Sexuality and Relationships in Health and Social Care Settings – Staff Perspectives and Training Needs

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Introductory Chapter: Thesis Overview

Sexuality is a broad umbrella term and the various definitions available emphasise the complex mix of factors involved. Sexuality is fundamentally a description of humans' holistic experience and approach to anything within the sexual realm. A highly cited definition, and the one used in the empirical paper presented here, is proposed by the World Health Organisation and defines sexuality as "…a central aspect of being human throughout life encompasses sex, gender identities and roles, sexual orientation, eroticism, pleasure, intimacy and reproduction. Sexuality is experienced and expressed in thoughts, fantasies, desires, beliefs, attitudes, values, behaviours, practices, roles and relationships. While sexuality can include all of these dimensions, not all of them are always experienced or expressed. Sexuality is influenced by the interaction of biological, psychological, social, economic, political, cultural, legal, historical, religious and spiritual factors." *(World Health Organisation, 2006).*

For the purposes of these papers, 'health settings' refers to physical and mental health settings. There are obviously examples in health care when sexuality is the explicit focus of the conversation. This may include, but is not limited to, sexual health clinics. For the purposes of these papers, health settings are referring to physical and mental health settings where this is not the explicit focus of the visit. Sexual health holds a definition separate to sexuality (World Health Organisation, 2006) and therefore discussions between sexual health professionals and patients are distinctive and do not meet the criteria for these papers. Whilst this study focuses on health and social care settings in the UK, it is acknowledged that the discussion of sexuality is a global phenomenon. Exact

practices addressing sexuality in global settings is likely to vary significantly. Kpokiri et al. (2022) note that further research is needed globally on sexuality, sex and sexual rights to fully understand these differences.

Frequently, the topic of sexuality is poorly addressed with service users within health and social care settings by professionals in the UK (Quinn et al, 2011; Bauer et al., 2016). There are many reasons for barriers to discussion of sexuality in these settings, such as embarrassment, personal discomfort and lack of awareness of sexual issues (Hinchcliff et al., 2005; Dyer & das Nair, 2012). Some studies, however, highlight how certain factors can facilitate discussion of sexuality. These factors include knowledge and professionals going beyond their comfort zone (Saunamäki & Engström, 2014). There is some literature focusing on training interventions for staff on the topic of sexuality, however these studies are limited and there are notable gaps, such as for educational interventions regarding older adult sexuality to support staff working in care homes (Horne et al., 2021).

The overall aim of this thesis was to explore staff experiences of how sexuality is considered in different health and social care settings. The first chapter of this thesis is a systematic review. This review evaluated studies reporting on educational interventions regarding sexuality delivered to staff working in health and social care long-term settings. Long-term care settings is defined by the researchers as any setting where a service user stays overnight to receive care that is not for a brief or acute reasons. The term does not refer to a specific number of days but moreover the nature of the stay. Due to the lack of research in this area, several different settings were looked at, including

(neuro)rehabilitation units, inpatient wards and care homes. Findings offer insight into the nature of educational interventions delivered to staff. Elements explored include the participants involved, objectives and outcomes assessed of these studies. Additionally, where studies sought participant feedback, findings were synthesised.

The second chapter in this thesis is an empirical grounded theory study. In-depth individual interviews explored care home staff members' experiences of how older age sexuality is considered within care homes. A theoretical model of the findings depicts the four main themes and their subcategories. It is hoped that these findings can inform future training and enable staff to better support residents when considering sexuality. The target journal for this paper is Journal of Aging & Health.

Both the systematic review and the empirical study have been presented at different events, such as the Liverpool Dementia & Ageing Research Forum. The researcher presented the research rationale, methodology and findings, creating opportunity for feedback and dissemination.

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Chapter 1: Systematic Review

Staff training interventions focusing on adult service user sexuality in long-term care settings: A mixed-methods systematic review

Abstract

Backgrounds: Sexuality is routinely not addressed in health and social care settings and can be a difficult topic for staff to initiate and discuss.

Objective: The aim of this systematic review was to assess all educational interventions (training) delivered to staff working in institutional long-term care settings. The focus of the interventions was adult sexuality.

Methods: Systematic searches were run on four databases and Google Scholar for papers between 2002 to January 2022. Search terms pertained to studies reporting on staff educational interventions for staff working on setting such as inpatient, (neuro)rehabilitation and residential settings. The initial searches yielded 3,662 papers.

Results: Ten studies were included and findings synthesised. Objectives of included studies including improving knowledge and permissiveness of attitudes. Content focused largely on older adult sexuality, LGBT+ older adults, and improving the discussion of sexuality on rehabilitation and inpatient units. All studies demonstrated improvements for participants following the education intervention and participants gave overall positive appraisals of training.

Conclusions: Sexuality education training for staff working in health and social care long-term care settings has received little empirical assessment. Where training has occurred, staff have benefited. Training has been effective through varied methodologies including online and in-person discussion groups.

Introduction

Adults may be required to live, either temporarily or permanently, in a health or social care setting for a variety of reasons. These settings could include, but are not limited to, care homes, neurorehabilitation units or inpatient wards. Between 2019 to 2020, there were 391,927 residents living in care home settings across the UK (Office for National Statistics, 2021). Additionally, in 2018, there were 4,600 neurorehabilitation inpatient beds in the UK (APPG-ABI, 2018). Whilst individuals are staying in these settings, it is vital and legally binding that their human rights, including respecting sexuality, be upheld (Miller et al., 2015). Sexual rights above all pertain to bodily integrity, the right to choose and freedom of sexual choices (Parker, 2011). Many applied psychologists recognise that abuses of human rights are common, often unintentionally, for the people they support particularly when they are in a vulnerable position, such as being a resident of a health or social care setting (Butchard & Kinderman, 2019). One issue that could lead to sexual human rights not being upheld is health and social care staff finding it difficult to discuss the topic of sexuality. One possible way to address this is through sexuality education and this review aims to assess what impact such interventions have for staff working in these settings.

There are expectations in terms of the support and training for staff working in health and social care settings. The Health and Social Care Act 2008 states that all staff should receive appropriate support, training, professional development, supervision, and appraisal to enable the duties of their employment to be carried out (Care Quality Commission: CQC, 2021).

For healthcare organisations, Health Education England in partnership with Skills for Health set out eleven training topics in the UK Core Skills Training Framework (CSTF; Skills for Health, 2019). This framework was initially introduced in 2013 and is continually being developed. It includes a focus on named areas such as equality, diversity and human rights, safeguarding, information governance and data security, preventing radicalisation, conflict resolution and health and safety at work. Despite these and many other guidelines for training, it is still common place that health and social care staff receive little opportunity for training (Islam et al., 2017).

When service users require longer-term stays in a health or social care setting, there are significant needs and changes to their cognitive, physical and psychological functioning that require consideration. Within these settings, the topic of sexuality may not be fully considered. For instance, sexuality was actively repressed and denied for many people with intellectual disabilities until the 1970s (Whittle & Butler, 2018) and it is still common for ageist erotophobia discourse to present a barrier for such discussion with older adults (Simpson et al., 2017). Previous literature has also identified that within healthcare settings, there are still multiple sources of resistance at assessment and intervention in regards to considering sexuality (Gill & Hough, 2007). These challenges will be discussed later in this paper.

Research has highlighted that a large proportion of health and social care staff consider sexuality to be an important area for consideration (Saunamäki & Engström, 2014). Nevertheless, there are many barriers to the discussion of this which have been identified, such as staff member's own concerns regarding their levels of knowledge, skill,

confidence and comfort discussing issues related to sexuality (Ussher et al., 2013). Additionally, service users have also recognised the impact of social taboos, such as older women and sexual pleasure, as preventing a focus on sexual health (Ejegi-Memeh et al., 2021). Systematic review findings have highlighted how certain factors contribute to sexuality being less likely to be discussed, such as working with particular populations including older adults, black and minority ethnic people, non-heterosexual individuals, people with intellectual disabilities and those of a different gender to the professional supporting them (Dyer & das Nair, 2013).

Whilst training on the topic of sexuality in adult health and social care settings is necessary, its availability is unfortunately limited (Charitou et al., 2021; Villar et al., 2017). This gap is also present in the available literature with recent published research suggesting a paucity of studies exploring the topic of sexuality in adult and social care services (Horne et al., 2021). Moreover, the reviews in this field predominantly focus on studies examining service users' experiences, whereas fewer studies are available regarding staff experiences. In the most recent scoping review on this topic, Horne et al. (2021) found that education interventions can positively impact care home staff attitudes towards older adult's sexuality, intimacy and relational needs and in turn enhance person-centred care. These findings appear to be very significant in the context of the lack of job training and support for care home staff identified during the pandemic (Hanna et al., 2022).

In the context of scarce literature examining the experiences and perceptions of sexuality amongst health and social care staff, this systematic review aimed to systematically identify evidence that assessed educational interventions on the topic of adult sexuality. Interventions were delivered to staff working in health and social care settings with service users as either an inpatient or resident. The review addressed the following research question: "What is the effectiveness of adult sexuality training interventions delivered to staff working in health and social care long-term care settings?".

Method

Protocol and registration

Initially, scoping searches were performed to ascertain that no previous reviews in this area had taken place. The review was pre-registered on PROSPERO in August 2021, [Ref:CRD42021275816; https://www.crd.york.ac.uk/prospero/display_record.php?RecordID=275816]. The review was undertaken and reported in line with the Preferred Reported Items and Meta-Analysis (PRISMA) guidelines (Page et al., 2021). Papers were quality assessed using

Search strategy

Systematic searches were completed using four electronic databases: EMBASE, PsychInfo, CINAHL and PUBmed. The following search terms were applied to each database (sexual* OR intimacy) AND (staff* OR professional*) AND (training OR education OR learning) AND (hospital OR residential OR care setting OR rehabilitation OR care home OR nursing home). Following consultation with a Trust librarian,

systematic searches took place in January 2022 and an additional Google Scholar search was conducted in April 2022 to ensure that any eligible, recent articles were identified. Endnote was used to initially organise the articles and remove duplicates and Microsoft excel was used for the screening process. Hand searching took place and grey literature was not searched. One paper was identified through searching reference lists of already included papers.

Inclusion and exclusion criteria

Articles were included if they met the following inclusion criteria: research published in peer-reviewed journals; published between 2000 and 2022; research reporting on a study where there was a training intervention focused on adult sexuality; the majority of the staff receiving the training intervention worked in a health or social care long-term setting.

Articles were excluded if they reported training interventions for staff working with children/adolescents; reported training interventions focusing on sexual abuse; focused on settings that were not long-term health and social care settings. Due to language restrictions of the lead researcher only papers either originally written in English or with a reliable translation freely available were included.

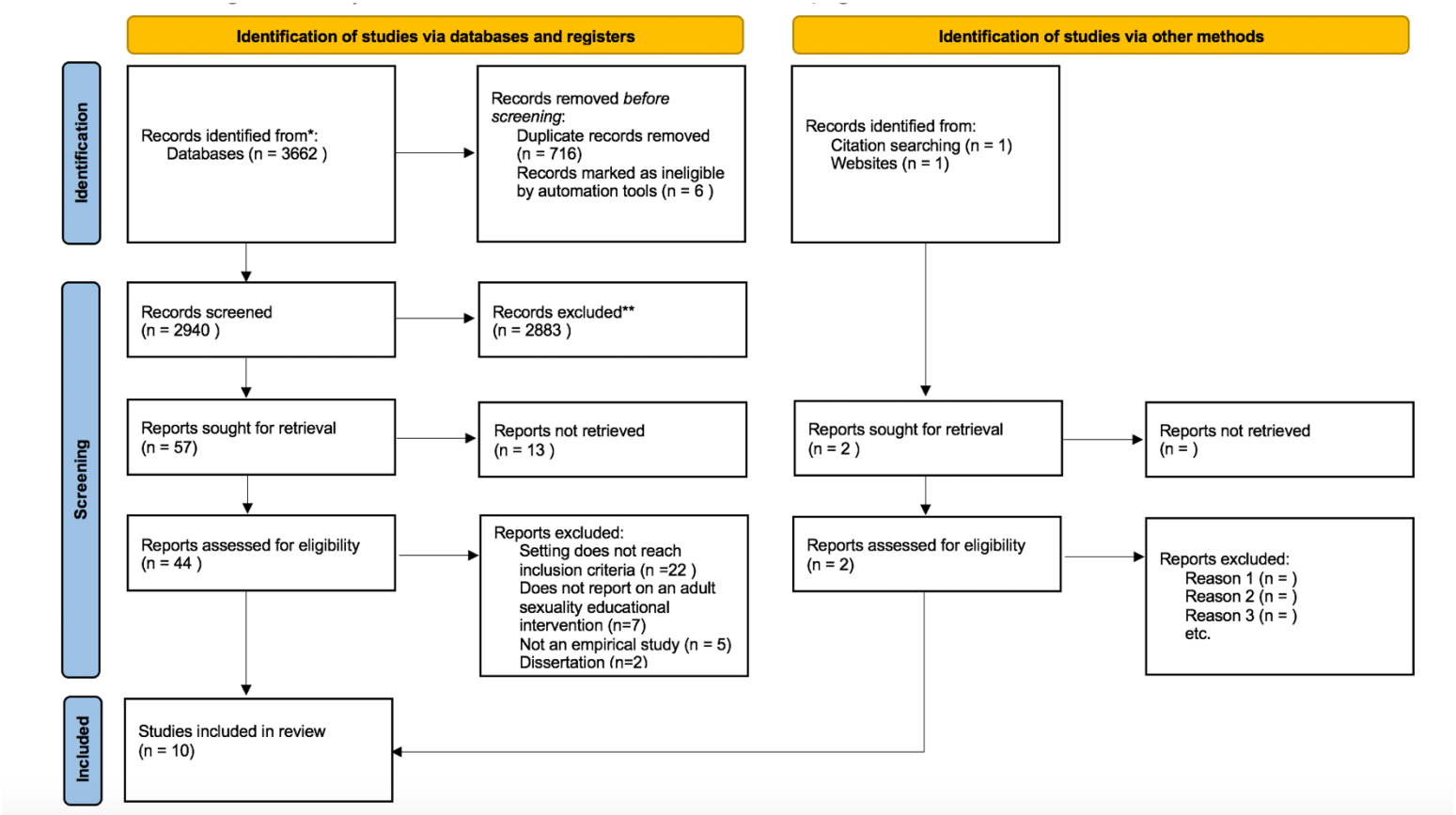
Study Selection

The search yielded 3,662 articles (EMBASE, 661; PsychINFO, 291; CINAHL, 420, PUBmed, 2290). Following the removal of duplicates, 2,940 papers remained. An additional two articles were found; one through references and one through a Google Scholar search. Two researchers independently screened abstracts/titles. In Stage 1, one researcher screened all titles and abstracts (FC) and one researcher screened a random

10% of all papers (MH). For Stage 2, both researchers read all remaining (n = 46) full texts against inclusion/exclusion criteria. Any discrepancies at Stage 1 or 2 were discussed between researchers. Where uncertainties surrounding inclusion or exclusion remained, a third researcher was consulted (CG or SB).

Figure 1

PRISMA flowchart depicting systematic identification of included studies



Page MJ, McKenzie JE, Bossuyt PM, Boutron I, Hoffmann TC, Mulrow CD, et al. The PRISMA 2020 statement: an updated guideline for reporting systematic reviews. BMJ 2021;372:n71. doi: 10.1136/bmj.n71. For more information, visit: http://www.prisma-statement.org/

Data extraction and synthesis

Two bespoke data extraction tools were designed by the author (Appendix E-F). Using the first tool, the following data was extracted: author, year of publication, title, setting and participants, geography, design, conclusions. The second tool extracted detailed information regarding the educational intervention and its' outcomes: author, year of publication, intervention, outcome measures, results.

Quality assessment

The quality of each of the included studies was assessed using the Standard Quality Assessment Criteria for Evaluating Primary Research Papers from a Variety of Fields (Kmet et al., 2004). This tool consists of two checklists; one for quantitative methods (Appendix A) consisting of 14 items, and another for qualitative methods (Appendix B), consisting of 10 items. Each item is rated against predetermined criteria regarding how accurately the study meets the domain (yes = 2, partial = 1, no = 0; Appendix C-D). The quantitative checklist has an additional option of 'N/A'. A summary score is then calculated, with a total possible sum of 28 for the quantitative checklist and 20 for the qualitative checklist. The summary score is then converted to an overall score, where a score of 0.75 (or 75%) is the threshold for indicating good quality.

Results

Ten papers met inclusion criteria and reported outcomes for training interventions on the topic of sexuality for staff working in long-term care settings (Walker & Harrington, 2002;

Post et al., 2008; Wright & Pugnaire-Gros, 2010; Bauer et al., 2013; Jones & Moyle, 2016; Pelts & Galambos, 2017; Donaldson et al., 2019; Holman et al., 2020; Chidiac et al., 2021; Rassem et al., 2022).

Data synthesis

Narrative synthesis was used to collate and summarise the main findings from the included papers, and the findings are described below. Where statistical forms of collating data is not appropriate, as in this case, a narrative approach enables similarities and differences between papers to be investigated, relationships in the data identified and assessment of the strength of evidence (Lisy & Porritt, 2016).

Design and participant characteristics

The 10 included studies were published between 2002 and 2022. Studies took place in different countries, including the UK, United States of America, Australia, Canada, Netherlands. Studies recruited participants from different settings, including residential aged-care facility (RACF)/care home, RACF specialising in veteran care hospices, rehabilitation settings for physical impairments and rehabilitation mental health units.

The studies employed different designs, with the majority using a pre- and post-test design (N= 8), whilst others used a cross-sectional design (N = 1) and sequential mixed-methods design (N = 1). In all studies, the majority of participants were female, whilst the average of other demographics was not calculated due to variations in reporting. There were a wide variety of different professions involved (see Table 1 and Appendix G for further details).

Table 1

Design characteristics of included studies

Author(s) Year	Location	Setting	Sample and characteristics	Design
Walker & Harrington 2002	Oklahoma, Virginia and Michigan, USA	Four separate long-term care facilities	N = 109 Gender: female 90.4%, male 9.6% Age: range 20-69, M = 38.47, SD = 11.04 Race/ethnicity: African American 66.4%, white 20.8%, Asian/Native American/Hispanic 12.8% Job title: RNs 8.8%, LPNs 4.4%, CNAs 50.4%, activity aides 11.7%, other professional, such as social worker, 18.2%, other staff, such as house-keepers/security/clerical staff 6.6%	Pre- and post- test
Bauer et al., 2013	Victoria, Australia	Residential aged care	N = 112 Gender: female 93%, male 7% Age: 18-30 years 7%, 31-50 years 39%, 51+ years 54% Job title: registered nurse 74%, enrolled nurse 26%	Pre- and post- test
Jones & Moyle 2016	Australia	Residential Aged Care Facilities (RACFs)	N = 42 Gender: female 90.5%, male 9.5% Age: Range 16-67 years. M=38, SD=17.2 Job title: Nursing student 38.1%, diversional therapists 4.8%, registered nurse 21.4%, enrolled nurse 7.1%, personal care workers 28.6%	Sequential mixed-methods design
Pelts. & Galambos 2017	USA	Three long-term care sites. All with 40 mile radius of one another.	N = 42 Gender: female 81%, male 19% Age: M = 38 years Ethnicity/race: Caucasian 83%, African-American or Black 9%, Hispanic/Latino 6%, other 2% Job title: nursing assistants 42%, activities or other support 19%, social workers/social services 12%, registered nurses 10%, licensed practical nurses 9%, other 8%	Pre- and post- test

Donaldson et al., 2019	USA	Geriatric extended care units for US military veterans	N = 26. Job title : Nursing n = 8, Medicine n = 3 (1 only at pre-), Social work n = 4, Occupational and physical therapy = 4, Psychology = 2 (only at post-), Chaplaincy = 1 (only at pre-), Recreation therapy = 2, Administration n = 2	Pre- and post- test
Holman et al., 2020	Ohio, USA	One senior living facility	N = 43 Gender: Female 84.09%, Male 15.91% Age: M = 34.21 years Race: White 75%, Other 25% Staff designation: Facilities services 15.91% Healthcare services 84.09%	Pre- and post- test
Chidiac et al., 2021	London and Essex, UK	Four hospices	N = 145 Gender: Female 93.79%. Male 6.21% Age:18-29 5.52%, 30-39 10.34%, 40-49 31.04%, 50-59 22.14%, 60+ 8.97% Ethnicity: Black/Black British 3.45%, Asian/Asian British 2.07%, Caucasian/White British 90.34%. Other 4.14% Job title: 1.38% chaplain, 0.69% complementary therapist, 15.86% counsellor, 6.90% doctor, 14.48% healthcare assistant, 39.31% nurse, 2.76% occupational therapist 10.34% others, 3.45% physiotherapist, 1.38% psychologist, 3.45% social worker	Pre- and post- test
Post et al., 2008	The Netherlands	Two rehabilitation centres	N = 282 Gender: female 83% Age: M = 39 years Job title: nurses 35.2%,physicians 14.3%, physical therapists 14%, occupational therapists 13.7%, psychologists and social workers 10.2%, other disciplines 12.6%	Pre- and post- test

Rassem et al., 2020	Canada	Tertiary rehabilitation facility for spinal cord injury patients	N = 86 Job title: 43% nurses 16% physical therapists 15% care aids 12% occupational therapists	Pre- and post- test
Wright & Pugnaire-Gros. 2010	Quebec, Canada	A rehabilitation inpatient unit of a large psychiatric hospital	N = 17 Job title: 12 nursing staff members (registered nurses and nursing assistants*), 2 patient educators, 1 psychologist, 2 unit managers (one head nurse, one assistant head nurse).	Participatory action research design

Objectives of interventions

The interventions described within the included studies varied in terms of their objectives. The broad term of 'training on sexuality' in this context incorporated different focuses. Specifically, two studies focused on improving attitudes (Pelts & Galambos, 2017; Bauer et al., 2007), three on increasing knowledge (Walker & Harrington, 2002; Post et al., 2008; Jones & Moyle, 2016) one on knowledge and skills (Donaldson et al., 2019) one on exploring barriers to discussing sexual health (Rassem et al., 2020), one on assessing staff's perceived preparedness (Holman et al., 2020), one on confidence and comfort using relevant terminology (Chidiac et al., 2021), and another one on promoting staff dialogue (Wright & Pugnaire-Gros, 2010).

Intervention characteristics

Detailed intervention characteristics of the included studies can be found in Table 2. The included studies each employed a different training intervention and the content of these varied. Study content can be considered in different categories. One such category was a focus on older adult sexuality (N= 3) (Walker & Harrington, 2002; Bauer et al., 2013; Jones & Moyle, 2016). These three studies all delivered interventions in distinct modules with the content consisting of clear themes. These themes included an overview of (1) sexuality, intimacy, sexual needs and sexual behaviour, (2) sexuality and dementia as well as assessment and legal issues including capacity and consent, (3) staff responsibilities and ethical considerations alongside considering policies and guidelines.

The second category was older adult sexuality with a specific focus on LGBT considerations (N=3) (Pelts & Galambos, 2017; Donaldson et al., 2019; Holman et al., 2020). The content of each of these three studies included an educational element on socio-political historical events that set the context for LGBT elders across their lifespan. The impact of such a history for the LGBT community was explored in terms of the impact on health disparities and specific concerns and considerations for LGBT people. Additionally, there was a focus on language and terminology. Each of the three studies presented either real older adult LGBT individuals or case vignettes to further educate and generate discussion. Finally, best-practice actions and practical skills were shared to allow participants to demonstrate and develop competencies when working with LGBT older adults. An education programme focusing on palliative care for LGBT+ individuals was also included in the ten studies (Chidiac et al., 2021). Similarly, there was a focus on terminology, LGBT+ issues and needs, which were more specifically relevant to end-of-life care, and also approaches for participants to ensure competency when providing care to LGBT+ individuals.

The three remaining studies reported on interventions delivered in rehabilitation or inpatient settings. Two of these settings provided care for individuals with physical impairment with both interventions providing an overview of the meaning of sexuality, with a focus on terminology and dispelling myths. Rassem et al., (2020) provided participants information on physiological changes post spinal cord injury and the impact on sexual functioning and relevant management options. Additionally, self-esteem and body image changes post injury were discussed. Similarly, Post et al., (2008) focused on caring for

individuals with physical impairments, with participants given a 170 page-reader and homework to support training. Patient, volunteers and actresses offered the opportunity for role-plays to promote talking about sex with patients. Wright & Pugnaire-Gros (2020) also focused on promoting dialogue about sexuality within a mental health unit. Case studies were used and articles provided, on topics such as client self-esteem, dating and relationships, and mothering with mental health difficulties. A 'context map' of themes introduced by the participants was described in the paper, although not depicted. This included culture, values, complex clinical situations, unit priorities, staff needs, unit approaches to client sexuality, staff strengths as well as staff beliefs, fears, frustrations, and knowledge gaps.

Effectiveness

Of the ten studies, nine reported quantitative results of effectiveness of the education intervention, and one reported qualitative outcomes (Wright & Pugnaire-Gros, 2010). For further information on effectiveness, see Table 2. Three studies (Walker & Harrington, 2002; Bauer et al., 2013; Jones & Moyle, 2016) reported on educational interventions for older adult sexuality using a variety of standardised tools to measure their effectiveness (see Table 2). All three reported increases in knowledge scores and, where measured an increase in permissiveness of attitudes. Jones & Moyle (2016) provided baseline measures of staff knowledge and attitudes toward later life sexuality. Statistical analyses varied across these studies, with the application of a t-test (Walker & Harrington, 2002), chi-square analyse (Bauer et al., 2013) and Wilcoxin signed-rank test (Jones & Moyle, 2016).

Two studies (Bauer et al., 2013; Jones & Moyle, 2016) reported no significant differences in scores based on demographic variables, whereas Walker & Harrington (2002) found pre-test knowledge and attitude scores (measured using the Knowledge and Attitudes Toward Elderly Sexuality scale) significantly related to gender (men as a group had higher scores than women) and ethnicity (White individuals had a higher mean score than African Americans individuals).

Four studies reported the effectiveness of education interventions specifically concerning LGBT+ individuals, in both older adult care facilities (Pelts & Galambos, 2017; Donaldson et al., 2019; Holman et al. 2020) and palliative care facilities (Chidiac et al. 2021). Tools included standardised scales such as the CATH, LGB-KASH and ATTIS, and bespoke adapted questions to assess knowledge, attitudes and skills. Donaldson et al. (2019), Holman et al. (2020) and Chidiac et al. (2021) all reported significant increases in participants' knowledge regarding working with LGBT individuals and specific concerns and needs following each of the educational interventions. Donaldson et al. (2019) found there was no significant increase in either attitudes or skills.

The three studies which reported on educational interventions in rehabilitation and inpatient settings used a variety of measures for outcome assessments such as a Dutch adaptation of the KCAASS (Post et al. 2008), a bespoke questionnaire (Rassem et al. 2020) and researcher field notes and interviews with two participants (Wright & Pugnaire-Gros, 2010). Post et al. (2008) and Rassem et al. (2020) both reported significant increases in participants' confidence and competence regarding sexological competence

and discussing sexual health. Post et al. (2008) found prior to training, psychologists and social workers had higher mean scores of sexological competence and immediately after training, scores were higher for all disciplines. Occupational therapists and physicians showed most improvement. At follow-up, most disciplines did not show significant change, although nurses showed a small but significant further improvement. Wright & Pugnaire-Gros (2010) concluded that their qualitative findings demonstrated the importance of discussion to ensure best practice and quality care with respect to client sexuality

Participant perceptions of training

Of the included studies, some of the methodologies included seeking participants' feedback and evaluation of the intervention used (N=5) (Walker & Harrington, 2002; Post et al., 2008; Wright & Pugnaire-Gros, 2010; Jones & Moyle, 2016; Chidiac et al., 2021). This included the use of programme evaluation forms. Positive feedback from participants included large majorities of participants responding that the information was very useful/useful (89.8%), very interesting/interesting (89.7%) and contained the right amount of detail (81.2%). Additionally, over 90% of participants rated handouts/visual, videos and case studies as very useful/useful (Walker & Harrington, 2002). A survey was also used by Chidiac et al. (2021) and the majority of their participants rated the training as excellent (79.3%), useful for their practice (99.3%), would recommend the training to others (100%) and would be interested in further training (95.1%). Post et al. (2008) found three-hour sessions were judged as a 'good' length by 76.5% of participants.

Some of the included studies also examined participant's qualitative feedback. For instance, Wright & Pugnaire-Gros (2010) asked participants which three aspects of the intervention they enjoyed the most. Answers aligned with three themes. First, the "open environment", citing sharing and acceptance, mutual respect, peer support and candour. Second, "breaking the silence", as a reference to discussing a taboo subject. Third, the benefit from "learning each other's perceptions" regarding client sexuality. Jones & Moyle (2016) sought feedback regarding the use of the self-directing eLearning resource. Findings reported that participants overwhelmingly stated the intervention had increased their understanding, changed views, and provided new ways of responding to intimate and sexual expression by older adults including those with dementia in care homes.

Participants also identified areas for development within the interventions. Walker & Harrington (2002) found some participants observed modules sometimes lacked detail compared to others. Findings from other studies also evidenced a need to include colleagues from various shift patterns and ensure follow-up from management (Wright & Pugnaire-Gros, 2010) as well as more time for discussion and more concrete ideas and solutions (Wright & Pugnaire-Gros, 2010; Jones & Moyle 2016). Post et al. (2008) also compared different disciplines' ratings of their ability to apply learning from the training, with the majority of moderately/good/very good ratings by physicians (88.5%) and the fewest by nurses (51.9%).

Table 3 summarizes the results following the application of the quality assessment tool. The overall quality of the included studies was deemed satisfactory with ratings all within

the good quality range (0.77 to 0.95). Lower scores on the quality assessment generally applied to insufficient description of sample selection and the absence of controlling for confounding baseline characteristics.

Table 2

Intervention characteristic of included findings

Author(s) Year	Main aims	Intervention	Outcome measures	Main findings
Walker & Harrington, 2002	Improve attitudes and knowledge	Attendance at 1-4 training sessions. Each session = 1hr of an introduction, 15-20 minute video and discussion of case studies. Videos showed staff and residents being interviewed and residents engaging in social activities. 4 modules: The need for sexuality and intimacy, Sexuality and dementia, Sex and aging, Family and personal issues	**Knowledge and attitude**: KATES	Staff knowledge and attitudes significantly improved after the training modules. No significant effects found when participants' demographics controlled for.
Bauer, et al., 2013	Improve attitudes	3-hour workshop. Designed specifically for nurses working in residential aged care. Delivered by 2 academics and 1 lawyer. Content: Hour 1: overview of sexuality, common attitudes, sexuality and normal ageing, illness, and treatment, sexual expression in residential care. Hour 2: sexuality, dementia, assessment and consent, role of RAC staff, residents' rights and staff responsibilities Hour 3: legal issues including capacity and consent, delivered via a 50-minute video	**Attitude:** ASKAS 8/20 items from the (SAID) Survey	Attitudes were significantly more permissive following the education intervention This applied to both the ASKAS attitudinal items and the additional items from the SAID survey.
Jones, C & Moyle, W 2016	Improve attitudes and knowledge	Self-directed eLearning resource based on *the Sexualities and Dementia: Education Resource for Health Professionals* (Jones & Moyle, 2014). Use of case studies, activities and resources. 4 modules: Intimacy sexuality and sexual behaviour, Dementia and the expression of	**Knowledge and attitude**: ASKAS, SAID Survey Qualitative: N = 9	ASKAS knowledge scores showed significant increase in scores between pre- and post-. No significant associations between demographics and ASKAS score.

		sexuality, Ethical considerations: policy guidelines development for sexualities and dementia in care settings, Developing sexualities and dementia policy guidelines for care practice.	Think-aloud case scenario (McAllister, Billett, Moyle, & Zimmer-Gembeck, 2009): 2 case scenarios of intimate and/or sexual relationships involving an older adults with dementia in RACFs.	ASKAS and SAID attitude scores: Significant difference between pre- and post- test for both ASKAS attitudes scores. No significant associations between demographics and ASKAS score. Qualitative: Three key themes: Being happy and well, Conferring with family, Workplace policy
Pelts & Galambos, 2017	Improve attitudes	Storytelling intervention. 20-minute video documentary and group discussion. Video development Two stories collaboratively developed into a single documentary; a lesbian woman aged 71 years and a gay man aged 74 years (both Caucasian).	**Attitude:** Components of Attitudes Toward Homosexuality Scale (CATH; LaMar & Kite, 1998). Qualitative: Written response to open-ended questions, Audio-recorded group discussion, Field notes, Memos completed during data review and analysis	After participating in the intervention, significant increases in positive attitudes toward lesbians, positive attitudes toward gay men and positive attitudes toward both LG were noted. Qualitative: Four key themes: Making meaning of the stories, seeking more information/understanding, applying to LTC and honouring individuals, debating
Donaldson et al., 2019	Improve attitudes, knowledge and skill	Online training material, entitled “LGBT Veterans in Long-Term Care: Cultural Competency and Considerations for Care” 1hr to complete.	**LG knowledge and attitudes**: 22 items from the Lesbian, Gay and Bisexual Knowledge and	Significant increase in LGB knowledge from pre to post.

		Content included: Terminology associated with sexual orientation and gender diversity, Case vignette, Unique aspects of LGBT older adults Participants also provided with actions for developing and demonstrating competency with LGBT veterans	Attitudes Scale for Heterosexuals (LGB-KASH) **Transgender-related issues**: 14 items from the Attitudes Toward Transgender Individuals Scale (ATTIS) **LGBT skills**: Items adapted from a study that assessed psychologists' ability to work with LGBT veterans (Johnson & Federman, 2014). **LGBT knowledge**: Four true/false statements	A significant increase in transgender knowledge from pre to post. LGB and transgender skills and attitudes were not significantly different between pre- and post-assessments. Chi-square analyses showed no statistical difference in belief assertions at pre and post.
Holman et al., 2020	Increase knowledge and assess staff's perceived preparedness	Three identical 4 hour face-to-face on-site training workshop. Content: Language and terminology within LGBT community Activity; evolving socio-political context affecting LGBT elders across lifespan Concerns and needs within context Best-practice and skills Role-play scenarios	**LGBT content knowledge** 9 MCQs **LGBT supportive attitudes** 12-item measure (LaMar & Kite, 1998) with Likert scale, strongly disagree to strongly agree. **Perceived preparedness** 1 item statement with Likert scale, very	Findings from this study indicate that short-term trainings can increase LGBT related knowledge of the staff. Preintervention LGBT content knowledge and post-intervention supportive attitudes varied by religion. Results showed significant increase in LGBT knowledge between pre- and post-intervention and significant decrease in perceived preparedness when working with LGBT elders.

			unprepared to very prepared	
Chidiac et al., 2021	Increase knowledge, and confidence and comfort using relevant terminology	1½ hour workshop; information presentation and interactive discussion. Content: Terminology and definitions related to gender and sexual identities, General LGBT+ issues and needs, LGBT+ issues and needs relevant to palliative and end-of-life care, Approaches to providing affirmative care at individual and organisational level and Trailer of Gen Silent documentary shown	Self-report questionnaire with 3-point Likert scale on following domains: General LGBT+ issues and needs Knowledge of LGBT+ issues needs specific to palliative and end-of-life care Confidence in providing palliative and end-of-life care for LGBT+ people Comfort with using terminology related to sexual and gender identities	There was a significant increase in all four domains: Knowledge of general LGBT+ issues and needs, knowledge of LGBT+ issues and needs in palliative and end-of-life care, confidence in providing palliative and end-of-life care for LGBT+ people, comfort with using terms related to gender and sexual identities. Levels of knowledge, confidence, and comfort significantly improved post- training within all age groups.
Post et al., 2008 The Netherlands	Improve attitudes and knowledge	Sexological competence of different rehabilitation disciplines and effects of a discipline-specific sexological training.	**Knowledge and attitude**: Bespoke questionnaire using Dutch school rates and Dutch adaptation of KCAASS Evaluation at 3 times points; start of training, end of training, 3-4 months after end of training.	Findings showed self-perceived sexological competence differed between disciplines. The brief training intervention resulted in improvement of self-perceived sexological competence for all disciplines.

Rassem et al., 2020	Increase knowledge and explore barriers to discussing sexual health	1-2 hour educational presentation. Content: Meaning of sexuality, Sexual response cycle and physiological changes post-SCI, Interventions/management re. sexual dysfunction, infertility, pregnancy considerations, contraception for those with SCI, Self-esteem/body images changes post injury, Common areas of concern e.g. equipment and positioning	Bespoke structured survey questionnaire composed by research team; Sexual counselling; confidence, barriers, experience/practices, Knowledge of sexual health within SCI populations Interest in becoming member of sexual health team	Participants reported higher levels of confidence with sexual health counselling after attending a single education presentation. The main perceived barrier to lack of sexual health counselling was insufficient training.
Wright, D. & Pugnaire-Gros. 2010	Promote staff dialogue	8 discussion sessions. Accommodated rolling attendance. Average attendance was 4 to 5 sessions with average of 6 participants at each session. Held weekly or bimonthly over 3-month period. Content: Case study analyses, journal clubs, information sessions	Field notes from researchers observing sessions. Interviews with the two unit managers; analysed for themes.	Key themes introduced and addressed by the group: Culture, values, complex clinical situations, unit priorities and staff needs, unit approaches to client sexuality, staff strengths, staff beliefs, fears, frustrations and knowledge gaps, there are no wrong answers, staff comfort zones, complex issues

Legend: ASKAS (Aging Sexuality Knowledge and Attitudes Scale), SAID survey (Staff Attitudes about Intimacy and Dementia, KCAASS (Knowledge, Comfort, Approach and Attitude towards Sexuality)

Table 3

Quality assessment outcomes for included studies

Quantitative	Donaldson et al. (2019)	Chidiac et al. (2021)	Rassam et al. (2022)	Post et al. (2009)	Walker & Harrington	Pelts & Galambos	Holman et al. (2020)	Bauer et al. (2013)	Jones & Moyle (2016)	**Qualitative**	Wright & Pugnaire-Gros (2010)
Question / objective sufficiently described	2	2	2	2	2	2	2	2	2	**Question/objective clearly described?**	2
Study design evident and appropriate	2	2	2	2	2	2	2	2	2	**Design evident and appropriateness to answer study question?**	2
Method of subject/comparison group selection or source of information/input variables described and appropriate	1	1	1	2	1	2	1	1	1	**Context for the study is clear?**	2
Subject (and comparison group, if applicable) characteristics sufficiently described	1	2	2	2	2	2	2	2	2	**Connection to a theoretical framework/wider body of knowledge?**	2
If interventional and random allocation was possible, was it described	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	**Sampling strategy described, relevant and justified?**	2
If interventional and blinding of investigators was possible, was it reported?	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	**Data collection methods clearly described and systematic?**	2

If interventional and blinding of subjects was possible, was it reported?	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	**Data analysis clearly described, complete and systematic?**	2
Outcome and (if applicable) exposure measure(s) well defined and robust to measurement/misclassification bias? Means of assessment reported?	2	2	2	2	2	2	2	2	2	**Use of verification procedure(s) to establish credibility of the study?**	2
Sample size appropriate?	1	2	1	2	1	2	1	2	2	**Conclusion supported by the results?**	2
Analytic methods described/justified and appropriate?	2	2	2	2	2	2	2	2	2	**Reflexivity of the account?**	0
Some estimate of variance is reported for the main results?	2	0	2	0	2	2	2	2	2		
Controlled for confounding?	0	1	0	1	2	0	2	2	2		
Results reported in sufficient detail?	2	2	2	2	2	2	2	2	2		
Conclusions supported by the results?	2	2	2	2	2	2	2	2	2		
Overall score	**0.77**	**0.82**	**0.82**	**0.86**	**0.91**	**0.91**	**0.91**	**0.95**	**0.95**		**0.90**

Note. 2 = yes, 1 = partial, 0 = no

Discussion

This systematic review synthesised 10 studies reporting on educational interventions on the topic of sexuality for staff working in long-term health and social care settings, and provides some of the first coherent evidence into health and social care staff training needs for those working in long-term care settings.

The studies included varied greatly in terms of their background rationale, aims, participant reported demographics, intervention content, mode of delivery, outcome measures and data analysis. This meant that direct comparisons between all studies was complex. Markedly, the papers included in this review pertain to research conducted in USA, Australia, UK, Netherlands and Canada. This means there is a Westernised bias to this review and a lack of inclusion of research and practices more broadly. Therefore any attempts to generalise this work needs to be done so cautiously, and further efforts to investigate the discussion of sexuality globally and its inclusion in reviews is warranted.

Studies were categorised in terms of their content focus, including older adult sexuality, LGBT+ older adult sexuality, and consideration of sexuality for adult patients staying in palliative care, rehabilitation or inpatient units. Furthermore, the studies examined a wide variety of interventions such as online teaching tools, video documentaries and participant led discussions among others. Six of the studies investigated staff training in Residential Age Care Facilities (RACFs) (Walker & Harrington, 2002; Bauer et al., 2013; Jones & Moyle, 2016; Pelts & Galambos, 2017; Donaldson et al., 2019; Holman et al., 2020) one in hospice settings (Chidiac et al. 2021), one in a rehabilitation centre for physical

impairments (Post et al., 2008), one in a rehabilitation centre for spinal cord injury (Rassem et al., 2020) and one rehabilitation inpatient unit (Wright & Pugnaire-Gros, 2010).

Despite their heterogeneity, all studies suggested significant improvements on at least one domain such as increased in knowledge, attitudes or enhanced confidence regarding discussing sexuality with individuals in their care. This is consistent with previous research which suggest that interventions addressing sexuality are effective in improving different professionals' self-efficacy when discussing sexuality (Miller & Byers, 2009; Sung et al., 2016; Verrasto et al., 2020). Self-efficacy and being equipped to approach talking about sexuality with service users is important for health and social care professionals as often staff do not feel confident or skilled enough to discuss sexuality. By staff effectively addressing sexuality, service users are able to access better care for issues such as intimacy and relationships, sexual identity and sexual health, (Guo et al., 2015; Gewirtz-Meydan et al., 2019).

Within the studies that sought participant feedback (Walker & Harrington, 2002; Post et al., 2008; Wright & Pugnaire-Gros, 2010; Jones & Moyles, 2016; Chidiac et al., 2021), staff valued the training experience and expressed a desire for further learning on the area. This is also consistent with research that suggests that the area of sexuality is neglected in training programs for staff in health and social care settings (Horne et al., 2021; Reissing & Giulio, 2010). Noteworthily, where the training program did not have a group discussion component, participants reflected on this to be a drawback for the

intervention. This is possibly consistent with research that suggests that experiential learning is an important component of new learning and development (Kolb et al., 2014). Psychologically, group experiential learning may be understood in the context of values such as belonging, connection and sharing which may activate emotional processes. Emotion can have a significant influence on cognitive processes such as attention, problem solving and memory all of which can enhance learning (Tyng et al., 2017).

Research is scare on how staff view sexuality in regards to service users with dementia (Wiskerke & Manthorpe, 2019). Limited literature reports on the ethical dilemmas staff face and challenging nature of this complex topic (Mahieu, Anckaert & Gastmans, 2014). Studies that focused on older adult sexuality varied in their approaches and assessment of training. Walker & Harrington (2002) concluded that the training modules presented to participants via didactic teaching, video presentation and group discussion, led to significant improvements in knowledge and attitudes. The training included a focus on ageing and dementia, areas that are necessary to specifically consider when supporting older adults in the context of sexuality (Træen et al., 2016). As highlighted through the quality assessment tool, Walker & Harrington (2002) did not thoroughly report on their sampling method or sample size. Therefore conclusions regarding participant's rationale for taking part, and the statistical analyses, are to be considered tentatively. Bauer et al., (2013) and Jones & Moyle (2016) similarly reported significant improvements in knowledge scores and attitudes. Both papers reported adequate sample sizes to allow for analysis and therefore such results may be more reliable. Jones & Moyle (2016) predominately offered training on sexuality and dementia and assessed changes in

knowledge accordingly. Yet the intervention did also include some reference to LGBT+ older adults and other areas such as sexually transmitted diseases. The pre-determined scales did not address knowledge and attitudes of these topics and therefore outcomes regarding these areas cannot be assessed.

Three studies addressed education interventions for specific considerations and issues for older adult LGBT+ individuals. These studies all took place in the last five years, suggesting LGBT+ specific education interventions are a more recent addition to training agendas. Holman et al., (2020) controlled for confounding variables and thus was able to report on differences between demographic groups and changes to knowledge scores. A weakness of both Pelts & Galambos (2017) and Donaldson et al., (2019) was the absence of controlling for confounding variables, and therefore comparison across these three papers and the effects of different demographics cannot be made.

The four remaining studies reported on education interventions regarding sexuality for staff working in varied patient settings. Chidiac et al. (2021) reported on training regarding approaches to caring for LGBT individuals in palliative care and akin to those papers with a similar focus, this suggests LGBT focused training is a recent development. Post et al. (2008), Rassem et al. (2020) and Wright & Pugnaire-Gros (2010) all centred their interventions around improving discussion regarding sexuality within staff teams. All three papers received the highest possible score for reporting on participant demographics as part of the quality assessment. This is beneficial in making conclusions regarding those staff who took part and therefore benefit from training to

enhance staff group discussions. Of the two quantitative papers, Post et al. (2008) and Rassem et al. (2020) did not sufficiently control for confounding demographics at analysis and therefore comparisons of different effects across staff professional groups cannot be made.

The quality assessment tool highlighted that none of the included studies used control groups as part of their methodology. This means that comparisons between the intervention and an equivalent control group were not possible. However, taking a clinical perspective on this, the opportunity to provide training on sexuality to all staff is more important and ethical than including a control group, given the scarcity of staff training in this area and clinical need for service users.

Clinical implications

The findings demonstrate the effectiveness of staff training regarding the sexuality of care home residents, and ultimately this has the implication of supporting the provision of training to improve resident care. The findings show that staff training does not require vast resources, either by way of materials or staff time, and can still be effective. Both online tools and face-to-face methods increased staff competency. Online tools benefited from being more accessible for staff, whilst in-person training allowed for group discussion which was valued by participants. The data illustrates that group discussion is a particularly effective component of education interventions for staff regarding sexuality. These findings demonstrate that it is feasible for similar training interventions in these papers to be used in varying long-term health and social care settings. This may include

the addition of an online training module on sexuality to any pre-existing online training or adding sexuality to the agenda of a staff team meeting to allow for discussion Long-term care facilities are under many pressures and therefore it would be necessary for the topic of sexuality to be considered important to allow for staff training to prioritise amongst competing demands.

Many of the included studies used either real-life scenarios or case vignettes to guide learning. Both generated discussion and allowed for meaningful personal stories to be shared. The effectiveness of this approach also suggests that case discussion and reflective group sessions for staff as ongoing support would contribute to an environment where staff continue to develop their competencies in discussing issues of sexuality.

The provision of education interventions is important for various reasons including increasing staff knowledge and enhancing attitudes where required. Collectively this enables societal stereotypes, and consequential prejudices and discrimination, to be overcome. Explicit discriminative practices continue today, with many Victorian style mental health inpatient wards still attempting to employ all-encompassing bans on consensual sexual activity, despite other efforts to enhance capacity assessments in this realm (Maylea, 2018). Where sexuality is discussed, factors such as age, religious affiliation and sexuality training have all been found to be predictors of professionals' comfort in addressing the topic (Low et al., 2022).

The included studies demonstrated how different methods of intervention delivery were effective. Validated and adapted tools were used effectively to measure different

domains. Crucially, however, there were critical outcomes that were not adequately assessed. Change in knowledge, attitudes and staff competencies were reported, however how these changes were implemented in daily work practice and ultimately the impact they had on the wellbeing of people they cared for was not. Additionally, the perspectives of those individuals staying in long-term care settings on the effect on training was not sought.

Strengths, limitations and future research

This is the first systematic review to synthesise studies reporting on education interventions on the topic of sexuality for staff working in health and social care long-term care settings. Strengths of the review include that it followed PRISMA guidelines, and three reviewers screened all eligible papers. A quality assessment tool was used to assess each paper's methodological quality. Furthermore, this review provides evidence of the importance of sexuality training programs, both in terms of improved outcomes and participants high satisfaction.

Despite the promising nature of these conclusions, this systematic review has some limitations. First, direct comparison between studies was complex given the broad nature of the term sexuality and the heterogeneity of the methodologies and settings of studies involved. Although this is appropriate for the first systematic review in the area, it is expected that as research in the area develops, reviews focusing on more specific methodologies and settings might be possible. Second, the interventions included in the studies were measured using different outcomes, often lacking consistency. It is difficult

to address this limitation by future studies as each study will utilise or develop different measures fitting the specific aims and needs of the intervention and setting. Third, there was a scarcity of follow-up assessment of outcomes and future studies should include follow-up measurements when evaluating the effectiveness of interventions. Finally, the present review included ten studies. Therefore, it is necessary to consider all conclusions tentatively as the results cannot be extrapolated to all health and social care long-term settings.

Conclusions

Research on the topic of resident sexuality in care homes, rehabilitation, inpatient or palliative care settings is a limited but growing area of research (Dyer & dasNair, 2013; Hjalmarsson & Lindroth, 2020). There are multiple factors identified in the literature contributing to the paucity of research such as ageist erotophobia (Simpson et al., 2018) and further research into these factors is further warranted. This growing field of research and practice would benefit from future studies focusing on practical outcomes of education interventions for both staff and service users.

This review demonstrated that education programmes and interventions on the topic of sexuality improved staff knowledge, attitudes and confidence. It is expected that such improvements in the competency of the workforce of long-term care settings would have directly improved patient care. In addition, staff who attended the various educational interventions across a wide range of settings valued the opportunity of attending such trainings and rated them positively. These results indicated that education programmes

in the area of sexuality are effective and valued and can contribute to a training curriculum that is person centred, meaningful and diverse.

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Chapter Two: Empirical Paper

"That sort of thing is quite taboo": Care home staff experiences and training needs regarding older adult residents' sexuality

Abstract

Background: Sexuality is an important aspect of life for adults of all ages and can be a difficult topic for care home staff to address with residents. The reasons for this are varied and complex.

Objective: The aim of this qualitative study was to gain an insight into care home staff perspectives of how residents' sexuality is considered in care homes.

Methods: Across the UK, twelve care home care workers, deputy managers, and managers were interviewed on an individual basis between August 2021 and May 2022. In-depth interviews followed a semi-structured framework and asked questions about the participants' experiences and observations of sexuality being considered in the care home setting. Grounded theory methodology was used to analyse the data and develop a model of the findings.

Results: A model was developed depicting a theory of how sexuality is considered in care home. Four distinct themes are presented which were developed as informed by the data (societal norms of sexuality, limited discussion of sexuality, broader consideration of sexuality and narrower consideration of sexuality). This highlighted how consideration of sexuality in care homes is largely confined to responding to residents' sexual behaviours. There is very little training and support for staff on this topic and it is rarely talked about proactively. Staff were enthusiastic about the topic and identified a wish for further support to support residents in this context.

Conclusions: Considerations of sexuality in care home is limited. Discussions are often confined to responding to inappropriate sexual behaviours and other aspects of sexuality are rarely considered proactively. There is a clear need for more staff training and support on the topic of older adult sexuality.

Keywords: sexuality, older adults, care homes, staff

Introduction

In the United Kingdom (UK), 19% of the population are aged 65 years or over (equating to 12.3 million older adults) (UK Parliament, 2021), of which 391,000 older adults live in a care home (Fraser et al., 2021). The term care home is used to describe both residential homes, where accommodation and support with daily tasks such as personal care is provided, as well as nursing homes, which additionally provide medical care (NHS, 2019). Across the UK, there are approximately 17,600 care homes, of which 70% are residential homes and 30% nursing homes. These establishments are staffed by just under 700,000 care home staff (Care home, 2021).

To provide adequate care for this population, it is recognised that care home staff should receive continuous support and suitable training. The link between staff training and support, and increased standard of care for care home residents, is well established in the literature (Elvish et al., 2014; Spector et al., 2013). Care homes are required to provide mandatory training for their staff, and this is defined by both statutory requirements and the care home regulator (Care Quality Commission, 2014). National minimum training

standards for adult social care workers in England focus on topics such as health and safety, equality, diversity and inclusion, safeguarding and person-centred care and support (Skills for Care & Skills for Health, 2013). Whilst initial training is mandatory, ongoing training and in-depth support for care home staff in the UK is often lacking, which has been exacerbated throughout the recent COVID-19 pandemic (Hanna et al., 2022). One of the main aspects which is often neglected in staff training relates to sexuality.

Sexuality is an integral aspect of the human experience throughout the lifespan (WHO, 2006) and the right to sexuality is a human right defined within various international human rights laws (Parker, 2007). The Declaration of Sexual Rights outlines that sexual rights are grounded within universal human rights recognised in international and regional documents, constitutions and laws (World Association for Sexual Health, 2014). Yet, it is not specifically mentioned within any statutory training for care home staff. Whilst sexuality can hold different meanings for different people, the commonly held stereotype that older adults no longer have sexual interests is misguided (Bauer et a., 2007; Hinchliff & Gott, 2017). There are changes to sexual functioning in later life; lack of inhibition regarding sexual behaviours can be present for those with behavioural variant frontotemporal dementias (Dubljević, 2020) and an increase in physical health issues can reduce levels of sexual activity in older age (Lee et al., 2016). Crucially, many older adults seek to maintain physical acts of intimacy (Ginsberg et al., 2005; Tetley et al., 2018) as well as emotional intimacy (DeLamater & Koepsel, 2015). Moreover, older adults also seek freedom for sexual expression through companionship and social presentation (Bauer et al., 2013; Mroczek et al., 2013).

Research highlights how sexuality and the needs of residents relating to intimacy can often be overlooked in care homes (Simpson et al., 2017). A notable aspect of this is the presence of ageist, heteronormative and cisgenderist assumptions (Simpson et al., 2018), which are impactful both as individual prejudices and at an intersectional level. Systematic review findings highlight how older care home residents often perceive staff as uninterested or lacking understanding of older adults' sexuality (Bauer et al., 2016). Alongside the commonly held belief that residents lack any interest in sexual activity (Taylor & Gosney, 2011), other barriers are also present that prevent staff from approaching the topic of sexuality. Gilmer et al., (2010) found that whilst many care home staff do acknowledge that residents have sexual needs, there is a discomfort created by sexual expression, which, alongside negative attitudes and difficulty in managing risk, prevent regular assessment or a team approach to issues of sexuality.

The concept of sexuality is complex and requires a multidimensional approach in the context of providing care to vulnerable adults. The literature highlights how staff receive little training and support on the topic of sexuality, as well as how personal factors influence how the topic is or is not approached (Magnan et al., 2005). There has been some previous research in the area of staffs' perspectives on the topic of sexuality, such as an investigation of nursing home staff views on dementia and sexuality, with the application of Interpretive Phenomenological Analysis to the findings (Vandrevala et al., 2017). The study presented offers the opportunity to contribute to this evidence bases and allow for a broader analysis of care home staff's experiences and approaches

towards caring for residents in the context of sexuality. An in depth understanding of staff experiences' of considering sexuality when supporting residents could provide opportunities for developing person-centred and multidimensional care.

Therefore, the objective of this qualitative study was to explore staff perspectives of their personal approach and that of the care home setting towards considering older care home residents' sexuality, intimacy, and relationships. Grounded theory allows for a new theory to be generated and model to be develop depicting the findings. It is proposed that a model of how sexuality is discussed within care homes and the factors that contribute to this could form the basis of training opportunities and other interventions to better support staff in their job role and ultimately enhance the experience of care home residents

Method

Ethics

The University of Liverpool Central University and Research Ethics Committee approved this study prior to study commencement (Ref: 8337; see Appendix H). All participants gave informed consent to participate, both written and verbal, prior to the interview. Participants were informed that they could stop the interview at any point without providing any rationale for such decision (see participant information sheet appendix J).

Design and qualitative methodology

This was a qualitative study which used a constructivist grounded theory approach. Grounded theory allows for the interpretation of personal meaning when considering social interactions (Glaser, 1992). As per this approach (Charmaz, 1996), data were

simultaneously analysed during the data collection phase and themes constructed which influenced the data collection process itself. Grounded theory applies in-depth interviews with a group of heterogenous participants, allowing for a range of different perspectives and experiences to be gathered and assimilated into one narrative. Constructivist grounded theory recognises the researcher as an active participant in the research process and allows for their personal position and perspectives to be acknowledged as impacting the construction of knowledge (O'Connor et al., 2018). Given the nature of the this topic of research, examining how care home staff consider sexuality within care homes, it was felt the constructivist approach of grounded theory to be appropriate.

Public advisor consultation

Central to the development of this study was the consultation of two public advisors. Both advisors were over the age of sixty-five, one of whom had a spouse living in a care home and the other had a diagnosis of dementia. Public advisors were paid and consulted on the aims of this research and both contributed to the formation of the topic guide questions. For instance, the importance of privacy for residents was noted and included as an important area for discussion in interviews.

Sample: strategy and recruitment

Participants were recruited using purposive sampling from different older adult care homes across the UK. Eligibility for the study included the following inclusion criteria: over the age of 18, employed as a member of staff in a care home providing care to elderly

residents and able to speak English to a level of fluency required for the interview. Exclusion criteria included being an unpaid carer not working in a care home.

The study was advertised by distribution of the study poster on social media, contacting individual care homes directly via e-mail and telephone, and through attendance at varying dementia and social care forums. This was by the lead researcher, supervisors and a research engagement officer. Additionally, some of the participants who took part then shared the advert and study information with colleagues. Participants registered their interest in taking part in the study by emailing the lead researcher. Upon receipt of the email, participants were sent the participant information sheet and offered the opportunity to ask any questions. Following this, participants were emailed a consent form and asked to return a signed copy via email.

Data collection

Participants were asked to take part in the interview whilst in a private, quiet and confidential space. At the start of the phone or videocall, participants were offered another chance to ask any questions relating to the study. During the call there were two separate recordings, one of verbal consent and a separate recording of the qualitative interview. These were recorded using a University of Liverpool electronic device. During the first recording, the consent form was read aloud by the researcher and verbal consent given by the participant, after which recording was stopped. Participants were then invited to complete the sociodemographic and professional experience questionnaire, which included questions on personal demographics, professional experience and their care

home setting (Appendix L). Participants were reminded that they were not required to answer any questions they did not wish to.

All participants were interviewed using a semi-structured interview topic guide (Appendix N) to explore their perspectives and experiences of how sexuality is considered in care homes. This included focus on the following topic areas: how sexuality is discussed with staff teams, how issues such as consent and privacy are considered and how staff might be best supported in their role when considering such matters.

After each interview, participants were sent a debrief document via email (see Appendix M). Participants received a £20 shopping voucher as reimbursement for completing the interview.

Reflexivity

Reflexivity is an integral part of grounded theory methodology and refers to the researcher's examination of their own assumptions, interests and position and how these influence the research process (Charmaz, 2014). A reflexive stance was taken to allow the researcher to consider how to approach the research, relate to participants and present the findings in written reports. As part of this approach, a reflexive statement was written (Appendix O).

Throughout the research, the approach of reflexivity was also taken at research meetings with supervisors, and memos were taken after each research interview. This allowed for

deeper reflection on themes being constructed, and for continued assessment of whether the researcher's own assumptions and interests may have influenced the processes in the research, for example by updating the topic guide as well as data analysis.

Data analysis

Qualitative data were analysed using a reflexive grounded theory approach. Interviews were transcribed, two by the researcher to allow for full emergence into the data, and subsequent interviews by a university approved transcriber. Transcripts were analysed using an electronic software package, NVIVO (released in March 2020).

The first stage of analysis began with initial coding. In line with grounded theory guidance, an active approach of line-by-line coding, where short labels called codes, were assigned to the data (Charmaz, 2012). Following this was the second stage of coding; focused coding. This involved identifying the most frequent and significant codes and synthesising them into theoretical categories. These theoretical categories were tested against new data and those that carried the most amount of data became the final themes.

This process of data analysis and amendments to the topic guide were supported by memo writing, reflective diary writing and use of supervision. After interview nine, no further themes were identified, and the subsequent interviews were used to refine the pre-existing themes and contribute to their data.

Results

Twelve care home staff were interviewed between August 2021 and May 2022. Interviews lasted between 20 and 60 minutes. The majority of staff were female and care home workers. Further participant demographic information can be found in Table 4.

Table 4

Participant characteristics

Characteristic	Descriptive	
Age (years)		
	Mean*	47.3 (SD=11)
	Range	24 - 59
Gender		
	Male	4[a]
	Female	6[a]
Ethnicity		
	White British	11[a]
	Prefer not to say	1[a]
Sexual orientation		
	Heterosexual	11[a]
	Homosexual	1[a]
Level of education		
	School (15 years)	4[a]
	School (18 years)	1[a]
	College (18-20 years)	2[a]
	University undergraduate degree	4[a]
	University Masters degree	1[a]
Job role		
	Care worker/care assistant	5[a]
	Staff nurse	1[a]
	Deputy care manager/leader	3[a]
	Care manager	3[a]
Time spent working in care sector (years)		
	Mean	16 (SD=13)
	Range	2-41
Bed size of care home currently working in		
	Mean	66 (SD=45)

	Range	13-130
Training on sexuality		
	No	8[a]
	Yes – 1hr as part of either equality and diversity, safeguarding or dementia and communication training	4[a]
Platform of interview	Videocall	7[a]
	Phone call	5[a]

***1 participant chose prefer not to say for age**
[a]=Number of participants

Summary of qualitative findings

Using a grounded theory approach, four themes were constructed from the data: Societal norms of sexuality (subthemes: desexualisation in older age, desexualisation in care homes); limited consideration of residents' sexuality (subthemes: sexual behaviours only, generational differences); narrower consideration of sexuality factors (subthemes: organisational, uncertainty, LGBT+ lack of consideration); and broader definition of sexuality factors (times are changing, intimacy as important and staff's personal values). The themes were constructed using a constant comparative method, whereby data collection, coding and analysis are combined and occur simultaneously (Kolb, 2012). The constructed themes enabled the development of a model describing how participants perceived residents' sexuality within the care home setting (see Figure 2).

Theme 1: Societal norms

Staff referenced many different societal norms, including the stereotypes, assumptions and attitudes commonly held within society regarding sexuality in older age. Subthemes of 'societal norms' are 'desexualisation in older age' and 'desexualisation in care homes'.

Desexualisation in older age

Many participants made reference to how sexuality and specifically older adult sexuality is viewed and talked about within society. References were made to how stereotypes and assumptions about older adults and sexuality are common, including the notion that old age equates to desexualisation. Some participants reflected on their own views and how working with older adults has increased their awareness about sexuality continuing to be an important part of many older adults' lives. Many participants commented on how such attitudes that are present generally are sometimes displayed by staff members and by the families of residents:

> *"there's still that, assumption that you know, it's no longer a part of life for people you know. And I think that goes for, most professionals, I think it often goes for families as well you know, who don't wanna think about that aspect of older relatives sort of thing"* **(participant 6, care home manager)**

Desexualisation in care homes

Participants also reflected upon the impact for residents of moving from their own homes within the community into a care home setting. The significance of moving into a care home was explored in terms of how societal views regarding older adult sexuality are often exaggerated in this setting. Considerations were made of residents' reliance on staff, for example to ensure privacy, to facilitate much of the intimate contact with other residents, and also to access pornographic materials. This concept was exemplified by one participant when talking about how sexuality is often seen as no longer important to a resident's life:

I think it's a society wide thing about people once, once they're at, er hitting a certain age, but I think it's magnified, by people coming into care" **(participant 6, care home manager).**

Whilst another participant commented:

"*Why's it gonna stop? Why's it gonna stop just because they've changed their address, you know? It's not".* ***(participant 3, care worker)***

Theme 2: Limited consideration of residents' sexuality

Participants recognised how there is 'limited consideration of residents' sexuality' within the care home setting. When it is spoken about, this is usually in the context of responding to 'sexual behaviours only'. It was also evident how participants would make comparisons between different staff groups and their approach to the discussion of sexuality, with particular references to 'generational differences'.

Sexual behaviours only

The idea that sexuality is rarely talked about for any other purpose than considering sexual behaviour, where usually deemed inappropriate, was suggested by all participants. This was both within the context of discussions directly with residents and conversations that take place between staff teams. The presence of discussions was reported as largely taking place at staff handover meetings. Some participants noted how sexuality is often only proactively considered at initial assessment stage for residents, where there is a 'sexuality box' on the assessment form. Notably however, it was

observed how this is often not completed. Participants also highlighted the connection between the misguided assumption of asexuality in older age and lack of discussion with care homes and their frustration with this:

> "*because it's not spoken about, it's not trained about, it's very, very much at a taboo subject. People in care, shouldn't have sex, people in care, shouldn't have sexual urgencies, it's a load of rubbish because they do"* ***(*****participant 2, deputy manager).**

Generational differences

Many of the staff drew comparisons between themselves and staff of a different age group. All except two participants reported their age as over 40 years, with six as 50 years or older. Many of these participants made reference to the 'younger staff'. Comments included recognition of younger staff often having less experience, in particular in delivering personal care and responding to behaviours that are challenging, as well as their attitudes towards sexuality more broadly. For instance one participant commented:

> "*What we do find a problem as I say is the younger care staff, who erm, yeah oh, oh, that's disgusting, and stuff like that, it's actually er then educating them, but then it's great when you actually hear them telling another member of staff, oh it's alright, they're just being them, they just want loving and what have you, so I think that's really good"* **(participant 3, care worker).**

In contrast, comparisons also included seeing 'younger staff' as discerning over what is deemed acceptable:

“if you had a young care assistant, erm, you know, who was working with somebody who was gay and lesbian, it would be quite acceptable. That is absolutely fine. But if they walked into an elderly gentleman who was masturbating, that wouldn't be” ***(participant 2, deputy care manager).***

The notion of generational differences was also considered for residents, and the differences for many staff and residents’ having grown up in different generations. The era in which many residents grew up in and how sexual expression was viewed was considered. Participants commented on how sexuality and in particular sex itself and diverse sexual orientations were not openly discussed. One participant explored how this is true for residents, as well as for their children who may be required to be consulted on their parent’s care:

“*people coming in to care, tend to be in their 90's, which means that their children, are in their 70's you know, so these aren't people who are, have as much of a, erm, a erm, you know, haven't had those discussions that perhaps younger generations now feel more comfortable having, you know”* **(participant 6, care home manager)**

The presence of generational differences was also explored in terms of how a family dynamic is often presented within the care home for staff and residents. The idea of staff and residents being like a family was shared by many participants, and by some as something that has been strengthened during the COVID-19 pandemic. One participant recognised how these relational dynamics impact discussion of sexuality within the care home, and make it feel awkward for both residents and staff to discuss the topic:

“a lot of the time as well we look at the, our, our, our residents and things as like our grandad or, you know, like family, they're like our family so it's a bit, (pause) I don't know, I wouldn't have that conversation with my Mum or my Dad or my grandad, you know and... I think that's why, why it feels a bit awkward” **(participant 12, care worker)**

Theme 3: Narrower consideration of sexuality

The theme ‘*narrower consideration of sexuality’* captures participant’s perspectives of the factors that contribute to the limited consideration and discussions regarding sexuality that are present within care homes. During coding, three themes were developed to account for these factors: ‘organisational’, ‘uncertainty’ and ‘LGBT+ lack of consideration’.

Organisational

Organisational factors and their influence on how sexuality is considered within the care home setting was explored by many participants. There was particular recognition of the lack of guidance for staff and in particular insufficiency of training both in preparation for starting a job in care and support whilst in the role itself. Of the participants, eight of twelve reported never having received any training on the topic of sexuality, and the absence of this was identified as a barrier to themselves and the wider staff team approaching the topic. The idea of training as a barrier was clearly stated by many participants, including:

“*I think some of the barriers are, well, kinds of like, training, there’s not training on it”* **(participant 9, staff nurse)**

Many staff described relying upon personal experience when addressing sexuality within their work context. Personal experience included previous job roles supporting both the elderly and adults with learning disabilities, upbringing and family attitudes towards sexuality. The interplay between lack of training and the reliance on experience was exemplified by one participant

> "*You just think, can you, you know, how, what've you done to support older people in your past? Yep, what, you know, we've all… mothers and fathers and this that and the other, yep you can do the job. And I think it would be nice to just sort of, have maybe a two, two, whatever week, training and, on… things to expect"* ***(*participant 4, care worker)**

Additionally, many staff often felt unprepared for unexpected situations in their job role. Participants spoke openly about having been surprised upon starting their job in a care home and not having been prepared for what they might encounter. This was particularly true of sexually disinhibited behaviours. In particular, many participants spoke about their experiences of seeing residents masturbating in communal areas. This is often experienced as shocking especially upon the first time witnessing this. Staff spoke of the priority in this situation to ensure the residents' privacy and to discreetly guide them to their bedroom. The personal impact of being unprepared for unexpected situations regarding sexuality was noted with particular consideration of younger female staff:

> *"…it should be a course that you should go on just to, to prepare you for what could happen because it can be, I don't know, it can be, it can, it can,*

it can be quite scary for young girls to be put in that situation" **(participant 12, care worker)**

An additional aspect of organisational factors was the importance of paperwork and procedures. Participants recognised the importance of accurate record keeping and reporting concerns. Some participants reflected on how procedures can often take priority over discussions and space to reflect. This was perhaps evident during some interviews where participants shared considerations they make in terms of paperwork without the addition of any discussion. The following quote is in answer to how consent, privacy and confidentiality are considered to support residents' expression of sexuality and notably no further elaboration was given:

"… individual basis like I've said. So for the coming in, there's like an assessment, erm, to assess them, to know… what they're needs are. And then to help, to support them to, you know to, to sort of fulfil their wishes or their needs or to maintain their sexuality… ye, and there's always care plan in place" **(participant 1, care home manager)**

The importance of paperwork was also clear for other participants. There was particular emphasis on necessary paperwork when considering two residents forming a relationship. This could create a difficult position for staff members with paperwork taking priority:

"for example there was, you know, two people who wanted to kiss, and, you know, no relation, because they've got dementia, they haven't got capacity, and we, in, in some

*ways we had to, let it happen, so we could make a note of it, and it's obviously inappropriate […]. So, you know, you can separate people, but unless it's written down, didn't happen. And unless you see it happening, you can't write it down so, it's a bit of a, it's a difficult situation. (**participant 5, care worker).***

Uncertainty

A strand that featured throughout the interviews was uncertainty. This related to both specific examples of situations where the appropriate response as a staff member felt unclear, as well as a sense of uncertainty about what to say in the interviews themselves.

Given the lack of guidance and preparation, many participants felt unsure about what their role was in particular situations. Specific examples centred around when new romantic relationships develop between residents. One participant described the following scenario:

> "… *they'll think that another, of the opposite sex is, their partner because they've obviously forgotten who their partner is. They'll kind of buddy up a bit, and this is where I get confused, if you've got no capacity to understand that they're doing, are they okay to be left alone, to hold hands and sit on the sofa and snuggle, or, or should we be interve, intervening"…"there's no clear guidelines, guidelines, from what I can gather"* ***(participant 4, care worker)***

Participants often expressed uncertainty about the language to use to describe different concepts and behaviours. This was particularly when talking either about diverse sexual

orientations or when considering how to refer to a resident with dementia. The following is an example:

> "*I don't wanna use the wrong words here, I don't wanna use the wrong words from, erm, (pause) oh dear, erm, (pause) I, I, oh god, forgive me (name of researcher), but I'm trying to I'm trying to find the right words"* ***(participant 3, deputy manager)***

Several participants, mainly those in management positions, commented on how they observed other staff to be uncertain in particular situations. Uncertainty was recognised through behavioural signs such as giggling. Within the interviews, the function of these reactions was compassionately explored and participants considered how colleagues may laugh or withdraw from situations when they feel uncomfortable and nervous and how this in turn prevents discussion.

LGBT+ 'wouldn't treat any differently'

The importance of diverse sexual orientations was weaved throughout the interviews. The definition of sexuality given by the author to participants included "encompasses… sexual orientation" (WHO, 2006) and there was a specific question on how participants consider issues specific to the LGBT+ community.

The notion of "wouldn't treat any differently" (participant 4, care worker) was offered by many of the participants when considering LGBT+ residents. This encapsulates two points that were made by participants regarding this topic. One, as highlighted through the use of an auxiliary verb, 'would', was participants' description of never having cared

for a LGBT+ identifying resident. Second, was the idea that should there ever be a LGBT+ resident in the care home, then they would be treated the same as heterosexual residents. Consequently, exploration of specific considerations for non-heterosexual residents was limited. It was evident that a pro-active approach to any future LGBT+ residents is rarely taken within the care homes.

One participant reflected on how more broadly the sexual needs of residents are not always full considered, which may be more severe LGBT+ individuals:

> "*I mean the, you could argue well, we're not doing anything to meet the, you know, the, the sexual needs of all the heterosexuals and, and so it's not really (laugh) a surprise, it's not necessarily that, you know, that the LG, erm, BTQ community aren't being, are being, treated differently, it's more a case of, they're being treated just as badly as the rest of erm, the er, the care home populatio*n" **(Participant 6, care home manager)**

The concept of generational differences between staff and residents was deemed influential for many participants and this was relevant also when talking about LGBT+ older adults. Many participants were thoughtful about the generation in which older adult residents grew up and historical attitudes to the LGBT+ community. It was noted how many residents may not wish for staff and fellow residents to have knowledge of their sexual orientation identity and may hold worries about others knowing. Some participants shared how they were unlikely to approach the topic of sexual orientation for fear of

making a resident feel uncomfortable. Of the twelve participants interviewed, one made reference to having cared for a LGBT+ individual:

> *"with the elder, population, that sort of thing is quite taboo, because, years ago, those people, quite often had to hide their sexuality. Erm, I did nurse a lady, that was, in her 80's, who are, being a lesbian, and she would not speak about her girlfriend, at all. They was, friends, yes? So, it, more often than not, if you come across somebody that is, elderly, that, is of gay or lesbian, sexuality, you'd be quite honoured if they actually spoke about it to you, because most of them don't".* **(Participant 2, care worker)**

Theme 4: Broader consideration of sexuality

Alongside the recognition of a lack of discussion about sexuality within care homes, there was often a sense from participants of their desire for the topic to be more of a priority. Factors associated with this aligned with three themes: staff's personal values, intimacy as important and times are changing.

Staff's personal values

Many participants reflected on their own and their colleagues' personal values and how this influenced the topic of sexuality within their work setting. Personal values that were noted as influential in how participants approach their job role included being caring, respectful and prioritising dignity for residents. Participants spoke of the importance of getting to know individual residents and their desire to support them and their wishes in

the best way they can. Staff recognised the importance of values both personally and within their staff team:

> *"we come into this job because we are caring and we are open-minded so I haven't found a lot of, a lot of prejudice or, anything because I think you know it takes a certain type of person to do this role, erm, people who are open-minded and people who want the best for our residents, as well".* **(participant 10, deputy care manager)**

Intimacy as important

On the whole, most participants used the interview as a space to talk about the importance of intimacy. There was recognition and importance placed on residents' needs for comfort and connection with others. This was explored in the context of sexually displayed behaviours and how it is necessary to consider the function of these, as often it is about seeking contact with others. Additionally, participants spoke more broadly about human's needs for connection, including older adult residents.

Whilst answering the specific question on the impact of the COVID-19 pandemic on residents' expression of sexuality, participants predominately reported how they had not observed any specific impacts. However, some shared how the pandemic had highlighted the necessity for closeness and intimacy for residents. It was reflected upon how this has always been important and during the pandemic intimacy with others was difficult to obtain. Staff made the observation that the desire for comfort, and when certain behaviours were framed in this way, it was widely recognised within the staff team:

"*two eighty-odd year olds that are tripping off to their room, it's not disgusting and it is, you know, it is comfort, it is finding that comfort. And, and, the, the staff are really good actually, they are really open to understanding that".* **(Participant 3, deputy manager)**

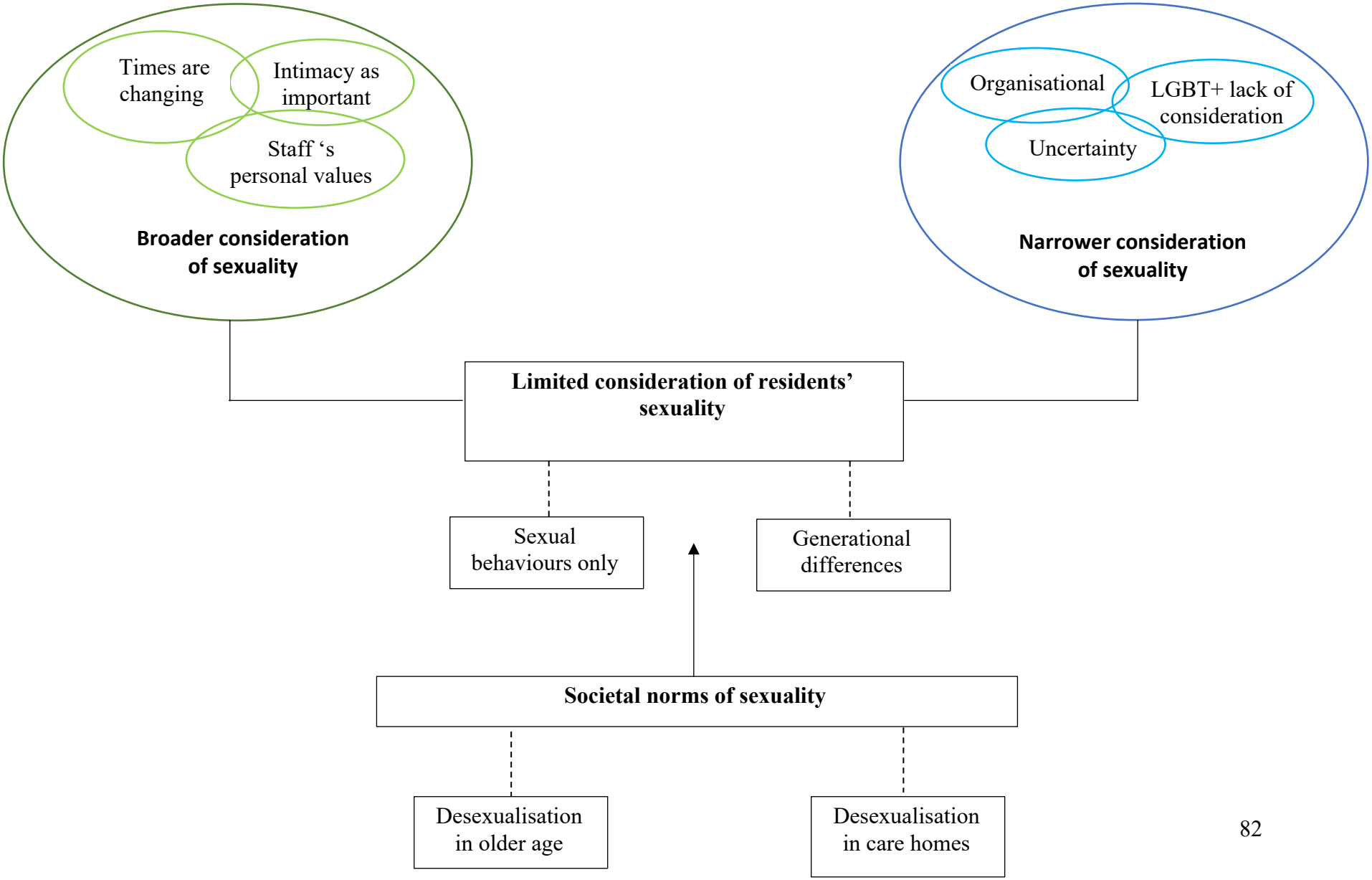
Times are changing

References to changes that have been made with respect to acknowledging older adult sexuality within the care home setting were acknowledged. The title 'times are changing' reflects the comments made that attitudes are changing both within society and the care home setting. Changes included amendments to paperwork, in particular additions to initial assessment forms, including multiple choice options for gender and more space for considering sexuality generally. Despite these changes, there was an overall sense and commentary on how such changes are small and are yet to create meaningful change in how sexuality is discussed within staff teams and with individuals living in the care home setting:

"I think it's becoming increasingly easy to talk, er, er, about it amongst professionals. Erm and I think it's possibly beginning to be a more widely talked about subject, but whe.., how that's translated into having those conversations with the individuals who are in our care, I'm not convinced there has been a great shift, forward from, you know, in, in certainly in the four years that I've been in, erm, care I can't see any difference in terms of, what it means to the residents at all. **(Participant 6, care home manager)**

Figure 2

Model depicting the theory of how sexuality is considered in care homes



Discussion

There have been some previous studies focusing on staff views of sexual behaviour in nursing homes (Roach, 2004; Vandrevala et al., 2017). Nevertheless, to our knowledge this study differs in that it is the first study to use in-depth qualitative interviews with care home staff to explore their experiences and views of how sexuality more broadly is considered within care homes. The outcomes of this study allowed for the development of a model, depicting a theory of how sexuality is considered in care homes. The primary finding from this study is that consideration of sexuality within care homes is significantly limited and largely confined to responding to residents' sexually inappropriate behaviours. The desexualisation of older adults that occurs within society more broadly appears to be magnified within care homes and there was little evidence of sexuality being consider proactively. Narrower consideration of sexuality factors that contribute to the limited discussion of sexuality pertain to the organisational setting, staffs' individual uncertainty, and lack of specific consideration for older LGBT+ individuals. Broader consideration of sexuality factors that participants identified as contributing to enriching consideration of sexuality included a sense of times are changing, attitudes towards intimacy as being important and the personal values of staff working in care homes.

Participants noted the significant impact of societal norms that surround sexuality in older age. The notion of assumed asexuality for older adults was referenced, both in respect to participants' own assumptions and those they perceive in colleagues. These observations are supported by literature which highlights the prevalence of an asexual stereotype in older age (Kenny, 2013). It is true that there are changes associated with ageing that may

affect an individuals' ability and/or choice to express themselves sexually. These include partner availability, physical health difficulties and effects of associated medications and changes to body image (Rheaume & Mitty, 2008; Hillman, 2008; Træen et al., 2017; Freak-Poli, 2019). However, participants accurately often noted how stereotypes of asexuality in older age are misguided, an observation that is supported by the literature (Evangelista et al., 2019).

Social psychology theories define stereotypes as an inevitable consequence of psychological and cognitive need to categorise information, as a mechanism to ensure simplification in a complex world (Augoustinos & Walker, 1998). Stereotypes can include beliefs about the characteristics and behaviours of members of different groups (Hilton & von Hippel, 1996). They allow for previous experience to inform a current situation and be responded to more rapidly. Consequently, this process has the significant disadvantage of incurring prejudicial views about individuals based on broad beliefs about a group (Kite & Whitley, 2016). As noted by participants in this study, stereotypes regarding older adult sexuality are common both in society and in care homes. It can be argued that these are likely to lead to prejudices and expectations regarding all older adult residents. This is important to consider as social, personal and cultural stereotypes prevalent for older age sexuality can have a negative impact for older adults (Ricoy-Cano et al., 2020).

The model also illustrates participants' observations of how the broad desexualisation of older adults is emphasised in care homes. There are restrictions on older adults'

opportunities to express their sexuality within the care home setting, including changes to rights such as privacy. The concept of privacy is complex within care homes. Spaces such as bedrooms are understood to be a private individual space for a resident, however staff may hold legitimate reasons for entering this space, therefore confounding residents' autonomy (Eyers et al., 2012). Additionally, staff noted residents' compromised independence and the consequential reliance on staff to fulfil their wishes and needs. Although not explored in-depth, some participants commented on having supported residents to access pornographic material, such as magazines or via the internet. This aspect of caring for older adults is likely to create different reactions from staff members. There is a paucity of research in this area, however a study investigating porneia and residential aged care offers some further insights into staff perspectives. Findings illustrated an inconclusive stance from staff on the topic of pornography (and porneia) in care homes, with many looking to management and policies for guidance (Henrickson et al., 2022). In the absence of clear processes for decision making, literature highlights how teams often adopt a hierarchical approach with individual staff assuming it is someone else's responsibility to make difficult decisions (Kinderman et al., 2018). Moreover, this issue may be considered in the context of human rights, for instance as relating to the FREDA (fairness, respect, equality, dignity and autonomy) principles and individuals with dementia's rights to express their identity (Butchard & Kinderman, 2019).

The findings revealed how participants experience discussions and considerations regarding sexuality in care homes to be limited. Discussions are apparently confined

predominately to responding to a resident's sexual behaviours with very little proactive discussion regarding the broader definition of sexuality. When referencing responding to sexual behaviours, these were predominately behaviours that within the context of older adults with dementia are defined as 'inappropriate sexual behaviour' (ISB). Although the most common change in sexual behaviour for those with dementia is indifference, ISB can also present (Derouesné et al., 1996). ISB in dementia appears to be determined by either intimacy-seeking or disinhibition and differs by dementia type, dementia severity and possibly any co-morbid behavioural disorders (Cipriani et al., 2016). Critically, ISB is a complex and subjective set of behaviours. How ISB is evaluated is dependent upon individual perceptions that are influenced by factors such as culture, religion, societal views of older adult sexuality and medicolegal issues (Joller et al., 2013).

Limits to the discussion of sexuality between staff and residents was also talked about in the context of generational differences. Literature supports these findings, such as the study by Simpson et al. (2018), which found that generational differences between older residents and younger or middle-aged care staff is one of many factors which make talking about sexuality difficult. Due to social and political change during the 1960s and 1970s, older adults in Western countries are now living in a generation with more accepting attitudes towards sexuality. Participants were sensitive to the fact that residents grew up and have lived much of their life in an era where sexuality was not talked about as openly as it is today and how this is likely to impact their openness in discussing the topic.

Additionally, many comparisons were made between the 'older and younger' staff. This may be seen through the theoretical lens of splitting or black and white thinking, where polarised views such as good and bad, arise as a way of coping with doubts, conflicting feelings and anxiety (Fotaki & Hyde, 2015). This might be considered as a common psychological process used by participants to organise complex information through more simplified lenses which can potentially create blind spots when considering sexuality for residents.

The theme '*narrower consideration of sexuality'* captured factors that maintain limited discussion of sexuality. It is well documented that care home organisations have limited processes and resources with which to support staff to address issues of sexuality. All participants spoke of lack of training on the topic of sexuality, and literature supports how this is often the case for care home staff (Horne et al., 2021). Additionally, the topic of paperwork was discussed by many participants. This was both in terms of how exploration of sexuality is often confined to assessments forms, and also the pressure to document any observed ISB. The presence of paperwork in care homes has increased drastically and research demonstrates how commissioners and regulators assume such paperwork benefits residents, when in fact they are often at its mercy as opposed to benefit (Warmington et al., 2014). Time spent completing paperwork can undermine other care responsibilities such as relationship building and responding to residents' wishes (Warmington et al., 2014). Literature also suggests how RACFs priority is to keep families satisfied and meet their expectations. Families are often informed of residents' relationships despite lack of resident consent, with decisions made jointly by staff and

families without residents' wishes included. Residents' relatives can be a further barrier in this way, as it's been reported they can find it difficult to acknowledge and accept sexual needs of parents and grandparents (Villar et al., 2014). In light of this, the potential for such sexual needs to be overlooked is a human rights issue as all individuals, irrespective of age and social situation, have the right to sexual freedoms (Valentiner, 2021).

The model highlighted, to some degree, how LGBT+ older adults are considered within the care home setting. The term LGBT+ stands for lesbian, gay, bisexual, transgender, with the '+' representing all other non-heterosexual and non-cisgendered identities. Initially the term 'LGBTQ+' was used within the interview topic guide, however upon consultation with others and literature, the historic nature of the word queer was considered. The word has been reclaimed in a positive way but was once a derogatory slur (Morgan 2019). Associations of the derogatory nature of the word were considered for potential older adult LGBT+ readers of this paper and therefore the term was changed. Within the interviews, participants spoke predominately of lesbian and gay individuals, with one participant referencing bisexuality and one referencing transgender issues. Development of this topic was limited, in part due to participants' experience of scarcely having knowingly cared for a resident who identifies as LGBT+. This is highly unlikely, given that 1.4 million adults in the UK identify as lesbian, gay or bisexual (Office for National Statistics, 2019). Those aged 16 to 24 years old are most likely to identify such as, with the proportion of older adults smaller, but this number is increasing. Literature highlights how despite a general increase in acceptance of sexual minorities, many LGBT community-dwelling adults perceive LGBT RACF residents to be discriminated against

because of their sexual orientation and gender identity (Mahieu et al., 2019). Importantly, whilst the topic of LGBT+ specific considerations was discussed, it requires much further exploration.

Collectively, findings highlighted the significant role of uncertainty for staff. A particular situation that appears to create uncertainty is the development of new romantic relationships between residents. Staff described being unsure of their role, any guidance to adhere to and whether or not to intervene. Whilst there are practical decisions to be made in these instances, such situations also create difficult ethical and moral challenges for staff (Wiskerke & Manthorphe, 2019). In such instances staff are aware of a necessity to consider individuals' capacity to consent to a new relationship and any physical contact. Despite this, there was an absence of any reference to the Mental Capacity Act (2005) in all twelve interviews. This piece of legislation exists to protect and empower individuals and their right to make decisions and provide informed consent (Mental Capacity Act, 2005) and therefore has clear relevance to assessing capacity regarding issues of sexuality. Evidently for many staff there is a lack of clarity regarding their role, both in terms of assessment of residents' capacity to consent and whether to enable or prevent a relationship from developing. Uncertainty also pertained to the use of language in the interview itself. This emphasis on saying what is acceptable suggests that participants considered it important to talk about the topic thoughtfully. It is conceivable that too strong a preoccupation may have stifled discussion, which may be mirrored within the care homes itself.

The findings from this study also illustrated the theme of 'broader consideration of sexuality*'.* This theme captured staff observations of how sexuality is, or will be in the future, considered in a broader sense in care homes. Participants' observations of changes in the discourse of older adult sexuality are reflected within society. In April 2021, the relationships charity, Relate and photographer, Rankin, promoted a national campaign titled Let's Talk the Joy of Later Life Sex (Relate, 2021). The included photographs all depict older adults and are described to feature people of varying ethnicities, sizes, shapes and sexual orientations. The aim was to break the taboo and empower everyone to think and talk about sex and intimacy in older age.

Staff also reflected upon how the personal values of care home staff are influential in creating an atmosphere where sexuality can be discussed more easily. Many staff described themselves and fellow colleagues as caring, open-minded and valuing the importance of respect and dignity for residents. These values are linked to the concept of psychological safety. Psychological safety refers to people's beliefs of the consequences of taking interpersonal risks and how safe it might be to do so in particular contexts, such as the workplace (Edmondson & Lei, 2014). Psychological safety is influenced by many factors, one of which in care settings, is a culture of priority for client safety (O'donovan & Mcauliffe, 2020). It can therefore be concluded that where staff perceive colleagues as caring and respectful for residents, they are more likely to feel psychologically safe and take small personal risks. This may apply to group discussions such as with staff team meetings or during training sessions. Group discussion has been shown to be one of the

most effective interventions in improving staff knowledge and attitudes towards older adult sexuality (Post et al., 2008; Wright & Pugnaire-Gros, 2010).

Implications

The findings and model from this study could be used as a basis for generating change in care homes. On an individual level, many participants feedback that the interview itself was effective in highlighting the importance of thinking about older adult sexuality. This suggests that purposeful discussions about the topic with individual staff members can be effective in generating new ideas and the exploration of sexuality in care homes. he model itself depicted in this study may be sufficient as a starting point for individual staff members to reflect upon and discuss with others.

On a care home level, this study supports the need for staff training. Training can improve individual knowledge of older adult sexuality and enhance permissiveness of attitudes (Bauer et al., 2013; Jones & Moyle, 2016), ultimately allowing staff to better consider issues of capacity, consent and to upheld the human rights of residents. Few participants in this study had received any training on sexuality and expressed a desire for specific training on the topic. Horne et al. (2020) findings show that training for staff can be varied, and include online tools, use of case studies and/or group discussions. In a resource lacking environment such as care homes, these findings demonstrate how training can be varied and adapted to the needs of the care home. For instance, it may be most beneficial to include training during the induction period for staff and prioritise follow-up sessions for further exploration and ongoing discussion of the topic. A Clinical

Psychologist has a clear role in this context, as they may be in a position to take the lead on delivering training and assessing the effectiveness of this empirically. A Clinical Psychologists' training would allow for them to pay attention to group processes within the training environment and apply theories of behavioural change as part of the intervention.

There are already resources available, such as the Alzheimer's Society Lift the Lid 'workshop in a box' which aims to help care staff address sex and intimacy addresses for individuals with dementia (Alzheimer's Society, 2019). Such a resource might be applicable for responding to participant's desire for more generalised guidance about how to address issues of sexuality, whilst maintaining individuality. Furthermore, the implementation of this training requires careful consideration

Change also needs to be sought at a policy level, both the internal policies of care homes and the CQC as the regulating body of care homes. The model highlights the influence of external factors, such as societal stereotypes regarding older adult sexuality. Sexuality is not a mandated topic for training and therefore the denial of older adult sexuality is perpetuated. By including sexuality on the agenda for staff training, both at induction and continuing professional development level, all staff would be given the opportunity to explore and learn about the topic.

Strengths, limitations, and future research

This is the first available qualitative study exploring care home staff perceptions on sexuality. A particular strength of the paper was the in-depth interviewing processes.

Using grounded theory methodology, interviews allowed for the topic of sexuality to be explored and reflected upon in-depth. Many participants reflected on how talking about the topic of older adult sexuality was a unique opportunity and created space to acknowledge the importance of the topic. Many shared that the experience alone stimulated ideas about how the topic might be addressed differently within the care home. Furthermore, the design of this study allowed for the inter-play between professional practice and personal values and attitudes to be acknowledged for staff within the complex context of old age sexuality. Much of this process was mirrored in the researcher's own experience through the course of the research process. For instance, the researcher was able to experience how the more exposure there was to discussion about sexuality, the less of a taboo subject it felt to talk about.

The main limitation of this study was the limited diversity of the sample. Participants were predominately female, aged forty to fifty years old, White British and heterosexual. In part, this is in line with characteristics of the UK adult social care workforce, with statistics of 17.7% male and average age of 43.9 years. However, 21.9% of the adult social care workforce are people identifying as a Black, Asian and or from other ethnic minorities. National statistics on sexual orientation are unfortunately not available to be reported on. Additionally, to ensure confidentiality of participants, the number of demographics reported was reduced. This has the disadvantage of not allowing for consideration of factors such as religion, which have been shown to be influential in studies on staff and sexuality (Joller et al., 2013). Future studies would benefit from a more diverse sample including recruitment of individuals from minority groups.

As discussed, the notion of 'sexuality' is broad and the working environment of care homes is complex. The concept of staff and residents as a family was noted by some participants, including one who reflected upon relating to a resident as a parent/grandparent figure and how this creates difficulties when approaching the topic of sexuality. It would be interesting to further the explore the relational roles that play out between staff and residents.

The importance of considering specific issues concerning LGBT+ residents was identified in this study, however further exploration of this is required. Clearly many residents are making the choice not to share their sexual orientation in care homes and the reasons for this need to investigated to best support those individuals who would wish to share this aspect of their identity and be welcomed as such. Keuroghlian et al., (2017) identify how professionals are well placed to address disparities for LGBT individuals and make environments more affirming.

Further investigation of any training on sexuality in the context of care homes that is taking place could be assessed empirically. From the author's experience of sharing initial findings of this research, feedback suggests that informal training is taking place. For instance, with the use of Alzheimer's Society's Lift the Lid tool (Alzheimer's Society, 2019). By assessing such interventions the elements of training that create change can be identified and results disseminated and best practice training developed.

Conclusions

The findings are depicted through a diagrammatical model which shows that consideration of sexuality within care homes is often limited. The model emphasised the impact of broader societal norms surrounding older adult sexuality and how these are emphasised in care homes. Many of those who took part have never received any training or support regarding addressing issues of older adult sexuality.

It is hoped the model will be used to inform better support and training for staff. The interview itself was effective in stimulating discussion and new ideas for many whom took part. This suggests that support for staff can involve discussion based interventions as well as more directive training.

The topic of sexuality is broad and individual's approaches and views towards sexuality are complex. Future studies will benefit this growing field of study by focusing more on the relational aspects of working in a care home, specific consideration of sexual orientation minorities, and evaluation of education interventions for staff. Ideally these will be assessed from both a staff and resident perspective. This will help to ensure that all older people who live in care homes are afforded the same rights dignity and respect in relation to sexuality as other member of society.

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Appendices

Appendix A – Quality Assessment Tool Quantitative Checklist

Table 1. Checklist for assessing the quality of quantitative studies

Criteria		YES (2)	PARTIAL (1)	NO (0)	N/A
1	Question / objective sufficiently described?				
2	Study design evident and appropriate?				
3	Method of subject/comparison group selection or source of information/input variables described and appropriate?				
4	Subject (and comparison group, if applicable) characteristics sufficiently described?				
5	If interventional and random allocation was possible, was it described?				
6	If interventional and blinding of investigators was possible, was it reported?				
7	If interventional and blinding of subjects was possible, was it reported?				
8	Outcome and (if applicable) exposure measure(s) well defined and robust to measurement / misclassification bias? Means of assessment reported?				
9	Sample size appropriate?				
10	Analytic methods described/justified and appropriate?				
11	Some estimate of variance is reported for the main results?				
12	Controlled for confounding?				
13	Results reported in sufficient detail?				
14	Conclusions supported by the results?				

of research. We determined that it was not feasible to develop a single, operational scoring system capturing the central notions of "quality" described in the literature as relevant to both qualitative and quantitative reports. We, therefore, developed two separate systems. Rather than developing explicit definitions for the two types of research, our distinction between the two was practical. Studies employing quantitative methods were appraised using the system for quantitative studies, while studies identified by the researchers as qualitative or employing qualitative methods such as focus groups, semi-structured interviews, etc.[20] were appraised using the system for qualitative studies.

Appendix B – Quality Assessment Tool Qualitative Checklist

Table 2. Checklist for assessing the quality of qualitative studies

Criteria		YES (2)	PARTIAL (1)	NO (0)
1	Question / objective sufficiently described?			
2	Study design evident and appropriate?			
3	Context for the study clear?			
4	Connection to a theoretical framework / wider body of knowledge?			
5	Sampling strategy described, relevant and justified?			
6	Data collection methods clearly described and systematic?			
7	Data analysis clearly described and systematic?			
8	Use of verification procedure(s) to establish credibility?			
9	Conclusions supported by the results?			
10	Reflexivity of the account?			

The original checklists and scoring manuals were developed following a review of various quality assessment documents and discussion by the authors of the elements considered central to internal study validity. Ten quantitative and ten qualitative studies were then randomly selected and independently scored by two reviewers. For the quantitative studies, 14 items (Table 1) were scored depending on the degree to which the specific criteria were met ("yes" = 2, "partial" = 1, "no" = 0). Items not applicable to a particular study design were marked "n/a" and were excluded from the calculation of the summary score. A summary score was calculated for each paper by summing the total score obtained across relevant items and dividing by the total possible score (i.e.: 28 – (number of "n/a" x 2)). Scores for the qualitative studies were calculated in a similar fashion, based on the scoring of ten items (Table 2). Assigning "n/a" was not permitted for any of the items, and the summary score for each paper was calculated by summing the total score obtained across the ten items and dividing by 20 (the total possible score).

Appendix C – Manual for quality scoring of quantitative studies

Appendix A: Manual for Quality Scoring of Quantitative Studies

Definitions and Instructions for Quality Assessment Scoring

How to calculate the summary score

- **Total sum** = (number of "yes" * 2) + (number of "partials" * 1)
- **Total possible sum** = 28 – (number of "N/A" * 2)
- **Summary score:** total sum / total possible sum

Quality assessment

1. *Question or objective sufficiently described?*

   Yes: Is easily identified in the introductory section (or first paragraph of methods section). Specifies (where applicable, depending on study design) *all* of the following: purpose, subjects/target population, and the *specific* intervention(s) /association(s)/descriptive parameter(s) under investigation. A study purpose that only becomes apparent after studying other parts of the paper is *not* considered sufficiently described.

   Partial: Vaguely/incompletely reported (e.g. "describe the effect of" or "examine the role of" or "assess opinion on many issues" or "explore the general attitudes"...); *or* some information has to be gathered from parts of the paper other than the introduction/background/objective section.

   No: Question or objective is not reported, or is incomprehensible.

   N/A: Should not be checked for this question.

2. *Design evident and appropriate to answer study question?*

   (If the study question is not given, infer from the conclusions).

   Yes: Design is easily identified and is appropriate to address the study question / objective.

   Partial: Design and /or study question not clearly identified, but gross inappropriateness is not evident; *or* design is easily identified but only partially addresses the study question.

   No: Design used does not answer study question (e.g., a comparison group is required to answer the study question, but none was used); *or* design cannot be identified.

   N/A: Should not be checked for this question.

3. *Method of subject selection (and comparison group selection, if applicable) or source of information/input variables (e.g., for decision analysis) is described and appropriate.*

   Yes: Described and appropriate. Selection strategy *designed* (i.e., consider sampling frame and strategy) to obtain an unbiased sample of the relevant target population or the entire target population of interest (e.g., consecutive patients for clinical trials, population-based random sample for case-control studies or surveys). Where applicable, inclusion/exclusion criteria are described and defined (e.g., "cancer" -- ICD code or equivalent should be provided). *Studies of volunteers:* methods and setting of recruitment reported. *Surveys:* sampling frame/strategy clearly described and appropriate.

   Partial: Selection methods (and inclusion/exclusion criteria, where applicable) are not completely described, but no obvious inappropriateness. Or selection strategy is not ideal (i.e., likely introduced bias) but did not likely seriously distort the results (e.g., telephone survey sampled from listed phone numbers only; hospital based case-control study identified all cases admitted during the study period, but recruited controls admitted during the day/evening only). Any study describing participants only as "volunteers" or "healthy volunteers". *Surveys:* target population mentioned but sampling strategy unclear.

   No: No information provided. *Or* obviously inappropriate selection procedures (e.g., inappropriate comparison group if intervention in women is compared to intervention in men). *Or* presence of selection bias which likely seriously distorted the results (e.g., obvious selection on "exposure" in a case-control study).

   N/A: Descriptive case series/reports.

4. *Subject (and comparison group, if applicable) characteristics or input variables/information (e.g., for decision analyses) sufficiently described?*

   Yes: Sufficient relevant baseline/demographic information clearly characterizing the participants is provided (or reference to previously published baseline data is provided). Where applicable, reproducible criteria used to describe/categorize the participants are clearly defined (e.g., ever-smokers, depression scores, systolic blood pressure > 140). If "healthy volunteers" are used, age and sex must be reported (at minimum). *Decision analyses:* baseline estimates for input variables are clearly specified.

   Partial: Poorly defined criteria (e.g. "hypertension", "healthy volunteers", "smoking"). *Or* incomplete relevant baseline / demographic information (e.g., information on likely confounders not reported). *Decision analyses:* incomplete reporting of baseline estimates for input variables.

   No: No baseline / demographic information provided.
   Decision analyses: baseline estimates of input variables not given.

   N/A: Should not be checked for this question.

5. *If random allocation to treatment group was possible, is it described?*

Yes: True randomization done - requires a description of the method used (e.g., use of random numbers).

Partial: Randomization mentioned, but method is not (i.e. it may have been possible that randomization was not true).

No: Random allocation not mentioned although it would have been feasible and appropriate (and was possibly done).

N/A: Observational analytic studies. Uncontrolled experimental studies. Surveys. Descriptive case series / reports. Decision analyses.

6. *If interventional and blinding of investigators to intervention was possible, is it reported?*

Yes: Blinding reported.

Partial: Blinding reported but it is not clear who was blinded.

No: Blinding would have been possible (and was possibly done) but is not reported.

N/A: Observational analytic studies. Uncontrolled experimental studies. Surveys. Descriptive case series / reports. Decision analyses.

7. *If interventional and blinding of subjects to intervention was possible, is it reported?*

Yes: Blinding reported.

Partial: Blinding reported but it is not clear who was blinded.

No: Blinding would have been possible (and was possibly done) but is not reported.

N/A: Observational studies. Uncontrolled experimental studies. Surveys. Descriptive case series / reports.

8. *Outcome and (if applicable) exposure measure(s) well defined and robust to measurement / misclassification bias? Means of assessment reported?*

Yes: Defined (or reference to complete definitions is provided) and measured according to reproducible, "objective" criteria (e.g., death, test completion – yes/no, clinical scores). Little or minimal potential for measurement / misclassification errors. *Surveys:* clear description (or reference to clear description) of questionnaire/interview content and response options. *Decision analyses:* sources of uncertainty are defined for all input variables.

Partial: Definition of measures leaves room for subjectivity, *or* not sure (i.e., not reported in detail, but probably acceptable). *Or* precise definition(s) are missing, but no evidence or problems in the paper that would lead one to assume major problems. *Or* instrument/mode of assessment(s) not reported. Or misclassification errors may have occurred, but they did not likely seriously distort the results (e.g., slight difficulty with recall of long-ago events; exposure is measured only at baseline in a long cohort study). *Surveys:* description of

questionnaire/interview content incomplete; response options unclear. *Decision analyses:* sources of uncertainty are defined only for some input variables.

No: Measures not defined, or are inconsistent throughout the paper. *Or* measures employ only ill-defined, subjective assessments, e.g. "anxiety" or "pain." *Or* obvious misclassification errors/measurement bias likely seriously distorted the results (e.g., a prospective cohort relies on self-reported outcomes among the "unexposed" but requires clinical assessment of the "exposed"). *Surveys:* no description of questionnaire/interview content or response options. *Decision analyses:* sources of uncertainty are not defined for input variables.

N/A: Descriptive case series / reports.

9. *Sample size appropriate?*

Yes: Seems reasonable with respect to the outcome under study and the study design. When statistically significant results are achieved for major outcomes, appropriate sample size can usually be assumed, unless large standard errors (SE > ½ effect size) and/or problems with multiple testing are evident. *Decision analyses:* size of modeled cohort / number of iterations specified and justified.

Partial: Insufficient data to assess sample size (e.g., sample seems "small" and there is no mention of power/sample size/effect size of interest and/or variance estimates aren't provided). *Or* some statistically significant results with standard errors > ½ effect size (i.e., imprecise results). *Or* some statistically significant results in the absence of variance estimates. *Decision analyses:* incomplete description or justification of size of modeled cohort / number of iterations.

No: Obviously inadequate (e.g., statistically non-significant results and standard errors > ½ effect size; or standard deviations > _ of effect size; or statistically non-significant results with no variance estimates and obviously inadequate sample size). *Decision analyses:* size of modeled cohort / number of iterations not specified.

N/A: Most surveys (except surveys comparing responses between groups or change over time). Descriptive case series / reports.

10. *Analysis described and appropriate?*

Yes: Analytic methods are described (e.g. "chi square"/ "t-tests"/"Kaplan-Meier with log rank tests", etc.) and appropriate.

Partial: Analytic methods are not reported and have to be guessed at, but are probably appropriate. *Or* minor flaws or some tests appropriate, some not (e.g., parametric tests used, but unsure whether appropriate; control group exists but is not used for statistical analysis). *Or* multiple testing problems not addressed.

No: Analysis methods not described and cannot be determined. *Or* obviously inappropriate analysis methods (e.g., chi-square tests for continuous data, SE given where normality is highly unlikely, etc.). *Or* a study with a descriptive goal / objective is over-analyzed.

N/A: Descriptive case series / reports.

11. *Some estimate of variance (e.g., confidence intervals, standard errors) is reported for the main results/outcomes (i.e., those directly addressing the study question/ objective upon which the conclusions are based)?*

Yes: Appropriate variances estimate(s) is/are provided (e.g., range, distribution, confidence intervals, etc.). *Decision analyses:* sensitivity analysis includes all variables in the model.

Partial: Undefined "+/-" expressions. *Or* no specific data given, but insufficient power acknowledged as a problem. *Or* variance estimates not provided for all main results/outcomes. *Or* inappropriate variance estimates (e.g., a study examining change over time provides a variance around the parameter of interest at "time 1" or "time 2", but does not provide an estimate of the variance around the difference). *Decision analyses:* sensitivity analysis is limited, including only some variables in the model.

No: No information regarding uncertainty of the estimates. *Decision analyses:* No sensitivity analysis.

N/A: Descriptive case series / reports. Descriptive surveys collecting information using open-ended questions.

12. *Controlled for confounding?*

Yes: Randomized study, with comparability of baseline characteristics reported (or non-comparability controlled for in the analysis). *Or* appropriate control at the design or analysis stage (e.g., matching, subgroup analysis, multivariate models, etc). *Decision analyses:* dependencies between variables fully accounted for (e.g., joint variables are considered).

Partial: Incomplete control of confounding. *Or* control of confounding reportedly done but not completely described. *Or* randomized study without report of comparability of baseline characteristics. *Or* confounding not considered, but not likely to have seriously distorted the results. *Decision analyses:* incomplete consideration of dependencies between variables.

No: Confounding not considered, and may have seriously distorted the results. *Decision analyses:* dependencies between variables not considered.

N/A: Cross-sectional surveys of a single group (i.e., surveys examining change over time or surveys comparing different groups should address the potential for confounding). Descriptive studies. Studies explicitly stating the analysis is strictly descriptive/exploratory in nature.

13. *Results reported in sufficient detail?*

Yes: Results include major outcomes and all mentioned secondary outcomes.

Partial: Quantitative results reported only for some outcomes. *Or* difficult to assess as study question/objective not fully described (and is not made clear in the methods section), but results seem appropriate.

No: Quantitative results are reported for a subsample only, or "n" changes continually across the denominator (e.g., reported proportions do not account for the entire study sample, but are reported only for those with complete data -- i.e., the category of "unknown" is not used where needed). *Or* results for some major or mentioned secondary outcomes are only qualitatively reported when quantitative reporting would have been possible (e.g., results include vague comments such as "more likely" without quantitative report of actual numbers).

N/A: Should not be checked for this question.

14. *Do the results support the conclusions?*

Yes: All the conclusions are supported by the data (even if analysis was inappropriate). Conclusions are based on all results relevant to the study question, negative as well as positive ones (e.g., they aren't based on the sole significant finding while ignoring the negative results). Part of the conclusions may expand beyond the results, if made *in addition to* rather than instead of those strictly supported by data, and if including indicators of their interpretative nature (e.g., "suggesting," "possibly").

Partial: Some of the major conclusions are supported by the data, some are not. *Or* speculative interpretations are not indicated as such. *Or* low (or unreported) response rates call into question the validity of generalizing the results to the target population of interest (i.e., the population defined by the sampling frame/strategy).

No: None or a very small minority of the major conclusions are supported by the data. *Or* negative findings clearly due to low power are reported as definitive evidence against the alternate hypothesis. *Or* conclusions are missing. *Or* extremely low response rates invalidate generalizing the results to the target population of interest (i.e., the population defined by the sampling frame/strategy).

N/A: Should not be checked for this question.

Appendix D – Manual for quality scoring qualitative studies

Appendix B: Manual for Quality Scoring of Qualitative Studies

Definitions and Instructions for Quality Assessment Scoring

How to calculate the summary score

- **Total sum** = (number of "yes" * 2) + (number of "partials" * 1)
- **Total possible sum** = 20
- **Summary score:** total sum / total possible sum

Quality assessment

1. *Question / objective clearly described?*

   Yes: Research question or objective is clear by the end of the research process (if not at the outset).

   Partial: Research question or objective is vaguely/incompletely reported.

   No: Question or objective is not reported, or is incomprehensible.

2. *Design evident and appropriate to answer study question?*

   (If the study question is not clearly identified, infer appropriateness from results/conclusions.)

   Yes: Design is easily identified and is appropriate to address the study question.

   Partial: Design is not clearly identified, but gross inappropriateness is not evident; *or* design is easily identified but a different method would have been more appropriate.

   No: Design used is not appropriate to the study question (e.g. a causal hypothesis is tested using qualitative methods); *or* design cannot be identified.

3. *Context for the study is clear?*

   Yes: The context/setting is adequately described, permitting the reader to relate the findings to other settings.

   Partial: The context/setting is partially described.

   No: The context/setting is not described.

4. *Connection to a theoretical framework / wider body of knowledge?*

   Yes: The theoretical framework/wider body of knowledge informing the study and the methods used is sufficiently described and justified.

   Partial: The theoretical framework/wider body of knowledge is not well described or justified; link to the study methods is not clear.

   No: Theoretical framework/wider body of knowledge is not discussed.

5. *Sampling strategy described, relevant and justified?*

   Yes: The sampling strategy is clearly described and justified. The sample includes the full range of relevant, possible cases/settings (i.e., more than simple convenience sampling), permitting conceptual (rather than statistical) generalizations.

   Partial: The sampling strategy is not completely described, or is not fully justified. Or the sample does not include the full range of relevant, possible cases/settings (i.e., includes a convenience sample only).

   No: Sampling strategy is not described.

6. *Data collection methods clearly described and systematic?*

   Yes: The data collection procedures are systematic, and clearly described, permitting an "audit trail" such that the procedures could be replicated.

   Partial: Data collection procedures are not clearly described; difficult to determine if systematic or replicable.

   No: Data collection procedures are not described.

7. *Data analysis clearly described, complete and systematic?*

   Yes: Systematic analytic methods are clearly described, permitting an "audit trail" such that the procedures could be replicated. The iteration between the data and the explanations for the data (i.e., the theory) is clear – it is apparent how early, simple classifications evolved into more sophisticated coding structures which then evolved into clearly defined concepts/explanations for the data). Sufficient data is provided to allow the reader to judge whether the interpretation offered is adequately supported by the data.

   Partial: Analytic methods are not fully described. *Or* the iterative link between data and theory is not clear.

   No: The analytic methods are not described. *Or* it is not apparent that a link to theory informs the analysis.

8. *Use of verification procedure(s) to establish credibility of the study?*

   Yes: One or more verification procedures were used to help establish credibility/trustworthiness of the study (e.g., prolonged engagement in the field, triangulation, peer review or debriefing, negative case analysis, member checks, external audits/inter-rater reliability, "batch" analysis).

   No: Verification procedure(s) not evident.

9. *Conclusions supported by the results?*

   Yes: Sufficient original evidence supports the conclusions. A link to theory informs any claims of generalizability.

   Partial: The conclusions are only partly supported by the data. *Or* claims of generalizability are not supported.

   No: The conclusions are not supported by the data. *Or* conclusions are absent.

10. *Reflexivity of the account?*

    Yes: The researcher explicitly assessed the likely impact of their own personal characteristics (such as age, sex and professional status) and the methods used on the data obtained.

    Partial: Possible sources of influence on the data obtained were mentioned, but the likely impact of the influence or influences was not discussed.

    No: There is no evidence of reflexivity in the study report.

Appendix E - Data Extraction Tool 1

Domain	
Author and year of publication	
Location	
Setting	
Sample and characteristics	
Design	

Appendix F – Data extraction tool 2

Domain	
Author and year of publication	
Main aims	
Intervention	
Outcome measures	
Main findings	

Appendix G – Participant demographic information from included studies

Author(s) Year	Sample and characteristics
Walker & Harrington 2002	N = 109 Gender: female 90.4%, male 9.6% Age: range 20-69, M = 38.47, SD = 11.04 Profession: RNs 8.8%, LPNs 4.4%, CNAs 50.4%, activity aides 11.7%, other professional, such as social worker, 18.2%, other staff, such as house-keepers/security/clerical staff 6.6% Marital status: single/never married 35.2%, married 37.6%, divorced/widowed/did not identify 27.2% Education: high school graduates 98.4%, completed a CNA or LPA program 20%, bachelor's degree 10.4%, master's degree 7.2% Race/ethnicity: African American 66.4%, white 20.8%, Asian/Native American/Hispanic 12.8% English as primary language: yes 83% Years of experience: range 1-33 years, M = 9.14, SD = 6.46 How important sexuality in own life: very important 56%, important 30.4%, not important 1.6%, no response 12%
Post et al., 2008	N = 282 Gender: female 83% Age: M = 39 years Profession: nurses 35.2%,physicians 14.3%, physical therapists 14%, occupational therapists 13.7%, psychologists and social workers 10.2%, other disciplines 12.6%
Wright & Pugnaire-Gros. 2010	N = 17 Profession: 12 nursing staff members (registered nurses and nursing assistants*), 2 patient educators, 1 psychologist, 2 unit managers (one head nurse, one assistant head nurse). Length of experience in mental health practice for nursing staff: Ranged from <18 months to > 30 years
Bauer et al., 2013	N = 112 Gender: female 93%, male 7% Age: 18-30 years 7%, 31-50 years 39%, 51+ years 54%

	Position: registered nurse 74%, enrolled nurse 26% English as first language: yes 94%, no 6% Years in aged care: 0-5 years 25%, 6-20 years 39%, 21+ years 36%
Jones & Moyle 2016	N = 42 Gender: female 90.5%, male 9.5% Age: Range 16-67 years. M=38, SD=17.2 Profession: Nursing student 38.1%, diversional therapists 4.8%, registered nurse 21.4%, enrolled nurse 7.1%, personal care workers 28.6% Nationality: Australian 64.3%, overseas 35.7% Most spoken language: English 92.9%, 7.1% Level of education: year 10 and/or below 7.1%, year 12 28.6%, TAFE Certificate I-IV 19%, TAFE Diploma 16.7%, Bachelor degree 11.9%, Graduate certificate/diploma 9.5%, Masters 7.1% Years working in aged care: range 0-25 years, M = 5.4 SD = 7.2 Prior education/training in sexuality & dementia: yes 23.8%, no 76.2%
Pelts. & Galambos 2017	N = 42 Gender: female 81%, male 19% Age: M = 38 years Job title: nursing assistants 42%, activities or other support 19%, social workers/social services 12%, registered nurses 10%, licensed practical nurses 9%, other 8% Work experience in LTC: M = 11 years, 4 with current employer Ethnicity/race: Caucasian 83%, African-American or Black 9%, Hispanic/Latino 6%, other 2% Education: certificate 35%, high-school diploma/General Educational Development or some college 27%, associate's degree 14%, bachelor's degree 12%, graduate degree 12%
Donaldson et al., 2019	N = 26. Profession: Nursing n = 8 Medicine n = 3 (1 only at pre-) Social work n = 4 Occupational and physical therapy = 4 Psychology = 2 (only at post-) Chaplaincy = 1 (only at pre-) Recreation therapy = 2 Administration n = 2
Holman et al., 2020	N = 43 Gender: Female 84.09% Male 15.91% Age: M = 34.21 years Staff designation:

	Facilities services 15.91% Healthcare services 84.09% Educational attainment: Less than college 27.27% Some college or more 72.73% Race: White 75% Other 25% Religion: Christian 77.27% Other 22.73% Years experience in elder care: 9.52 years, M = 2.96 years at location
Chidiac et al., 2021	N = 145 Gender: Female 93.79% Male 6.21% Age: 18-29 5.52% 30-39 10.34% 40-49 31.04% 50-59 22.14% 60+ 8.97% Clinical role: 1.38% chaplain 0.69% complementary therapist 15.86% counsellor 6.90% doctor 14.48% healthcare assistant 39.31% nurse 2.76% occupational therapist 10.34% others 3.45% physiotherapist 1.38% psychologist 3.45% social worker Sexual orientation: Lesbian 1.38% Bisexual 0.69% Heterosexual 97.24% Pansexual 0.69% Ethnicity: Black/Black British 3.45% Asian/Asian British 2.07% Caucasian/White British 90.34% Other 4.14%
Rassem et al., 2020 Canada	N = 86 Profession: 43% nurses 16% physical therapists 15% care aids 12% occupational therapists

Appendix H - Ethical Approval

Central University Research Ethics Committee A

21 June 2021

Dear Dr Butchard

I am pleased to inform you that your application for research ethics approval has been approved. Application details and conditions of approval can be found below. Appendix A contains a list of documents approved by the Committee.

Application Details

Reference:	8337
Project Title:	Staff member's views on older adult sexuality in care homes.
Principal Investigator/Supervisor:	Dr Sarah Butchard
Co-Investigator(s):	Miss Frances Chaisty, Dr Clarissa Giebel
Lead Student Investigator:	-
Department:	School of Psychology
Approval Date:	21/06/2021
Approval Expiry Date:	Five years from the approval date listed above

The application was **APPROVED** subject to the following conditions:

Conditions of approval

Please note: this approval is subject to the University's research restrictions during the pandemic, as laid out on the research ethics webpages. Therefore, wherever possible, research should be conducted via remote means which avoid the need for face-to-face contact with human participants during the pandemic. The process for requesting an exemption to these restrictions is described on the research ethics webpages.

- All serious adverse events must be reported to the Committee (ethics@liverpool.ac.uk) in accordance with the procedure for reporting adverse events.
- If you wish to extend the duration of the study beyond the research ethics approval expiry date listed above, a new application should be submitted.
- If you wish to make an amendment to the study, please create and submit an amendment form using the research ethics system.
- If the named Principal Investigator or Supervisor changes, or leaves the employment of the University during the course of this approval, the approval will lapse. Therefore it will be necessary to create and submit an amendment form within the research ethics system.
- It is the responsibility of the Principal Investigator/Supervisor to inform all the investigators of the terms of the approval.

Kind regards,

Central University Research Ethics Committee A

ethics@liverpool.ac.uk

CUREC-A

Appendix - Approved Documents

(Relevant only to amendments involving changes to the study documentation)

The final document set reviewed and approved by the committee is listed below:

Document Type	File Name	Date	Version
Evidence Of Peer Review	Frances Chaisty Proposal RRC Approval letter 09.11.2020	09/11/2020	1
Advertisement	Research poster	29/01/2021	1
Interview Schedule	Research topic guide	04/02/2021	1
Study Proposal/Protocol	Research proposal. Final version	04/02/2021	2
Interview Schedule	Sociodemographic form	17/06/2021	3
Participant Information Sheet	Research. PIS	17/06/2021	6
Participant Consent Form	Consent form	17/06/2021	6
Debriefing Material	Debrief document	17/06/2021	3

Appendix I - Research Poster

UNIVERSITY OF LIVERPOOL

Do you work in an older adults care home in the UK?

Can you spare 45 minutes to help us with our research?

We are asking carers/support worker staff working in care homes to take part in our research which is looking at the topic of older adult sexuality.

This would involve an online video or telephone interview for around 45 minutes and you will receive a gift voucher for your time.

You are not expected to have any specialist knowledge on the topic and your interview will remain **anonymous**.

If you'd like to take part or have any questions, please contact Fran Chaisty at frances.chaisty@liverpool.ac.uk

Appendix J - Participant Information Sheet

An exploration of care home staff's perspectives on older adult residents' sexuality

Version 6. 17th June

You are being invited to participate in a research study. Before you decide whether to participate, it is important for you to understand why the research is being done and what it will involve. Please take time to read the following information carefully and feel free to ask us if you would like more information or if there is anything that you do not understand. Please also feel free to discuss this with your manager if you wish. We would like to stress that you do not have to accept this invitation and should only agree to take part if you want to.

Thank you for reading this.

1. What is the purpose of the study?

Research shows us that sexuality and intimacy is still a very important part of the human experience in later life. In care homes however, staff are very often not supported in their role in terms of supporting their residents in the context of their sexuality. In fact there has been very little research that looks at how older adult sexuality is thought about, talked about and addressed in care homes. The purpose of this study is to find out more about how care home staff (specifically carers/support workers/nursing assistants) address the sexuality of their older adult residents and what influences this. The long-term aim is to develop an understanding of what might be needed to best support staff in their role within this context.

2. Why have I been chosen to take part?

You have been chosen to take part in this study because you are a member of staff working in a care home for older adults.

3. Do I have to take part?

No, giving consent to participant in the study and taking part in the interview is completely voluntary. You can stop taking part in the interview at any point without giving a reason.

4. What will happen if I take part?

If you choose to take part in this study, you will be invited to an informal interview with one of our researchers, Frances Chaisty. You will be given the choice for this to take place either online, via Microsoft Teams video call or by telephone and the interview will be recorded using a university issued password protected iPad. You will be assigned a 'participant number', meaning your name won't be used at any point during the study, ensuring anonymity. The interview will last approximately 45-60 minutes and you will be asked a series of open-ended questions. These questions will be about your role as a member of care home staff and relating to issues of resident's sexuality. There are no 'right answers' to any of the questions, this is purely an exploration of staff's experiences and perspectives. Prior to the interview you will be sent a 'sociodemographic form' to complete.

You will be asked to take part in the interview in a quiet and private space. This is important to ensure the interview remains private and confidential. Interviews will be audio recorded, using a university password protected iPad, to allow for analysis of the discussions.

Details of your interview and answers will **not** be shared with any members of your work team, including management and colleagues. An exception to this is if you share something that concerns the researcher that there is a risk to either yourself or somebody else, then confidentiality may need to be broken. If there is a disclosure of malpractice or safeguarding issue in the care home, confidentiality may need to be broken and that information shared with relevant professional bodies to ensure the welfare of care home residents.

5. How will my data be used?

Data (including sociodemographic information, consent forms, interview recordings and email addresses) will be stored securely on a password protected university M:drive. Only authorised personnel of this organisation would be able to see the data and would have a duty of confidentiality to anyone taking part in the study.

The interview recordings will be transcribed into interview transcripts and anonymised. We will then not be able to identify who participated in the study. We will look through these transcripts and identify themes, so topics that come up frequently. These themes will then be written up for academic publication. For this, we will be using some anonymous quotes (ie, your name will never be used). The recordings are strictly confidential within the research team and following transcription, by a university approved transcriber, the audio recordings will be destroyed.

The University processes personal data as part of its research and teaching activities in accordance with the lawful basis of 'public task', and in accordance with the University's purpose of "advancing education, learning and research for the public benefit".

Under UK data protection legislation, the University acts as the Data Controller for personal data collected as part of the University's research. The Principal Investigator acts as the Data Processor for this study, and any queries relating to the handling of your personal data can be sent to Frances Chaisty.

How will my data be collected?	The consent form and sociodemographic form will be collected via email. The interview will be recorded using a password protected university iPad. Email addresses will be collected through correspondence.
How will my data be stored?	Data will be stored on the password protected university M:drive. Email addresses will be held on a password protected excel spreadsheet within the M:drive.
How long will my data be stored for?	Electronic copies of the forms will be archived for 10 years, as per university protocol. Recordings of the interviews will be destroyed following transcription, where the content of interviews will be anonymised. These transcripts will also be destroyed after 10 years. Email addresses will also be destroyed after 10 years.
What measures are in place to protect the security and confidentiality of my data?	All data will be stored on the university password protected M:drive.
Will my data be anonymised?	Yes
How will my data be used?	Sociodemographic data will be used as part of the analysis and write up of the project, to detail information regarding the participant sample as a whole. Recordings of the interview will be transcribed, and the transcript will then be used for analysis.

Who will have access to my data?	University approved transcribers will have access to the interview recordings to allow for transcription. All other data will only be accessible by the research team (Frances Chaisty, Dr Sarah Butchard and Dr Clarissa Giebel).
Will my data be archived for use in other research projects in the future?	No
How will my data be destroyed?	After 10 years, all data on the M:drive will be deleted. This will be by the data custodians of this project, Dr Sarah Butchard and Dr Clarissa Giebel.

6. Expenses and / or payments

You will also receive a £20 gift voucher as a thank you for taking part.

7. Are there any risks in taking part?

We're aware that for some it may feel uncomfortable and embarrassing to talk about this topic. There are no expectations to give the 'right answer', and you will be encouraged to tell the researchers if you wish to stop the interview at any point. We also acknowledge that the covid-19 pandemic has been an incredibly stressful time for those working in care homes and may contribute to it feeling harder to talk about your job role. You will be interviewed by someone who has clinical experience of working with people who are distressed and should you become upset or uncomfortable you will be supported in taking a break from the discussion.

8. Are there any benefits in taking part?

By taking part in the interview, you can share your experiences of working as a care worker and how you think about issues of older adult sexuality and how this is addressed in care homes. This is important to understand to inform how care home staff can be supported in this role and ultimately improve the experience of care home residents.

9. What will happen to the results of the study?

Once all participants have been interviewed and the information from the interviews analysed, the results of our findings will be written up. We will seek publication in an academic journal. We will also write up the

results in a two page summary for care homes, to ensure that the findings can be shared with all care home staff. You will emailed with details on how to access both of these.

10. What will happen if I want to stop taking part?

Prior to and during the interview itself you can withdraw at any point without providing a reason. Once the interview has finished you will no longer be able to withdraw from the study. This is because the recording will be anonymously transcribed, and findings from all interviews collated into themes, therefore making it impossible to identify your particular interview and remove it from the data.

11. What if I am unhappy or if there is a problem?

If you are unhappy, or if there is a problem, please feel free to let us know by contacting Fran Chaisty, frances.chaisty@liverpool.ac.uk and we will try to help. If you remain unhappy or have a complaint which you feel you cannot come to us with then you should contact the Research Ethics and Integrity Office at ethics@liv.ac.uk. When contacting the Research Ethics and Integrity Office, please provide details of the name or description of the study (so that it can be identified), the researcher(s) involved, and the details of the complaint you wish to make.

The University strives to maintain the highest standards of rigour in the processing of your data. However, if you have any concerns about the way in which the University processes your personal data, it is important that you are aware of your right to lodge a complaint with the Information Commissioner's Office by calling 0303 123 1113.

12. Who can I contact if I have further questions?

Frances Chaisty; frances.chaisty@liverpool.ac.uk

Contact details of investigatory team:

Principal Investigator: Dr Sarah Butchard
butchard@liverpool.ac.uk

Lead Investigator: Frances Chaisty
frances.Chaisty@liverpool.ac.uk

Supervisor: Dr Clarissa Giebel
clarissa.Giebel@liverpool.ac.uk

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Appendix K – Participant Consent Form

#1

Participant consent form

Version number & date: v3, 17th June 2021
Research ethics approval number: xxx
Title of the research project: An exploration of care home staff's perspectives on older adult residents' sexuality
Name of researcher(s): Principal investigator: Dr Sarah Butchard. Lead researcher: Frances Chaisty.
Supervisor: Dr Clarissa Giebel

Please initial box

1. I confirm that I have read and have understood the information sheet dated 17th June 2021 for the above study, or it has been read to me. I have had the opportunity to consider the information, ask questions and have had these answered satisfactorily. ☐
2. I understand that taking part in the study involves completing an audio recorded interview regarding the topic of older sexuality in care homes. ☐
3. I understand that my participation is voluntary and that I am free to stop the interview at any time without giving any reason and without my rights being affected. In addition, I understand that I am free to decline to answer any questions. ☐
4. I understand that if I disclose malpractice during the interview, confidentiality will be broken by the researcher Frances Chaisty in order to inform any relevant agencies. ☐
5. I understand that following the interview I will no longer be able to request access to or withdrawal of the information I provide. ☐
6. I understand that the information I provide will be held securely and in line with data protection requirements at the University of Liverpool until it is fully anonymised. ☐
7. I understand that signed consent forms (if completed and returned) or confirmation of consent recorded at the start of the interview will be retained in the University of Liverpool file store (accessed by this research team) for ten years. ☐
8. I understand that the recording of the interview will be retained on the University of Liverpool password encrypted drive until fully transcribed. ☐
9. I understand that anonymised quotations from the interview may be used in reports/presentations/publications. ☐
10. I agree to take part in the above study. ☐

Please consider your responses to each of the statements above.
If consent is given to all statements, please return to Frances Chaisty via email; frances.chaisty@liverpool.ac.uk

_____	_____	_____
Participant name	Date	Signature
_____	_____	_____
Name of person taking consent	Date	Signature

#1

Principal Investigator: Dr Sarah Butchard

Lead Investigator: Frances Chaisty

Supervisor: Dr Clarissa Giebel

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Appendix L – Participant Sociodemographic and Professional Experience Questionnaire

Version Number: 3

Date of this version: 17th June 2021

Study Title: An exploration of care home staff's perspectives on older adults residents' sexuality

Principal investigator: Dr Sarah Butchard

Lead investigator: Frances Chaisty

Supervisor: Dr Clarissa Giebel

Sociodemographic and professional experience questionnaire

Please answer the following questions by writing your response or circling the relevant answer. We appreciate some of these questions are personal; you **do not** have to answer any questions you do not wish to.

Question	Response
1. What is your age?	
2. What is your gender?	Female Male Transgender female Transgender male Non-binary Other gender identity: Prefer not to say
3. What is your ethnic background?	White: English, Welsh, Scottish, Northern Irish or British White: Irish White: Gypsy or Irish Traveller Any other White background (please state) Black, African, Carribbean or Black British: African Black, African, Carribbean or Black British: Carribbean Any other Black, African or Caribbean background (please state) Asian or Asian British: Indian Asian or Asian British: Pakistani Asian or Asian British: Bangladeshi Asian or Asian British: Chinese Any other Asian background (please state) Mixed or multiple ethnic groups: White and Black Caribbean Mixed or multiple ethnic groups: White and Black African Mixed or multiple ethnic groups: White and Asian Any other Mixed or Multiple ethnic background (please state) Other ethnic group: Arab Any other ethnic group (please state) Prefer not to say
4. What is your sexual orientation?	Heterosexual Homosexual Bisexual Pansexual Asexual Other: Prefer not to say

5. How many years did you spend in formal education?	
6. What is your job role?	
7. Please list any relevant occupational experience you have had prior to current role	
8. How long have you spent working in the care home service?	
9. What is the bed size of the care home you are currently working in?	

Appendix M – Participant Debrief Document

UNIVERSITY OF LIVERPOOL

Version Number: 3
Date of this version: 17/06/21

Study Title: An exploration of care home staff's perspectives on older adult residents' sexuality

Principal Investigator: Dr Sarah Butchard

Lead Investigator: Frances Chaisty

Supervisor: Dr Clarissa Giebel

DEBRIEFING DOCUMENT

If you should experience personal distress after completing the interview, please refer to the following support resources or contact your GP:

Samaritans Helpline for NHS and social care workers (Mon-Sun 7am – 11pm):
Tel.: 0800 069 6222

NHS Carers Direct Helpline (Mon – Fri 9am – 8pm, Sat & Sun 11am – 4pm):
Tel.: 0300 123 1053

National Sexual Health Helpline (Mon – Fri 9am – 8pm)
Tel.: 0300 123 7123

Switchboard LGBT+ helpline (7 days a week 10am-10pm)
Tel.: 0300 330 0630

Appendix N – Topic Guide 1, 2, 3 & 4

Version Number: 1

Date of this version: 29/01/2021

Principal Investigator: Dr Sarah Butchard
butchard@liverpool.ac.uk **Lead Investigator:** Frances Chaisty
frances.Chaisty@liverpool.ac.uk **Supervisor:** Dr Clarissa Giebel
clarissa.Giebel@liverpool.ac.uk

Topic Guide

Interview questions

1. How long have you been working in the care home sector and what type of training have you received?

2. What does the term 'older adult sexuality' bring to mind for you?
   - *Following this question, a definition of sexuality will be given.*

3. How is it for you to talk about the topic of older adult sexuality in the workplace?

4. Can you tell me about your experiences of considering the sexuality of the residents in the care home where you work?

5. What issues do you think need to be thought about when considering the sexuality of older adult care home residents?

6. What do you feel has prepared you in your job role to address issues regarding the sexuality of your residents?

7. How do you see issues relevant to gender, sexuality and relationship diversity being addressed in the care home setting?

8. How do you consider the rights, including consent, confidentiality and privacy of your residents in terms of being able to express their sexuality?

9. How has the COVID-19 pandemic impacted care homes, in terms of residents' expression of their sexuality?

10. Lastly, is there anything else about the topic you feel we haven't covered yet but you feel is important?

Definition of sexuality –

The term 'sexuality' has a working definition, according to the World Health Organisation (WHO). Sexuality is considered "a central aspect of being human throughout the lifespan, and encompasses sex, gender identities and roles, sexual orientation, eroticism, pleasure, intimacy and reproduction" (WHO, 2006).

Version Number: 1

Date of this version: 29/01/2021

Principal Investigator: Dr Sarah Butchard
butchard@liverpool.ac.uk **Lead Investigator:** Frances Chaisty
frances.Chaisty@liverpool.ac.uk **Supervisor:** Dr Clarissa Giebel
clarissa.Giebel@liverpool.ac.uk

Topic Guide

Interview questions

1. How long have you been working in the care home sector and what type of training have you received?

2. What does the term 'older adult sexuality' bring to mind for you?
   - *Following this question, a definition of sexuality will be given*

3. How is it for you to talk about the topic of older people and sexuality in the workplace and what do you feel has prepared in your role in this context?

4. What factors do you think impact how sexuality is considered and discussed amongst staff in a care home?

5. What issues do you think need to be thought about when considering the sexuality of older adult care home residents?

6. How do you see issues relevant to LGBTQ+ older adults being addressed in the care home setting?

7. How do you consider the rights, including consent, confidentiality and privacy of your residents in terms of being able to express their sexuality?

8. What do you feel is necessary in terms of training and support for staff working in care homes to best support residents in the context of sexuality?

9. How has the COVID-19 pandemic impacted care homes, in terms of residents' expression of their sexuality?

10. Lastly, is there anything else about the topic you feel we haven't covered yet but you feel is important?

Definition of sexuality –

Version Number: 1

Date of this version: 29/01/2021

Principal Investigator: Dr Sarah Butchard
butchard@liverpool.ac.uk **Lead Investigator:** Frances Chaisty
frances.Chaisty@liverpool.ac.uk **Supervisor:** Dr Clarissa Giebel
clarissa.Giebel@liverpool.ac.uk

Topic Guide

Interview questions

1. How long have you been working in the care home sector and what type of training have you received?

2. What does the term 'older adult sexuality' bring to mind for you?
   - *Following this question, a definition of sexuality will be given (ask after if any response from participant)*

3. How is it for you to talk about the topic of older people and sexuality in the workplace and what do you feel has prepared you for your role in this context?

4. What do you think are some of the barriers to sexuality being considered in the care home setting?

5. How do you perceive how older adult resident's sexuality is discussed within staff teams?

6. How do you see issues relevant to LGBTQ+ older adults being addressed in the care home setting?

7. How do you consider the rights, including consent, confidentiality and privacy of your residents in terms of being able to express their sexuality?

8. What do you feel is necessary in terms of training and support for staff working in care homes to best support residents in the context of sexuality?

9. How has the COVID-19 pandemic impacted care homes, in terms of residents' expression of their sexuality?

10. Lastly, is there anything else about the topic you feel we haven't covered yet but you feel is important?

Definition of sexuality –

Version Number: 1

Date of this version: 29/01/2021

Principal Investigator: Dr Sarah Butchard
butchard@liverpool.ac.uk **Lead Investigator:** Frances Chaisty
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Topic Guide

Interview questions

1. How long have you been working in the care home sector and what type of training have you received?

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3. How is it for you to talk about the topic of older people and sexuality in the workplace and what do you feel has prepared you for your role in this context?

4. What do you think are some of the barriers to sexuality being considered in the care home setting?

5. How do you perceive how older adult resident's sexuality is discussed within staff teams?

6. How do you see issues relevant to LGBTQ+ older adults being addressed in the care home setting?

7. How do you consider the rights, including consent, confidentiality and privacy of your residents in terms of being able to express their sexuality?

8. How much control do you feel you have in your role to influence how sexuality is discussed?

9. What do you feel is necessary in terms of training and support for staff working in care homes to best support residents in the context of sexuality?

10. Lastly, is there anything else about the topic you feel we haven't covered yet but you feel is important?

Definition of sexuality –

Appendix O – Reflexive statements

Prior to starting research:

I am a 28 year old, white, heterosexual, female. I am currently working as a Trainee Clinical Psychologist and prior to gaining a place on DClinPsy training, I worked as a support worker in a residential setting for individuals with learning disabilities. Additionally I worked for many years as an Assistant Psychologist. During this time, I worked in an older adult mental health service, predominately within a day hospital setting. Following this, I spent many years working in neurorehabilitation settings; both a long-term rehabilitation unit and an inpatient ward.

The first time I encountered formal training within the workplace was upon starting my role as a support worker. This training was incredibly thorough and informative, however I was struck by some topics receiving extensive focus whilst others were not mentioned. Some years later, I worked as part of a multi-disciplinary team with older adults experiencing mental health difficulties and/or dementia. During this time, I noticed differences amongst staff in their approach with this population. A particular moment that stood out was whilst conducting a joint session with an older man and a member staff involved in his care. The session was focusing on values and identifying the man's personal values. This involved going through a set list and discussing each and their relevance for him. The value of 'sexuality' was skipped by both patient and staff member, without comment. At the time I felt silenced myself in this situation about whether to point out the obvious oversight. This experience fascinated me and made me question why for both the older adult patient and staff member, who had been working together for many months, discussing the value of sexuality had clearly not felt

possible. Experiences such as these led me to wanting to investigate such interactions through research.

It is important for me to consider how my personal reactions about how sexuality is discussed in workplace settings may influence the way the results are interpreted and themes constructed. This includes an awareness that as a Trainee Clinical Psychologist part of my training involves learning how to ask 'difficult' questions and this is a rare opportunity to have. It is therefore important to recognise and consider that others will hold different perspectives and have different experiences than my own on the topic and remain open to this when analysing the data.

Extracts of reflective diary during research process:

After interview 1.

Multiple references to sexual behaviours and the impact of dementia for many individuals living in the care home. References to types of practice in care home, including terminology often used in training settings. In further interviews be mindful of whether participants feel like they might be being tested and how to ensure it's clear that this is not the case … interview was shorter than I had anticipated. Going forward, consider given longer pauses for answers to be given and offer more carefully considered prompts …

After interview 7.

This interview was with a manager, and there were differences in how some of the discussion points were talked about. Reference was made to the importance of

individuals at management level prioritising the topic of sexuality and how this informs staff and organisational culture. Important to consider this when thinking about clinical implications.

After presenting early findings to an audience

Today I presented an update on my research project in one of my university research group session. I noticed how, compared to the first time I presented the project two years, I was significantly less nervous. I felt able to talk about sexuality and some of my findings without feeling self-conscious or hesitant talking about a 'taboo' topic. On reflection I can see how having spent so much time talking about sexuality, I no longer have some of the worries or sense of embarrassment I initially did. I wonder whether this is mirrored in some of staff's experiences? If the care home environment is one where sexuality is discussed regularly then over time it might feel less of a difficult subject to talk openly about and become more normalised?

Appendix P – Representation of line by line data coding

Transcript	Code
Interviewer: what do you feel has prepared you in your job role to address issues, regarding the sexuality of your residents?	
Participant: Experience.	
Interviewer: Ok, yeah	Experience over everything
Participant: 100%. Yes.	
Interviewer: Ok, can you tell me a little bit more about that?	
Participant: Erm, (sigh) obviously, erm, because I've worked in care for so, so long, for so, so many years, erm, you know, I worked on the [setting] when I first started out… So, and I've come in, you know, this sort of situation, you know, with elderly people, erm, with sexual tendencies, so many times, you know, you could be looking at thousands, so, you, you deal with something, every single day, you know, it becomes normal, and you become experienced and learning, how to deal with the situation better. Erm, you know whereas, you know, if it's your first time, of seeing something, sometimes it can be a shock, you know, I mean you can have young girls in care now, as young as 18, they may not have seen a man's genitals before. You know and then suddenly, you know, to come into contact with somebody, who is, sexual exposing themselves, can be a shock. You know, nothing shocks me, because I've probably seen it all.	Experience over everything The unexpected Younger staff Sexual behaviour The unexpected Experience over everything
Interviewer: Mm, mm.	