

Let's Talk About Sex! - Improving sexual health for patients in stroke rehabilitation

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Abstract

Sexual health contributes greatly to quality of life. Research shows that stroke survivors want to learn and talk about sexual health, but are not given information. In keeping with the Canadian Best Practice Recommendations for Stroke Care, this project aimed to provide all stroke rehabilitation inpatients with the opportunity to discuss sexual health concerns with healthcare providers at West Park Healthcare Centre, a rehabilitation and complex continuing care centre in Toronto. Gap analysis conducted via staff member interviews and retrospective chart reviews showed that close to no patients were given the opportunity to discuss sexual health concerns at baseline.

Plan-Do-Study-Act (PDSA) methodology was used as the project framework. The changes implemented included a reminder system, standardization of care processes for sexual health, patient-centred time points for the delivery of sexual health discussions, and the development of a sexual health supported conversation tool for patients with aphasia. By the end of the ten month project period and after three PDSA cycles, the percentage of patients provided with the opportunity to discuss sexual health during inpatient rehabilitation increased to 80%. This quality improvement project successfully implemented the Canadian Best Practice Recommendations for Stroke Care with respect to sexual health.

Lessons learned included the importance of early baseline data collection and advance planning for tools used in QI projects. Future projects may focus on improving the discussion of sexual health concerns during outpatient stroke rehabilitation.

Problem

Sexual health contributes greatly to a person's overall quality of life. There is a large body of evidence across cultures and stroke severities that patients after stroke want to learn and talk about sexual health, but are not receiving the information that they want from healthcare providers[1-4].

West Park Healthcare Centre is a community hospital located in Toronto, Ontario, Canada with 470 beds distributed across specialized rehabilitation, complex continuing care, and long term care. Due to a variety of barriers, stroke rehabilitation patients on unit 3EC (Neuro Rehab) were infrequently given the opportunity to discuss sexual health concerns with their healthcare providers one-on-one during their rehab stay. Potential barriers included:

1. There was no standardized point during the rehabilitation stay that sexual health concerns were discussed with patients. The onus was instead on the patient to approach a healthcare provider with their concerns, which was difficult for many reasons such as the taboo nature of sexual health and the lack of awareness among patients that they could seek help from the rehabilitation team about sexual health concerns.
2. Unlike other commonly addressed stroke rehabilitation issues like mobility or post-stroke depression, sexual health as an issue did not have clear ownership among the team members. Team members agreed that it was important, but thought that other disciplines may be addressing the issue.

Discussions about sexual health would be more likely to occur if it was clearly delineated to be the responsibility of one discipline.

Background

There are no quality improvement projects focusing on the sexual health of patients after stroke in the literature. Research studies such as Song et al.[5] demonstrated improved sexual health for patients after stroke using one-on-one counselling and the provision of information booklets. Based on the currently available evidence, the Canadian Best Practice Recommendations for Stroke Care state that patients should be given the opportunity to discuss their sexual health concerns with healthcare providers during rehabilitation [6].

Baseline measurement

Gap analysis of the unit's baseline practice during the three months before project initiation (Dec 12th, 2014) was conducted via retrospective chart reviews and staff member interviews/surveys. On average, 10-15 patients were admitted to the stroke rehabilitation program each month. The charts of the first 10 stroke patients admitted each month to the program were reviewed, and 0/30 patients were documented to have been provided with the opportunity to discuss sexual health.

Since healthcare providers may be having discussions about sexual

health but not documenting them in the charts, team members were also surveyed about the frequency that they have engaged in a conversation about sexual health with their patients/clients in the aforementioned time period. 16 out of 18 of the unit's regular physicians and allied health professionals were surveyed; two team members could not be contacted due to maternity leave and vacation. Anonymous paper surveys were distributed to the 25 regular nurses on the ward and 17 responses were obtained. Data obtained through surveys were nearly congruent with chart documentation. Only two healthcare providers reported having had a discussion with a patient regarding sexual health during the three months before project initiation.

Overall, the gap analysis demonstrated a clear difference between current practice and guideline recommendations.

Design

The aim of this QI project was that all stroke rehabilitation inpatients at West Park Healthcare Centre Unit 3EC would be given the opportunity to discuss sexual health with one of their healthcare providers by July 15th, 2015.

Stakeholder interviews were held with team members and five discharged patients. Based on the barriers that had been identified, standardization and reminders were selected as initial options for change concepts.

The occupational therapists (OTs) on the team proposed that discussions about sexual health concerns could take place during their intake assessments. They also felt that addressing sexual health was within their scope of practice. Another three potential time points had been identified via a process flow exercise, but were less optimal due to team members' existing clinical workloads, or because the time point would be too late in the rehabilitation stay for new issues to be adequately addressed.

The OTs and the author MG then suggested potential solutions to ensure that a discussion would take place as intended. The occupational therapists used a paper-based checklist to keep track of issues that they address with patients during their rehabilitation stay. Sexual health was added to this checklist as a reminder mechanism.

Furthermore, a script was created by consensus to describe what constituted a discussion about sexual health, in order to standardize the process. The script had four components:

1. Normalize the situation - ex. "Often, people after stroke have concerns about sexual functioning, intimacy, and relationships."
2. Give examples to help patients understand - ex. "For example, people might have questions like 'Is it safe for me to go back to intimate and sexual activities with my partner?' or concerns like 'my relationship with my partner has completely changed'."
3. Offer to listen to patients' concerns. - ex. "We want to help you because sexual health is an important part of being

healthy and having a good quality of life. Do you have any concerns right now?" If patients don't have any concerns at the time of the discussion, they will be informed that they can feel free to bring up concerns later in their rehabilitation process.

4. Inform patients of other resources that they can access to learn about sexual health after stroke.

The group felt that the proposed interventions were realistic and sustainable. There were no supply costs to the rehab program and the time commitment for discussions was not expected to be onerous.

Strategy

PDSA Cycle 1

Sexual Health was added to the occupational therapy admission checklist as a reminder (Figure 1, supplementary materials). The new checklists and the scripts were distributed to the occupational therapists on 3EC, and the float occupational therapists who occasionally cover the unit. In the first month of implementation, the most common reason for patients to not receive an opportunity to discuss their concerns was aphasia. Implementing a visual supported conversation tool for sexual health would allow patients with aphasia to also have the opportunity to discuss their sexual health concerns.

PDSA Cycle 2

After a literature search and professional communications with other stroke speech language pathologists, no suitable supported conversation tool that could be used in the QI project was identified. Thus, a working group consisting of two speech-language pathologists (SLPs), a communication disorders assistant, and a physical medicine and rehabilitation resident developed over the course of four months a visual supported conversation tool for sexual health that mirrored the standardized script. One sample page from the supported conversation tool can be viewed in the supplementary materials (Figure 2). Feedback about the tool and the optimal user of the tool was solicited from stroke rehab team members.

The team came to the consensus that SLPs would use the supported conversation tool to screen patients with aphasia about their sexual health concerns. The OTs and SLPs opted to communicate during team rounds to ensure that patients would not be missed due to the division of responsibility for sexual health screening. The percentage of patients who received the opportunity to discuss sexual health concerns continued to increase.

PDSA Cycle 3

Team members noted over the course of the project that patients were more likely to bring up sexual health concerns later in their rehabilitation stay due to greater familiarity with their healthcare providers and the anticipated transition back to the home environment. In addition, some patients were not suitable for raising

the topic of sexual health when initially admitted to rehabilitation due to the constant presence of adult children or acute medical issues. However, these patients may be more able to talk about sexual health concerns later in their rehabilitation stay. The team thus discussed again the most optimal time point for the opportunity to be offered to patients, and came to the consensus that the OTs and SLPs should choose the most opportune time based on individual patient needs such as before the first overnight leave or closer to discharge (Figure 3, supplementary materials). The percentage of patients who received the opportunity to discuss sexual health concerns continued to increase with the introduction of more patient-centred and flexible time points for sexual health discussions.

See supplementary file: ds6518.pdf - "Supplementary Materials"

Post-measurement

The percentage of patients each month documented to have received the opportunity to discuss sexual health concerns during their inpatient stroke rehabilitation stay increased over the course of the QI project (Figure 4 run chart, supplementary materials section). Two runs were observed for ten data points, which suggested that the pattern observed was not due to chance but rather reflected special cause variation[7].

Overall, the percentage of patients increased from the baseline measurement of 0% (months 1-3) to 80% by the end of the project. The project's target goal percentage of 100% was reached in month 9. No incidences of harassment or other unintended effects from the sexual health discussions had been reported by the team members.

See supplementary file: ds6420.png - "Figure 4 - Run chart, the percentage of patients who had received the opportunity to discuss sexual health concerns per month."

Lessons and limitations

The most significant factor for the project's success was the highly-energized and collaborative allied health stroke rehabilitation team. Team members problem-solved together to find effective solutions demonstrating the "wisdom of crowds". Thus, the generalizability of this project's success to other environments would depend on the local work culture and team dynamics.

The biggest challenge during this project was ensuring that patients with aphasia would also receive the same opportunities to discuss sexual health as patients without aphasia. Since no suitable supportive conversation tool already existed, the team developed our own tool. The tool was very valuable as an avenue for patients with aphasia to discuss sexual health concerns, but it was developed in a time-intensive process that delayed the progression of PDSA cycles. To help others interested in starting a similar project, our supported conversation tool in its entirety can be made available via email (see Figure 2, supplementary materials, for contact information).

Another challenge was that a relatively small number of stroke patients were admitted to the inpatient program each month. Data could not be collected more frequently than once/month, so both baseline and project data collection were lengthy processes. Overall, the lesson that we want to share with others is to not underestimate the length of time required for the development of tools needed for a QI project. In addition, baseline data collection should be started as early as possible after a project is conceptualized.

Conclusion

This project successfully implemented the Canadian Best Practice Recommendations for Stroke Care with respect to sexual health at the West Park inpatient stroke rehabilitation program. Through the use of Plan-Do-Study-Act methodology, changes implemented included a reminder system, standardization of care processes, patient-centred time points for the delivery of care, and the development of a visual supported conversation tool for patients with aphasia to engage in sexual health discussions. The changes implemented were not resource-intensive and they are likely to be sustainable. As a result of the project, most patients at West Park are now receiving the opportunity to discuss their sexual health concerns during inpatient stroke rehabilitation.

The focus of this project was the inpatient rehabilitation setting, but some patients may only bring up sexual health concerns after their discharge home. Future projects may thus aim to improve the discussion of sexual health concerns during outpatient stroke rehabilitation.

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Declaration of interests

Nothing to declare.

Acknowledgements

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Ethical approval

This project received a formal letter of exemption from the Joint Research Ethics Board(JREB) at West Park Healthcare Centre. The JREB deemed the nature of the project as quality assurance/quality improvement, as defined in Article 2.5 of the Tri-Council Policy Statement: Ethical Conduct for Research Involving Humans, 2nd edition (TCPS2).

Name: _____ Age: _____ Room: _____ Adm Date: _____ D/C Date: _____

Consent: Requested _____ Documented _____
 Equipment: Float Equip _____ Requested _____
 Initial Ax: _____ EPR: _____
 Plan of Care: _____ RA Assgn: _____
 FIM # completed: _____
 Ambulation/Aid: _____ Bed Mobility Ax: _____

Transfers Ax: Bed: _____ Chair/wc: _____
 Toilet: _____ Tub: _____

Driving: ☐ Driver ☐ License Other: _____
 Parking Permit: ☐ Has ☐ Needs

Dx & Chart Info:

Work: _____ Leisure: _____

ADLs	Current	Previous
Eating		
Grooming/Hygiene		
Bathing		
Dressing UE		
Dressing LE		
Toileting		

IADLs	Current	Previous
Meal Prep		
Laundry		
Cleaning		
Bedmaking		
Child/Elder/Pet Care		
Telephone Use		
Call Bell		
Outdoor Main.		
Shopping		
Banking/Finances		
Computer Use		
Env. Control Unit		
TV/Ent. System		
Medication Mgmt		

HOME ENVIRONMENT

Live with:

Type of Residence: House ☐ Townhouse ☐
 Apartment ☐ Other _____

Rent/Own? Rented ☐ Own ☐

of Levels: _____ Accessibility: _____

In-Stairs: _____ Railing: _____

Out Stairs: _____ Railing: _____

Bathrooms: _____

Self-Meds: Yes ☐ No ☐



Sexual health conversation had: yes ☐ no ☐

If no, why?:

Unintended Consequences:

Equipment List	Description	Own	Rent
Bathroom Devices		<input type="checkbox"/>	<input type="checkbox"/>
Bedroom Devices		<input type="checkbox"/>	<input type="checkbox"/>
Mobility Devices		<input type="checkbox"/>	<input type="checkbox"/>
Assistive Devices		<input type="checkbox"/>	<input type="checkbox"/>
Medical Equipment		<input type="checkbox"/>	<input type="checkbox"/>

Figure 1. Updated Occupational Therapy admissions checklist. A section dedicated to sexual health is included on the lower right portion of the page (see blue star).

Changes After Stroke

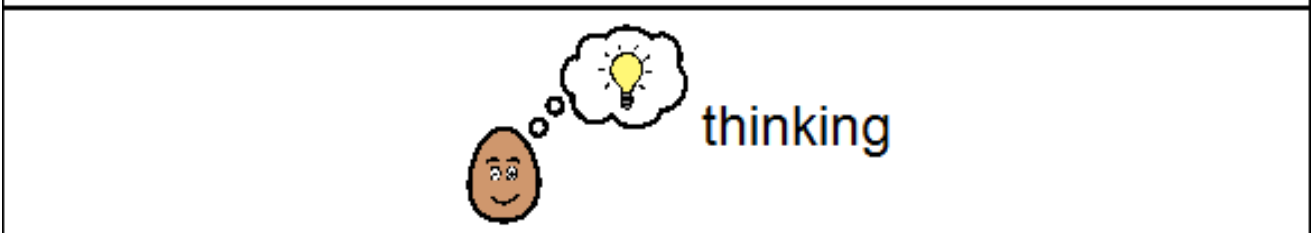
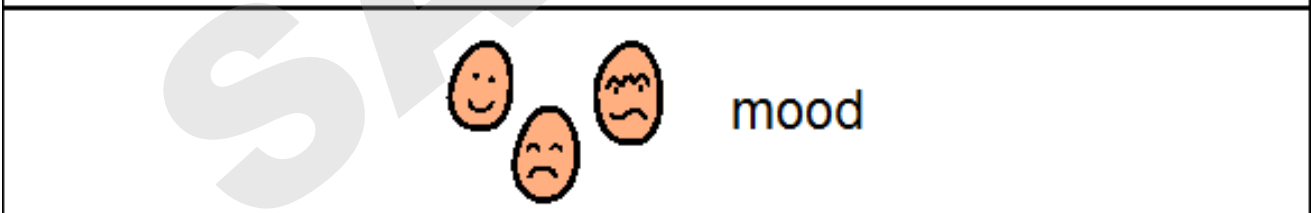
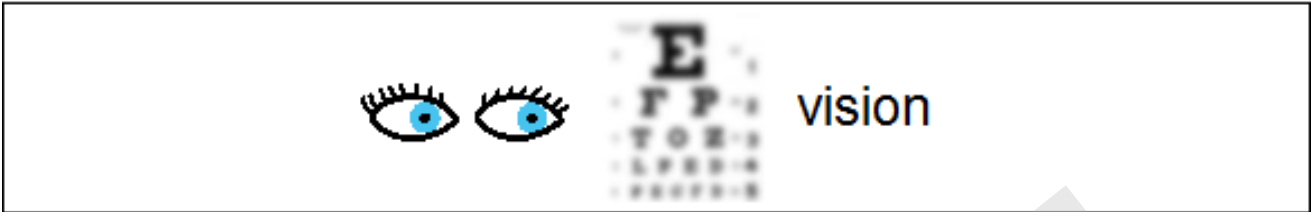


Figure 2. Sample page from the supported conversation tool. Please email Candice.Fourie@westpark.org or MeiQi.Guo@uhn.ca if you would like a copy of the supported conversation tool in its entirety for your project. The Picture Communication Symbols ©1981–2015 by Mayer-Johnson LLC a Tobii Dynavox company. All Rights Reserved Worldwide. Used with permission. Boardmaker® is a trademark of Mayer-Johnson LLC.

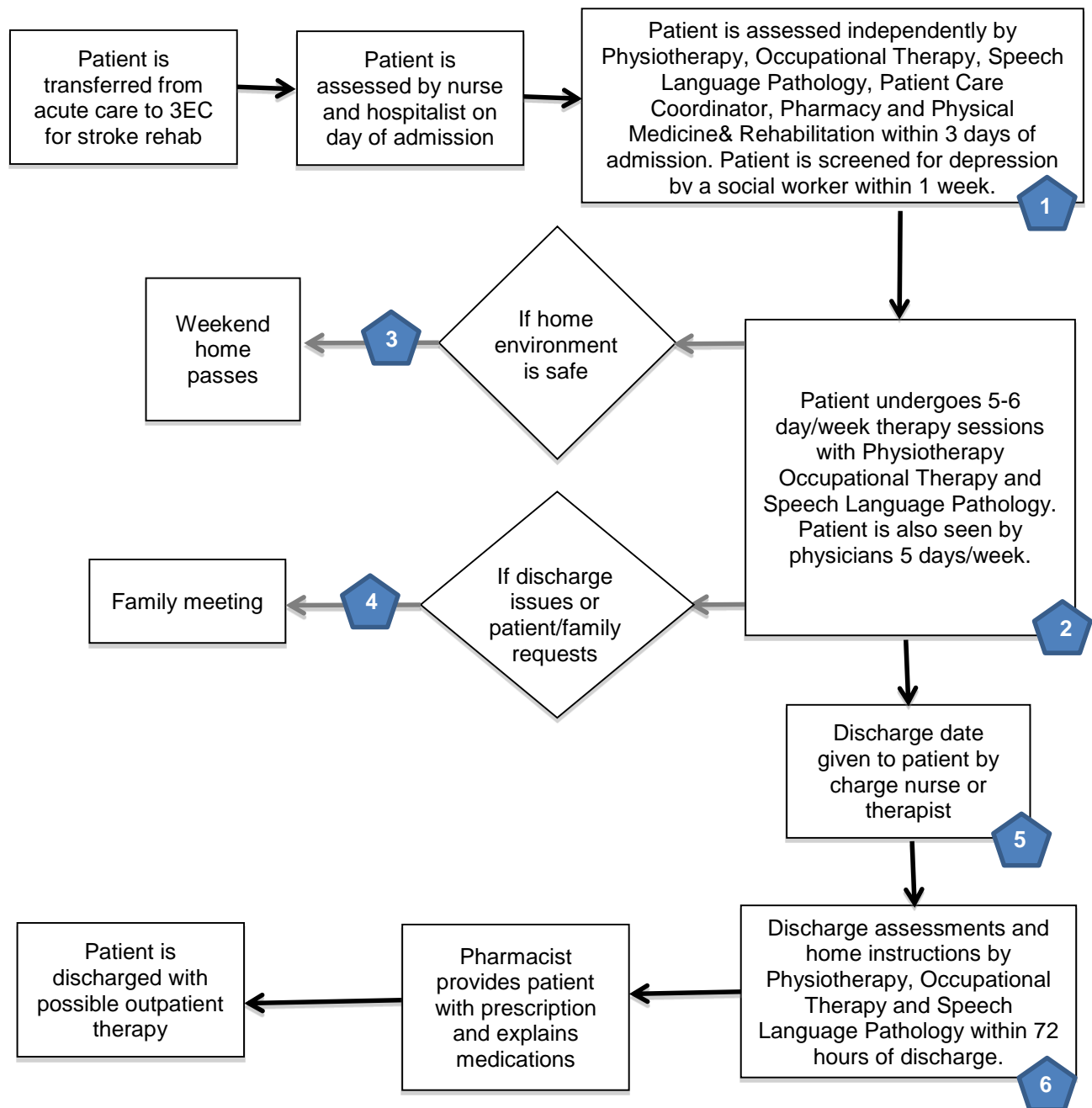


Figure 3. Potential Time Points for Sexual Health Discussion. In PDSA Cycle 3, the team came to the consensus that the OTs and SLPs should choose the most opportune time based on individual patient needs. Examples may include 1) at the admission assessment, 2) during therapy sessions, 3) before a planned home pass, 4) before a family meeting, 5) when a discharge date has been chosen and communicated to the patient and 6) during discharge assessments.