamel, 2003)

These factors may predispose older residents in ARCFs to sexual abuse and inappropriate sexual behaviours (ISB) hence some nurses might respond in a restrictive manner with the desire to protect patients (Everett, 2007). Inappropriate sexual behaviours are defined as behaviours that are characterised by verbal and physical acts which are sexual and explicit in nature and unsuitable within a social context (Johnson, Knight & Alderman, 2006). These may include sexual acts such as touching, kissing, grabbing, use of explicit language and inappropriately exposing one's self in public (Subramani et al., 2011). Hallucinations and delusions are common in older patients with dementia and these may trigger ISB. It is more common for men with dementia to display ISB than women (Hajjar & Kamel, 2003).

Judgements of what is considered explicit and inappropriate within a social context may be influenced by the individual's culture, values and beliefs as well as the institution's policies and procedures (Johnson et al., 2006). These cultural differences might lead to differences in tolerance of sexual expression of older adults among individuals (Jones & Moyle, 2016). This may be more difficult especially for individuals who have migrated to a country with different values and norms to their country of origin which may hold different views and values on sexuality and ageing including feelings of hostility towards individuals who identify as LGB (Knocker, 2012).

Nurses acknowledge that dementia influences the way older residents express their sexuality and intimacy. Some nurses believe that sexuality continues to be a significant aspect of health

and wellbeing and should continue in the presence of dementia while others believe that dementia changes the quality and nature of sexual relationship making it inappropriate and unacceptable in ARCFs (Heath, 2011). It is in view of these complexities for the older residents with dementia that their expression of sexuality may bring out several ethical dilemmas (Wilkins, 2015).

Nurses in ARCFs are at the forefront of developing a holistic plan of care and are expected to take the sexuality of the individual into consideration (MacGabhann, 2015). Nurses are expected to act as patient advocates who recognise and value everyone as unique and provide care that is not judgemental (MacGabhann, 2015). According to the International Council of Nurses' code of ethics (2012) nurses are expected to provide care that is respectful, free of judgement and is not restricted by age, colour, culture, sexual orientation, gender, disability or illness. Within the New Zealand RNs' scope of practice this would be considered part of the cultural safety competence which directs nurses to consider the uniqueness of each individual whilst acknowledging differences (Cochrane, Barkway & Nizette, 2010; Nursing Council of New Zealand, 2007).

The attitudes of health care staff can positively or negatively impact the delivery of nursing care, quality of that care and quality of life as well as patient outcomes (Peate, 2004; Rondahl, 2009). Nurses' attitudes have been identified as a barrier to older people expressing their sexuality in ARCFs (MacGabhann, 2015; Mahieu & Gastmans, 2015; Wilkins, 2015). Lack of education on geriatric sexuality was found to influence nurses' attitudes (Hajjar & Kamel, 2003; Mahieu van Elssen & Gastmans, 2011). In such situations nurses were found to base their clinical decisions on their biased views of sexuality and ageing without using profession-based knowledge (Gilmer, Meyer, Davidson & Kaziol-McLain, 2010). This is also supported by Salzman, (2006) who reported similar findings that nurses who lacked education about sexuality in older age viewed the expression of sexuality by older adults as

problematic. Some nurses used inappropriate humour when uncertain about responding to older peoples' sexual expression (Bauer, 1999).

Nurses' attitudes towards the older person expressing their sexuality was also found to be influenced by the level of the nurses' comfort to discuss subjects related to sexuality as well as the ethos of the ARCFs (Saunamaki, Anderson & Engstrom, 2009). A study by Saunamaki et al. (2009) revealed that there is a correlation between the nurses' number of years in practice and the level of education and the level of confidence to address patients' sexual issues and sexuality. Nurses who had furthered their education beyond their nursing degree were more confident and open to discussing patients' sexuality compared to nurses without postgraduate education (Saunamaki et al., 2009).

Cultural diversity was also found to negatively influence the attitudes of staff, older residents and their families towards geriatric sexuality (Hajjar & Kamel, 2003) as for older people cultural differences may stem from differences in moral, social and religious backgrounds (Hajjar & Kamel, 2003). These differences may lead to conflicting approaches in creating environments that facilitate older residents to express their sexuality needs as well as inconsistent provision of care (Hajjar & Kamel, 2003). However, according to Kraus, (1995) attitudes and behaviour do not always correlate as having a liberal attitude may not result in non-restrictive behaviour in actual practice.

Most of the literature that is available on the sexuality of the older person in ARCFs reveal the existence of barriers in the expression of sexuality in ARCFs settings (Aguilar, 2017; Garrett, 2014; Gott & Hinchcliff, 2003, Hajjar & Kamel, 2003; Heath, 2011; Kamel & Hajjar, 2004; MacGabhann, 2015). Nurses' attitudes have been found to impact on the expression of sexuality by older people residing in ARCFs (Elias & Ryan, 2011; Mahieu et al., 2013) and yet the literature reviewed suggests that there is lack of support and guidance to permit nurses

to facilitate older people in ARCFs to express their sexuality. The focus of this integrative literature review will be to highlight the limiting or facilitating factors for registered nurses in assisting older people in ARCFs to express their sexuality

2.6 Summary

Sexuality is an important aspect of life which does not cease with ageing or in the presence of disease. Sexuality of the older person is not commonly addressed in ARCFs as it is overshadowed by the need to meet the physiological aspect of care and maintain safety for the older person. Lack of privacy, lack of staff education about sexuality and stereotypes that sexuality is non-existent in the older person continue to restrict opportunities for older people in ARCFs to express their sexuality. The limited focus on the expression of sexuality of the older person in ARCFs continues to exist despite the emphasis that is placed on individual and holistic needs assessments. While it may be a challenge to address the expression of sexuality for older people in ARCFs, the assumption of heterosexuality which is reflected in most social settings including ARCFs may further marginalise the expression of sexuality for residents who identify as LGB. This may result in these individuals experiencing discrimination and being excluded from receiving optimal care.

Chapter Three

Methodology and Methods

3.0 Introduction.

In this chapter the integrative review approach and the rationale for choosing this methodology is described. An overview of the research methods including how the articles included in the literature review were selected and the quality appraisal and data extraction processes will be provided. Braun and Clarke's thematic process was used to carry out the analysis and synthesis of the data and an overview of this process is included in this chapter (Braun & Clarke, 2006).

3.1 Integrative literature review methodology

A literature review is a methodology that explores a review question to critically appraise and analyse an area of interest in the research field (Hopia, Latvala & Liimatainen, 2016). An integrative literature review is a methodology that organises and synthesises extensive evidence derived from a range of research articles and or grey literature to provide comprehensive findings that inform practice (Polit & Beck, 2010; Whitemore & Knafl, 2005). It is used to summarise past empirical or theoretic literature to provide a more comprehensive understanding of a phenomena or a specific health problem (Broome, 2000; Whitemore & Knafl, 2005). The integrative literature review methodology is appropriate for answering the proposed question as it captures findings from multiple studies which may be used to inform evidence-based practice (Polit & Beck, 2010; Whitemore & Knafl, 2005). The integrative review approach provides the capacity to capture complex and varied perspectives and phenomena, incorporating literature with various methodologies may contribute to inaccuracy and a lack of rigour (Guest, MacQueen & Namey, 2014; Hopia et al., 2016; Whitemore & Knafl, 2005). Of the ten studies included in the review, eight studies

used a qualitative research design (Cook, Schouten, Henrickson & MacDonald, 2017; Palacios- Cena et al., 2016; Roach, 2004; Tzeng, Lin, Shyr & Wen, 2009; Vandrevale, Chrysanthaki & Ogundipe, 2017; Villar, Celdran, Faba & Serrat, 2014; Villar, Faba, Serrat & Celdran, 2015; Villar, Serrat, Celdran & Faba, 2016), and two studies used a quantitative research design (Lester, Kohen, Stefanacci & Feuerman, 2016; McAuliffe, Bauer, Fetherstonhaugh & Chenco, 2015). Strategies that enhance the rigour of integrative reviews include, clearly identifying the problem or question under investigation and variables such as the target population and the inclusion criteria of literature as well as clearly defining the literature search and the data extraction methods (Whittemore & Knafl, 2005). Additionally, the use of suitable tools for the analysis of data will increase the rigour of the integrative literature review (Braun & Clarke, 2006).

3.2 Research Aim

The aim of this integrative review was to address the question, “What are the limiting or facilitating factors for nurses in assisting older people in ARCFs to express their sexuality?” A secondary aim was to identify the strategies and guidelines that assist nurses with facilitating the sexuality preferences of older people in ARCFs.

3.3 PICO

The PICO framework was used to guide the search of the proposed topic (Joanna Briggs Institute, 2014). This integrative literature review methodology utilised the PICO mnemonic to represent, Population, Intervention being investigated or Phenomena of interest and Context (Joanna Briggs Institute, 2014). The population of this study were nurses irrespective of how they were classified by their registration bodies. The population under study was the most relevant to the question under review as nurses are at the forefront of planning individual holistic care for older people in ARCFs (MacGabhann, 2015). The phenomena of

interest were the limiting and facilitating factors in the expression of sexuality for the older person while the context was ARCFs. ARCFs were chosen as the most appropriate as older people who live in these settings are more likely to require assistance with activities of daily living (Trewin & Madden, 2017).

Table 1: *PICo framework*

P	Population	Nurses irrespective of how they are classified by their registration bodies
I	Phenomena of interest	Limiting and facilitating factors in the expression of sexuality for the older person
Co	Context	Aged residential care facilities (ARCFs)

(Joanna Briggs Institute, 2014).

Inclusion criteria

Primary research articles published in English from the year 2007 to 2018 were used. This timeframe allowed for past studies which were relevant and current studies to be considered for inclusion. Literature published before 2007 was considered and included only if it was deemed to be seminal. Articles that include literature on nurses and older residents' perspectives on the sexuality of the older person in ARCFs were also included. Only articles that included older people aged 60 years and over who resided in ARCFs were included.

Exclusion criteria.

Articles that included older people over the age of 60 years who did not reside in ARCFs and those under the age of 60 residing in ARCFs were excluded. Articles with ARCFs in which nurses were not employed were excluded and articles not published in English were excluded.

3.4 Search strategy

An initial search of the data bases was conducted, and relevant published literature was identified. No similar reviews on the proposed topic were identified on either the Cochrane or The Joanna Briggs Institute databases. The available literature included qualitative and quantitative studies, expert opinions and grey literature. Titles, abstracts and key words were initially reviewed and articles which met the inclusion criteria were read in full. Further literature was sourced from the reference list of potential articles and then reviewed.

Databases Searched.

Research articles were sourced from databases using search engines namely: The Cumulative Index to Nursing and Allied Health Literature (CINAHL), Excerpta Medica Database (EMBASE), Medical Literature Analysis and Retrieval System (MEDLINE), ProQuest and Psych Info. Search terms included sexuality, intimacy, older adults*, nurse*, aged, barrier*, facilitator* and attitude*. A combination of search terms was used by the Boolean logic and operators “and” as well as “or”.

Literature Search Limitations

Despite the legislation of same sex marriage and World Health Organisation, (2006) guidelines for sexual rights and sexuality, there are no specific guidelines around older persons’ sexuality, this could be a limitation.

3.5 Critical Appraisal

Quality appraisal should be done to evaluate the methodological quality of a study to exclude studies with poor methodology (Jirojwong, Johnson & Welch, 2011; Joanna Briggs Institute, 2014; Thomas & Harden, 2008). Articles that met the inclusion criteria of the review were quality appraised by the author of this work and her two supervisors using the Joanna Briggs Institute quality appraisal tools, namely the JBI-QARI, (Appendix A) and the Critical Appraisal Checklist for Studies Reporting Prevalence Data (Appendix B) (Joanna Briggs Institute, 2014). This tool was selected because it offers comprehensive and well-developed methods of analysis that are recognised internationally (Joanna Brigg Institute, 2014). The cut off score for the inclusion of articles in this review was set at 70% and quality aspects of the studies including design, methods, analysis, ethical approval by an appropriate body and the representation of participants voices were all considered to be of critical significance to the need of this review (Joanna Briggs Institute, 2014; Polit & Beck, 2010). The scoring was undertaken separately by the author and the two supervisors and differences in scoring were resolved through discussion between the three parties (Joanna Briggs Institute, 2014).

3.6 Data extraction

Data was extracted from the included appraised articles using the JBI- QARI, (Appendix C) data extraction tools (Joanna Briggs Institute, 2014). The data extracted included the following elements: title of the article, methodology, phenomena of interest, setting, participants, data analysis, author's conclusion and the reviewers' comments (Joanna Briggs Institute, 2014).

3.7 Data analysis

The purpose of analysing data in research and literature reviews is to organise, structure and deduce meaning from the data (Polit & Beck, 2010). Due to the expected heterogeneity of the

included articles data analysis was undertaken using a process of thematic analysis (Joanna Briggs Institute, 2014). A thematic process of analysis assists in providing detailed and rich findings from complex data as well as maintaining rigour and reliability (Braun & Clarke, 2006). An analysis of Braun and Clarke's (2006) six stages of thematic process and how it was utilised in this review is provided in this section.

3.7.1 Phase 1- Familiarising oneself with the data.

Each article was read several times in depth to gain an understanding of the data (Braun & Clarke, 2006; Guest et al., 2014). Key findings relating to this review were identified from the included studies and were extracted using the JBI-QARI data extraction tools (Braun & Clarke, 2006; Joanna Briggs Institute, 2014).

3.7.2 Phase 2- Generating initial codes

The key findings from the included studies were reviewed noting specific patterns and words, these were synthesised and used to inform the generation of codes (Braun & Clarke, 2006; Guest et al., 2014; Thomas & Harden, 2008). A total of twenty-two initial codes were generated from the extracted the data.

3.7.3 Phase 3- Searching for themes

In this phase the initial codes were analysed and studied in detail identifying possible relationships between codes and potential themes and categories. Seven initial themes were developed, and potential overarching themes were also noted (Braun & Clarke, 2006).

3.7.4 Phase 4-Reviewing themes

In this phase, the resulting themes were reviewed and clarified ensuring that each coded extract was consistent with the identified themes. The coded extracts were analysed and

compared against the extracted data and the included articles to ensure accuracy of themes (Braun & Clarke, 2006).

3.7.5 Phase 5 Defining and naming themes.

In this Phase themes were redefined, and overarching themes were selected and named. Five final themes and 13 categories were identified, and the themes are lack of privacy, perceptions towards sexuality as an inappropriate behaviour, roles and relationships and attitudes towards sexuality (Braun & Clarke, 2006).

3.7.6 Phase 6- Producing the report.

The emerging themes were used to write up the analysis to answer the research question of this review. A selection of compelling extract examples from the included studies were used in the review to support points represented by the themes (Braun & Clarke, 2006).

Table 2: *Thematic analysis process*

1 Familiarising oneself with data	Immersing oneself in the data and exploring initial ideas from the data.
2 Generating of initial codes	Identifying interesting features from the data and producing initial codes.
3. Searching for themes	Organising codes into potential themes and gathering relevant data for each potential theme.
4 Reviewing themes	Reviewing the themes and considering if they form a coherent pattern with the coded extracts (Level 1) as well as the entire data set (level 2), generating a thematic map of analysis.
5. Defining and naming themes	Ongoing analysis to redefine the specifics of each theme.
6. Producing the report	Final write up of analysis including a selection of compelling extract examples which represent the points one is demonstrating.

(Braun & Clarke, 2006, p. 35)

3.8 Ethical consideration

There was no direct contact with or impact on participants therefore no ethical approval was required. However ethical considerations of the included articles were reviewed in the appraisal process. Professional integrity was maintained by the author through the provision of accurate representation of the findings of the articles.

3.9 Summary

Integrative literature reviews provide rich and detailed findings from complex data gathered from a range of sources. This allows for a deeper understanding of the research question or phenomenon of interest which can be used to guide nursing practice. The synthesis of key findings and the generation of codes was conducted using the thematic analysis process (Braun & Clarke, 2006).

Chapter four

Findings

4.0 Introduction

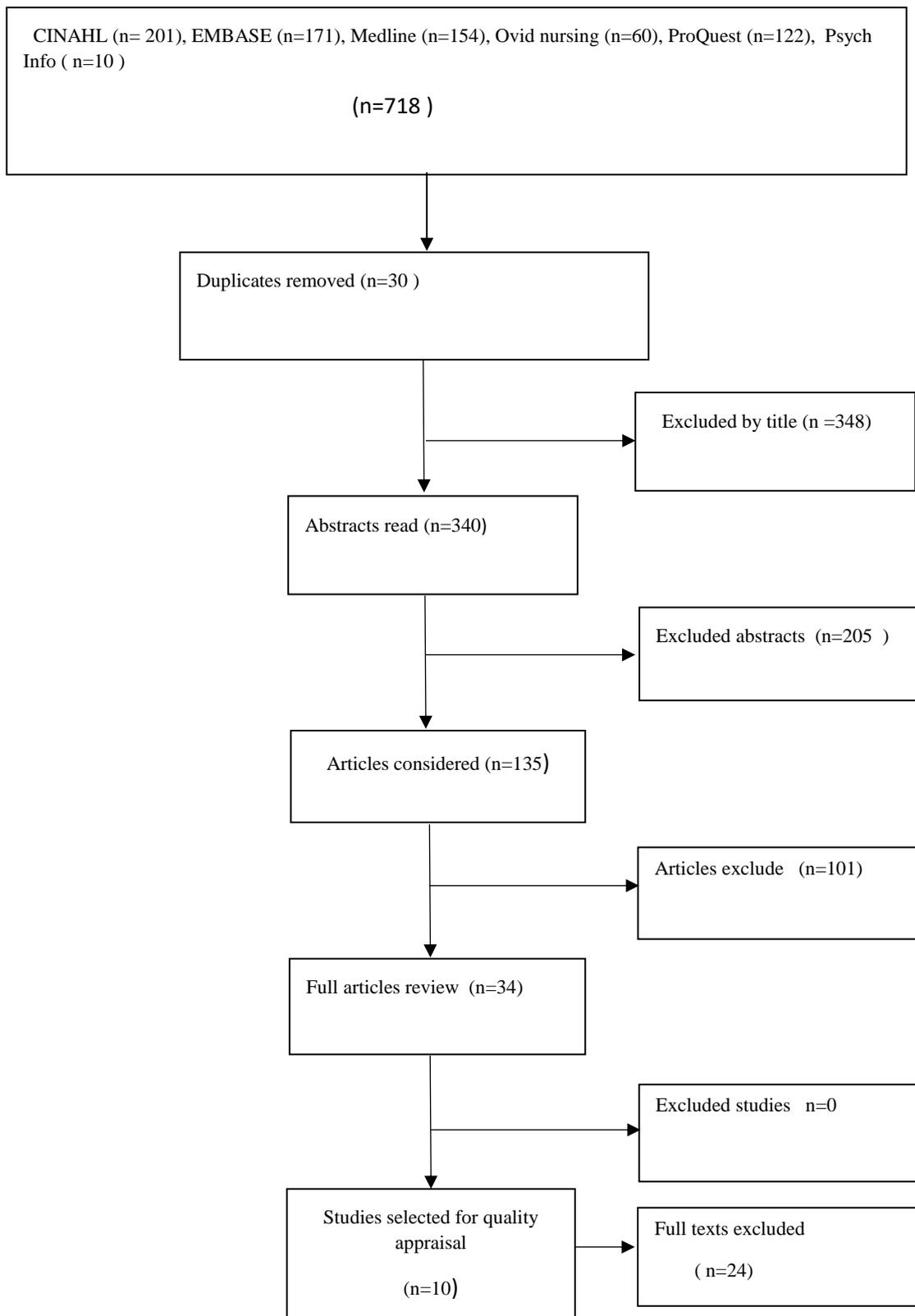
In this chapter a brief overview is provided of the search strategy results along with a synopsis of the 10 included articles which met the critical appraisal criteria. Data was extracted from the 10 articles using the JBI MASTARI data extraction tool and the data was analysed and synthesised using Braun and Clarke's process of thematic analysis (Braun & Clarke, 2006). The process informed the integration of corresponding evidence across the included studies. A summary of the synthesised findings from the 10 articles is also presented. A total of 76 findings were identified from the extracted data from the 10 included articles. The analysis and subsequent synthesis revealed five themes namely lack of privacy, perceptions towards sexuality, expression of sexuality as an inappropriate behaviour, roles and relationships and finally attitudes towards sexuality.

4.1 Results of the search strategy and critical appraisal.

The literature search from CINAHL, EMBASE, MEDLINE, OVID, ProQuest and Ovid nursing data bases yielded 718 potential articles. No information was found from grey literature or government websites. Thirty articles were removed as they were duplicates and 348 articles were excluded after reading the titles. Out of the remaining 340 articles, 205 articles were removed following the review of abstracts, or because they were pamphlets, systematic reviews, had no full text information and did not include the sexuality of the older person in ARCFs. Systematic reviews were eliminated to avoid replication of findings from existing reviews (Joana Briggs Institute, 2014). A full text review of the remaining 135 articles was performed and a further 101 articles were eliminated as they focused on the effects of treatment procedures and interventions on older persons' sexual function. A full

review of 34 articles was carried out and a further 24 articles were eliminated as they did not meet the inclusion criteria of adults over 60 years and above or the older person did not reside in ARCFs. Articles that only included health care staff who had the care givers' role were excluded. A reference check of the articles did not reveal any new articles. Ten articles were selected for critical appraisal all of which met the appraisal criteria. A further reference check of the 10 included articles did not reveal new articles. One article, published in 2004 was deemed seminal and was included in the studies (Roach, 2004). The 10 articles were included in the integrative literature review.

Figure 1: Search strategy flow chart



4.2 Synopsis of included studies.

A synopsis of the geography, setting, research design, participants and core findings of the 10 included articles is provided in this section (Appendix D).

4.2.1 Geography and setting.

The included studies covered a wide range of countries: Australia (McAuliffe, et al., 2016; Roach, 2004), Spain (Palacios-Cena et al., 2016; Villar, et al., 2014; Villar, et al., 2015; Villar, et al., 2016), Sweden (Roach, 2004), Taiwan (Tzeng, et al., 2009), United Kingdom (Vandrevala, et al., 2017) the United States of America (Lester, et al., 2016) and New Zealand (Cook, et al., 2017).

The included studies were conducted in different geographical settings, all which have legislation that allow for same sex marriage allowing for comparability of sexuality in these settings (Cortina, Laplante, Fostile & Martin, 2013; Fish & Karban, 2015, McParland & Camic, 2016). However, religion was noted to influence residents' views towards the expression of sexuality especially for women (Iveniuk & Muirheartaigh, 2016) It was indicated in Yelland and Hosier (2016)'s study that ARCFs nursing staff who identified as Catholic held more positive attitudes towards the expression of sexuality of the older person. Thus, religion may have influenced the perceptions of the participants of the four included studies from Spain which has a predominantly Catholic population (Cortina, Laplante, Fostile & Martin, 2013).

Three of these studies were conducted by the same authors in the same socio-economic area of Barcelona in Spain (Villa et al., 2014; Villa et al., 2015; Villar et al., 2016). Even though the research questions were different, conducting the studies in a different socio-economic area of Spain may have provided varied perspectives to the research topic of this review.

Seven studies were conducted across a total of 29 ARCFs (Cook et al., 2017; Palacios-Cena

et al., 2016; Tzeng et al., 2009; Vandrevalla et al., 2017; Villar et al., 2014 ; Villar et al., 2015; Villar et al., 2016). One study was conducted in ARCFs in Australia and Sweden, (Roach, 2004), however there is no mention of how many facilities participated in this study.

4.2.2 Participants

Across the 10 included studies the total number of participants amounted to 1760. Included in this group of participants was one family member, 127 ARCFs residents aged 60 years and above and 1456 ARCFs health care staff (Cook et al., 2017; Lester et al., 2016; McAuliffe et al., 2016; Palacios- Cena et al., 2016; Roach, 2004 Tzeng et al., 2009 ; Vandrevalla et al., 2017 ; Villar et al., 2014; Villar et al., 2015; Villar et al., 2016). Of the 127 ARCFs resident participants, 75 were female and 52 were male (Cook et al., 2017; Palacios-Cena et al., 2016 ; Villar et al., 2014; Villar et al., 2015; Tzeng et al., 2009), 12 of these resident participants had a diagnosis of dementia (Tzeng et al., 2009). The residents' perspectives were integrated with the perspectives of nursing staff in the analysis of emerging themes that were used to answer the research question (Cook et al., 2017; Palacios-Cena et al., 2016; Villar et al., 2014; Villar et al., 2015; Tzeng et al., 2009). Compelling extracts of residents' voices were used as examples to support emerging themes that answered the research question (Braun & Clarke, 2006). Two studies used the same group of participants to answer different research questions (Villa et al., 2014; Villa et al., 2015) The use of the same group of participants in these two studies affected the number of counts of resident participants in this review as they were counted twice.

Out of the 1456 health care staff, 366 were Directors of Nursing (DONs), 25 were RNs, 23 were nursing assistants, nine were nursing educators, one was an enrolled nurse (EN) and 1,032 were either DONs or unit managers (Cook et al., 2017; Lester et al., 2016; McAuliffe et al., 2015; Roach, 2004; Vandrevalla et al., 2017; Villar et al., 2014; Villar et al., 2016). Of

the 1456 staff participants, 1054 were female (Cook et al., 2017; McAuliffe et al., 2015; Roach, 2004; Vandrevalla et al., 2017; Villar et al., 2014; Villar et al., 2015; Villar et al., 2016; Tzeng et al., 2017), 108 were male (McAuliffe et al., 2015; Vandrevalla et al., 2017; Villar et al., 2014; Villar et al., 2016) and other participants had their gender undisclosed (Lester et al., 2017). All of these studies focused on capturing the perspectives of DONs, RNs and ENs as they are the ones who interact closely with residents in ARCFs (Cook et al., 2017; Lester et al., 2016; McAuliffe et al., 2016; Palacios-Cena et al., 2016; Roach, 2004; Tzeng et al., 2009; Vandrevalla et al., 2017; Villar et al., 2014; Villar et al., 2015; Villar et al., 2016).

4.2.3 Research design

Of the 10 included studies, eight studies used a qualitative research design approach (Palacios-Cena et al., 2016; Vandrevalla et al., 2017; Villar et al., 2014; Villar et al., 2015; Villar et al., 2016). Cook et al. (2017) specifically utilised the discursive qualitative approach while Roach, (2014) and Tzeng et al. (2009) used a grounded theory approach and two studies used the quantitative research design (Lester et al., 2016; McAuliffe et al., 2015). Of the 10 included studies, six used the purposive sampling techniques (Lester et al., 2016; McAuliffe et al., 2015; Palacios-Cena et al., 2016; Tzeng et al., 2009; Vandrevalla et al., 2017; Villar et al., 2015), two studies used a random sampling technique (Villar et al., 2014; Villar et al., 2016), Cook et al.(2017) used the snow balling sampling techniques and Roach, (2004) used the theoretical sampling.

Various data collection methods were used. Eight studies utilised face to face interviews (Cook et al., 2017; Palacios-Cena et al., 2016; Roach, 2004; Tzeng et al., 2009; Vandrevalla et al., 2017; Villar et al., 2014; Villar et al., 2015; Villar at al., 2016) and two studies conducted surveys, one online and one postal (Lester et al., 2016; McAuliffe et al., 2015). Villar et al.

(2015) conducted interviews over a period of seven months. Seven studies utilised semi structured questions (Cook et al., 2017; Palacios-Cena et al., 2016; Tzeng et al., 2009; Vandrevala et al., 2017; Villar et al., 2014; Villar et al., 2015; Villar et al., 2016). Villar et al. (2016) used vignettes depicting sexual activity among residents in ARCFs and Tzeng et al. (2009) observed behaviour of residents with dementia displaying sexual behaviour in conjunction with interviews. Palacios-Cena et al. (2016) also used structured questions. Cook et al. (2017) used in-depth interviews and structured questions while Roach, (2014) used unstructured questions and guided discussions with nominal group members. One study did not require ethical approval as it reported that it did not directly involve patient care or patient information (Lester et al., 2009) and ethical approval was gained for the other nine studies (Cook et al., 2017; McAuliffe et al., 2015; Palacios-Cena et al., 2016; Tzeng et al., 2009; Roach, 2004; Vandrevala et al., 2017; Villar et al., 2014; Villar et al., 2015; Villar et al., 2016).

4.2.4 Data analysis

Different methods were used to analyse data across the 10 studies. Four studies utilised the thematic analysis method (Cook et al., 2017; Palacios-Cena et al., 2016; Villar et al., 2014; Villar et al., 2016). Out of the six remaining studies, three used different analytic software including the Statistical Software Package version. (SPSS) and the Chi- squared test to analyse descriptive statistics as well as the relationship between variables (McAuliffe et al., 2015). Lester et al. (2016) also used the SAS version 9.2 for windows in conjunction with the McNemar test and the Chi- squared test to analyse descriptive statistics, corresponding variables and the relationship between variable. Villar et al. (2015) used the content analysis method with the NVivo version 2.0 analysis software while Vandrevala et al. (2017) used the Interpretive Phenomenological analysis procedures (IPA) and Roach, (2004) used the

Constant Comparative method. However, the data analysis method used by Tzeng et al. (2009) is not clearly specified.

4.2.5 Conclusion of Synopsis.

Of the 10 included studies, eight studies utilised the qualitative approach research design and two utilised the quantitative approach research design. The composition of participants, the research methods and the data analysis methods varied across the studies. Participants consisted of males and females aged 60 years and over residing in ARCFs, nurses working in ARCFs and one female family member.

The method mostly used to collect data across the 10 included studies was face to face interviews with the use of structured and unstructured questions. In two of the studies interviews were used with nominal groups in conjunction with observations of the sexual behaviour of residents with dementia. However, no clear definition was given of what constituted sexual behaviour amongst the residents (Tzeng et al., 2009).

The included studies used various sampling techniques; the purposive sampling technique was utilised by six of the studies. Four of the studies were conducted in Spain,

(Palacios-Cena et al., 2016; Villa et al, 2014; Villa et al., 2015; Villa et al., 2016),

nevertheless the 10 included studies had an international coverage. One study was conducted in two countries, namely Australia and Sweden. Thematic data analysis was used to analyse data in some studies while other studies used various analytic software programmes and the interpretive phenomenological analysis procedure (IPA) as well as the comparative method.

4.3 Emerging Themes.

In this section an in-depth narrative is provided of the five themes and 13 categories that emerged from the findings. The five themes are lack of privacy, perceptions towards

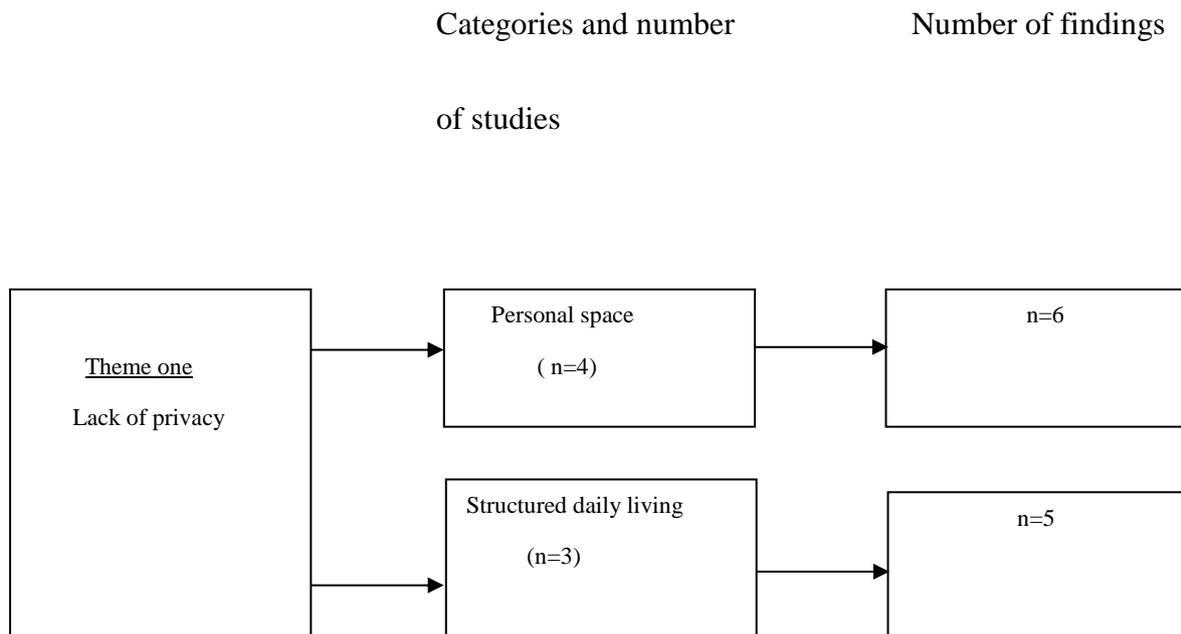
sexuality, expression of sexuality as an inappropriate behaviour, roles and relationships and attitude towards sexuality.

Theme one.

4.3.1 Lack of privacy

Lack of privacy in personal spaces was identified by both residents and staff as a limiting factor for older people residing in ARCFs to express their sexuality. Privacy has been described as a state in which one is not interrupted or controlled by other individuals (Cambridge, 2015). This theme was supported by five studies, two categories and a total of 11 findings (Cook et al., 2017; Tzeng et al., 2017; Vandrevalla et al., 2017; Villar et al., 2014; Villar et al., 2015). Lack of privacy was attributed to facility design such as the lack of single occupancy rooms, shared bathrooms (n=4) (Cook et al., 2017; Tzeng et al., 2009; Villar et al., 2014; Villar et al., 2015) and structured daily living (n=3) (Cook et al., 2017; Vandrevalla et al., 2017; Villar et al., 2014).

Figure 2: Summary of theme one



Category one

4.3.1.1 Personal space

Four studies and six findings identified facility design as a contributory factor in the lack of privacy in ARCFs particularly the use of open shared bathrooms and lack of single occupancy rooms for residents (Cook et al., 2009; Tzeng et al., 2009; Villar et al., 2014; Villar et al., 2015). In one study nine residents and one health care staff member mentioned that the bedrooms at the facility were not private enough to facilitate the forming of relationships (Villar et al., 2015). Lack of privacy was attributed to shared bathrooms and this was more frequently pointed out by staff than residents (Villar et al., 2014; Tzeng et al., 2009) and some participants reported that the residential facilities did not feel like home (Cook et al., 2017; Villar et al., 2014).

“...sharing a room and that rooms have no lock doesn’t help (...) Even the bathrooms are shared. Your room is supposed to be your private space, but even there you can’t be sure that

nobody is going to come in...you don't have a single space you can call your own...that doesn't exist in a residential home". (Villar et al., 2014, p. 2522).

In addition, some rooms lacked privacy as they had doors with transparent glass (Tzeng et al., 2009). One resident expressed that the lack of locks on their bedroom doors made them feel less assured that the rooms would provide enough privacy, and that the invasion of privacy would bring about feelings of embarrassment,

"No. Couldn't do anything here because if the door opened and somebody like [manager] walked in I'd be mortified. There are no locks on doors, as you can see...So there really is no privacy here..." (Cook et al., 2017, p. 3021).

Residents' privacy was further compromised by interruptions caused by staff entering residents' rooms without waiting for the invitation to enter, the presence of other residents who tended to control the expression of sexuality of others by way of criticism and gossip and the lack of locks on doors (Cook et al., 2017; Villar et al., 2014). Lack of privacy in personal spaces was associated with diminished chances of forming relationships and lack of autonomy in expressing sexuality (Cook et al., 2017; Villar et al., 2015).

Category two

4.3.1.2 Structured daily living

It was noted in two studies, (Vandrevala et al., 2017; Villar et al., 2014), that residents' privacy was compromised by ARCFs' ways of working that promote structured daily living, continual surveillance of residents for safety reasons and communal activities precluding individuals from deciding on how they want to spend their time,

“Well, they are limited by the ways things are organized, by the rules. You have to follow what others do, now it’s time for lunch, now it’s time to go to the bathroom...You ‘re not free, it’s not being at home” (Villar et al., 2014, p.2522).

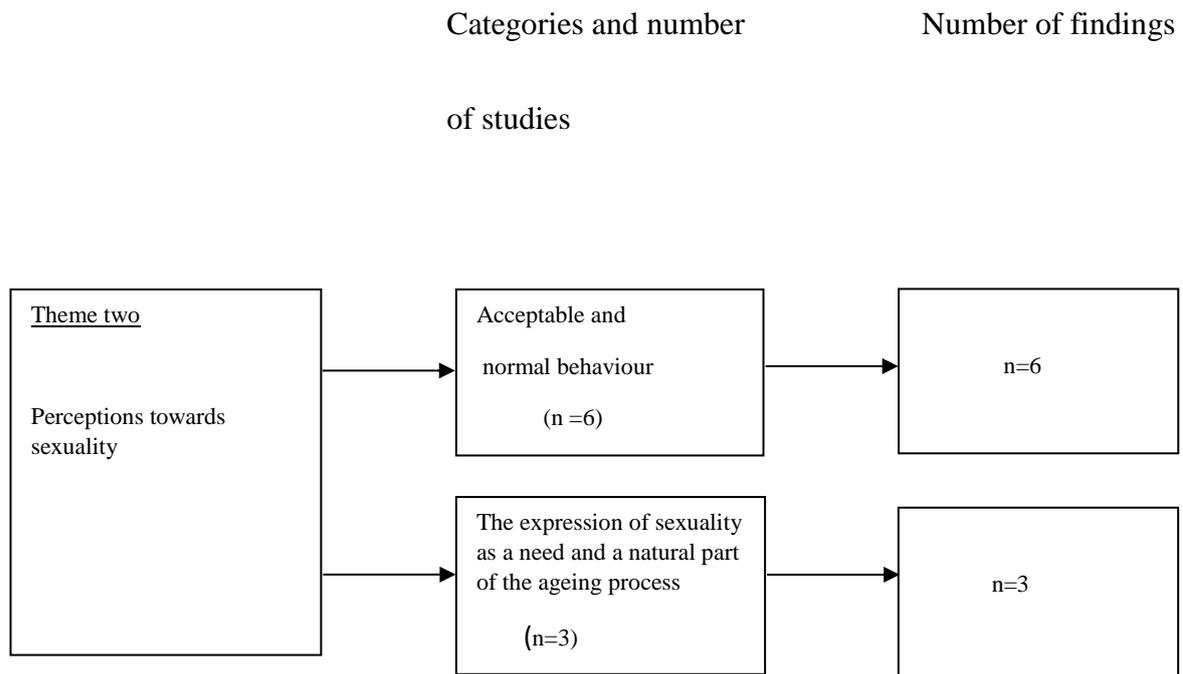
In addition, staff continuously monitored residents for safety reasons and only allowed them to express their sexual desires in controlled environments (Vandrevala et al., 2017), which in turn tended to restrict the residents’ expression of sexuality (Villar et al., 2014). While staff acknowledged that residents with dementia should be allowed to express their sexuality freely in ARCFs, the health and safety of these residents took precedence over the expression of their sexuality when delivering care (Vandrevala et al., 2017).

Theme Two

4.3.2 Perceptions towards sexuality

Perception refers to an opinion or belief held by a group of people (Cambridge, 2015). In this context, this refers to opinions and beliefs held by nurses, residents and their families towards the expression of sexuality by older people residing in ARCFs. This theme was supported by seven studies, two categories and nine findings (Cook et al., 2009; Lester et al., 2016; Palacios-Cena et al., 2016; Tzeng et al., 2009; Vandrevala et al., 2017; Villar et al., 2015; Villar et al., 2016).

Figure 3: *Summary of theme two*



Category one

4.3.2.1 Acceptable and normal behaviour.

The word acceptable has been defined as welcome or tolerable and normal has been defined as usual or expected (Cambridge, 2015). In this context, the meanings are related to staff and residents’ perceptions towards the expression of sexuality by older people residing in ACRFs. Fifty-seven health care staff and 24 residents considered the expression of sexuality by older people residing in ARCFs as appropriate and as a basic human right that continues to be important throughout a person’s life regardless of age, gender, sexual orientation and cognitive ability (Lester et al., 2016; Vandrevalla et al., 2017; Villar et al., 2015; Villar et al., 2016). Six studies and six findings supported this category (Cook et al., 2017; Lester et al., 2016; Tzeng et al., 2009; Vandrevalla et al., 2017; Villar et al., 2015; Villar et al., 2016).

While the health and safety of residents were the primary concern of ARCFs staff, some staff considered the expression of sexuality by older people as acceptable (Cook et al., 2017;

Lester et al., 2016; Tzeng et al., 2009; Villar et al., 2015; Villar et al., 2016), including residents affected by dementia (Vandrevala et al., 2017).

“ Yes, they should be able to express any concerns, wishes or views they have. They are still, a person who is going to have feelings and they should be able to express the ways they want to. But in a controlled safe environment, where they are not going to cause harm to themselves and other people ”.(Vandrevala et al., 2017, p114).

Some staff perceived dementia as part of normal ageing process and a form of illness that should not limit the expression of sexuality in older adults with dementia,

“ ...Yeah just because you got an illness doesn't mean to say that suddenly the whole world stops. You still got to live your life, some of them will have dementia for ten or twenty years so it doesn't mean the whole world got to stop because you got dementia (mhn). I feel, you still got , even though it is not about having sex or whatever it is still the kissing, the cuddling, the affection and holding hands ”.(Vandrevala et al., 2017, p.115).

Forty three percent of the DON respondents were open to allowing those affected by moderate to severe dementia to participate in sexual relationships. Eighty-eight percent of the respondents reported that residents with dementia should be permitted to have sexual activity with their spouse and 10 % reported that residents affected by dementia should be allowed participate in a sexual relationship (Lester et al., 2016). The perceptions of staff were influenced by their personal, cultural values and level of education (Tzeng et al., 2009).

Category two

4.3.2.2 The expression of sexuality as a need and a natural part of the ageing process.

Participants who considered the expression of sexuality by older people in ARCFs as an appropriate and normal behaviour viewed it as a natural need and significant part of the

ageing process (Palacios Cena et al., 2016; Vandrevalla et al., 2017; Villar et al., 2016). People affected by dementia were also viewed by these participants as having the need to initiate and maintain a sense of personhood through individual and intimate relationships. Whilst some residents expressed that while they still feel the need to express their sexuality, others felt that their time had passed (Palacios-Cena et al., 2016; Vandrevalla et al., 2017; Villar et al., 2016).

Theme Three

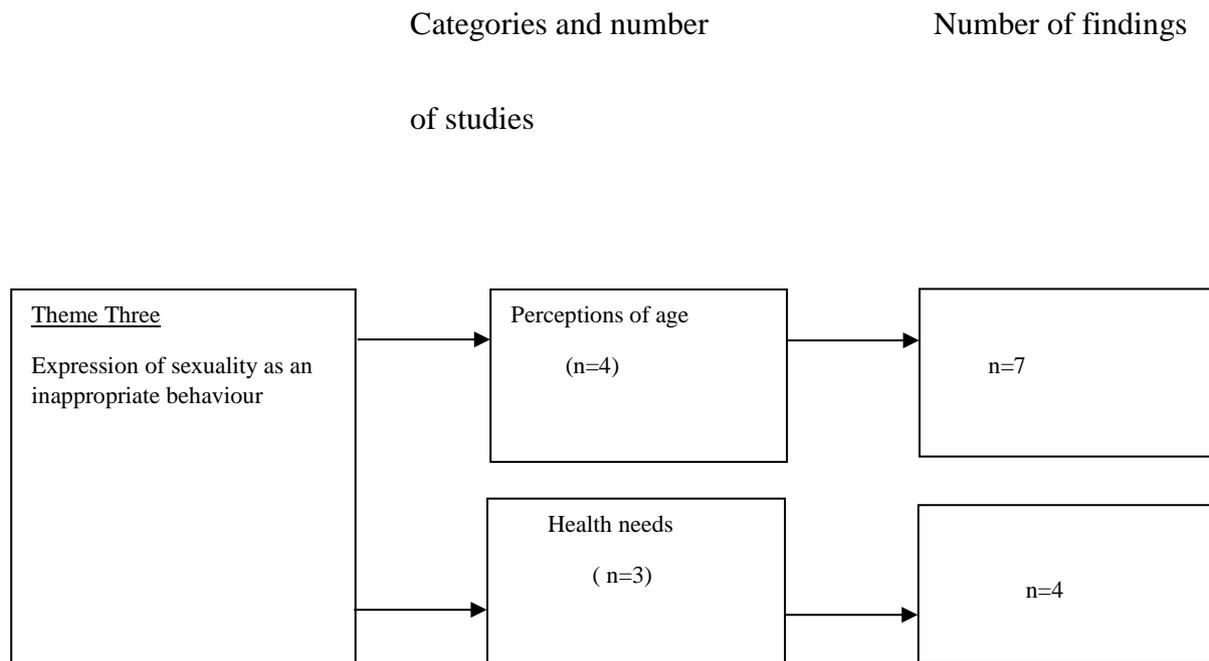
4.3.3. Expression of sexuality as an inappropriate behaviour

The word inappropriate is defined as unsuitable (Cambridge, 2015). In this context the meaning is related to the perceptions of residents and health care staff towards the expression of sexuality by older people residing in ARCFs. The theme of inappropriateness of the expression of sexuality by older people residing in ARCFs emerged across five studies and was supported by two categories and 11 findings (Palacios-Cena et al., 2016; Vandrevalla et al., 2017; Villar et al., 2014; Villar et al., 2015; Villar et al., 2016).

Participants especially residents, found sexual activity between male and female residents residing in ARCFs as inappropriate and this was mostly attributed to health problems and the perceptions of the age of residents,

“It’s complicated, firstly because here most people are women and ...you know, there are few men and most of them are too old !” (Villar et al., 2014, p. 2523).

Figure 4: Summary of theme three



Category one

4.3.3.1 Perceptions of age

Four studies considered the expression of sexuality by older people residing in ARCFs as inappropriate because of the age of the residents (Palacios- Cena et al., 2016; Villar et al., 2014; Villar et al., 2015; Villar et al., 2016). This perception was influenced by the belief that the expression of sexuality was socially and morally inappropriate for older people (Palacios-Cena et al., 2017; Villar et al., 2014; Villar et al., 2016). Some residents reported experiencing social pressure within ARCFs as well as from their own spouses as to how they express their sexuality through the way they dressed or initiated relationships (Palacios-Cena et al., 2017).

“ You have to think that you did what you could at the time, but now in a place like this and at this age, you’re not really supposed to. Flirting and doing silly things isn’t appropriate anymore” (Villar et al., 2014, p. 2522).

Some participants viewed older people as not interested in sex or not as capable to participate in sexual activities (Villar et al., 2014; Villar et al., 2015; Villar et al., 2016). These views were influenced by education or lack of it about the sexuality of older people as well as religious views held by the older generation (Palacios-Cena et al., 2017; Villar et al., 2014), “...In my case I have been influenced a bit by religion...sex is for procreation, you know, so, if there’s nothing to procreate then the right thing is to control yourself and retire” (Villar et al., 2014, p. 2522).

Category two

4.3.3.2 Health needs

Health has been defined as the state of well-being and a need has been defined as conditions or circumstances that require attention (Cambridge, 2015). In this context, health needs refer to health conditions and circumstances experienced by older people residing in ARCFs that impact on the expression of their sexuality. The impact of health needs was mentioned more often by health care staff than residents. Some diseases lead to a loss of independence and an inability to participate in intimate and sexual activity,

“ Many people here are not independent enough to go to the toilet by themselves ...so they can’t get involved in sexual matters; they would even need help to masturbate” (Villar et al., 2014, p. 2523).

Other diseases lead to sexual disability,

“ It’s been years since I had an erection...so this is the main barrier, you know ? You’d like to, but you are unable to” (Villar et al., 2014, p. 2523).

However, some health care staff and families of residents residing in ARCFs did not view cognitive impairment as influencing intimacy and relationships (Cook et al., 2017; Vandrevalla et al., 2017). On the other hand, some participants held contrasting views and

believed that the loss of memory associated with dementia can cause people to lose their sense of self and not be able to express their sexuality in ways familiar to them,

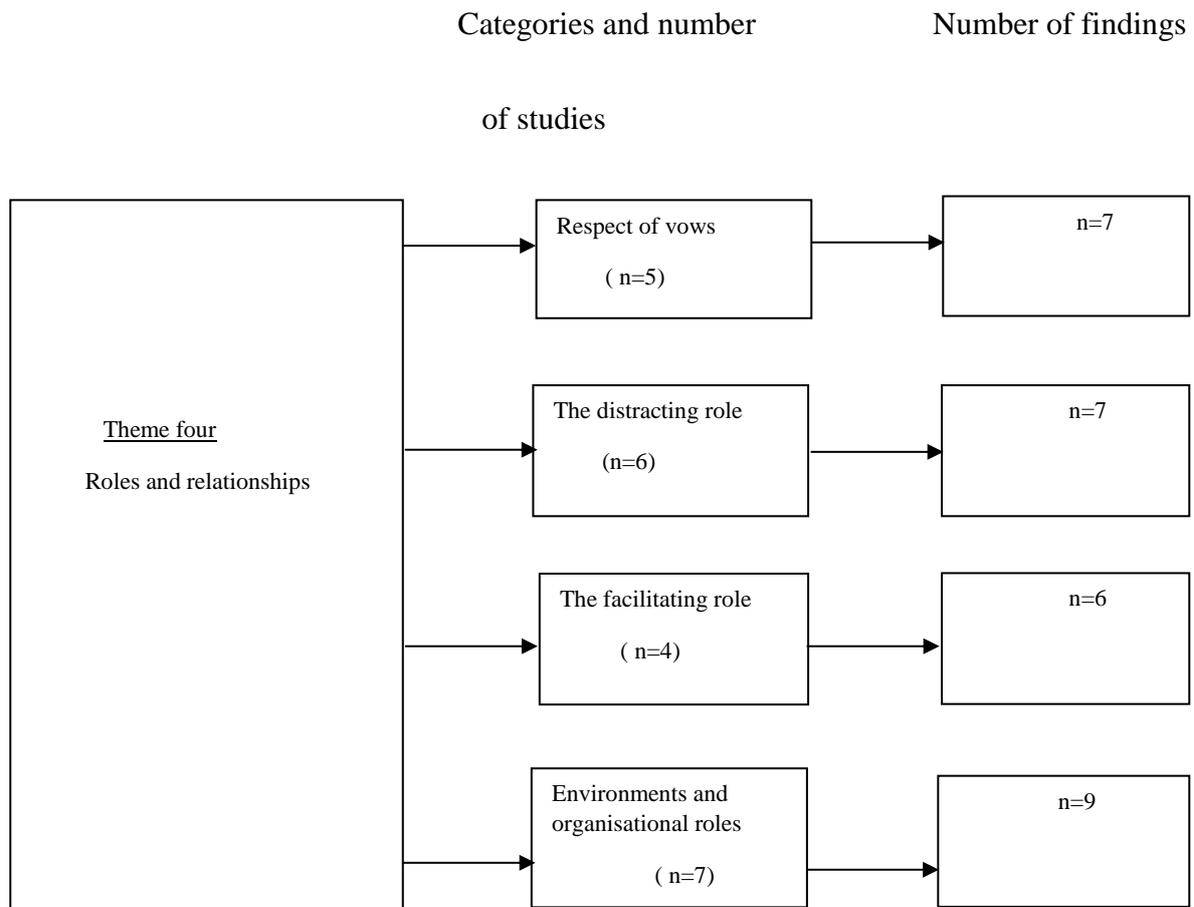
“ I don't really know because, dementia got nothing to do with sexuality (Laughs) because, when you have dementia that sexual side is gone. So it is not there, the desire is going, the feelings is gone, [sic] so it is difficult really. It is really difficult” (Vandrevala et al., 2017, p. 115).

Theme four

4.3.4 Roles and relationships

A role refers to the duty that an individual is expected to have (Cambridge, 2015). The perceptions of staff, residents and their families towards the expression of sexuality by older people residing in ARCFs was noted to be influenced by the views these individuals held towards their roles (Cook et al., 2017; Lester et al., 2016; Palacios-Cena et al., 2016; Vandrevala et al., 2017; Villar et al., 2014). Five studies informed this theme and four categories comprised this theme: respect of vows (n=5) (Cook et al., 2017; Lester et al., 2016; Palacios-Cena et al., 2016; Vandrevala et al., 2017; Villar et al., 2014), the distracting role (n=6) (Roach, 2004; Tzeng et al., 2009; Vandrevala et al., 2017; Villar et al., 2014; Villar et al., 2015; Villar et al., 2016), the facilitating role (n=4) (Tzeng et al., 2009; Vandrevala et al., 2017; Villar et al., 2015; Villar et al., 2016), and environmental and organisational roles (n=7) (Cook et al., 2017; Lester et al., 2016; McAuliffe et al., 2015; Roach, 2004; Tzeng et al., 2017; Vandrevala et al., 2017; Villar et al., 2014).

Figure 5: Summary of theme four



Category one

4.3.4.1 Respect of vows

ARCFs nurses, residents and families expressed the view that they were accepting and respectful to the expression of sexuality and intimacy that occurred within a marriage and relationships that existed before a diagnosis of dementia or admission in an ARCFs (Cook et al., 2017; Lester et al., 2016; Palacios-Cena et al., 2016; Vandrevala et al., 2017; Villar et al., 2014).

“...It is not like I have a wife and my wife will say because, I have dementia she will no longer sleep with me, no that is not fair. It is not right for somebody to say that. (...) because,

if you have dementia and you have a wife or a partner, nothing will stop you for [Sic] doing that” (Vandrevala et al., 2017, p. 117).

Thirteen widowed residents did not see the need to form new relationships after the death of their husbands out of respect for their previous marriage vows,

“ Since my husband died, I haven’t had relations again with anyone. The truth is, I don’t even think about it, it feels very strange” (Palacios-Cena et al., 2016, p. 474).

Three married women and seven widows viewed the expression of sexuality as a wife’s marital duty, with their own needs being secondary to their husbands’ needs,

“ I don’t know if it’s correct to have sex, but all I feel is that I fulfill my duty as a wife. I show him my love and accept him... ” (Palacios Cena et al., 2017. P474).

Their views were influenced by their religious beliefs, their desire to preserve their late husbands’ memories and a personal choice not to form new relationships (Palacios-Cena et al., 2016). In addition, families intervened in residents’ relationships and made decisions regarding residents’ expression of sexuality in ARCFs particularly in situations where residents had dementia or cognitive decline,

“ If the resident has dementia, then his or her family will probably be against it. You know, as children we often don’t approve of our parents having a relationship with someone who is not your ...your father or mother... ” (Villar et al., 2014, p.2523).

This led to restrictions in the expression of sexuality by older people residing in ARCFs (Cook et al., 2017 ; Lester et al., 2016; Villar et al., 2014). Of the DON respondents 56.6 % reported that cognitively impaired residents required their families or a nominated person to approve sexual activity as compared to 12.4 % for residents with no cognitive impairment (Lester et al., 2016).

Category Two

4.3. 4.2 The distracting role

Health care staff are defined as trained or qualified individuals approved by a regulatory service to provide health care services (Cambridge, 2015). Six studies and seven findings supported this category. Staff perceived their roles to be limited to provision of personal care, assistance with ADLs and maintaining residents' safety (Vandrevala et al., 2017; Villar et al., 2014). Those who dealt with sexual behaviours determined the expression of sexuality and intimacy in clients with dementia as problematic. This was also considered as an additional role that was not readily accepted by some staff (Vandrevala et al., 2017).

Nurses not comfortable with dealing with issues related to residents expressing sexuality employed tactics such as distraction, teasing and reprimanding as well as expressing disapproval of residents' expression of sexuality thereby limiting residents' expression of their sexuality (Roach, 2004; Tzeng et al., 2009; Vandrevala et al., 2017., Villar et al., 2015., Villar et al., 2016). This occurred more often in situations where residents had advanced dementia and sexual activity was non-consensual (Tzeng et al., 2009; Vandrevala et al., 2017; Villar et al., 2015; Villar et al., 2016). Staff considered residents with dementia to be more vulnerable to abuse as they perceived them as not having the capacity to consent to sexual relationships or refuse any sexual activity advances resulting in staff acting as distractors to safeguard the residents' safety (Vandrevala et al., 2017).

On the other hand, the expression of sexual activity behaviour between men was viewed as less risky as they were of the same sex and was often ignored by nurses (Tzeng et al., 2009). This response was attributed for example to Chinese values and traditions that view men as superior to women, which often led female nurses to respond neutrally to men having intimate relationships with other men (Tzeng et al., 2009). Such a response seemed to give

more respect to the expression of sexuality between men than other individuals of different sexual orientation (Tzeng et al., 2009).

Category three

4.3.4.3 The facilitating role.

A facilitator is defined as an individual who participates in making an activity easier to participate in (Cambridge, 2015). In this context, a facilitator is an individual who engages with older people residing in ARCFs to make the expression of their sexuality easier. The facilitators' perceptions were influenced by factors such as the need to promote residents' privacy, dignity and the desire to promote a culture of acceptance of older people's sexuality, including those affected by dementia (Vandrevala et al., 2017; Villar et al., 2016). This role was aligned to values and ARCFs' guidelines such as respecting residents' rights, privacy, dignity and choice,

“ You play a role in like[sic] if, somebody says “I want to put on that dress and I want to look sexy’, you will say yes put on that dress and look sexy (laughs). Because, if it is going to make them happy, I will put that dress on and the shoes and the bag.”(Vandrevala et al.,2017, p.115).

In some instances, nurses facilitated the expression of sexuality of residents who participated in sexual activity such as masturbation by improving their privacy (Tzeng et al., 2009), and in two other studies, two residents and four health care staff respectively reported that they would directly support the residents to express their sexuality (Villar et al., 2015; Villar et al., 2016). Participants who were supportive of the expression of sexuality by older people residing in ARCFs suggested the use of double beds, do not disturb signs and the provision of private spaces as ways of safeguarding residents' rights to the expression of their sexuality

(Vandrevala et al., 2017). Four health care staff reported that they would discuss the event with others and find ways of supporting the residents,

“ I will probably mention it to the managers...what I have witnessed, because then maybe we could discuss the possibility of finding them a place so...so that they can enjoy their sexuality” (Villar et al., 2015, p.1060).

Category four

4.3.4.4 Environments and Organisational roles

The presence or lack of organisational policies and procedures has an impact on the way nurses respond to the expression of sexuality by older people residing in ARCFs (Cook et al., 2017; Lester et al., 2016; Roach, 2004). In one study, 63.4 % of facilities indicated that they did not have policies regarding residents’ sexuality in place (Lester et al., 2016) despite 66.1 % of the facilities indicating that disruptive sexual behaviour incidents were the most commonly gathered information (McAuliffe et al., 2015). It was noted that 89.7 % of assessments were carried out after family initiated the discussion and 87.3 % after a resident initiated the discussion. Less than 33.3 % of the facilities surveyed reported collecting information on residents’ intimacy needs, sexual orientation, sexual history and sexual needs at any time (McAuliffe et al., 2015). In ARCFs with no policies relating to or direction from management about older people’s expression of sexuality, participants used their own personal and moral judgements to inform the decision-making process,

“It [sexuality-related issues] does happen, I’ve seen it happen and nobody talks about it and, we’ve got to make a judgement call, which I have done on a few occasions and just don’t know which the right way is...” (Cook et al., 2017, p. 3022).

In such situations, staff had to evaluate residents’ capacity to consent to sexual relationships, intimacy and the effects of the intimate relationship on residents’ well-being (Cook et al.,

2017; Lester et al., 2017), particularly for cognitively impaired residents as they were considered to require protection (Vandrevala et al., 2017). Nurses took up this role without legal and formalised structures in place to support their decisions (Cook et al., 2017; Lester et al., 2017).

Personal beliefs, educational histories, religious backgrounds and life experiences of nurses as well as those of the older people themselves influenced their judgements and views on the expression of sexuality in this population (Cook et al., 2017; Roach, 2004; Vandrevala et al., 2017; Villar et al., 2014).

“Their sexual education has been very repressive. They couldn’t talk about sex; they’ve been very limited and coerced ” (Villar et al., 2014, p. 2522).

It was noted that there were some variations with staff perceptions as their views and judgements were informed by their personal beliefs and religious background (Cook et al., 2017; Roach, 2004). In view of the cultural diversity of health care staff in ARCFs and the influence of culture on the expression of sexuality, the importance of considering other staff members’ perspectives was highlighted (Cook et al., 2017). On the other hand, nurses would still divert residents’ expression of sexuality despite having policies and procedures in place. This was attributed to policies being guided by the beliefs of the Catholic Church which were more conservatives than other belief systems (Tzeng et al., 2009).

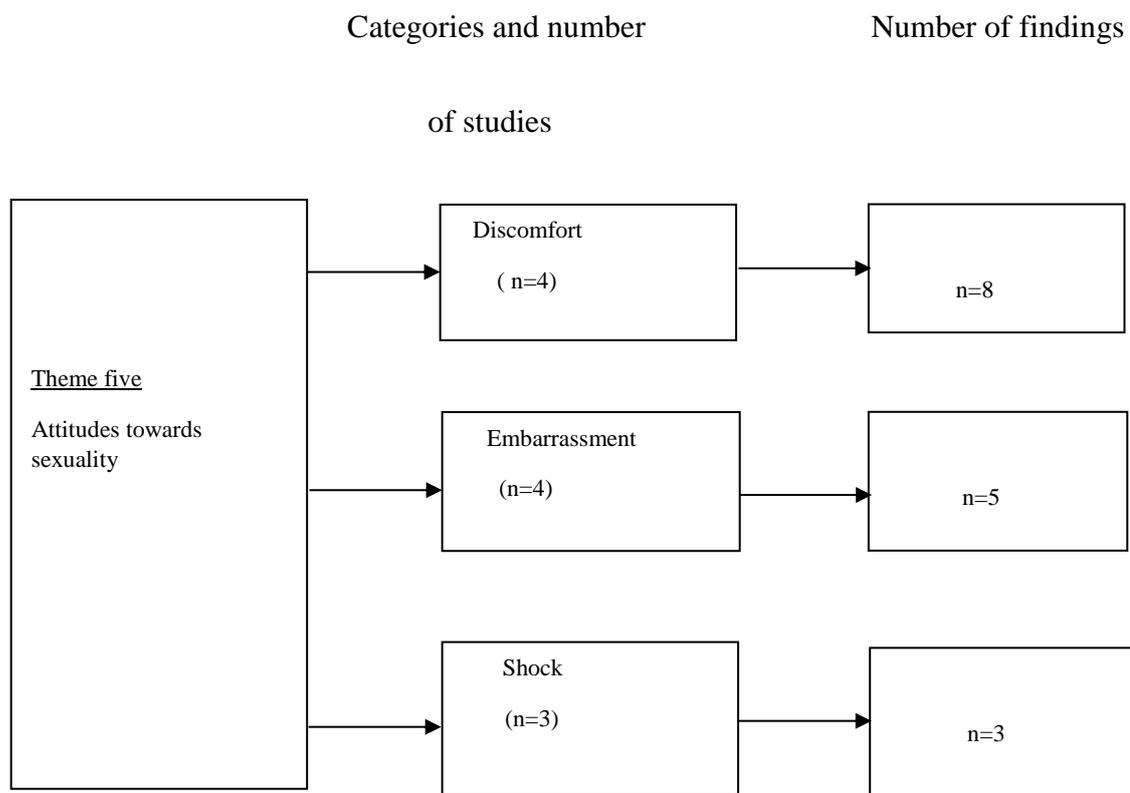
Theme five

4.3.5 Attitudes towards sexuality

Attitude is defined as an opinion or feeling towards something (Cambridge, 2015). Attitude has an influence on how one responds to a situation (Tzeng et al, 2009). The emotions of residents and health care staff have been noted to influence the expression of sexuality of the older persons residing in ARCFs (Palacios-Cena et al., 2016; Roach, 2004; Tzeng et al.,

2009; Vandrevalla et al., 2017; Villar et al.,2015;Villar et al.,2016). This theme was informed by six studies, three categories and 16 findings: discomfort (n= 4) (Roach, 2004; Vandrevalla et al., 2017;Villar et al., 2015; Villar et al., 2016), embarrassment (n=4) (Tzeng et al., 2009; Villar et al., 2014; Villar et al., 2015; Villar et al., 2016) and shock (n=3) (Palacios-Cena et al., 2016; Vandrevalla et al., 2017 ; Villar et al., 2015).

Figure 6: *Summary of theme five*



Category one

4.3.5.1 Discomfort.

Discomfort is defined as a feeling of uneasiness or being uncomfortable physically or mentally (Cambridge, 2015). In this context, discomfort refers to feelings of uneasiness experienced or perceived by participants associated with the expression of sexuality by older people residing in ARCFs. Health care staff experienced discomfort when the subject of sexuality was brought up or when they were faced with situations that required them to

respond to residents' expression of sexuality (Roach, 2004; Vandrevalla et al., 2017). Two nurses and six residents reported that they would find witnessing sexual activity between older people in ARCFs to be unpleasant,

“ It would be horrible, wouldn't it ? Seeing that...I don't know. It's not the same as doing it with your own partner; it's not the same if you catch someone else in the act, is it ?” (Villar et al., 2015, p.1058).

Discomfort around engaging with the topic of sexuality and supporting residents to express their sexuality often led to nurses avoiding addressing incidents associated with the expression of sexuality by older people in ARCFs (Roach, 2004; Vandrevalla et al., 2017).

The avoidance by nurses to support elderly people with the expression of their sexuality was associated with lack of life satisfaction, lack of close interpersonal relationships and declining well-being for the elderly person (Roach, 2004).

In addition to staff and residents' discomfort, organisational ethos was also noted to contribute to individuals' ease or uneasiness with sexuality and to influence the way staff responded (Roach, 2004; Tzeng et al., 2009). The word ethos is defined as a set of beliefs, attitudes and ideas held by a community about a social behaviour (Cambridge, 2015). In this context, the ethos of an organisation refers to the attitudes, beliefs and values that exist in a facility that are related to the expression of sexuality by older people living in ARCFs.

ARCFs with a restrictive culture towards residents' sexuality needs, enabled practices such as moving residents who displayed overt sexual expression to different rooms and used threats to safe guard the comfort levels of staff (Roach, 2004).

“ ...We will have to contact your family', and most people don't like that – they don't want their families involved. ‘ if you continue with that behaviour... ” (Roach, 2004, p. 375).

Organisations with a restrictive ethos further influenced staff attitudes and discomfort with

sexuality as they may fail to provide education and support in areas related to residents' expression of sexuality (Roach, 2004).

Category two

4.3.5.2 Embarrassment.

The word embarrassment is defined as feeling shame, experiencing discomfort and of being of self-conscious (Cambridge, 2015). In this context, embarrassment refers to the experienced or perceived feelings of shame that are associated with the expression of sexuality by older people residing in ARCFs. Three nurses and three residents reported that they would feel embarrassed to witness an older man and woman involved in a sexual activity in an ARCF, “*I'd die of shame.*” (Villar et al., 2015, p. 1058).

Eight participants reported that they would feel embarrassed for invading the residents' privacy and interrupting their sexual pleasure and six participants mentioned that they would feel embarrassed for the resident who may be feeling embarrassed for having been found being intimate,

“*I'd say: 'poor guy, I've interrupted him with the job half done' And probably he's the one who feels really embarrassed, maybe not for doing it but for having been discovered*” (Villar et al., 2016, p.823).

Some residents mentioned that feelings of shame were brought about by the need to suppress the expression of sexuality as it was thought to be socially and morally inappropriate (Villar et al., 2014). In one study residents with advanced dementia could not adopt a formal response towards sexuality as they had no capability to respond, however a few residents with dementia were observed to respond to witnessed public displays of affection such as touching others by saying words such as,

“shameful or embarrassing” (Tzeng et al., 2009, p.997).

Category three

4.3.5.3 Shock.

The term shock is defined as a sudden and unexpected emotional reaction to an unpleasant event or experience (Cambridge, 2015). In this context shock refers to a sudden emotional reaction to a perceived or real experience towards the expression of sexuality by older people residing in ARCFs. Several nurses reported that they would find it shocking to discover residents involved in sexual activity as it is not something, they would have expected in an ARCF. Two residents also reported that they would feel shocked as they did not consider older residents to be capable of participating in sexual activity (Villar et al., 2015). Some residents purposely limited their expression of sexuality due to the fear of facing judgement by health care staff and other residents (Palacios-Cena et al., 2016) while some nurses were apprehensive about residents' ability to acknowledge relationships and maintain boundaries (Vandrevala et al., 2017).

4.4 Summary of themes

The five themes that have emerged from the findings are lack of privacy, perceptions towards sexuality, expression of sexuality as an inappropriate behaviour, roles and relationships and attitudes towards sexuality. The emerging themes have identified that the sexuality of the older person remains an important part of their life despite the stereotypes that sexuality is non-existent in older adults. Some of these stereotypes have been shown to be influenced by individuals' cultures, religion, education and life experiences. The neglect of the older person's sexuality in ARCFs was associated with negatives outcomes such lack of life satisfaction in residents' lives and declining health status. The emerging themes brought to attention some of the perceptions, attitudes, behaviours and structures that exist in the

environments of ARCFs and how these impact on the ability of the older people in expressing their sexuality.

Chapter Five

Discussion

5.0 Introduction

In this chapter the findings of this review are discussed. It was evident throughout the findings, that the expression of sexuality of older residents in ARCFs was influenced by lack of privacy, perceptions towards sexuality, roles and relationships and attitudes towards sexuality. Findings from the wider literature that are consistent with the themes of this study are also discussed in this chapter. Due to the interconnected nature of the findings, considerations about organisational and environmental policies are posited with further commentary about the attitudes and beliefs of all parties as well as the health of the older person. The strengths and limitations of this study, implications for practice and further research areas and recommendations are also presented in this chapter.

5.1 Environment and organisational policies

Lack of privacy emerged as a key finding affecting the expression of sexuality for older people residing in ARCFs (Cook et al., 2009; Vandrevalla et al., 2017; Villar et al., 2014; Villar et al., 2015; Tzeng et al., 2009). Lack of privacy was also identified as a barrier to sexual expression (Calkins, 2018; Gilmer et al., 2010; Aggarwal, Vass, Minard, Garfield & Cybyk, 2003). The environments in ARCFs have been noted to have an impact on the delivery of care (Calkins, 2018; Rodriguez-Martin, Stolt, Katajisto & Suhonen, 2016). In this integrative review, lack of privacy was mostly associated with poor physical environments and interactions that do not provide enough privacy and support for the expression of sexuality of older residents in ARCFs (Tzeng et al., 2009; Vandrevalla et al., 2017; Villar et al., 2015).

In this review, lack of privacy was associated with poor physical barriers, the need to assist older residents with ADLs and the need to safeguard the health and safety of residents (Tzeng et al., 2009; Vandrevalla et al., 2017; Villar et al., 2015). This is despite the regulations provided in bills such as The Patient Bill Of Rights, (Bauer et al., 2014; Heath, 2011), The Code of Health and Disability Services Consumers' Rights Regulations (1996) (Health & Disability Commissioner, 2009) and the Charter of Residents' Rights and Responsibilities (Bauer et al., 2014) stipulating that health consumers including those residing in ARCFs are entitled to privacy, have the right to be treated with respect and dignity and the right to form relationships and hold conversations with whomever they choose (Bauer et al., 2014; Kamel & Hajar, 2004).

Other studies have highlighted additional facets of the environment which limit the expression of sexuality for the older resident. These include not having policies, practices, procedures and staff training that facilitate and promote a supportive environment in which older people can express their sexuality (Bauer et al., 2014; Doll, 2013; Parker, 2006; Rheume & Mitty, 2008; Shuttleworth, Russell, Weerakoon & Dune, 2010). Having no policies in place was noted to contribute to putting staff in a position where they had to make their own decisions and judgements when faced with situations related to the expression of sexuality of the older people in ARCFs (Doll, 2013). While it is crucial to have policies and procedures to guide staff with practice related to the sexuality of the older person in ARCFs, it was reported that in some instances staff may base decisions on their personal attributes and beliefs and still make judgements which do not adhere to organisational principles (Moore, 2007).

A lack of resources to aid in the assessment of sexuality in older persons residing in ARCFs was identified as a limitation towards the assessments of sexuality as well as supporting the sexual needs of residents (Bauer et al., 2014). This led to nurses not taking a proactive

approach towards addressing residents' sexuality (Gilmer et al., 2010). A Sexual Assessment Tool (SexAT) for example was found to be beneficial in aiding the assessment of physical environments, policies and staff training needs developed to enable an environment that is supportive to meeting residents' identified needs (Bauer et al., 2014).

The World Health Organisation (2010) sexual rights stipulates that individuals have the right to choose to participate in consensual sexual relationships and are entitled to access to the correct information relating to sexual health as well as a safe and satisfying sexual life (Heath, 2011; World Health Organisation, 2015). In the New Zealand context, Competency 1.4 of the Nursing Council of New Zealand competencies requires RNs and ENs to practice in a manner that promotes environments that encourage client safety, independence and quality of life (Nursing Council of New Zealand, 2007). The right to participate in consensual relationships is of significant relevance to older residents in ARCFs especially for those with cognitive impairment as they may not have the capacity to consent to or provide cues to accept or reject sexual relational advances (Jones & Moyle, 2016; Rheaume & Mitty, 2008; Tolo, Nortvedt, Slettebo, 2015; Wilkins, 2015).

For older residents in ARCFs affected by dementia, the expression of sexuality can give rise to ethical dilemmas for staff and residents' families (Wilkins, 2015). The ethical dilemma for older residents with dementia lies between balancing residents' rights to autonomy in pursuing sexual relations, determining their ability to consent and safeguarding them from personal harm (Dewing, 2008; Rheaume & Mitty, 2008; Wilkins, 2015). While dementia brings about changes to the affected person's memory, reasoning and language, an individual's capacity cannot be established based solely on the diagnosis of dementia (Dewing, 2008). When assessing capacity to consent to sexual relationships for older residents affected by dementia consideration should be given to the context of the relationship, particularly to long term relationships that continue to be significant to the

resident and their partner despite cognitive decline and admission into ARCF (Dewing, 2008).

Failure to promote a conducive environment that supports the expression of sexuality by older persons in ARCFs is a breach of the older persons' right to sexual expression and freedom which may adversely affect their mental and physical health and is also a form of elder abuse (Kamel & Hajar, 2004; The World Health Organisation, 2002). The definition of elder abuse provided by the Toronto declaration on the global prevention of elder abuse defines elder abuse as “ a single or repeated act, or lack of appropriate action, occurring within any relationship where there is an expectation of trust which causes harm or distress to an older person” (The World Health Organisation, 2002, p. 2). Neglect is considered a form of elder abuse characterised by providing care that does not meet the physical, emotional or social needs of the older person (New Zealand Age Concern, 2018). It is in view of the above stipulations of individual sexual rights and the definitions of abuse and neglect that ARCFs have a mandate to provide an environment that is conducive to residents expressing their sexuality (Bauer, Haesler & Fetherstonhaugh, 2016; Calkins, 2018; Gilmer et al., 2010; Parker, 2006; World Health Organisation, 2015). Presently ARCFs in Australia and New Zealand are not required to meet any accreditation standards around the development of policies and the provision of staff education on the sexuality of the older person (MoH, 2008; Shuttleworth et al., 2010).

While the international and national policy documents promote healthy ageing, minimal attention has been given to the sexuality of the older person in these documents (Andrews, 2001; MoH, 2001; 2016; Ministry of Social Development, 2015; United Kingdom Department of Health, 2014). However, the New Zealand Positive Ageing Strategy is committed to promoting the development of age friendly communities that support older people to age positively and have dignified end of life care that meets the individuals'

personal, spiritual and cultural needs (MoH, 2016). The lack of reference to sexuality of the older person in national documents is attributed to the prevailing assumptions that sexuality is not important in older people and attitudes of staff working in ARCFs that do not place value on the sexuality of older adults hence there is no need to develop policies (Bouman et al., 2007; Gott & Hinchcliff, 2003; Hajjar & Kamel, 2003; Moore, 2007; Shuttleworth et al., 2010).

To lessen the negative impact of the environment in ARCFs on the provision of care, some studies have suggested that ARCFs adopt a person-centred approach. This approach is appropriate as it goes beyond residents' medical diagnoses and considers individual psychosocial needs, previous life experiences and preferences (Calkins, 2018; Phelan & McCormack, 2016; Sundarajoo, 2017). Person-centred care is focused on providing nursing care that values the individual as a unique person incorporating their values, desires and wishes into their care plan regardless of, gender, age or socio-economic status (McCormack, Van Dulmen, Eide, Skovdahl & Eide, 2017). The expression of sexuality by older residents affected by dementia can be further facilitated through the creation of spaces that support familiarity, orientation to time, place and person as well as providing comfort and dignity (Calkins, 2018). One way of achieving this would be to create households of between 10 to 20 residents with supportive staff dedicated to fostering a way of living that is self-directed and provides a sense of security (Calkins, 2018).

Moving into an ARCF itself has been described by older people as a stressful experience for which they required continued support to adjust to their new environment especially in circumstances where residents had no alternatives (Bland, 2005; Ellis & Rawson, 2015; Phelan & McCormack, 2016). Moving into an ARCF is also associated with loss of the financial autonomy, emotional security and privacy that comes with living in one's own home (Bland, 2005). Adopting a person-centred approach towards the delivery of care and

providing a supportive environment that considers residents' psychosocial needs, previous life experiences and preferences including sexuality have been identified as effective in reducing residents' stress and their perceived loss of independence associated with transitioning into ARCFs and their perceived loss of independence (Calkins, 2018; Phelan & McCormack, 2016; Sundarajoo, 2017).

As well as supporting nurses to provide care that addresses the needs of the residents as unique individuals, the person-centred care approach allows nurses to have insight into residents' previous life circumstances (Bland, 2005; Doll, 2013). The person-centred approach ensures that the physiological, emotional, social and cultural aspects of care for residents including those under palliative care are addressed regardless of the environment in which they live (Bauer et al., 2014; Benoot, Enzin, Peremans & Bilsen, 2018). This is in line with the philosophy of holistic care which is based on providing care that meets the needs of the whole person (Benoot et al., 2018; Calkins, 2018; Jones & Moyle, 2016).

In this review, most sexuality assessments were performed by nurses following disruptive behaviour from residents as opposed to the time of admission (McAuliffe et al., 2015). These were undertaken in response to a perceived adverse event rather than a proactive exploration of the patients' desires and practices (Lester et al, 2016; McAuliffe et al., 2015). While the person-centred approach is focused on developing and coordinating care alongside the older residents' families and care givers (McCormack et al., 2010; McCormack et al., 2017), relying on families and care givers to provide social history including the sexuality of the older person may not be effective in facilitating the expression of sexuality of the older person (Doll, 2013). Some families may not have up to date knowledge of their loved ones' sexuality or the older residents may not have been open about their sexuality (Doll, 2013).

5.2 Attitudes and beliefs

The staff, residents and families' attitudes towards sexuality have been identified as barriers towards supporting the expression of sexuality of older people living in ARCFs. Attitudes such as discomfort, embarrassment and surprise were noted to influence the expression of sexuality for older people in ARCFs (Bauer, Haesler & Fetherstonhaugh, 2015; Doll, 2013; Gilmer et al., 2010; Rheaume & Mitty, 2008).

Nurses found it uncomfortable to gather information on sexual orientation, gender and identity or have discussions about sexuality (Doll, 2013; Dorsen & Van Devanter, 2016; Gilmer et al., 2010). Lack of knowledge on how disease affects sexuality and how to address sexual health concerns of individuals who identify as LGB brought about feelings of worry and discomfort out of fear of offending the residents (Benoot et al., 2018; Gilmer et al., 2010; Rheaume & Mitty, 2008; Saunamaki & Engstrom, 2014). Amongst the nurses with enough knowledge and work experience to enable them to address older residents' sexuality with ease, some still experienced conflict between their professional responsibility and personal values and beliefs (Saunamaki & Engstrom, 2014).

Conflict is defined as a disagreement between people who hold different opinions or principles (Cambridge, 2015). In this context conflict can be described as the existence of active discord of values, beliefs, needs and principles in an individual because of professional responsibilities and their own personal values and beliefs. Conflict was attributed to staff's personal values and attitudes towards ageing and sexuality that did not value older persons as worthy of quality care. These attitudes were associated with nurses' perception of the older residents as having poor cognitive function and a poor prognosis (Moore, 2007). Such attitudes and the existing myths and stereotypes that older people are asexual, incompetent at expressing their sexuality or have lost interest and desire to express their sexuality influenced

nurses' attitudes towards the expression of sexuality for older residents in ARCFs (Gilmer et al., 2010; Parker et al., 2018; Rheume & Mitty, 2008; Thompson, Sullivan, Byers & Shaughnessy, 2014).

These beliefs and stereotypes are so deeply rooted in society that some adults incorporate these myths and stereotypes within themselves and conform to them as they age (Bouman et al., 2007). Syme and Cohn's (2016) study showed that stigmatic beliefs towards the sexuality of the older person increased with age. On the other hand, Bouman, Arcelus and Benbow, (2007) identified that younger health care staff with less than five years of working experience in ARCFs were reported as having more overt negative attitudes towards ageing and the expression of sexuality by older people when compared to staff with more than five years work experience (Saunamaki, Anderson & Engstrom, 2009; Thomas et al., 2014).

Despite this, other studies did not find any differences in staff attitudes towards ageing and the expression of sexuality based on age (Bauer, McAuliffe, Nay & Chenco, 2013; Jones & Moyles, 2016). Notwithstanding their age and experiences negative staff attitudes subsequently impacted negatively on their desire or interest in facilitation of the expression of sexuality for older residents in ARCFs (Gilmer et al., 2010; Moore, 2007).

Restrictive behaviours demonstrated by staff are closely associated with lower level of education, strong religious beliefs and less experience working with older people in ARCFs (Bouman et al. 2007; Iveniuk & O' Muirheartaigh, 2016; Saunamaki et al., 2009). The influence of religion on the expression of sexuality for older people varied with gender. Views of female residents and behaviours towards the expression of their sexuality were found to be more likely influenced by religion than those of men (Iveniuk & Muirheartaigh, 2016). For unmarried older people, strong religious beliefs were negatively associated with sexual activity engagement more so for women than men and in contrast married older

individuals with strong religious beliefs were more likely to have pleasurable sexual activity (McFarland, Ueker & Regnerus, 2011).

Another source of conflict for nurses identified by Benoot et al. (2018) was related to palliative care and the expression of sexuality. While a person-centred care approach should be focused on both the living and the dying, nurses reported experiencing tension when attempting to reconcile their own interpretations of the philosophical principles of palliative care with the expression of sexuality in the dying patient (Benoot et al., 2018; Moore et al., 2017). Some nurses viewed addressing the expression of sexuality in palliative care as part of the holistic model of care aimed at promoting quality of life (QoL) as well as reducing end of life agitation while others took it to mean that the resident was not accepting that they were dying (Benoot et al., 2018). Nurses reported feeling reluctant and helpless to address sexuality issues in palliative care and they attributed this to their own perceptions that the dying person had limited time to explore sexuality needs (Benoot et al., 2008; Moore et al., 2017; Saunamaki & Engstrom, 2013).

Evidence suggests that populations that identify as LGB experience an increased rate of suicide, bullying, alcohol and substance abuse and poor mental health in comparison to populations that identify as heterosexual, both internationally and within New Zealand (Ministry of Social Development, [MSD] 2006). Of concern, these adverse outcomes continue to exist despite the human rights of individuals who identify as LGB being imbedded in legislation such as the Human Rights Act, (1993), the Civil Union Act, (2004) and the Human rights Law in relation to Sexual Orientation and Gender Identity, (2007). All this legislation requires all countries within the United Nations to respect the rights of individuals who do not identify their sexual orientation as heterosexual (MSD, 2006).

Older men who identify as gay were noted to be more open and comfortable with disclosing their sexual orientation to health care staff who appeared to be more understanding to them (Clover, 2006). There is a need to develop national statistical measures and public health policies to address the health inequalities to improve health outcomes of members of the LGB community (Fredrick- Goldstein & Kim, 2015).

Communication barriers causing discomfort and reluctance to discuss sexuality between nurses and older adults have played a part in the neglect of older people's sexual health and consequently this has led to the rise of STIs particularly HIV in older adults (Gledhill & Schweitzer, 2013; Ports, Barnack-Tavalaris, Syme, Perera & Lafata, 2014; Rheume & Mitty, 2008). The Permission, Limited Information, Specific Suggestions and Intensive Therapy model (PLISSIT) can be used to assist nurses to assess the sexuality of older people in ARCFs as well as guide nurses with appropriate interventions (Rheume & Mitty, 2008). Using the PLISSIT model reduces the discomfort associated with discussing sexuality with older people as asking for permission as well as giving them permission to talk about sexuality individually reduces anxiety and feelings of loss of control during discussions (Rheume & Mitty, 2008). Giving the older person permission to discuss their fears and concerns gives them the reassurance that their feelings are normal (Rheume & Mitty, 2008). Providing basic information on ageing, disease and how that is related to sexuality can open discussions on sexuality and help rectify the misconceptions surrounding older person's sexuality (Rheume & Mitty, 2008). The third stage of the model involves engaging therapists to work with the older individuals and to come up with interventions to improve sexual activity for them while the fourth stage is utilised in situations where couples have relationship problems (Rheume & Mitty, 2008). Health providers also identified other barriers to supporting the expression of the older person's sexuality such as lack of time, lack of privacy and training (Ports et al., 2013; Saunamaki et al., 2009).

There is need for sexuality education to be included in undergraduate and postgraduate nursing education, as well as for staff already in practice in order to debunk these myths and stereotypes (Bauer et al., 2013; Doll, 2013; Jones & Moyle, 2016; Saunamaki et al., 2009). The positive impact of nursing education interventions on attitudes towards sexuality have been affirmed. Staff attitudes towards the sexuality of the older person became more permissive following a short education session about sexuality of the older person (Bauer et al., 2013; Jones & Moyle, 2016). However, the influence of the observed changes on nursing practice were not investigated in these studies (Bauer et al., 2013; Jones & Moyle, 2016; Saunamaki et al., 2009).

5.3 Health outcomes related to sexuality and aging

Contrary to the prevailing stereotypes and beliefs that sexuality ceases to be important in old age, older people continue to yearn intimacy and the need to be connected to others (Gott and Hinchliff, 2003; Rheume & Mitty, 2008).These stereotypes are influenced by media images that portray young people as beautiful and attractive as opposed to those of older people who are potrayed as less so. These stereotypes are well entrenched as the internalised generational cultural and moral values date back as far as the early 20th century (Bouman et al., 2007; Rheume & Mitty, 2008). During these times sexual activity was concerned more with procreation than self-expression and pleasure (Rheume & Mitty, 2008).

Despite a change of focus in sexuality, from physical sexual activity to other forms of expression such as showing affection through touch, companionship and the desire to feel attractive and well groomed (Hajar & Kamel, 2003), older women and men reported that sexuality was a significant part of their life that remains present through-out life (Gledhill & Schweitzer, 2013; Mroczek et al., 2013; Rheume & Mitty, 2008; Waite, Laumann, Das & Schumm, 2009). In a study investigating the importance of psychosexual needs for older

people residing in ARCFs physical closeness, intimate connection and living together were perceived as less important compared to other needs such as conversation, tenderness and respect despite the presence of chronic diseases (Mroczek et al., 2013). Gender was noted to have an influence on the value placed on different aspects of sexuality, with more men valuing tenderness while more women placed greater importance on respect (Mroczek et al., 2013). These differences were attributed to factors such as age, an awareness of ones' loneliness and level of sexual interest (Mroczek et al., 2013).

Health issues such as prostate cancer, diabetes and peripheral vascular disease (PVD) are associated with erectile dysfunction (ED) (Gledhill & Schweitzer, 2013; Lindau et al., 2010 ; Parker, 2007), were noted to limit sexually active life more for men than women (Lindau & Gavrilova, 2010). ED has been described as an ongoing difficulty with maintaining an erection to allow sexual penetration. It is associated with reduced sexual function and satisfaction (Gledhill & Schweitzer, 2013). Some men reported that ED brought about feelings of inadequacy, frustration and helplessness and this was associated with poor mental health. Women who were partnered with men who had experienced ED found the sexual encounters unfulfilling. However, most couples regarded the relationship to be more valuable than the sexual activity (Gledhill & Schweitzer, 2013). This is consistent with Mroczek et al.s' (2013) findings that older people in ARCFs valued conversations, tenderness and respect than physical closeness.

However, older men were reported to have higher sexual interest and were more sexually active than older women and the gap increased with age (Beckman, Waern, Gustafson & Skoog, 2008; Lindau & Gavrilova, 2010; Mroczek et al., 2013). This was attributed to older men getting married to much younger women which in turn positively affected libido and from having more years of partnership than women (Lindau & Gavrilova, 2010).

The expression of sexuality in patients affected by cancer and undergoing treatment was overshadowed by the concerns for life, particularly in situations where patients perceived their illnesses and treatments to be severe (Doll, 2013; Gledhill & Schweitzer, 2013; Olsson, Athlin, Sandlin- Bojo & Larsson, 2013). Patients undergoing cancer treatment reported that the treatment impacted on their sexual function, sexual relationships, intimacy and body image (Doll, 2013; Gledhill & Schweitzer, 2013; Olsson et al., 2013). Some patients considered sexuality to be an important part of their life during cancer treatment and others did not view it as significant (Olsson et al., 2013). Perceptions on the importance of sexuality were noted to be influenced by age, the level of intimacy in the relationship and sexual activity before the illness, anxiety, fear of dying and adverse effects of cancer treatments such as nausea and fatigue which impacted on physical strength and sexual desire (Olsson et al., 2013).

Some older residents with cognitive impairments in ARCFs, particularly those affected by dementia may display behaviours that may be misunderstood as sexual in nature while others may be unaware of their surroundings and display overt sexual behaviours in public (Kamel & Hajjar, 2004). The expression of sexuality becomes even more challenging for older residents with cognitive impairments and complex for staff to address as they must determine the older persons' capacity to consent to sexual relationships (Dewing, 2008; Jones & Moyle, 2016). Compounding these difficulties there are no formal guidelines to assist nurses with assessing residents affected by dementia's capacity to consent to sexual activity (Lyden, 2007). Nurses are having to rely on the residents' history obtained from family members and staff who know the resident and mini mental status examinations (MMSE) to assess capacity (Calkins, 2018). However, White, (2010) argued that the MMSE is not a suitable indicator for determining incapacity especially for residents with dementia. Jones and Moyle, (2016) noted that staff valued discussions between themselves and families if they had any concerns. The

challenge presented by ascertaining capacity to participate in consensual sexual activity may result in residents with severe dementia being prevented from expressing their sexuality when staff perceive them as not having the capacity to consent to participate in sexual relationships (Jones & Moyle, 2016) to protect them from harm (Calkins, 2018).

5.4 Strengths and limitations of included studies

The studies were conducted across a total of 29 ARCFs and 1760 participants in the study.

Two studies were conducted through online surveys and both yielded high responses rates.

Health care staff who took part in the studies included, DONs, RNs, ENs, Unit Managers and nurse educators. This allowed the integrative review study to have a wider perspective on the sexuality of older people in ARCFs from staff that were involved with the provision of care to the residents.

The included studies included male and female staff of different age groups, cultural and religious background, education levels, professional backgrounds and working experience.

This degree of difference provided diversity of meanings to the topic under exploration in this integrative review. Twelve of the resident participants had dementia and this provided insight into the expression of sexuality for those with cognitive impairments. However, given the total number of participants, having only twelve residents with dementia can be viewed as limitation to this integrative review.

Out of the ten included studies eight used the qualitative research design and two used the quantitative research design to explore the phenomena of sexuality in older people residing in ARCFs. Different analytic methods suitable to the methodological approach were used. The qualitative methodology is useful when investigating the human lived experience (Polit & Beck, 2010). Ethical approval was sought and gained for nine studies, one study stated that no ethical approval was required as this study did not involve direct patient contact (Lester at

al., 2009). However, the study engaged with DONs through an online survey who were required to provide information on residents' sexual behaviour as well as their views on residents with dementia participating in sexual activity. The study also stated that participants were to remain anonymous but had an opportunity to participate in a draw to iPad (Lester et al., 2016). This reduces the credibility of the statements and assurances by the researchers of the participants' anonymity.

Despite the international coverage of the 10 included studies, the sexuality of older individuals with intellectual disabilities or those who identified their sexual orientation as non-heterosexual was not explored. Two of the studies were conducted by the same authors in the same socio-economic area of Barcelona, Spain using the same group of participants. Even though the research questions were different, conducting the studies in different socio-economic areas with different participants may have provided a different perspective to their study questions. Two studies were conducted through online surveys which both yielded high responses.

No expert or grey literature was utilised in this study and this may be a limitation. All included articles were written in the English language and this excluded articles written in other languages. This can be a limitation as data published in other languages was not represented. The author of this integrative review has more than 10 years work experience with older people in a rehabilitation unit for people aged 65 years and above. This background may have influenced the author to expect evidence to affirm observations from their area of clinical practice. However, this bias was mitigated by both the supervision undertaken as part of the research and using thematic analysis in the integrative review (Braun & Clarke, 2006).

5.5 Implications for practice and research.

This integrative literature review has uncovered some limiting and facilitating factors for nurses in assisting older people in ARCFs to express their sexuality. The expression of sexuality by older people in ARCFs is viewed as problematic and inappropriate in most ARCF settings, particularly in situations where residents have a cognitive impairment and their capacity to consent to participate in sexual relationships is challenging to ascertain (Dewing, 2008 ; Rheaume & Mitty, 2008; Tzeng et al., 2009).

Nurses need education and support around the assessment of sexuality and the needs related to sexual health in older people in ARCFs. There is a need to educate nurses on the importance of making these assessments at the time of admission into an ARCF as well as revisiting these assessments on a regular basis. ARFCs should develop customised templates to assist nurses and guide nurses to comprehensively assess each resident's sexuality needs to inform care (McAuliffe et al., 2016). There is also a need to include sexuality and ageing in the undergraduate and postgraduate nursing curriculum, however, while education may be effective in improving knowledge and attitudes the impact of this on nursing delivery is yet to be researched (Jones & Moyle, 2016).

The delivery of nursing care in ARCFs is mostly concerned with addressing physiological problems, keeping residents safe and maintaining a monitored environment (Cook et al., 2017; Vandrevale et al., 2017; Villar et al., 2014). The structuring of daily activities and monitoring of the environment contributes to residents losing autonomy over most aspects of their lives (Hajar & Kamel, 2003). While the expression of sexuality encompasses sexual activities, some residents may need privacy to hold private conversations with their families and friends, sit next to each other or hold hands (Calkins, 2018). Health care staff need to create environments that are conducive for individuals to engage with each other in private and to participate in activities of their choosing (Calkins, 2018). According to Bland, (2005) an ideal ARCF is one that provides comfort and feels like a resident's home. An environment

that feels like home for residents can be achieved by providing an environment that has a continuum of public, semi-private and private spaces and opportunities for residents to participate in activities of their own preference and to interact in ways that are meaningful to them (Bauer, Haesler & Fetherstonhaugh, 2015, Calkins, 2018; Parker, 2006).

The admission into an ARCF is considered a stressful event especially when individuals have no choice over the admission and because of this, some residents may not be able to feel at home (Bland, 2005). To improve this experience for residents, nurses need to be sensitive to residents' personal circumstances and the reasons for their admission (Bland, 2005). Nurses can also enhance residents' sense of being at home by providing person-centred care (McCormack et al., 2017). According to Calkins, (2018) the core values of person-centred care include comfort, dignity and respect for individual's, rights to personal autonomy, self-determination and working in partnership with residents and their families (McCormack et al., 2017).

Comfort has been described as free from anything that causes affliction and dignity has been described as a state of being worthy of respect (Cambridge, 2015). In ARCFs frequent discussions should be undertaken with residents about their experience of autonomy, self-determination and respect within the setting (McCormack et al., 2017). Minton and Batten, (2018) pointed out that psychological and relational aspects of care are not always documented, and this makes aspects of that care invisible. Working in ways that facilitate the autonomy and self-determination for residents can be challenging for health care staff who are educated, trained and work in cultures that view being autonomous and having professional control as a form of expertise (McCormack et al., 2017). In the context of older people residing in ARCFs and the expression of their sexuality, the autonomy and self-determination of residents can be achieved by holding the values of the residents and their families central in all decision-making processes (McCormack et al., 2017).

There is need for health care staff to work on creating a balance between their professional expertise with residents' choices and perceptions of their health (McCormack et al., 2017). Health care staff should acknowledge the need to change their practice and organisational cultures in order to promote practice development, reflection and value ongoing feedback from everyone (Lynch, McCance, McCormack & Brown, 2017; McCormack et al., 2017). Additionally, Brown, Nolan, Davies, Nolan and Keady, (2008) pointed out that staff who lack appropriate knowledge, skills and adequate resources foster negative attitudes towards older people in ARCFs. Improving such environments is more likely to encourage positive attitudes towards older residents and positively influence the provision of care. Therefore, it is essential for ARCFs to focus on providing adequate resources and environments that foster learning and culture change (Lynch et al., 2017; McCormack et al., 2010). In the context of ARCFs "culture change involves the complete transformation of the institutional practices, routines and schedules that govern the delivery of care to residents- in other words a person-centred culture" (Lynch et al., 2017, p.428). Change in practice can be facilitated by reflection which enables nurses to review their beliefs, values and assumptions against practice and become more aware of the need for change. The reflection process can be facilitated by a leader who can assist nurses to remove barriers and become more effective at facilitating the expression of sexuality for older residents (McCormack et al., 2010).

The Person-Centred Situational Leadership Framework (PCSLF) has been identified as an appropriate nursing leadership framework that can enable nurses to achieve a heightened awareness to the needs of residents in ARCFs (Lynch et al., 2017). The three attributes of PCSLF are “connecting with the person in the instant”, “relating to the essence of being” and “listening to the other person with the heart” (Lynch et al., 2017, p. 437). These can be applied to nursing leadership in ARCFs and assist nursing leaders to nurture nurses to develop a heightened sense of sensitivity to resident’s needs (Lynch et al., 2017; McCormack et al, 2010).

Organisational structures that support ongoing learning and open ways of communication between staff, management, residents and families can facilitate the necessary changes required to promote open communication (Bauer et al., 2014; McCormack et al., 2017). Other ways of supporting the expression of sexuality at an organisational level, would be to build ARCFs that have beauty salons, libraries and chapel services as well as promoting privacy by providing and respecting do not disturb signs and facilitating the ability for couples to share rooms (Bauer et al., 2014).

In view of the increased cultural diversity within New Zealand because of increased migration to New Zealand (MoH, 2016), it is both timely and important to consider the impact of culture, migration and disease on the expression of sexuality. Furthermore, across populations, there is a requirement for research into the sexuality needs for older populations who identify as LGB, adults ageing with intellectual disabilities and those affected by HIV and AIDS residing in ARCFs.

5.6 Recommendations.

Moving into an ARCFs is a major life event which can bring about social, physical and psychological challenges to older residents and nurses should acknowledge their role in

assisting these residents to adjust to their new home (Ellis & Rawson, 2015). It is recommended that nurses are provided with education on how to support older residents with the settling in process. It is important to provide staff with education in areas such as how to interact with residents in open and supportive ways that facilitate residents' expressions of sexuality despite the physical environmental barriers that may exist in ARCFs (Bauer et al., 2014).

It is recommended that nursing practice guidelines based around the person-centred care approach be established to assist nurses with developing care plans that include all aspects of residents' care (Ellis & Rawson, 2015; Heggstad et al., 2015). Adopting a person-centred approach facilitates and supports the principle that residents should be treated as unique individuals with dignity and respect (Heggstad et al., 2015).

It is essential that organisations implement policies and procedures that inform, guide and support staff to facilitate the expression of sexuality of older residents in ARCFs. Nursing assessments exploring residents' sexuality should be completed upon admission and at regular intervals as opposed to when problems arise (Bauer et al., 2014). In conjunction with implementing policies and procedures that support staff to maintain regular assessments on the expression of sexuality of older residents in ARCFs, organisations also need to consider the architectural design, the interior design and the landscape of the ARCFs and how interactions between residents, families and staff occur (Calkins, 2018). It is recommended that the maintenance of privacy within ARCFs should be part of the accreditation standards for ARCFs within New Zealand. The aims of the New Zealand Health Strategy are that all adults live well and age well (MoH, 2016). While positive aging is acknowledged within the New Zealand positive ageing strategy, it is recommended that it also specifically addresses sexuality of the older person.

5.7 Summary

Moving into an ARCF has a huge impact on the social interaction of the older person. Furthermore, it is associated with loss of financial independence, autonomy and result in decreased opportunities for the older person to express their sexuality and can be stressful on the residents. Nurses should have an awareness of the impact that moving into ARCFs has on older people and should seek to facilitate a smooth transition into care. There is a need for nurses to include the principles of person-centred care into their practice to encompass all aspects of care, including sexuality

Chapter Six

6.0 Conclusion

The expression of sexuality continues to be a significant aspect of emotional and mental well-being throughout the life span, despite the prevalent stereotypes and beliefs that sexuality ceases to be important in old age. The expression of sexuality is not limited to intimate behaviours, it also expressed through beliefs, values, behaviours, practices, companionship and attractiveness. The expression of sexuality can be challenging for older people especially those residing in ARCFs. Nurses play a significant role in providing care to older people residing in ARCFs, however the expression of sexuality of these residents has been given limited consideration.

Nurses were noted to take the distracting or facilitating role in the expression of sexuality for older adults in ARCFs. Perceptions that the expression of sexuality was inappropriate and problematic for older residents in ARCFs and negative staff attitudes such as discomfort, embarrassment and surprise influenced their responses to the expression of sexuality by older people residing in ARCFs. These perceptions and attitudes became barriers to the gathering of information and assessment of residents' sexual health as well as addressing situations and residents' concerns related to the expression of sexuality.

Factors such as nurses' age and their level of experience of working with older people, inadequate knowledge about sexuality and how disease affects sexual expression influenced nurses' responses towards the expression of sexuality by older residents in ARCFs. Nurses who had appropriate knowledge and skills were more open to facilitating the expression of sexuality for the older residents in ARCFs, however some nurses still experienced conflict between their own values and beliefs and the principles of the provision care despite having adequate knowledge. Education on sexuality and ageing is required in undergraduate and postgraduate nursing as well as for those already in practice. Some residents expressed that

they were not comfortable discussing sexuality concerns they may have with nurses. This was attributed to the internalised stereotypes by the older residents that the expression of sexuality was inappropriate in the ARCFs as a result of perceptions of their age and marital status.

The impact of physical structures on privacy and the expression of sexuality of the older residents in ARCFs was highlighted in this integrative review. While physical structures such as a lack of locks on doors, shared bedrooms and bathrooms limited the expression of sexuality for older residents in ARCFs, some interactions between nurses and residents were also noted to influence the expression of sexuality. Nurses were focused on assisting residents with their ADLs and maintaining a safe environment for older people which in turn increased surveillance on residents and adversely affected their privacy. Despite all these challenges some nurses supported the expression of sexuality of the older person out of respect for the older person's right to autonomy, maintenance of privacy and dignity and a desire to promote a culture of acceptance of older people's sexuality including affected by dementia.

The expression of sexuality is more challenging for older residents with cognitive impairment and those who identify their sexual orientation as LGB. For older residents affected by dementia, the expression of sexuality posed a dilemma between establishing the residents' capacity to consent to a romantic relationship and maintaining the residents' right to autonomy. Therefore, the expression of sexuality by residents with dementia was considered problematic. Limited consideration was given to the expression of sexuality of the older residents who identified as non-heterosexual in the included studies. This could be attributed to the bias that heterosexuality is the only normal which made nonheterosexuality invisible in the ARCFs.

Nurses should be provided with education that is focused on improving their knowledge and assessment skills of sexual health and sexuality of the older person. The ARCFs organisations

should provide nursing leadership that is supportive of nurses' and provide them with support to reflect on their values and beliefs.

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Appendix A: JBI QARI Appraisal tool.

JBI Critical Appraisal Checklist for Qualitative Research

Reviewer _____ Date _____

Author _____ Year _____ Record Number _____

	Yes	No	Unclear	Not applicable
1. Is there congruity between the stated philosophical perspective and the research methodology?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
2. Is there congruity between the research methodology and the research question or objectives?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
3. Is there congruity between the research methodology and the methods used to collect data?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
4. Is there congruity between the research methodology and the representation and analysis of data?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
5. Is there congruity between the research methodology and the interpretation of results?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
6. Is there a statement locating the researcher culturally or theoretically?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
7. Is the influence of the researcher on the research, and vice-versa, addressed?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
8. Are participants, and their voices, adequately represented?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
9. Is the research ethical according to current criteria or, for recent studies, and is there evidence of ethical approval by an appropriate body?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
10. Do the conclusions drawn in the research report flow from the analysis, or interpretation, of the data?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Overall appraisal: Include Exclude Seek further info

Comments (Including reason for exclusion)

APPENDIX B Critical Appraisal Checklist for Prevalence Studies

JBI Critical Appraisal Checklist for Studies Reporting Prevalence Data

Reviewer Date

Author Year Record Number Yes No Unclear Not applicable

1. Was the sample frame appropriate to address the target population?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
2. Were study participants sampled in an appropriate way?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
3. Was the sample size adequate?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
4. Were the study subjects and the setting described in detail?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
5. Was the data analysis conducted with sufficient coverage of the identified sample?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
6. Were valid methods used for the identification of the condition?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
7. Was the condition measured in a standard, reliable way for all participants?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
8. Was there appropriate statistical analysis?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
9. Was the response rate adequate, and if not, was the low response rate managed appropriately?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Appendix C: JBI Data Extraction Tool

JBI QARI Data Extraction Form for Interpretive & Critical Research

Reviewer Date

Author Year

Journal Record Number

Study Description

Methodology

Method

Phenomena of interest

Setting

Geographical

Cultural

Participants

Data analysis

Authors Conclusions

Comments

Complete

Yes

No

Appendix D: Data Extraction Table.

Ethics, intimacy and sexuality in aged care. Cook et al., (2017).
Qualitative, discursive mixed method, semi structured interviews. Sampling technique- Snow balling.
An analysis of staff, family residents accounts of ethics, intimacy and sexuality in aged care.
ARCFs, New Zealand
Age range 55-80, two females, two undisclosed gender all European descent.
Four Participants, One RN, one health care assistant, one female relative and one female resident with no diagnosis of advanced cognitive impairment or significant language difficulties
Thematic analysis
<p>Mediated intimate relationships and every day ethics in ARCFs</p> <p>Lack of privacy</p> <p>Some residents had not had relationships since moving into ARCFs as not confident that privacy will be respected.</p> <p>No locks on doors- privacy would be invaded and this would lead to embarrassment.</p> <p>Does not feel like home</p> <p>Lack of autonomy</p> <p>Privacy was compromised by interruptions caused by staff entering residents' rooms without waiting for the invitation to enter.</p> <p>One RN felt the need to mediate and reassure families.</p> <p>There was uncertainty as to whether it is the staff's responsibility to be involved in the couple's decision or whether to assume the responsibility.</p> <p>Families interference in the expression of sexuality to assess for safety in residents' relationships.</p> <p>One daughter reported monitoring her widowed mother and the new partner to plan about the safety of the relationship.</p> <p>An education would enable staff to develop in- depth reflection skills with regards to assumptions about men's' sexual aggressiveness and women's vulnerability.</p> <p>Referencing to self</p> <p>Lack of direction from management, participants used personal moral judgements to inform the decisions making process instead of being guided by formal institutional policies.</p> <p>AD1 reported that she did not require assistance to make decisions about her mother 'sexuality as she felt comfortable taking the lead in making decisions about her mother's relationship.</p> <p>RN1's attitude of promoting freedom while ensuring that the residents' well- being was maintained.</p> <p>RN1 also highlighted the need to consider other staff members' perspective as there was cultural diversity in the team.</p> <p>RN placed value on well- being and autonomy.</p>

Knowing the person's history and present

A person's history can be useful in making decisions and guiding the course of action in complex situations.

A strong bond can develop between staff and residents that can be used to guide the decision-making process related to residents' expression of sexuality and well-being.

ADI used the knowledge from her mother's long history and characterises to assess her mother's safety in the new relationship.

Understanding a person's current need for affection is useful in guiding the evolution of relationships with residents.

In as much as the families may have knowledge to assist in proxy decision making, they are some areas that they may not know.

Ethical priorities

Lack of formalised ethical decision-making pathways, participants had to evaluate issues such as :

- a) The residents' capacity to consent
- b) The resident right to be involved in an intimate relationship on wellbeing
- c) The effects of the intimate relationships on well-being
- d) The appropriateness of placing restrictions on residents' expression of sexuality for safety reasons

Emphasis was placed on rights and well-being

Reviewers' comments: Lack of privacy and a sense of inadequate privacy can influence older people's expression of sexuality.

Sexuality policies can guide nurses make decisions related to sexuality activity.

Families can support nurses by providing resident's social history, however their influence can limit the expression of sexuality.

2) Journal Article and Authors	Sex in Nursing Homes: A survey of Nursing Home Policies Governing Resident Sexual Activity. (Lester et al., 2016).
Method/ Methodology	Purposive sampling, anonymous on-line survey, open questions.
Phenomena of interest	Directors of Nursing 's experiences and perspectives on the sexual activity and sexual relationships of patients with dementia and policies related to it.
Setting/ Geography	Nursing homes, bed capacity of 50-199 facilities for 73% of the respondents, United States of America.
Culture	Nursing homes residents, Directors of Nursing (DONs), other characteristics not disclosed

Participants	366 DONs, gender not disclosed.
Data analysis	Data was analysed with the SAS 9.2 for windows, core.
Findings	<p>71.2% of the respondent reported issues of resident’s sexual activity in their nursing homes, with over 58 % of the respondents reporting cases of sexual activity between residents.</p> <p>60% of the respondents reported sexual activity related to masturbation</p> <p>21.7% of the respondents reported sexual activity between residents and visitors.</p> <p>56.6% of the DONs reported that cognitively impaired residents needed their family’s members or a nominated person to approve sexual activity as compared to 12.4% of the facilities requiring approval for sexual activity from a family member or a designated member.</p> <p>Prevalence of policy in nursing homes</p> <p>63.4% of the facilities did not have the policies regarding residents ‘sexual activity in place.</p> <p>58.6% of the facilities have documented policies in place, with 51.7% of these facilities applying policy to all policy despite the presence or absence of medical condition and 22.4 % of the facilities the policies applied to cognitively impaired residents.</p> <p>16.4 % applied when sexual activity was observed and 21.6% where sexual activity was requested.</p> <p>11.2% needing a doctor’s order to permit sexual activity.</p> <p>9.5 % needing a doctor’s order to control residents’ sexual activity.</p> <p>Of the facilities with policies regarding masturbation in place 79.2% applied the policy to all residents despite medical condition with 22.9% applying policy when masturbation is observed.</p> <p>8.3% of facilities applied the policy to residents with cognitive impairment.</p> <p>6.3% of facilities applying policy where masturbation was requested.</p> <p>Directors of Nursing perspective on sexuality.</p> <p>45.3% of the respondents were open to allowing residents with moderate to severe dementia to engage in sexual relationships with</p>

	<p>88% of the respondents reporting that residents with dementia should be permitted to have sexual activity with their spouse.</p> <p>10% reported that the residents with moderate to severe dementia should be permitted to have sexual relationship with another person.</p> <p>50.4% of DONs reported concerns related to sexual relationships, and these were likely more likely related to cognitively impaired individuals.</p> <p>Reviewers comments: There is need for facilities to formulate policies that guide nurses with practice related to the expression of sexuality for older people.</p> <p>More education is required around dementia and the expression of sexuality.</p>
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3) Journal Article and Author	Assessment of sexual health and sexual needs in residential aged care . McAuliffe et al., (2015)
Methodology/ Method	Qualitative study, purposive sampling, Postal surveys to 2766 residential aged facilities addressed to the directors of nursing or nurse unit managers. Copies of the survey were sent out four weeks after the first mail, and the final deadline of the surveys were sent out four weeks after the second mail. Direct questioning techniques used to facilitate gathered information such as sexual health, sexual intimacy, sexual needs, sexual orientation, disruptive behaviour that was sexual in nature.
Phenomena of interest	To conduct an inquiry into how the assessments related to the sexual health and needs of residents occur in Australian residential aged care facilities.
Setting / Geographical	ARCFs, Australian Capital Territory- (14), New South Wales-(337), Northern Territory-(5), Queensland-(137)South Australian-(109), Tasmania- (42), Victoria- (324) and Western Australia. Facilities providing low level of care- (113), high level care- (280) and mixed-(694). Non-profit facilities- (807) and profit facilities- (271)
Culture	Males and females, age range 18 to 61 and above. A total of 1032 respondents

	936 Females and 96 Males
Participants	1032 participants, 634 DONs, 163 Nurse unit managers, 200 managers and 87 other undisclosed roles.
Data analysis	Data was analysed using the statistical software package
Findings	<p>Assessments</p> <p>Most frequently gathered information regarded disruptive sexual behaviour with (66%) of the facilities gathering that information.</p> <p>Least gathered information was sexual history prior to entering care with 13.7 % of the facilities gathering that information.</p> <p>Residents' intimacy- (31.7%), Sexual health-(24.7%,) Sexual orientation-(20.5%), sexual needs- (20.5%).</p> <p>Assessment timing</p> <p>Assessments occurred more often because of disruptive behaviour at 96%</p> <p>Assessment also occurred following initiation of discussion by family- (89%)and patient-(87.3).</p> <p>On admission, 86.7% upon request by General practitioner (GP)- 82% and on resident's care plan review- (80.5 %) and on other occasions such as when sexually inappropriate behaviour was displayed or when required (10 %)</p> <p>Methods of collecting residents' information</p> <p>Most of the information was verbally collected from the resident- 76%, residents' families-78%, 73.2% from other admission paperwork.</p> <p>Twenty-four of the facilities used an assessment form designed especially for sexual health needs.</p> <p>Roles of who performed assessments</p> <p>Sexual health, needs and preferences were performed mostly by RNs, 62%, followed by GPs, 18.5% and ENs and diversional therapists with a similar percentage of 16.4%.</p>

	<p>With 5.7 % of DONs performing assessments.</p> <p>Comparingly, post hoc analysis showed that for profit facilities were more inclined to collect residents' information with 26% versus 18% on sexual needs and 38% versus 37% on intimacy needs and 26% and 19% respectively for sexual orientation and 73% and 64% for sexual disruptive behaviour.</p> <p>Larger facilities with a bed capacity above 91 beds were more inclined to gather information on residents' sexual orientation while facilities with a high number of residents with dementia gathered information about resident's sexuality at admission</p> <p>Reviewers comments: Assessments related to the expression of sexuality should be performed at admission and at regular intervals.</p> <p>There is need for facilities to develop assessment forms deigned to assess the sexual health of residents.</p>
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4) Journal article and Authors	Expressing sexuality in nursing homes. The experience of older women: A qualitative study. Palacios- Cena et al., (2016).
Methodology/ Methods	Descriptive qualitative study. Face to face in- depth interviews using structured and semi structured questions, Sampling technique- purpose sampling
Phenomena of interest	Women's experiences of expressing their sexuality in nursing homes.
Setting/ Geographical	Seven ARCFs- Southern Madrid, Spain
Culture	ARCFs, residents above the age of 60 with a mean age of 83.4 years.
Participants	Twenty female participants, 13 widows, 6 married and one single
Data analysis	Thematic analysis
Findings	<p>Expression of sexuality</p> <p>All participants expressed that they continue to feel desire but felt as if their time had passed.</p> <p>Sex was overvalued while other forms of expressing sexuality were undervalued.</p> <p>Fear</p>

	<p>Residents purposefully limited their sexual expression of sexuality for fear of being judged by healthcare professionals and other residents.</p> <p>Negative perceptions</p> <p>Residents reported experiencing of social pressure within the homes with regards to how they express their sexuality through the way they dressed or initiate relationships.</p> <p>Some participants reported that their desire to express their sexuality needs and desires were negatively viewed on at a social level as well as by their own spouses.</p> <p>Some residents viewed sexuality as a wife’s marital duty, with their own needs being secondary to their husbands’ needs.</p> <p>Three married women and seven widows who had had partners with Alzheimer’s disease in the past or during the course of the study also held the sense of duty perception to their husbands</p> <p>The perception of duty was attributed to participants’ education level, norms and values derived from their youthful years.</p> <p>Respect of vows</p> <p>All the 13 widows interviewed reported that they did not see the need to form new relationships after the deaths of their husbands</p> <p>Some of the participants views were influenced by their religious beliefs while other’s views were influenced by the need to preserve their husbands’ memories and personal choice not to form new relationships.</p> <p>Reviewers comments : Residents can purposively and unintentionally limit the expression of their sexuality.</p> <p>Attitudes and perceptions of staff can limit the expression of sexuality.</p> <p>Nurses need support with reflective practice</p>
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5) Journal Article and Authors	Sexual behaviour of nursing home residents- staff perception and responses. (Roach, 2004).
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Methodology/Method	<p>Grounded theory, In- depth interviews using unstructured questions and guided discussions for the nominal group members.</p> <p>Theoretical sampling, 30 participants involved in face to face interviews, 18 participants in three nominal groups and another five participants as key informants.</p>
Phenomena of Interest	Nursing home staff's perspective and responses on affectionate and sexual behaviours of nursing home residents.
Setting/ Geography	ARCFs- Perth, Melbourne- Australia, Stockholm Sweden.
Culture	<p>Age range for participants in two of the nominal group was 31-57 years, average of 45 years.</p> <p>Males and females</p> <p>Age range of other participants undisclosed.</p>
Participants	<p>A total of 53 participants, 30 interview participants, 18 participants in nominal groups and an additional five key informants.</p> <p>Interview participants</p> <p>Nine RNs- two from Perth, five from Melbourne, Australia and two from Stockholm, Sweden.</p> <p>Nominal group members</p> <p>One EN, five RNs</p>
Data analysis	The comparative method
Findings	<p>Preserving comfort</p> <p>Individuals and organisations safeguard themselves against behaviours that brought them discomfort.</p> <p>Discomfort to engage with sexuality was associated with negatives outcomes such as lack of respect of individual's rights and the right to express one's sexuality while organisations that have a responsive culture and staff who are comfortable with sexuality are associated with positive outcomes.</p> <p>Organisational cultures can sometimes facilitate or restrict the expression of sexuality in older adults residing in nursing homes.</p>

	<p>Organisations may direct their attention on protecting staff's comfort levels and formulate procedures to address residents' sexual needs.</p> <p>Staff who are comfortable with sexuality issues also safeguard their comfort levels and vice versa.</p> <p>Guarding discomfort- Four categories:</p> <p>Standing guard</p> <p>Refers to the measures and interactions of nursing staff who are uncomfortable with sexuality and work in an environment with an organisational that is restrictive of sexuality expression.</p> <p>Staff members' level of easiness to respond to the expression of sexuality in ARCFs was influenced by religious and cultural beliefs, level of education and life experiences.</p> <p>For some it was easier to overlook the expression of sexuality.</p> <p>To address residents' expression of sexuality staff would need to confront their own views and attitudes and this might be too uncomfortable for them and this in turn lead them to safeguard experiencing discomfort.</p> <p>Facilities that have a restrictive culture towards residents' sexuality needs influence staff as they may fail to provide education and support in areas regarding residents' expression of sexuality.</p> <p>Management practices related to safe guarding.</p> <p>Practice that is restrictive and controlling may continue in some facilities as managers may ignore sexuality issues for not wanting to face them which results in them viewing such practices as normal.</p> <p>Creation of physical barriers to the overt expressions of sexuality in older people by separating them, through moving them to different rooms.</p> <p>Psychological barrier created through threats and punishment.</p> <p>Negative outcomes of avoiding sexuality include lack of satisfaction in residents' lives followed by a decline in residents 'health.</p> <p>Reactive Protection</p>
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	<p>Staff still controlled by their discomfort feeling of sexuality and responding in a similar way in the standing guard.</p> <p>Discomfort which was felt more regularly in which turn increased staff member's guarding reactions.</p> <p>Cultures as they may face opposition from managers.</p> <p>Staff would become defensive and use religious, moral or cultural reasons to justify their actions with some staff taking a higher ground for others.</p> <p>Guarding the guards</p> <p>A combination of organisation with a restrictive culture and staff members comfortable sexuality issues.</p> <p>A staff member with comfort sexuality issues may suggest different ideas of sexuality from others and end up isolated and lacking support.</p> <p>The staff member comfortable with sexuality issues may assume a role of standing guard to oppose the restrictive ethos of the organisation and others.</p> <p>The staff member places high value on residents' sexuality, advocates for the resident's rights as well as educating staff, residents and their families.</p> <p>Proactive protection</p> <p>Refers to environments that promote residents' expression of sexuality.</p> <p>These organisations have structures that support residents' sexuality needs such as providing privacy to residents, providing staff with support and education on residents 'sexuality issues as well as developing appropriate policies.</p> <p>Staff interactions with residents demonstrated empathy for residents and the desire to create rapport with residents.</p> <p>Outcomes of proactive protection.</p> <p>Positive for both residents and staff</p> <p>Residents-had the freedom to express their sexuality and had their sexuality needs addressed.</p> <p>Strong relationships between residents, families, staff and other and other community members.</p>
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	<p>Better health status and improved sense of well-being.</p> <p>Increased satisfaction with life.</p> <p>Staff- Were able to address residents 'sexuality issues.</p> <p>This model is more fitting to Sweden than Australia due to the existence of sexuality education in their curriculum.</p> <p>Reviewers' comments:</p> <p>Sexuality education needs to be included in undergraduate, postgraduate nursing curriculum and to those in practice.</p> <p>ARCFs environments influence the expression of sexuality.</p> <p>Staff can adapt their practice to fit the environment they are practicing in.</p> <p>Staff attitudes and environments can interact and influence their practice in relation to supporting residents with expressing their sexuality.</p>
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6) Journal Article and Authors	Sexual behaviours of institutionalised residents with dementia- a qualitative study. Tzeng et al., (2009).
Methodology/Method	Grounded theory, Informal face to face interviews with residents with a diagnosis of dementia. Purposive sampling.
Phenomena of interest	To explore the distinctive features and the contexts associated with sexual behaviours among nursing home residents with dementia.
Setting/Geography	Three dementia units, long term care facilities, Northern Taiwan.
Culture	Male and females, residents mean age of 74.3 years formal care with a mean age of 46.3 year.
Participants	Twenty- four participants identified as displaying sexual inappropriate behaviour were selected out of 25 residents. Three RNs
Data analysis	Thematic analysis
Findings	Three types of sexual behaviours were identified: a) Sexual behaviours involving contact with others, b) non-contact with others and verbal sexual abuse. Sexual behaviours involving contact with others.

	<p>Male resident undressed a female resident with advanced dementia (Observed finding)</p> <p>Stroking each other's genital areas- two male residents involved.</p> <p>Sleeping on the same bed- two male reported to have been sharing a bed.</p> <p>Sexual behaviours with no contact with others</p> <p>Stroking one's own genital areas- eight male residents involved in this sexual activity, five of the residents performed this sexual activity in their rooms, with two of those residents carrying out the activity in the bathroom and one in the communal area (Observed finding)</p> <p>Four male residents attempted to stroke or stroke or touch a care giver who was passing through the provision of care in any other activities.</p> <p>One male resident kept staring at a female nurse's breast during personal care interventions. One male resident threatened to grab a care givers' breast when they prompted to take a bath.</p> <p>Verbal sexual behaviours</p> <p>Three residents frequently made request sexual in nature such as kissing, stroking and sleeping together to caregivers and female residents.</p> <p>One male resident threatened to grab a care givers breast when they were prompted to take a bath.</p> <p>Existing factors influencing sexual behaviour.</p> <p>Opportunity</p> <p>Three categories emerged which are opportunity, mutual target and personal space with no privacy.</p> <p>Opportunity occurs in three circumstances, through unplanned meetings in group activities or during personal cares where a resident of the opposite gender would unanticipatedly touch or make body contact with someone.</p> <p>Cooperative target.</p> <p>Involved participants out of mutual affection and compulsion, with expression occurring. For example, in instances where a resident who has dementia and the ability to verbalise their choice</p>
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to participate or not in sexual activity chooses to participate in unsolicited sexual behaviours from others.

On the hand, a resident with advanced dementia who is unable to verbally express their choices may be unwillingly exposed to sexual behaviours.

Lack of privacy in personal spaces.

Shared open public bathrooms and shared bedrooms.

Resident forced to a room with a divider that was only a meter high.

In addition, some rooms lacked privacy as they had doors with transparent glass.

Three residents were observed masturbating looking at the door which suggested that they were concerned with being discovered by others during sexual activity.

Other people' response.

Responses of other people who may be close by when the sexual behaviour occurs, such as other residents, care givers, families and visitors.

Residents responses

Most residents did not adopt a formal position towards sexual behaviours, female residents with advanced dementia had no capability to respond and other residents did not display any observable facial or body language reactions, so it was challenging to ascertain their comprehension of the situation.

Most residents could not convey their feelings during interviews

Few residents responded to the display of sexual behaviours by others such as touching and kissing by calling it shameful and embarrassing as well as informing the nurse.

One resident with moderate dementia was observed to be upset and called out looking for nurses.

Mutual affection sometimes occurred between two female residents with mild to moderate dementia, where the other resident with dementia responded positively to touching by smiling back or extending their hand to holds.

Health care staff responses.

	<p>Interviews with health care staff showed that mostly ignored sexual behaviours between men as supposed they were less vulnerable because they were of the same sex.</p> <p>Health care staff at institution A, appeared more respectful to residents to sexual activity such as masturbation as they were discreet when dealing with such situations.</p> <p>The responses of health care staff were guided by the institution's policies and the individual themselves.</p> <p>Health care staff employed tactics such as distraction, supervision and distraction in situations where sexual activities considered to be non- consensual such as in cases where the residents would have advanced dementia.</p> <p>Health care staff would sometimes ignore sexual behaviours that were directed towards them, however this affected their mood.</p> <p>Health care staff would sometimes give residents who participated in sexual activity such as masturbation privacy by placing calendars to block the transparent areas on residents' door while others called residents derogatory names and laughed about amongst them.</p> <p>Health care staff at institution B, recognised masturbation as a resident's right and tolerated it as a residents' sexual activity however they did not encourage it.</p> <p>Institution B's main reason for not encouraging masturbation was that there was no sufficient privacy in nursing homes and if the masturbation was not posing problems it was often ignored.</p> <p>Institution C's policies were based on religious beliefs hence health care staff were not supportive of this behaviour.</p> <p>Institutions and sexuality policies.</p> <p>Institution A</p> <p>Residents' sexual activity were respected in circumstances where it was not thought to cause problems.</p> <p>Health care staff regularly hugged and gave residents kisses on the face where appropriate.</p> <p>The design of residents' rooms and bathrooms had consideration of privacy.</p> <p>Institution B</p>
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	<p>Residents at Institution had little interaction</p> <p>Institution C</p> <p>Institution C’s policies were reinforced by religious beliefs of the Catholic Church.</p> <p>Healthcare staff at this institution would divert residents’ attention from masturbation and have discussions with them to ensure that this behaviour does not occur again.</p> <p>Health care staff at institution C were more conservative.</p> <p>Reviewers Comments :</p> <p>The expression of sexuality was viewed as problematic.</p> <p>Privacy influenced the expression of sexuality.</p> <p>While some staff were supportive of residents ‘expression of sexuality others ignored it.</p> <p>There is need for nurses to receive education regarding the expression of sexuality.</p>
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7) Journal Article and Author	“Behind Closed Doors with open minds” :A qualitative study exploring nursing home staff’s narrative towards their roles and duties within the context of sexuality in dementia. Vandrevalla et al. (2017)
Methodology/ Methods	Qualitative Face to face individual in-depth interviews, using semi structured questions. Purposive sampling
Phenomena of interest	Nursing home staff perspective on their roles and duties within the context of sexuality in dementia.
Setting/ Geographical	Two nursing homes, with one nursing home specialising in dementia care, both nursing homes had a 50-75 bed capacity. Greater London, United Kingdom.
Culture	Males and females, two males and six females, age range 20-50 years. Four identified their religion as Christian, one as Muslim and 3 had no religion.
Participants	Eight aged health care staff, unit manager.

Data analysis	Interpretation Phenomenological Analysis Procedures (IPA)
Findings	<p>Interpretation of sexuality in dementia</p> <p>Dementia brings about changes in the person and influences the way they express their sexuality and intimacy.</p> <p>Sexuality and intimacy are neglected</p> <p>Sexuality remains a significant part of the ageing process, quality of life and well-being with personhood predominating dementia. Participants who held this view challenged the restriction of sexuality and intimacy in people with dementia and advocated for their rights and autonomy.</p> <p>Some participants especially staff contradicted this view and believed that the progression of dementia affects the quality and nature of sexuality relationships and hence has little accommodation in ARCFs.</p> <p>Dementia becomes a characteristic feature which helps to define the person and negatively affect their rights and sexual needs.</p> <p>Expression of sexuality and intimacy in people with dementia is affected by memory and cognitive decline.</p> <p>People with dementia are not able to make decisions about their care hence they become passive participants of care.</p> <p>Residents affected by dementia require protection.</p> <p>Participants held the view that as dementia progresses residents tend to forget some details of their past lives and lose their physical and mental function as well as the expression of their sexuality.</p> <p>Sexuality important through-out the life span.</p> <p>The expression of sexuality is a basic human right and continues to be important throughout the persons' life span regardless of age, gender, sexual orientation and cognitive ability.</p> <p>People affected by dementia have the need to initiate and maintain a sense of personhood through individual and intimate relationships.</p> <p>Older adults with dementia continue to experience sexual urges and they should be allowed to freely express them.</p> <p>The expression of sexuality by older people should have a place in nursing homes and older adults with dementia with dementia</p>

	<p>continue to express sexual desires which they should be allowed to express freely.</p> <p>For health care staff the health and safety of residents took precedence over the expression of sexuality.</p> <p>The expression of sexuality was only allowed in a controlled environment to prevent harm to the residents and others.</p> <p>Health care staff who held liberal views perceived dementia as part of normal ageing and a form of illness that should limit the expression of sexuality.</p> <p>Challenged by stigma, myths and stereotypes associated with dementia and ageing and advocated for changes in the way society view and treat people with dementia.</p> <p>The importance of embracing the essence of personhood for the person living with dementia while acknowledging the cognitive decline brought about by dementia.</p> <p>Roles and responsibilities associated with delivering care to people affected by dementia.</p> <p>Participants dealing with behaviours related to the expression of sexuality and intimacy in clients with dementia required taking up an additional role.</p> <p>Intimacy of residents with dementia was viewed as an additional role that was not readily accepted.</p> <p>These roles were based on the participants viewed dementia and evolved over time depending on the level of cognitive decline.</p> <p>Health care staff who held liberal views were more flexible and accepting of their evolving roles as well as the residents' needs.</p> <p>In contrast staff who had their view of dementia shaped by the biomedical care focus tended to pay more attention to the functional and cognitive decline of the individual with dementia.</p> <p>Their roles were guided by their own attitudes and the views of the families of the resident affected by dementia which often did not complement each other.</p> <p>Staff experienced discomfort and embarrassment when the subject of sexuality was brought up.</p> <p>Staff perceived their roles to be limited: to provided personal care.</p>
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	<p>-Helping with ADLS</p> <p>-Promoting interactions</p> <p>Treating residents with respect, dignity and compassion.</p> <p>The facilitator</p> <p>This role involved normalising the expression of sexuality and intimate relationships in ARCFs as well as upholding residents’ wishes and needs.</p> <p>The facilitating role was aligned to values and guidelines such as respecting residents’ rights to privacy, dignity and choice.</p> <p>The facilitators views were influenced by factors such as the need to promote the residents’ privacy and dignity and promote a culture of acceptance of older people’s sexuality and intimacy.</p> <p>The use of double beds and do not disturb signs as well as the provision of private space may safeguard residents with dementia from displaying sexual behaviours in inappropriate places.</p> <p>It is challenging finding the balance between the provision of care and monitoring residents for safety and the need to preserve residents’ right to privacy.</p> <p>Conflicting view.</p> <p>Facilitating sexual intimate relationships behind closed doors was also considered to be inappropriate and a risk to patient safety.</p> <p>The empathiser</p> <p>Empathetic role highlighted the need to be respectful and considerate to the sexual needs of residents with dementia.</p> <p>Many extended empathies beyond their roles and expected to be treated with the same respect and understanding should they be in a similar situation in future.</p> <p>The participants got emotional fulfilment from their role by actively engaging with residents in a non-judgemental manner.</p> <p>However, having such a role did not mean that the care provided included actions to facilitate sexual expression as participants can choose to observe rather than assist.</p> <p>Staff who take up this role may be influenced by feelings of embarrassment or lack of knowledgeable skills or experience to address issues relating to the expression of sexuality.</p>
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	<p>Staff may avoid addressing incidents related to sexuality to manage their own discomfort and stress arising from such incidents.</p> <p>The role of observer was accompanied with mixed feelings towards their role and the significance of sexuality in dementia.</p> <p>Leading staff to adopt the in between mindset instead of becoming active participants in the facilitation of sexuality in residents with dementia.</p> <p>The informant</p> <p>Some staff may take up the role of the informant seeking assurance from residents' family's members or other team members about their decisions.</p> <p>The role may change from informant to an overseer of the families wishes and needs, depending on the families demands and the residents' mental capacity.</p> <p>This role was adopted to avoid conflict with families.</p> <p>Families were perceived as having a lot of knowledge about residents and provided staff with resident's information regarding their values and wishes before having dementia.</p> <p>Collateral history about residents was thought to contribute to nursing homes to address issues relating to residents' expression of sexuality effectively.</p> <p>Relying on families for information was considered to hinder residents' autonomy.</p> <p>The distractor.</p> <p>The expression of sexuality in dementia is seen as a behavioural problem.</p> <p>Despite being aware of the signs that residents were expressing were related to their sexuality, staff responded by diverting resident's attention from expressing their sexuality.</p> <p>In addition, staff felt they were opposed to residents expressing their sexuality in dementia due to the residents' families' anxieties that something bad would happen and disapproval of intimate relationships developing in nursing homes.</p> <p>The custodian role.</p> <p>Serving the best interest</p>
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	<p>Staff took the supervisory role to reduce the perceived risk of abuse or sexual activity with no consent.</p> <p>This role was not based on the view that the expression of sexuality was a basic human right or the view that dementia plays a part in the expression of sexuality in residents with dementia.</p> <p>The choice between promoting autonomy and safeguarding was determined by the residents' capacity to consent and the severity of dementia.</p> <p>Residents with mild dementia were considered to have the capacity to make personal decisions and staff respected their views.</p> <p>The assumption was that residents with mild dementia were able to verbally communicate their needs and wishes which made nurses to be confident in the safety of the residents and respect their choice to be involved in intimate relationships.</p> <p>In contrast ARCFs staff considered the expression of sexuality by residents with severe dementia to be even more complex as one or both residents may not have the mental capacity to consensual activity.</p> <p>Nursing staff adopted a more custodial approach for residents with severe dementia as they believed them to be more vulnerable to sexual abuse due to their inability to verbally communicate or actively refuse to engage in sexual activity.</p> <p>Nursing staff were apprehensive about residents' ability to acknowledge relationship expectations and maintain boundaries.</p> <p>While holding and cuddling did not cause strong reactions from residents, for some it was considered to cause anxiety and confusion to others.</p> <p>Respecting Marriages.</p> <p>Health care staff were more respectful to the expression of sexuality that occurred within a marriage or a relationship that was present before the diagnosis of dementia and admission in a nursing home.</p> <p>The expression of sexuality in a recognised relationship was thought to bring about intimacy and closeness to both partners.</p> <p>Despite the relationship being a recognised staff continued to take the safe guarding role by continuously assessing for the capacity.</p>
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	<p>Staff were opposed to any form of sexual expression or relationships between an individual with dementia and another person other their partners, they felt the duty to protect the sacredness of that marriage.</p> <p>Personal beliefs and religious background.</p> <p>Cultural, morals, religious, ethical world views and personal views of some nursing staff particularly who held strong views influenced their judgement of and views of sexual expression in dementia.</p> <p>The role of safe guarding was preferable and comfortable for the nursing staff who did not want to confront their own religious and moral beliefs.</p> <p>Reviewers Comments :</p> <p>The expression of sexuality is influenced by culture, religion, marital status an individual’s level of education.</p> <p>The expression of sexuality for residents with dementia also need to be considered in ARCFs.</p> <p>A diagnosis of dementia has an impact on the expression of sexuality to those affected by it.</p> <p>The expression of sexuality was even more complex for people affected by dementia.</p>
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8) Journal Article and Authors.	Barriers to sexual expression in residential aged care (RACFs) : A comparison of staff and residents’ views. Villa et al. (2014).
Methodology/Method	Qualitative descriptive study. Face to face using semi structured interviews. Short vignettes read out the interviewer. Random selection.
Phenomena of interest	Staff and residents’ perspective on barriers to sexual expression in residential care facilities and a comparison of both views.
Setting/ Geographical	Five different ARCFs, with a capacity of up to 90 residents- Barcelona, Spain.
Culture	Staff, males and females, age range 22-63 years with a mean working experience of 11.3 years in ARCFs. Residents, males and females, age range71-96 years, mean 84.3. Education level -

	three residents- completed university studies, 8- secondary level, 27- primary studies and 9 had no formal education.
Participants	53 staff participants, 48 females, 5 males, 23nursing assistants, five managers, four educators, seven nurses. Forty-seven residents, 20 males, 27 females with no diagnosis of cognitive impairment, dementia or any psychiatric disorders, permanent resident in ARCFs for at least six months.
Data analysis	Thematic analysis, NVivo 2.0 software.
Findings	<p>Most participants did not identify barriers to sexuality.</p> <p>Nineteen participants out of the residents’ sub group did not identify any form of barriers.</p> <p>Not enough privacy was mentioned more by staff than residents.</p> <p>Inadequate privacy was attributed to communal living such as shared bathrooms and lack of single occupancy rooms.</p> <p>Structured daily living which tended to promote communal activities over individual deciding how to spend their time.</p> <p>Lack of privacy was also attributed to continued surveillance of residents for safety reasons which tended to monitor residents’ sexual behaviour.</p> <p>Not enough privacy was closely associated with lack of freedom.</p> <p>Residents’ attitudes</p> <p>Mentioned more frequently by staff than residents.</p> <p>Expression of sexuality limited by the belief that sexuality is not morally and socially appropriate for older people.</p> <p>These attitudes were attributed to lack of education and the religious held by the older generations.</p> <p>Mentioned by some participants more so by staff members themselves than residents.</p> <p>It was identified that staff members needed to be mindful of intimacy matters.</p> <p>Communications</p> <p>Staff and residents perceive sexuality as a difficulty subject to talk about.</p>

	<p>Sexuality is not usually discussed in ARCFs which contributes it being invisible</p> <p>Health needs and disease.</p> <p>Mentioned more often by staff members than residents.</p> <p>Some disease lead to loss of independence while others lead to sexual disabilities.</p> <p>Family interference</p> <p>This was mentioned nine times by both groups.</p> <p>Family can impose restrictions on the expression of sexual needs of their relatives living in ARCFs</p> <p>The family restrictions seemed to be more appropriate in situations where the resident had dementia</p> <p>No opportunities</p> <p>Was mentioned by six residents.</p> <p>Unavailability of suitable partners, partners are either of the same sex or too old.</p> <p>Reviewers' comments :</p> <p>The expression of sexuality was influenced by inadequate privacy, continued surveillance from health care staff and health problems.</p> <p>Sexuality is a difficult subject to talk about.</p>
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9) Journal article and Authors	What Happens in their bedrooms stays in their bedrooms: Staff and Residents 'Reactions toward Male-Female Sexual intercourse in Residential Aged Care Facilities. Villar et al. (2015).
Methodology/Method	Qualitative. Face to face interviews staff and residents, using semi structured questions over seven months

	<p>Vignettes depicting anonymous residential residents involved in different sexual behaviours used to explore staff's reactions towards these behaviours</p> <p>Purposive sampling</p>
Phenomena of interest	A comparison of staff and aged facilities residents' reactions towards male – female sexual intercourse occurring in private spaces within facilities.
Setting/ Geographical	Five long term ARCFs with a bed capacity of 90 residents, Barcelona, Spain.
Culture	<p>Staff, Males, Females, with an age range of 22 to 63 years and a mean age of 42.5 years</p> <p>Residents, Males, Females, with an age range of 71 to 96 and a mean age of 84.3 years.</p>
Participants	<p>Fifty-three staff participants, subgroups consisted of 23 nursing members of staff and 30 managerial staff.</p> <p>Forty- eight females</p> <p>Five males.</p>
Data analysis	Content analysis, using the NVivo 2.0 analysis software
Findings	<p>Perceptions and emotions towards situations depicted from vignettes</p> <p>Appropriate behaviour</p> <p>Participants (13 professionals and 24 residents) who responded to a sexual activity situation depicted in the vignette and some interview questions considered the sexual activity between male and female living in the aged care facilities to be appropriate.</p> <p>This group viewed this type of sexual activity in aged care facilities as a natural way of expressing needs.</p> <p>Inappropriate behaviour.</p> <p>Participants especially residents found sexual activity depicted in vignettes between male and females as inappropriate.</p> <p>The most common reason attributed to this view was that the bedrooms at the facility were not private enough to facilitate this type of relationship. This was mentioned more by residents by nine residents and one health care staff.</p>

Sexual activity was also considered by five residents as inappropriate due to the age of residents.

Emotional reactions to vignettes

Eleven health care staff and two residents- most common form of negative emotions experienced was regret

Regret was associated with not knocking and interrupting the sexual activity.

Discomfort

Two health care staff and six residents reported that they would find witnessing the sexual activity unpleasant.

Embarrassment/ Shame.

Three health care staff and three residents reported that they would feel embarrassed to witness such type of sexual activity in an aged care residential facility.

Neutral emotions

Several health care staff reported that they would find it shocking to discover two residents having sex as it is not something they would have expected or experienced.

Two residents also reported that they would feel shocked as they did not consider residents to be capable of participating in such activity.

Positive

Three health care staff and three residents reported that they would feel a sense of joy for the older people involved as it would demonstrate that sexuality exists in old age.

One health care professional reported that they would find it funny to witness such as situation.

Behavioural Reactions

Limiting behaviours

Cited by eight health care staff and nine residents.

Consisted of reactions that could be considered as a barrier to sexual activity between male and female in residential aged care facilities, further preventing such as behaviours in the future.

	<p>Two types of limiting behaviours namely teasing and reprimanding.</p> <p>Teasing- Asking indiscreet information that is not relevant to the provision of the resident's care.</p> <p>Addressing the situation to one or both residents in a joking manner.</p> <p>Reprimanding- Cited by one professional and five residents.</p> <p>Behavioural responses included expressing disapproval of the sexuality activity to the residents involved and rebuking the for their behaviour.</p> <p>Respectful.</p> <p>Most common behaviour with 48 health care staff and 42 residents.</p> <p>The behaviours neither create barriers or promote the expression of sexuality but accept it.</p> <p>Can be divided into three subcategories, reducing interruptions, apologising and letting the staff know.</p> <p>Reducing interruptions- Reported by 40 health care staff and 40 residents.</p> <p>Behaviours that aim to reduce interruptions as much as possible by quietly closing the door or ignoring the observed sexual activity</p> <p>Apologising-Cited by 20 health care staff and ten residents</p> <p>Apologising to one or both residents for going in the room without permission.</p> <p>Informing staff- Let other staff know of the sexual event.</p> <p>Supportive behaviours- Least common, cited by nine professionals and two residents.</p> <p>Behaviours that were aimed at facilitating the involved residents to fulfil their sexual needs.</p> <p>Direct support- six healthcare staff and two residents participated reported that they would directly support the residents involved while others (Four healthcare staff) reported that they would discuss the event with others and find ways of supporting the residents.</p>
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	<p>Reviewers' comments:</p> <p>The response adopted by health care staff towards the expression of sexuality was also influenced by their level of comfort in discussing sexuality.</p> <p>There is need for ARCFs to develop policies related to the expression of sexuality to support staff with practice.</p>
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10) Journal Article and Authors.	Staff attitudes and reactions towards residents' masturbation in Spanish long term- care facilities. (Villar et al., 2016)
Methodology/ Methods	<p>Qualitative descriptive</p> <p>Face to face interview, using semi structured questions</p> <p>Vignettes read out by the interviewer</p> <p>Random sampling</p>
Phenomena of interest	Staff attitudes and reactions towards residents' musturbation in long term facilities.
Setting/ Geographical	Five long term care facilities, with a capacity of 48 -90 residents, Barcelona, Spain.
Culture	Age range of 22- 63 years, mean age of 42.5 females and five males.
Participants	Five managers, six education specialist, 23 nursing assistants.
Data analysis	Thematic analysis
Findings	<p>Several participants considered masturbation to be normal behaviour and acceptable among residents.</p> <p>Viewed as a natural and as a human biological need.</p> <p>On the hand some participants viewed older people as not interested in sex or as not capable to participate in sexual activities.</p> <p>Surprise</p> <p>Some participants expressed surprise as masturbation is an event that they do not expect to see in an ARCF.</p> <p>Embarrassment</p>

	<p>Eight participants reported that they felt embarrassed for invading the residents' privacy and interrupted their sexual pleasure.</p> <p>Sympathy for the resident</p> <p>Six participants reported that they would feel sorry for the residents observed to be masturbating who were presumed to be feeling guilty and embarrassed for being discovered.</p> <p>Management of situations depicted in vignettes</p> <p>The most common response for managing was to avoid interrupting the residential and act as if the staff had not observed anything</p> <p>Apologising</p> <p>Some participants reported that they would apologise to the residents for invading their privacy while others would go further and explain to the resident that the intrusion was not intentional and justify the reason for invading the resident's privacy.</p> <p>Informing others</p> <p>Fifteen participants mentioned that they would inform other professionals, in view of getting advice on how to deal with such situations as well as to warn others and avoid future incidences.</p> <p>Discussing with the resident</p> <p>Eight participants reported that they would talk to the resident about the incident so that they would gain an insight into the resident situation.</p> <p>Some participants reported that the conversation would be to inform the resident that masturbation might create problems such as embarrassment due to lack of privacy in ARCFs</p> <p>Not informing others.</p> <p>Some participants reported that they would not say anything to anyone to avoid a negative response from other residents and health professionals and to uphold the residents' right to privacy.</p> <p>Offering help.</p> <p>Four participants mentioned that they would support the residents to continue with their sexual activity in a safe manner by removing objects that could be in the way.</p> <p>Other members of staff reactions</p>
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	<p>Fifteen participants mentioned that some members would respond by making derogatory remarks, create jokes or gossip about the residents' sexual activities.</p> <p>Responses from twelve participants represented negative reactions towards masturbation which conveyed the view that masturbation was problematic and had to be prevented.</p> <p>Some responses showed a preference to rebuke the resident for them to stop repeating masturbation.</p> <p>Eleven participants responses suggested that other staff members would avoid interference out of respect for residents' right to privacy.</p> <p>Ten health care staff mentioned that other staff would find masturbation as normal and acceptable.</p> <p>One response attributed the view in this category to the improved acceptance of musturbation which was not permitted the past generation.</p> <p>Two responses mentioned that some staff would tell others.</p> <p>Reviewers comments:</p> <p>Health care staff were using their moral compass to guide practice. There is need for policies and guidelines to be developed to guide staff in their practice.</p> <p>The expression of sexuality by older adults was viewed as problematic.</p>
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