Using research to identify why nurses do not meet established sexuality nursing care standards*

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Article:

ALTHOUGH A main objective of quality assurance (QA) activities is to improve the nursing care given to patients. many QA activities focus on uncovering deficiencies rather than on developing strategies to assist nurses in meeting quality patient care standards. Intervention strategies may be quickly and poorly planned and often result in no improvement or only a temporary rise in monitoring scores. This article will examine a recurrent nursing QA problem experienced at the University of Kentucky Hospital and the research activities taken to discover the underlying reasons for failure to meet the department's care standards in the area of sexuality. The results of this research then served as the basis for developing a comprehensive intervention plan to change the practice of nurses within the institution.

The philosophical framework of the department of nursing at the University of Kentucky Hospital is based on the concept that all people have the same eight basic human needs: oxygenation, nutrition. elimination, activity and rest, security, communication and sensation, sexuality, and self-esteem. All assessment. planning. documentation, and evaluation tools cover these eight basic human needs, with specific standards of care established to meet each one of these needs, including sexuality. The overall objective for the sexuality standard states: Each patient is assisted to cope effectively with interferences in his or her body image, role and sexual behavior."[1] A series of 24 individual standards has been adopted by the department as components of the overall sexuality objective. This format is similar to standards that have been established by professional nursing organizations. In 1974, the division of medical-surgical nursing of the American Nurses' Association (ANA) included sexuality as one of the areas warranting nursing assessment of function and status.[2] The standards of the Nurses Association of the American College of Obstetricians and Gynecologists (NAACOG) include reference to health teaching about changes in sexual function in prenatal and postnatal patients and their families.[3] The standards for oncology nurses set jointly by the Oncology Nursing Society (ONS) and the ANA include sexuality criteria across five standards for data collection. nursing diagnoses, planning, intervention, and evaluation.[4] That these organizations have established nursing care standards that address the sexual concerns of patients validates the importance of ensuring that nurses meet these established standards.

The clinical monitoring tool used by the University of Kentucky to evaluate the nursing process, the concurrent audit. reports scores for each of the basic human needs. Since 1985, scores for the human need "sexuality" have consistently fallen below the standard minimum score of 85% set for each basic human need in all nursing divisions (Table 1). Members of the concurrent audit committee at first assumed that nurses simply needed to be educated in the importance of addressing sexuality with patients. Therefore two all-day workshops plus numerous inservice sessions were presented to nurses in the hope of improving this area of nursing practice. Follow-up concurrent audits showed either

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Table 1. Concurrent audit data

Unit	No. of concurrent audits	Audits with sexuality completed	Yes	No	Not applicable	No (%)
Obstetrics (OB)	50	43	290	78	239	20
Pediatrics (Peds)	37	27	111	55	226	28
Psychiatry (Psych)	14	12	71	31	80	31
Medical-surgical (Med-Surg)	181	167	955	563	834	36
Intensive care unit (ICU)	57	53	276	224	242	42

Note: These data were collected from March 1987 to March 1988 and represent the number of concurrent audits; concurrent audits with sexuality portion completed; number of "yes," "no," and "not applicable" responses; and mean percent "no" responses [No/(Yes+No)] on the sexuality portion for each nursing unit.

little or no improvement. The nursing history form was changed several times in an effort to better guide nurses in interviewing patients on admission. This also had no noticeable effect on scores.

By 1987, the concurrent audit committee was frustrated at its failure to correct the continuing problem in the area of sexuality. The committee decided to turn the problem over to the central nursing research committee to discover the reason for the low scores in sexuality. Various committee members and a clinical nurse specialist developed the research design that was implemented in late spring 1988. The purpose of the research study was to identify why nurses at the University of Kentucky Hospital do not address their patients' sexual concerns.

OVERVIEW OF THE LITERATURE

Previous research and published material in the areas of sexuality provide dues as to Individual variables that may prevent nurses from addressing sexual concerns of patients. Nurses may not perceive sexuality as a basic human need and, therefore, may either not include it in their definition of holistic nursing care[5] or consider it a part of their role as a nurse.[6] Others may perceive that most sexual problems are too complex to be within the realm of nursing practice. However Woods states that intervention in identified sexual problems does fall within the scope of nursing practice.[6] Nurses may consciously or unconsciously be perpetuating myths and stereotypes concerning sexuality. Poorman summarizes several myths that nurses may hold about sexual issues.[5] These include that the elderly are not sexually active, homosexuality is abnormal. masturbation is harmful, and variations in sexual practices are not healthy. In addition, nurses may think that hospitalized patients have either little or no sexual concerns, or that hospitalization itself does not affect a person's sexuality.[7] Nurses also may deny that patients in nursing homes have sexual concerns or want to be sexually active.[8] Lion emphasizes that nurses need to clarify their own values about sexual issues to prevent their own feelings, attitudes, and beliefs from interfering in discussions of sexual concerns with patients.[9]

Woods,[6] Lion,[9] and Hogan[7] have addressed the sexual problems that occur with illness. injury, disability, birth, and aging. However, nurses may not have knowledge of the common sexual problems that occur with changes in health care status. Furthermore, Anderson states that both the patient and the nurse may be too anxious to discuss sexuality.[10] Anderson also observes that nurses may have difficulty saying words with sexual connotations such as penis, vagina, or penile-vaginal intercourse. Additionally, nurses may encounter barriers that interfere with providing sexual health care, such as lack of role models for discussing sexual concerns with patients, fear of rejection from other health care professions for addressing sexual concerns, and a lack of emphasis in the nursing basic education programs on sexuality.[10] Another barrier is that nurses may not see other nurses addressing patients' sexual concerns and feel that they cannot ask their peers for help. Finally nurses may be told by their managers or other administrators that addressing sexual concerns is either not appropriate or is a low priority.[11]

These authors then considered other possible causes of low sexuality scores. Additional contributing factors were thought to include failure to document sexual assessment and interventions, lack of time, and nurses' perceptions that patients are too ill to discuss sexual concerns.

DESIGN AND METHODOLOGY

Based on the above information a 3-part, 53-item questionnaire was developed to answer the following questions.

- Do nurses perceive that they have the skills and support to enable them to discuss patients' sexual concerns?
- Do nurses perceive sexual problems as a high priority concern of their patients?
- Given certain patient scenarios, what level of knowledge do nurses have about specific sexual problems that occur with illness, and how willing are nurses to intervene through discussion with patients in those scenarios?
- Is there a difference in results among various nursing units?

Part 1 of the questionnaire listed 13 variables that might interfere with nurses addressing sexual concerns. Each variable was presented in both a positive and negative form, and nurses were asked to rate their level of agreement with the statement on a Likert-type scale (Table 2).[12] Part 2 presented a patient scenario. different for each type of nursing unit examined, but yet containing essentially the same basic information. Nurses were asked to rank by priority five nursing interventions related to pain control, activity, elimination, sexuality, and discharge or transfer teaching (see boxed material). Part 3 presented various patient scenarios, again individualized, that contained the constant variables of a "sexual concern" using the three dimensions of sexuality identified by Woods[13] and a role of the nurse as identified by Woods[6] (Table 3). To control for variance, the patient initiated the discussion of sexual concerns in each scenario. Nurses were then asked to rank their level of knowledge and willingness to address the sexual concerns of the patient in each scenario.

Reliability of the instrument was tested for internal consistency using a coefficient alpha for sections 1 and 3, resulting in an alpha of 0.93. A five-month test/retest reliability was conducted with 24 clinical nurse managers, which computed at 0.65. Validity of the Instrument was determined by using research committee members to review content of questions and scenarios to ensure appropriateness to each nursing unit.

Table 2. Section 1: Example of instrument

Response items	Strongly disagree	Disagree	Agree	Strongly agree
I have a good understanding of my role in discussing sexual concerns with my patients	1	2	3	4
Often my own anxiety interferes with discussing sexual concerns with the patient for whom I care	1	2	3	4

Section 2: Example of Instrument

Case study

Mr. F., age 55 years, underwent a microdiskectomy for long-term back pain two days ago. He is in stable condition, and states his pain is under control with the Tylox he is taking, but wants to know how to do relaxation exercises so I can get off these pills. He tells you he has not gotten up to walk in the hall yet. He is complaining of gas, and has not had a bowel movement in two days. His wife wants to know how to take care of his incision when he goes home tomorrow. He also asks you, I need to know when I can start having sex again without hurting my back?

Interventions

- Teaching relaxation techniques for pain control.
- Ambulation in the hall three times a day to prevent mobility problems.
- Relieving gas and treating constipation.
- Discharge teaching regarding incision care.
- Discharge teaching regarding resuming sexual activity.

A total of 555 questionnaires were distributed to full and part-time registered nurses employed by the hospital 187% of all employed RNs). Nurses were asked to complete the questionnaire during the shift they received the form and to deposit it into a sealed box located on each nursing unit. A cover sheet explained the purpose of the study, the confidentiality of responses, the voluntary nature of the study, and that the return of the completed form implied consent. Of the 555 questionnaires distributed, 312 completed forms were returned, for a return rate of 56%.

Table 3. Section 3: Classification of patient scenarios

Nurse's roles	Categories of sexual concerns		
	Sexual function	Sexual self-concept	Sexual relationships
Educator	32*	No items	40
	33		41
Provider of anticipatory guidance	46	38	34
	47	39	35
Validator of normalcy	48	44	42
	49	45	43
Facilitator of a milieu conductive to sexual health	No items	No items	36
			37

*All numbers refer to the questionnaire item number.

RESULTS

The mean response for each variable identified in section 1 is illustrated in Table 4. In analyzing results, the authors ranked all responses from 1 (strongly disagree that the variable is a factor in their inability to address sexual concerns) to 4 (strongly agree that the variable is a factor). Thus for a variable to be considered a factor in determining nurses' ability to address sexuality. the mean had to be above 2.5. Most variables were not viewed as barriers by nurses on any of the nursing units. However four variables had high overall mean scores throughout the hospital: (1) 'other RNs do not discuss sex." (2) -mentality is not seen as a problem by the nurse,' (3) 'the patient too ill to discuss sex." and (4) 'discussing sexuality causes the patient anxiety.' Results varied

slightly by each nursing unit although every unit except psychiatry identified at least one of these variables as a problem area. The psychiatric nurses identified the variables "it is hard to discuss sex' and 'it causes the RN anxiety" as their two problem areas. Additionally the overall means for obstetric and psychiatric nurses had the lowest overall means for all items, indicating they had the least problem with all the variables. The means for operating room, pediatrics, intensive care units, and medical-surgical units were very similar but significantly higher than obstetrics and psychiatry. It appears obstetric and psychiatric nurses have the greatest abilities and support to address patients' sexual concerns.

Results of section 2 are illustrated in Table 5. Overall, nurses ranked 'pain management teaching" as the number one priority, with the "discussion of sexual concerns

Table 4. Results of section 1: Mean response for each topic area on section 1 of the questionnaire for each nursing unit, and marginal means

Topic area	OB	Psych	ICU	Med-Surg	OR	Peds	Item mean
Lack of management support	1.69	1.50	1.87	1.91	2.08	1.88	1.86
Unwillingness to chart	1.93	1.86	1.93	1.97	2.06	2.00	1.96
Insufficient time	2.00	2.29	1.99	2.04	2.11	2.11	2.04
RN values different from patient	2.13	2.14	2.01	2.16	2.06	2.05	2.10
Not part of role	1.99	2.36	2.09	2.26	2.42	2.20	2.18
Hard to discuss sex	1.88	2.64	2.12	2.36	1.97	2.23	2.20
Deemphasis in RN education	2.06	1.86	2.27	2.31	2.25	2.19	2.23
Causes RN anxiety	2.04	2.57	2.18	2.49	2.19	2.25	2.30
Discomfort asking peer help	2.39	2.43	2.41	2.40	2.39	2.39	2.40
Other RNs do not discuss sex	2.15	1.79	2.61	2.59	2.69	2.74	2.53
Not seen as a problem	2.19	2.29	2.71	2.41	2.42	3.29	2.55
Patient too ill	2.16	2.00	3.04	2.46	2.89	2.51	2.56
Cause patient anxiety	2.51	2.43	2.66	2.74	2.75	2.65	2.67
Unit mean	2.09	2.17	2.30	2.32	2.33	2.34	2.28

falling fourth, only preceding the intervention of -discharge or transfer teaching'. Ranking of interventions varied greatly among the individual nursing units, with sexuality ranked first among the pediatric and operating room nurses, and either third, fourth, or last among the other units. In retrospect, the difference among units was felt to be related to the way the patient scenarios were written, which were inconsistent across units, therefore perhaps influencing the decisions of the nurses. In section 3 nurses were asked to rate themselves as either knowledgeable or willing to address the sexual concerns presented in 11 patient scenarios. Once again a mean score of 2.5 was needed to indicate that nurses were not knowledgeable or not willing to address these patient-initiated concerns. Each scenario reflected a different kind of sexual concern and a different role of the nurse. Overall. nurses perceive themselves as both knowledgeable and willing, as indicated by the mean scores of 2.14 and 1.92 (Tables 6 and 7). The results seem to suggest that nurses have greater difficulty with some sexual concerns than others, and that nurses' knowledge and willingness to address sexual concerns varied among units. However, it is likely these variations in results are due to the difference in scenarios rather than actual differences in the abilities of the nurses.

To examine the significance of the results, the authors computed repeated measures of analysis of variance on the combined data for sections 1 and 3. Results indicated

- significant differences between nursing units $F(5.306) = 12.49$. ($p < .001$);
- significant differences between questionnaire items $F(34, 10404) = 25.98$, ($p < .001$);
- and significant units by items interaction $F(170, 10404) = 10.26$. ($p < .001$).

Testing for significance on section 2 was not done.

SUMMARY OF FINDINGS

The questionnaire results provided the research and concurrent audit committees the following insights into the low sexuality quality monitoring scores.

- The nurses perceived patients as too ill and too anxious to discuss sexual concerns.
- If patients initiated the discussion, the

Table 5. Results of section 2: Mean rank for each nursing intervention in section 2 of the questionnaire for each nursing unit

Intervention	Psych	Peds	OB	ICU	OR	Med–Surg	Item mean
Pain management teaching	1.29	2.13	2.86	1.32	2.94	2.47	2.23
Increased activity teaching	4.29	3.10	3.30	2.54	3.39	1.85	2.54
Maintaining elimination	4.29	3.13	3.20	2.96	2.44	2.29	2.74
Discussing sexual concerns	3.00	2.00	3.42	4.04	2.11	4.31	3.66
Discharge (transfer) teaching	2.14	4.65	2.22	4.15	4.11	4.09	3.83

Table 6. Results of section 3: Knowledge

Item	OB	Peds	ICU	Psych	Med–Surg	OR	Item mean
Facilitator/sex relationships	1.84	1.70	1.90	1.57	1.73	2.50	- 1.82
Guider/sex relationships	1.56	2.15	2.07	1.86	2.04	2.28	1.99
Validator/sex self-concept	1.54	1.63	1.52	2.00	2.66	1.33	2.00
Guider/sex self-concept	1.64	1.65	1.97	2.14	2.41	1.78	2.05
Educator/sex function/high	1.82	1.53	2.46	1.71	2.19	2.28	2.10
Validator/sex relationships	1.66	1.78	2.25	2.57	2.41	1.50	2.13
Guider/sex function	1.62	1.93	2.16	3.00	2.35	3.17	2.20
Educator/sex relationships	1.80	1.65	2.29	2.14	2.50	2.33	2.22
Educator/sex function	1.30	1.88	2.61	1.71	2.41	3.22	2.24
Validator/sex function	2.04	1.80	2.42	3.43	2.52	3.00	2.38
Guider/sex self-concept/high	1.24	1.88	2.80	2.14	2.76	3.17	2.42
Unit mean	1.64	1.78	2.02	2.21	2.36	2.41	2.14

  nurses perceived themselves as able and willing to address the problem.
- The nurses perceived the sexual concerns of patients as minor problems of low priority.
- Nurses report that they do not see other nurses addressing patients' sexual problems.

- Obstetric and psychiatric nurses reported higher levels of skill in, support for, and knowledge about interventions for patients' sexual problems than did operating room, pediatric, medical-surgical, and critical care nurses.

REVIEW OF SURVEY DATA WITH STAFF NURSES

After completion of the data analysis, the principal investigator conducted a series of programs on all the units to share the outcomes of the study with the nursing staff. The purpose was to see if the nurses agreed with the findings of the study and also to generate ideas of what they thought would be successful methods for meeting the established nursing standard of care in the area of sexuality. More than 300 nurses attended one of the 80 programs presented. Interest in the survey results was high. Basically, staff agreed that the reasons identified in the survey were valid although many felt that the expressed high levels of knowledge and willingness may have been due to the fact that all the scenarios were patient Initiated, which enabled the nurse to feel more comfortable in dealing with the situations. They also believed that the differences among units was due more to variations in the patient scenarios than to actual differences or priorities of the nurses.

Table 7. Results of section 3: Willingness

Item	OB	Peds	ICU	Psych	Med-Surg	OR	Item mean
Facilitator/sex relationships	1.60	1.68	1.71	2.22	1.87	1.59	1.71
Guider/sex relationships	1.54	1.75	1.86	1.89	1.83	1.75	1.74
Guider/sex self-concept	1.50	1.53	2.00	1.56	1.90	1.99	1.81
Validator/sex self-concept	1.50	1.60	2.00	1.28	1.49	2.39	1.88
Educator/sex function	1.20	2.45	1.43	2.28	2.03	1.86	1.88
Educator/sex function/high	1.52	1.63	1.71	1.89	2.32	1.96	1.92
Educator/sex relationships	1.66	1.95	1.71	1.83	1.96	2.12	1.96
Validator/sex relationships	1.68	1.78	2.43	1.33	2.04	2.22	1.99
Guider/sex function	1.64	2.18	2.29	2.50	1.91	2.02	1.99
Guider/sex self-concept/high	1.30	1.68	1.71	2.72	2.35	2.45	2.14
Validator/sex function	1.86	1.78	2.71	2.33	2.30	2.25	2.15
Unit mean	1.55	1.82	1.96	1.99	2.00	2.07	1.92

Collectively, the nurses felt that they needed written resources specific to their patient populations so that they could use the material in talking with patients about sexual concerns. These resources could be easily and efficiently incorporated into their usual routines of care and might assist nurses in initiating discussions with patients about sexual concerns. They also identified a need for role model; that might help them overcome their own anxieties and negative peer pressure in talking to patients about their sexual concerns.

In addition, the investigators saw the need to inform nurses of the finding of studies, which have consistently shown that their types of patients do have significant sexual concerns and that these patients want nurses and physicians to initiate discussions on sexual matters even though it may cause anxiety.[14-17]

PLANS FOR AN INTERVENTION STUDY

Planning is now underway for an intervention study to see if quality monitoring scores can be improved by focusing on the reasons that nurses have identified as barriers to providing appropriate nursing care in the area of sexuality. Two surgical nursing units will be compared to see if a variety of intervention strategies will have more effect on quality monitoring scores than simply providing nurses with written resource materials alone. Additional strategies will include (1) role modeling. (2) teaching strategies to reduce patient anxiety, and (3) education regarding the importance that patients attach to sexual issues. Future clinical monitoring will serve as the basis for comparison before and after the interventions are implemented.

The results of nursing research can be used to identify the underlying reasons why nursing care does not meet the standards of care set by an institution. In this case, quality monitoring scores had consistently shown deficiencies in meeting the standard for the basic human need of sexuality. Traditional education strategies had failed to improve monitoring scores. By using a sur vey, nurses identified the most significant variables that interfered with their appropriate assessment and interventions of patients' sexual concerns. The information was used to design intervention strategies that will be applied in a research model to improve the standard of nursing care in the area of sexuality. This approach links QA activities and nursing research in a positive and effective relationship that can serve to enhance nursing practice.

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