What Knowledge is Required by an Advanced Practice Nurse in the Position of a Sexual Health Clinician?

Masters Project

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Question Statement

In this project, I ask the question: What knowledge is required by an Advanced Practice Nurse in the position of a Sexual Health Clinician? With respect to the title, it is important to note that not all Sexual Health Clinicians are or will be Advanced Practice Nurses. This title and the project include an orientation curriculum for preparing the novice learner to become a Sexual Health Clinician. Specifically, the scope of this project looks at the current orientation requirements for a new, entry-level clinician working in the Sexual Health Rehabilitation Service at Vancouver Coastal Health (VCH) and makes recommendations for ongoing professional development towards an advanced level. These recommendations will assist with alleviating the tension between the practice demands of specialty areas that are expediting nurses into advanced practice roles without the required educational preparation. The orientation typically has a time frame of three to six months in length and generally is conducted on an individual basis since there are so few of these positions.

I use the words position or role interchangeably in this project to refer to the Sexual Health Clinician job. The orientation has a greater emphasis on the practical aspects of observing educational sessions or client counselling appointments as opposed to adapting theoretical knowledge and educational strategies to learn the role. Classic research over the past two decades has concluded that nurses rarely have the needed theoretical knowledge to be able to teach, counsel, or care for their patients in the area of sexuality (Grigg, 1997). The educational strategies of this demanding orientation consists of individual reading, one on one education with an experienced clinician, small group

work with other Sexual Health Clinicians and/or the Sexual Medicine Consultant, formal/informal lectures, and observations.

I have made recommendations that incorporate approaches to learning and teaching that maximize efficiencies and effectiveness of the orientation and, most importantly, results in a better prepared clinician. There is a direct correlation between nurse recruitment, retention, and adequate orientation (Meyer & Meyer, 2000). By incorporating all these aspects: practical, theoretical, and educational knowledge, I believe will sufficiently prepare the Advanced Practice Nurse to become a Sexual Health Clinician.

As a Sexual Health Clinician myself, I have the lived experience of orientation to the role when I was working at GF Strong Rehabilitation Centre, specifically in the Sexual Health Rehabilitation Service (SHRS) and the Prostate Centre at Vancouver General Hospital (VGH), both part of VCH. I believe that, in order for learning to occur, there must be meaning from experiences (Mezirow, 2000); this is why I am suggesting that experience be included in the orientation to the Sexual Health Clinician position. By exploring the meaning of experience, a nurse can have a deeper understanding of assumptions made and reflect on those for self-learning (Yorks & Sharoff, 2001). Reflective practice is a means of self-examination that involves looking back on your practice in the hopes of improving professional growth (Ruth-Sahd, 2003). For this project, I have reflected on those orientations, experiences, and gaps to see where my knowledge has come from, how I have interpreted it, and expanded on where it needs to go. The recommendations I have made have been tailored to an entry-level clinician since there is a timely, practical need to have the clinician practicing competently within the

first three months due to the waitlist of consultation requests for clients to be seen in the service.

Significance of the Topic

Hicks and Thomas (2005) state, “It is essential that appropriate training and updating of skills are provided for all staff working within the domain of sexual health” (p. 324). In addition, classic research done by Grigg (1997) offers “the appropriate preparation of educators is fundamental to how the subject is delivered” (p. 62). Sexual Health Clinicians (SHCs) work autonomously and in consultation/collaboration with other health care professionals and educational resources to achieve excellence in client-centred care, education, and research; thus, there is a significant amount of knowledge to learn for this role. Working autonomously exists in the form of counselling a client either alone or with their partner/family and recommending sexual health interventions that are individualized to the client. They manage their own caseload of clients and discharge them when they feel it is appropriate to do so, based on satisfactory client outcomes. SHCs are also consulted to assess sexual health concerns of individuals in community agencies and make recommendations. The contextual variation in their role from working autonomously to consultation/collaboration with others supports an in-depth, comprehensive orientation with the required specialized knowledge needed in order to practice in the role of an SHC.

Chapter 1: Considerations to Orientation

In this chapter, I offer some considerations to orientation that may already be in existence as in the case of ethical considerations and values clarification to be expanded upon coupled with some new suggestions (for example, novice to expert and discourses) or learning activities to explore. I propose Jean Watson's Caring Theory (as cited in Cara, 2003; Ryan, 2005) as the theoretical knowledge needed and the concept of embodiment in health, illness, and healing for inclusion in orientation.

To commence orientation, I think it is important to start at the beginning by sharing the history and future vision of the role within the SHRS department, the VCH organization, and nationally across Canada. This would provide the strategic direction of the specialty at a local and national level, creating the big picture and reasons why the role is structured and implemented as it is. Health care professionals continually hear how health care is called upon to be more efficient and fiscally responsible with its resources, and providing this context to the role contributes to the department's and organization's responsibilities.

The SHC position has traditionally been a nursing one. The requirements listed in the job description are that of a baccalaureate prepared nurse (BSN) with three years of nursing experience. Historically, it has been a departmental challenge to fulfill the BSN requirements, whether the job posting was internal at VCH or external (advertised publically). Of the nurses who have ever worked in the position, only two have been masters prepared. I am proposing that the role be that of an Advanced Practice Nurse when possible as observed with the current trend towards specialty areas seeking advanced nursing practice knowledge and from personally being engaged in a master's

program. To expand on this, I believe the knowledge and experience gained in a master's program with courses on nursing theory, discourses, ideology, views on health and healing, research, evaluation, and practicums in educational settings translates to this specialty area succinctly.

Advanced Practice Nurse

The definition of an Advanced Practice Nurse (APN) can be understood as "an advanced level of clinical nursing practice that maximizes the use of graduate educational preparation, in-depth nursing knowledge and expertise in meeting the health needs of individuals, families, groups, and populations" (Canadian Nurses Association, 2008a, p. 9). Gardner, Chang, and Duffield (2007) describe the APN as engaging in "nursing roles that involve higher level knowledge and skills that enable clinicians to practice with autonomy and initiate nursing actions but do not include diagnostic and treatment decision-making" (p. 383). The APN in the specialty role of a SHC can impact the clients' and families' experiences of health and, more specifically, their sexual health, by addressing sexual health needs at the individual, family, community, or health care system level.

Novice to Expert

I believe a novice clinician would better understand competency statements and levels, anticipate their learning curve, and be able to understand the progression of his or her knowledge accumulation by reading Patricia Benner's (1982) novice to expert model of skill acquisition. Even though the clinician may be a very experienced nurse, this new role would posit him or her back into a novice within this context. Benner (1982) states that "experience is not the mere passage of time or longevity; it is the refinement of

preconceived notions and theory by encountering many actual practical situations" (p. 407). This statement invites the experienced nurse who is now a novice SHC to look with a new lens at the nursing knowledge and experience he or she has come to know and challenge and integrate current understandings of the education provided: for example, conduct a general nursing assessment with a client, but with a sexual health focus throughout each of the areas for assessment.

Ethical Considerations

The Canadian Nurses Association (2008b) *Code of Ethics* states that Registered Nurses provide safe, compassionate, competent, and ethical care (p. 8). Ethical care is a concept central to nursing and means care that is based on moral nursing actions when working with human beings. Blondeau (2002) proposes, "There is a way to be and to live when one is a nurse and caring for others" (p. 255). The ethical practice of respect for human dignity is of the utmost importance when providing sexual health care. Sexual health counselling requires the intensely intimate nature of enquiry into someone's sexual life, which emphasizes the need to provide ethical care to clients.

Kalb and O'Conner-Von (2007) recommend nine learning strategies for ethics education that an SHC can incorporate: role play, online learning activities, ethics in the news, structured controversy exercises, doing the right thing, comparing codes of ethics, case studies, panel presentation by advanced practice nurses, and creating common language. I have addressed common language later in this chapter. These other eight learning strategies can be a learning activity for ethics education in the orientation of an SHC. A suggestion is that one strategy is utilized each week of the orientation with a sexual health example, and the particular strategy is facilitated in turn by each of the

experienced clinicians. For example, the experienced clinician will facilitate ethics in the news by having the novice clinician look for sexual health examples in the newspaper to discern the ethical issue and dialogue about it.

Values Clarification

An existing key element of orientating a new clinician into the role of SHC is values clarification. Sexuality and sexual health can be areas that surface and/or challenge a person's values and beliefs. This could be from the individual's culture, upbringing, life experiences, or relationships. Kalb and O'Conner-Von (2007) assert that there is a need to separate our personal values and beliefs as well as cultural and religious differences from those of our patients in this value-laden area of sexual health. Values clarification exercises are a series of questions or statements about sexuality or sexual practices that a person answers. These should be done with the novice clinician prior to him or her addressing the area of sexuality and sexual health with any clients and should be an ongoing activity during the care of clients.

It is extremely important to remain value neutral while in this role, thus ensuring impartiality in all interactions, since personal values and beliefs may differ from those of clients and peers. As a learning activity, commonly held sexual myths/prejudices or discourses could be explored as part of values clarification. The experienced clinicians can share some of the myths/prejudices or discourses they have encountered, and the new SHC can share those from his or her experience. The essential perspectives to explore these myths/prejudices or discourses would be both personally to see what one thinks about these statements and then professionally for the responses one might give if they

were present for these statements from other individuals, including from clients themselves. Some example statements I have heard as part of my clinical work are:

1. Sex is for young people.
2. Sex is for able-bodied people only.
3. The majority of sexual activity for homosexual men is anal sex.
4. Postmenopausal women don't want to be sexual anymore.
5. If you talk about sex with an adolescent, they will become sexually active.

Discourses

When it comes to the topic of sexuality, it has been my experience that societal discourses are highly present in the practice setting. Discourses are used here to mean unchallenged or unexamined assumptions that have been generalized or stereotyped to the particular example. Another way in which to describe discourses are the statements one hears or are stated as fact and our views on that particular subject—also referred to as myths/prejudices above. Connell and Hunt (2006) add, "Most if not all discourses contain, explicitly or implicitly, some indication about the closely associated ideas about what is normal and a normative judgment that endorses that normality" (p. 24).

Discourses often appear as verbal statements (as the examples listed under "Values Clarification") or visual portrayals in society, such as advertisements or television shows showing only young, beautiful people being sexual. Taking one of my examples, "Sex is for able-bodied people only", if I were to believe this, then I am essentially saying that I do not believe that persons with a disability have any right to be engaging in sexual relations. This belief could impact on the care I give my client by not listening to his or her sexual concerns or not offering any suggestions to help with those

concerns. I would, therefore, not be fulfilling my role as an APN nor my ethical responsibilities to my client.

It is hoped that the SHC would be in a position to develop his or her own thoughts and challenge or disrupt these unexamined assumptions in a respectful manner accordingly. This potentially may not be a simple undertaking for the novice clinician because of the inexperience in addressing these discourses or with exposure to sexual health knowledge that comes with working in the role. A learning strategy to assist with assuming a level of comfort when addressing these discourses is role-playing between the novice and experienced clinician to increase the level of comfort with learning how to respond. For example, a role play could situate a nursing student in a practicum who has come by to see the SHC to learn more about the services they provide. In the midst of conversation, the student asks the SHC why she sees clients with a disability, stating, "They can't have sex anymore so why do you see them for counselling?"

Confidentiality and Trust

As an employee of VCH, you sign a confidentiality agreement to not disclose any information obtained while an employee, but understanding the significance of confidentiality in sexual health extends far beyond signing a piece of paper. I state this because of my experience of being told many extremely personal utterances over the years that would have had devastating consequences if I did not hold confidentiality in high regard or did not completely understand the ramifications of breaking confidentiality. This is verbally by what I have said to others and in what I have written in the client's health record, my own consultation notes, or on consult letters back to the

referring source. Once the assurance of confidentiality has been established between the clinician and the client, trust in the therapeutic relationship can be fostered.

As an SHC, there is not a great deal of time for the establishment of trust: one hour of time for a consultation or for subsequent follow-up visits. The building of trust is of great significance in therapeutic relationships. It allows for the relationship to continue and seemingly for more communication to occur at the appointments. Typically, when there is trust, there is an open exchange of feelings and ideas. In some cases; it took a great deal of inner strength to get the client to the appointment to see you in the first place. That is why it is ever so important to make a client as comfortable as possible as his or her medical, relationship, social, and sexual history are being asked of him or her all while in a medical setting; this assists with building trust. A patient's willingness to trust may reflect experiences of past trust relationships; perception of the trustworthiness of a nurse will depend on how the nurse meets the patient's criteria to judge the trustworthiness of others (Sellman, 2007).

A simple statement I have used in the past to help build rapport and trust, increase the client's comfort, and demonstrate understanding is: "Did you sleep last night knowing you had this appointment today?" I believe this statement acknowledges how the client may be feeling and is based on the nursing theoretical perspective of Jean Watson that lists the development of a helping-trust relationship as one of the ten carative factors (Ryan, 2005).

Jean Watson's Caring Theory

Currently, there is not a disciplinary theoretical focus in the orientation of an SHC. I propose that by reading and learning about Jean Watson's caring theory (as cited

in Cara, 2003; Ryan, 2005) and having discussions with the current SHCs on how it could be included into the orientation curriculum and in the SHRS is a start. Having been exposed to various nursing theorists and their work at the beginning of the master's program, I believed that Watson's theory supported my work with clients and their family members with her philosophy that provides nurses with a way of being in their interactions with clients. One of the characteristics of an APN is that they understand, interpret, and apply nursing theory to meet the health needs of all (Canadian Nurses Association, 2008a).

Nursing theory can inform and guide nurses as to how to be with clients; this can help make the SHC feel confident and comfortable while assimilating the role. From this standpoint, SHCs could be ambassadors by spreading the message of nursing theory when they are facilitating education, as in sexual health workshops to other health care professionals. Envisioning beyond SHCs, if more nurses embraced nursing theory and what it means to see the whole client, perhaps more would feel comfortable addressing a client's sexual health concerns as part of holistic health care. Many nurses are uncomfortable when the topic of sexuality is raised (Ekland & McBride, 1997).

Cara (2003) states, "In fact, Watson is one of the few nursing theorists who consider not only the cared-for but also the caregiver" (p. 51). I think because of the intimate nature of enquiry in a client's personal aspect of self (sexuality) and the nature of the therapeutic relationship between client and caregiver (SHC) that Watson's theory captures that therapeutic relationship. Felgen (2004) offers "initiating and sustaining a therapeutic relationship with patients and their families is central to caring and healing environments" (p. 288). Caring theory describes this relationship as the transpersonal

caring relationship. Transpersonal is detailed as moving beyond one's ego, allowing deeper spiritual connections for the promotion of the client's healing and comfort, with the goal of enhancing and preserving the person's humanity, dignity, inner harmony, and wholeness (Cara, 2003).

Watson (as cited in Cara, 2003) highlights "the nurse goes beyond an objective assessment, showing concerns toward the person's subjective and deeper meaning regarding their own health care situation. The nurse's caring consciousness becomes essential for the connection and understanding of the other person's perspective" (p. 53). An environment of care significantly affects the way care is given. It influences how patients react and heal (Felgen, 2004). This is where the SHC can conduct a sexual health assessment in the course of the client appointment and use that information to better understand how the sexual concern is affecting the client physically, emotionally, and spiritually within the context of his or her life.

In my context, I refer to this as their personal environment. It can range from job satisfaction, relationship satisfaction, living arrangements, children, leisure, weight, smoking, upbringing, intimacy, abuse, monetary issues, stress, privacy, fatigue, family and friends, age, medications, life expectations, and sexual history. Knowing your client in his or her personal environment and/or context is part of the counselling towards sexual rehabilitation. By creating a healing environment at all levels, this provides an example of Watson's theory. I invite the new SHC to explore Jean Watson's theory (as cited in Cara, 2003; Ryan, 2005) in more depth or find a theory that compliments or guides his or her practice with the hope that the knowledge gained may assist with the assimilation of becoming an SHC.

Health, Illness, and Healing

When working with clients, I believe it will help the entry-level SHC to consider the concept of embodiment, which encompasses the body. Wilde (1999) defines embodiment as "a different way of thinking about and knowing human beings, one that is in contrast to our usual Western thinking of mind and body as separate (dualism)" (p. 25). The notion of embodiment is that a person is more than their body parts; they are whole, with influences of their culture, family, lived experiences, discourses, and ideologies (Griffin, 2008).

Holistic health views human beings as having three integrated systems: mind, body, and spirit with peace and harmony between all three (Duldt & Pokorny, 1999). Considering the mind, body, and spirit of a person will contribute to his or her embodiment. As Wilde (1999) states, "An assumption of embodiment is that all parts of the body are integral to the human being; no part can be separated from the rest or objectified" (p. 26). Not seeing the whole person may result in disembodiment. This occurs, according to McDonald and McIntyre (2001), "through the objectification of bodies in medical or technical discourse" (p. 237).

The body is a physical form of a person. There are many considerations that have shaped our views of the body to date. Bodies are configured by historical and cultural representations of thought and action (Parker, 1997). In addition, societal and religious views contribute to our present understandings of the body. Being a nurse means we work with bodies; having an understanding of bodies in time and context lends itself to our practice settings of today. Parker highlights this by stating, "Nurses' work closely with other people's bodies and the body is therefore a central concern in nursing practice"

(p. 11). Further, McDonald and McIntyre (2001) offer that being present with patients in their lived embodied experiences and the meanings they hold, is central to nursing practice. McDonald and McIntyre reinforce this notion by stating, “The nurse herself, in her body, is the primary and essential instrument of her practice” (p. 234). These ways of thinking about the body may assist the SHC to practice holistically: seeing the body as being comprised of both body and mind regardless of this specialty area of practice.

Chapter 2: Orientation Curriculum

Orientation curriculum identifies what educational and experiential components augment learning of the current sexual health orientation. This will ensure that the clinician is deemed by his or her peers to be practice ready in a full Sexual Health Clinician capacity.

Sexual Health Assessment

The Sexual Health Assessment Framework (SHAF) is a tool most commonly used by the SHC for assessment of sexual concerns in order to know the best practice for working with the client. The accuracy of the assessment data could have implications for the client's life, thus an in-depth understanding of the SHAF is essential. I have listed the main components of the framework that the new clinician can define to increase understanding on how the client can be holistically viewed: (a) sexual orientation; (b) sexual response; (c) sexual self-image, including gender identity and expression; (d) sexual interest/desire; (e) sexual activities; (f) sexual behaviour; (g) sexual knowledge; (h) fertility/contraception/safer sex; (i) hygiene, bowel, and bladder issues; and (j) medications affecting or assisting with sexual function (Stevenson & Elliott, 2009, p. 6).

Seven key questions can be used to guide the conversation with the client to complete the SHAF. As a learning activity, I would suggest written case studies that have clients` expressing sexual concerns for the clinician to practice using the framework and the seven key questions. The seven key questions to be used with the SHAF that are the basis for assessment enquiry of sexual concerns when interviewing individuals with or without their partners are:

1. What are the sexual concerns in their own words?
2. What is the duration and onset (need to discern if the concern is lifelong or acquired and generalized or situational) of the sexual concerns?
3. What is the context of the sexual concerns?
4. What is sexual response like (arousal, plateau, orgasm, resolution)?
5. What is the reaction to the concerns?
6. Has there been any previous treatment?
7. What is the motivation to work on the sexual concerns?

Pathophysiology of Sexual Response, Disability, and Chronic Illness

Sexual health can be influenced by disability and chronic illness. In order to seek treatment in the SHRS, the client needs to have a sexual concern from a diagnosed physical, neurophysiological disability, or chronic illness. This means that the clinician needs to have a broad scope of knowledge of some of the more major illnesses, diseases, or conditions and some symptoms with respect to their potential impact on sexual health. The list provided in Table 1 comprise some illnesses, diseases, conditions, and symptoms more commonly seen; not all render a person with a physical or neurophysiological disability, but may be co-morbidities. This list is meant to serve as a learning activity with the new clinician providing a definition and listing the potential impact on sexual health.

Table 1. *Illnesses, Diseases, Conditions, and Symptoms that may Impact Sexual Health*

Illnesses, Diseases, Conditions, and Symptoms	
Amputation	Parkinson's Disease
Anxiety	Pelvic Trauma
Arthritis	Personality Disorders
Cancers	Prostate
Cardiovascular Disease	Psychotic Disorders
Depression	Renal Disease
Diabetes	Spina Bifida (congenital disabilities)
Endocrine Disorders	Spinal Cord Injury
Fatigue	Stress
Neurological Disorders (MS)	Substance Abuse
Pain	Traumatic Brain Injury

Sexual Changes

Sex is part of a full and healthy life. Kotronoulas, Papadopoulou, and Patiraki (2009) remind us that "every human being has a sexual dimension; even patients with advanced cancer or terminal care persons preserve their fundamental need for human intimacy" (p. 497). However, changes to sexual function are common and can be very distressing. These changes may be medically referred to as sexual dysfunctions or sexual disorders and can occur from a variety of sources; they may signal other illnesses or may be a medication side effect. The concept sexual dysfunction may be defined as a discontent or dissatisfaction with any emotional, physical, or relational aspect of sexuality (Traeen & Olsen, 2007).

In addition to pathophysiology of sexual response, it is essential that the SHC have some knowledge of potential changes to sexual functioning in order to refer on if the client's presenting concern is beyond the clinician's abilities/scope of practice. This is not to say that the clinician will be able to make a diagnosis; rather they may recognize some of the signs and symptoms that may be present.

Guiding Principles of Practice

The guiding principles of practice in the SHRS include the three pillars of sexual health care, which are emotional support, tangible support, and educational support. Emotional support examines the effects of the client's illness or injury on their experience of sexuality. Tangible support suggests which medical interventions or common therapies will facilitate sexual expressions, functioning, or managing sexual concerns. Educational support provides the client with sexual health knowledge regarding their sexual concern.

Emotional Support

Emotional support by way of counselling is a nursing/sexual health intervention in the treatment of sexual concerns. Therefore, knowledge and comfort with the principles and techniques of counselling with individuals and/or their partners is critical to understanding the role. The novice clinician will need education on how to counsel and on communication skills that could come from courses, readings, observations, role-plays, tape recording, or videotaping of mock interviews. Thornby (2006) states, "Once it is accepted that being competent in skilled communication is essential to excellent patient care, it then takes skill development and added courage to hold crucial conversations and address difficult situations" (p. 268).

This statement reinforces that strong, effective communications skills are an asset, as this is the tool that SHCs use with their clients for all interactions. A new clinician learning to communicate with and respond to clients about their sexual concerns may want to start with the following statement and two simple questions that I use in communication with clients:

> Many men/women have concerns or questions about the sexual aspect of their lives.
>
> 1. Have you thought about this at all?
>
> 2. Would you like talk about it?

When providing emotional support, some guiding principles need to be considered first. Unique to the SHRS is the key principle of "client readiness"; the main consideration here is that the client's readiness to talk about their sexual concern is based on when the client is ready to and not when the clinician thinks it is time. Readiness refers to asking the questions, hearing the answers, or exploring the sexual options (Breen & Rines, 1996). For example, an indication of readiness is often expressed in how the client seeks answers to sexual problems: (a) directly as a presenting concern, question, or statement; (b) indirectly with hints of a sexual nature; or (c) routine enquiry. Other guiding principles are:

1. Ask permission prior to exploring the sexual area with your client.
2. Ensure a private setting where you have time to explain all options.
3. Use neutral, sensitive language that the client can understand.
4. Obtain a full health and sexual health history.
5. Move from general to specific questions.

6. Allow response time.
7. Listen with empathy.
8. Normalize and validate concerns.
9. Use open-ended questions, such as “Can you tell me more about your concern?”
10. Clarify understanding.

Whether communicating with a client, colleague, or other health care professional, it is important to have an awareness of the language being used. The language must remain neutral, sensitive, and thoughtful to foster the therapeutic relationship with the client.

For example, words like partner, as opposed to wife or husband, avoid assumptions of sexual orientation. Performance-oriented words should be avoided for the same reasoning, with an example of that type of word being “achieve.”

There are some common phrases that guide the SHC’s interactions with the client that help to elicit sexual concerns when articulation is difficult. These phrases are particularly helpful to the novice clinician as he or she begins to develop his or her own comfort level with the language to be used. Some examples are:

1. Many people have this concern.
2. I can appreciate how difficult it must be to discuss such a private and intimate area of your life.
3. Do I understand your concern correctly?
4. When you say (slang term) are you meaning your (medical terminology for anatomy)?

5. Can you tell me more about your experience with…?
6. That must be difficult for you and your partner.

A learning activity for this section that I have found helpful to increase my comfort is to practice saying these words and phrases in front of a mirror to see if they fit with the clinician's personality. If they do not, I would suggest the creation of a list of similar terms and practice saying them out loud and later in client interactions.

In my interactions with clients, I have experienced many clichés, slang, vulgar, and personal terms used to describe their sexual concern or parts of their anatomy. For client teaching, it is important to rephrase the word the client used with the medically equivalent word to increase their sexual knowledge and to ensure their correct understanding of the word. For example, if the client says, "My Willy won't work," a response could be, "When you say Willy, I am thinking you are referring to your penis?"

Having some of these potential terms early in the SHC orientation would be prudent to enhance the understanding of sexual communication. A learning activity would be to write out the medical terms and self-test with the slang and vulgar terms.

Tangible Support

Tangible support is recommending medical interventions or common therapies such as medications, medical aids, or equipment that will assist with sexual activity or expression. For any of the common therapies, the SHC should know the current cost, dosage, precautions, and where to obtain each of these options as that is part of the client support that he or she would provide. The partner should also be encouraged to be involved in the decision-making process.

Educational Support

Educational support is a nursing/sexual health intervention in the treatment of sexual concerns. When teaching a client to use any of the medical interventions or common therapies, the SHC should demonstrate the chosen therapy for the client and clarify understanding with a return demonstration from the client. This provides a timely opportunity for feedback. In cases of sexual health equipment recommendations, it is important to use the same equipment in the demonstration that the client will be using at home.

After teaching, spend time exploring how the client will incorporate the therapy into their intimate life. To help increase the client's comfort, encourage the client to practice the therapy on their own prior to using it in a partner situation. Provide written resources or use media such as videos or DVDs when possible to reinforce the teaching if the client is a visual learner and needs to actually see the therapy. Encourage the client to discuss the therapy with his or her partner and provide suggestions on how to do this. Once you have summarized the consult, schedule a follow-up appointment to see how the therapy is working and to provide further support and encouragement.

Sexual Health Competencies

Competencies are role outcomes, knowledge, skills, and attitudes required for role performance and then assessed by behavioural standard criteria (Axley, 2008). Bourgault and Smith (2004) state, "Multi-levelled competency statements define clear expectations for the new orientee, in addition to providing a framework for the advancement of the intermediate and experienced nurse" (p. 16). Nursing practice at VCH is moving towards the use of competencies to demonstrate nurses' safe and competent practice, knowledge

acquisition, and mastery of skills. The newly developed sexual health competencies should be utilized throughout the orientation process for the new clinician, which demonstrates the knowledge and skills needed based on sexual health and educational principles and for the evaluation of job performance (see Appendix A).

Chapter 3: Approaches to Learning and Teaching

The theoretical underpinnings of constructivism are used here for approaches to learning and teaching. Young and Maxwell (2007) state, "Constructivism holds that learning is a process of meaning making or knowledge building in which learners integrate new knowledge into a pre-existing network of understanding" (p. 9). An ideal place to start learning and teaching is with who the learner is. The new learner brings individuality, learning/teaching style, life experience, cultural background, generation, values, and beliefs to the SHC role. The experienced SHC can ask questions about the learner, such as: What are some experiences with the topic being presented? What is hoped for learning? What is the motivation for being present (this forms a relationship with the new educational content to the learner's prior knowledge)? This information can be factored into the orientation through the professional development plan discussed later in this chapter.

Hanson and Stenvig (2008) propose, "Educators must view students as unique individuals and guide the learning experiences to meet their needs" (p. 39). It is important to recognize that learners learn in different ways, thus the need to incorporate various strategies that foster a learner-centred approach; this encourages active engagement of the learners in the construction of new knowledge. The experienced clinicians in the SHRS will become the educators and mentors to the new clinician. This interaction forms the working relationship to engage them intellectually and emotionally in the content, creating that need to know. The experienced SHCs are helping the new clinician integrate knowledge to practice, create experiences, and foster him or her in becoming a knowledgeable practitioner. Brown and Hartrick Doane (2007) offer, "All learning and

all nursing practice involves an engagement with knowledge. This engagement requires the formation of a relationship to knowledge" (p. 103). This statement encourages the clinician to consistently be engaged with his or her learning.

Knowledge acquisition on the principles of adult education would also be an asset, as frequently, SHCs are requested to provide education on sexuality in the form of workshops, seminars, or paper/poster presentations at conferences to other health care professionals ranging from students to practicing professionals. This is in addition to providing education to clients, family members, and community agencies/groups. Some of the principles of adult education are that adults want to know why they should learn something, are self-directed in their learning with deciding what they want to learn, and they bring their experiences to their learning to make knowledge connections (Murrell, Russell, Hartig, & Care, 2007). Knowing your audience, the learning objectives of the session, and how best to facilitate knowledge of the topic is crucial for understanding, education, and meaningful dialogue.

Strategies

The constructivist learning and teaching strategies highlighted in this section can be utilized for the learner throughout this orientation, in peer-to-peer workshops, or with client education as appropriate.

Role play.

Comer (2005) suggests that role-playing or

> clinical simulations of real-life patient care situations that relate directly to classroom material allow students to build patient care skills while applying theoretical knowledge in a controlled setting. Such simulations reinforce material learned in lectures and promote an active learning environment. (p. 358)

It has been my experience that role-playing is one of the most effective strategies for learning sexual health. For example, it creates a safe practice scenario that mimics what it would be like in a counselling session with a client without the client actually present. This provides an opportunity to practice asking questions and obtain feedback with a peer.

Talk aloud.

Talk aloud or think aloud problem solving (TAPS) is helpful when working through a particularly challenging learning situation and can assist in evaluating the clinician's understanding. Banning (2008) states, "The main concept of the think aloud approach is to gain access to student's thought processes when investigating an important subject" (p. 10). This is useful because it allows for critical thinking and clinical decision-making processes to be heard. An example of this strategy would be talking about a case study out loud or a personal situation with a client and asking some specific questions related to the problem, such as: "What are the issues/challenges with this problem?" and "What strategies could I use to resolve them"?

Case study.

Case studies provide space and opportunity to engage with the topic(s) because they tell a story and ask questions about the story that then prompts a discussion and dialogue with the learners completing the case study. Schoessler and Farish (2007) support this concept with "the quality of the learning climate and the richness of the knowledge shared at the patient care level are critical to ongoing learning and development" (p. 173). This statement refers to the case study creating the ability to connect with and learn from each other by answering the case study questions together.

An example of a case study is a female client who has been diagnosed with a traumatic brain injury who is experiencing a decrease in her sexual drive. She is not interested in being sexual with her partner, yet she still wants to be intimate in other ways. What assessment might you do with your client? What interventions might you suggest to her?

Storytelling.

Storytelling or story-based learning (SBL) is a powerful learning and teaching strategy; SBL builds on current knowledge and learning through interactions; SBL contains principles of education to assist professionals in their practice, such as active learning develops engaged learners, and learning in groups prepares for team work (Young, 2007). Storytelling can be used as a suggested strategy that I will call Clinician Stories. This strategy posits the story from the perspective of the experienced clinician or from the perspective of any learner participating in the orientation.

Professional Development Plan

These learning and teaching strategies could be incorporated into a structured professional development plan or learning plan that identifies and constructs the learning priorities for the first three to six months. This plan is an educational tool used to identify strategies and resources to help accomplish learning goals.

Interprofessional Knowledge

In the practice of sexual health, there are relatively few professions that specialize in this area, so it is essential to establish collegial relationships for continuity of client care and clinician competence. A significant portion of orientating the new SHC to the role is the responsibility of the experienced SHCs along with the Sexual Medicine Consultant to the service. Additional time should be allotted in orientation to spend with

other members of the interprofessional team, such as the physiotherapist, occupational therapist, and colleagues in Sexual Medicine, to orientate to their role, specifically to how their various disciplines address client's sexual health concerns. This will provide the clinician with: (a) co-construction and integration of knowledge from other disciplines, (b) knowing who to refer to if the client's treatment is beyond the clinician's abilities, and (c) when the client could benefit from a collaborative approach.

A learning strategy may consist of job shadowing, whereby the clinician spends some time in discussion with the team members to gather information on their role then observes some client interactions to solidify the experience. An opportunity to ask questions could be incorporated as well as documenting the observations for reference and reflection.

PLISSIT

The model used in the SHRS to outline the four levels of sexual health interventions is called PLISSIT—Permission, Limited Information, Specific Suggestions, and Intensive Therapy (Annon, 1976). The model has an ascending and descending shape; the SHCs often draw it as the shape of the pyramid, which is used to signify the number of health care professionals who are able to intervene in any part of the model. The permission giving portion is the largest, thus more professionals are expected to be able to intervene at this level. Conversely, the intensive therapy portion is smallest, indicating that there are only a limited number of professionals able to intervene at that level. This model assists in identifying which domain a generalist nurse and an SHC could intervene with clients' concerns.

The permission giving level is the first level of the model. This level is where all nurses should be able to comfortably have some dialogue with their clients to allow them to articulate any concerns of a sexual nature. The nurse does not have to have the answers, but be able to convey a message that "Sex is spoken here", validating that they have heard and understood the question(s), and if they themselves do not have the answer, they will refer the client on to someone that does.

Many nurses will also be comfortable functioning in the second level of limited information, which is where a nurse may provide limited information about a specific client concern if they have the knowledge and level of comfort to be able to do so. The specific suggestions or intensive therapy levels are where the SHC or colleagues, such as sexual medicine physicians, psychologists, psychiatrists, or sexual therapists, can intervene due to their level of knowledge and comfort with the nature of the clients' inquiry. They may also be able to address more complex sexual health concerns potentially requiring more medical intervention or treatments.

Traditionally, there has been a lack of formal sexual health training in nursing programs. Bishop and Blake (2007) advise that "two-thirds of practice nurses (68%) say they do not proactively ask their patients about their sexual health because they have not been trained to do so" (p. 8). Kotronoulas et al. (2009) tell us that, "despite their importance, incidence, and impact on psychosocial well-being, sexual health care is a matter not frequently dealt with by nurses in daily practice" (p. 479).

It is evident from these quotations that more effort is required to educate nurses in sexual health, thereby increasing their understanding of sexuality and their ability to address this aspect of their client's health. The APN can mentor other nurses in

addressing their clients' sexual health concerns by teaching and mentoring them about the PLISSIT model of sexual health intervention.

A learning activity is for the entry-level clinician to seek out information on what those specific suggestions or intensive therapies might be from conversations or observations with colleagues experienced in sexual health. For example, in an observation of a client consultation for concerns of hypoactive sexual desire, what treatment did the clinician recommend?

Evaluation

An evaluation tool is important because it is used to evaluate whether or not there has been a contribution to a learner's learning or knowledge from the context in which the learning has occurred. Tanner (2006) supports the evaluation of learners' experience by stating that it "contributes to their ongoing clinical knowledge development and their capacity for clinical judgment in future situations" (p. 209).

The Sexual Health Competencies I have discussed in Chapter 2 are used as the evaluation tool to identify and evaluate where learning has occurred and where ongoing learning needs may be present. For example, the clinician can complete the indicators in writing for the competencies of application of knowledge and code of ethics.

With potentially many clinicians involved in the orientation process, it is important to have the learning plan, introduced in this chapter, in place for the new clinician, with designation of who is responsible for what aspects of his or her orientation. The new clinician could participate in self-assessment by maintaining a survey of his or her own learning needs to ensure continuity in orientation and knowledge acquisition. Galbraith, Hawkins, and Holmboe (2008) offer, "Self-assessment-defined as

a broad process of self-directed assessment that is initiated and driven by the individual and is used for ongoing improvement" (p. 20). This would also serve as an evaluation tool for assessing the impact of the curriculum on knowledge for assuming the role.

A weekly self-review of the learning plan is recommended, as revisions may need to be done depending on the ability to meet the learning outcomes each day and his or her comprehension of the knowledge to date. In addition to this weekly self-review, the coordinator of the SHRS meets with the new clinician once a month to conduct a more formal review. Crouch (1999) states, "Self-assessment is a necessity if nurses are to act ethically when meeting the sexual health needs of clients" (p. 672). The College of Registered Nurses of British Columbia (2009) standards of practice could also be incorporated into the evaluation tool.

Much of what is learned may not be used in practice until days or months into the learner's journey, and there will be ongoing learning for the clinician that will occur outside of the context of the three- to six-month orientation. Some recommended areas for professional development are listed in Chapter 4.

Chapter 4: Recommended Professional Development

Recommended professional development contains advanced knowledge curriculum as the SHC becomes more comfortable in his or her role as an advanced practitioner. This knowledge would need to be learned outside of the initial orientation time frame of three to six months. The curriculum would be comprised of self-directed, active learning in conjunction with clinician identified learning needs.

In addition to the recommended professional development curriculum, the area of sexual health, as in any nursing specialty, requires that the clinician remain current in sexual health related knowledge for best practice. This can be accomplished by attendance at conferences, producing or reading publications, knowledge of resources, rounds, case conferences, or with any other relevant professional development identified. Hicks and Thomas (2005) state, “It is essential that appropriate training and updating of skills are provided for all staff working within the domain of sexual health” (p. 324). The following sexual health areas are recommended for ongoing professional development based on my experience as an SHC:

1. The history of sex;
2. Sexuality across the life span (childhood, adolescence, adult, middle-aged, and elderly);
3. Societal beliefs/media portrayal;
4. Cultural sexual practices and communications;
5. Alternative sexual practices;
6. Sexual fantasies;
7. Non-heterosexual orientations;

8. Gender identity and expression;
9. Components of a gynecological exam; and
10. Sexual health equipment (e.g., vibrators, sexual toys, adaptive equipment, devices used in fertility treatments)

A learning activity would be to have the new clinician work towards knowledge and understanding of these areas by researching them then putting the research into the context of how the client can be holistically viewed. For example, a client with a spinal cord injury may have challenges holding a vibrator for sexual activity. Based on your research, what suggestions would you as the clinician make to the client?

Sexual Attitude Reassessment

Another resource for values clarification for those practicing in the area of sexuality is a Sexual Attitude Reassessment (2009). This is an intensive three day group seminar that consists of attitudes, values, and beliefs clarification by increasing awareness and understanding both personally and professionally in the domain of sexuality and sexual health. This seminar encourages the individual to look at themselves on many different levels to understand where they see their beliefs and values on a variety of topics specific to sexuality and sexual health.

A Sexual Attitude Reassessment (SAR) is not the only means of values clarification, as there exists various activities one could complete in order to assess this area, but it is a concerted effort of focus for three days that allows for concentration on the subject. I would see attendance at an SAR as an advanced activity for ongoing professional development once the entry-level clinician has a solid grounding in the area

of sexuality. This grounding would potentially provide the basic understanding on sexuality to reflect upon while attending a SAR.

Relationships

As an SHC seeing clients and/or their partners for consultation to address their sexual concerns, you do need to have an in-depth understanding of the types of relationships (i.e., friendships, family, partnerships, and marriage) that exists. This is because of the connection human relationships have to sexuality, which is one of the contexts in which sexuality may be expressed. I am not suggesting that the clinician becomes a relationship counsellor, but having an understanding of relationship dynamics does assist in the role. Having this knowledge of relationships may assist the clinician to help clients and their partners to develop realistic perceptions of their sexual concerns and increase their ability to interact with each other about their experiences.

For example, if in the course of counselling my client, it became evident that either my client and/or his or her partner's concerns stemmed from or had elements of relationship difficulties, I would refer them on to a relationship therapist. Relationships are not the clinicians' area of expertise. This referral is an example of an interprofessional approach to client care.

University of British Columbia Clinical Skills

Annually, the SHCs are involved in assisting in the University of British Columbia Sexual Medicine Program with teaching of clinical skills to the first-year medical residents. The role is as a tutor in the facilitation of the students practicing interviewing skills with standardized patients assigned various sexual dysfunctions.

Knowledge of the objectives of the clinical skills is needed in order to facilitate these sessions and include:

1. Take a detailed assessment of sexual problems, including appropriate introductory and closing remarks.
2. Ask questions assessing various aspects of sexual dysfunctions, appropriate for a single patient or couple interview.
3. Demonstrate introductory remarks and closing statements to a detailed assessment of sexual problems.

The curriculum for these clinical skills includes: (a) assessing sexual function—male, female, and couples; (b) applied sexual physiology; (c) general principles of sexual history assessment; (d) interview skills; (e) content of interview for assessment of sexual problems; (f) seven key questions—sexual problems in their own words, duration and onset-lifelong/acquired and generalized/situational, context, sexual response, reaction, previous treatment, and motivation; (g) diagnosis of sexual disorder, (h) screening for sexual problems; and (i) sexual response cycles.

The Sperm Retrieval and Self-Injection Clinics

An aspect of the SHC role is to work in the Sperm Retrieval Clinic at VGH and the Self-Injection Clinic at GF Strong Rehabilitation Centre. This would require additional education and orientation and would be done after the initial orientation of three to six months. The rationale for this is that each clinician is cross educated to work in both the specialty clinics to be able to support other clinicians for work and vacations.

The Legal Environment

It is critical for the clinician to know the sexual rights of all individuals, which can include forms of abuse, when to report abuse or sexual assault, and the available resources when working with clients who have had theses experiences for their safety and well being. I say this from experience of the likelihood that the clinician will be working with a client who has experienced this either in the past or currently. I have listed this as an advanced practice skill because the novice clinician would not be placed on their own in a position to see a client with a known history of or suspected abuse for consultation.

Public and Private Sources

It would be beneficial for the SHC to have knowledge of public and private sources of health services and how they differ. This is important to know as there are some sexual health services offered that are private that may need to be utilized by clients for holistic client health. An example of this would be a Sexual Therapist. The SHC would initially assess and triage based on the findings in their sexual health assessment. In order to triage, the SHC needs a broad understanding of the knowledge to be able to direct the client to the most appropriate resource.

Research

Research for best practices in the SHRS has become more common place, with the clinicians participating in randomized clinical trials, the development and trial of new assistive sexual devices, and qualitative research. For example, this has been in the research capacities of a principal investigator, co-investigators, study coordinators, and research assistants. Therefore, the new clinician's ongoing development should include an assessment of his or her research experience, knowledge of research methodology, and

depending on that outcome, have him or her take some basic research courses. A local resource for research courses is VCH with the offering of such courses as:

1. Confidence intervals;
2. Hypothesis testing;
3. Making posters;
4. Power and sample size in statistical inference;
5. Searching the journal literature and accessing library resources;
6. Survey methodology: surveys that make a difference: survey design and questionnaire development; and
7. Using online surveys to get the answers you need: tools and best practices for conducting surveys.

Resources

Resources for the clinician should be compiled with knowledge of internal (VCH) organizational resources, such as Nursing Professional Practice, Ethics Consultation Service, Risk Management, Research Services, and external sexual health related agencies' written and electronic resources. Basic knowledge of these resources is the intention and not that the clinician needs to be an expert in all these resources. Rather, knowledge of how to respond to the client and who and when to refer on, if the concern is not within the realm of practice for the SHC, is the purpose here.

There are many external or community resources for both the client and clinician available on the shared computer drive in the SHRS that the new clinician will be utilizing in the initial orientation process. What would be useful for ongoing professional development is the addition of new resources that the clinician has discovered during the

orientation process with a listing of recommendations for the resource. This activity would demonstrate knowledge of why the resource was sought and what the options are.

The Development and Facilitation of Education

One of the duties of the SHC is to educate other health care professionals and community agencies on various topics concerning sexual health; this generally involves public speaking. Having to speak in public on a sensitive and intimate topic can be a source of anxiety for the clinician. Generally, a great deal of comfort and knowledge is needed in order to be a credible speaker on the subject. Therefore, public speaking skills are an asset and I would recommend the four-day Instructional Skills course at BCIT (n.d.). This course teaches you how to engage with your audience, troubleshoot difficult questions, and manage your audience: all components of adult education.

Computer Skills

Knowledge of advanced computer skills for the development of workshops, lectures, and presentations as examples are recommended as these are primarily created by the clinician contracted to be speaking at the particular venue. Computer programs such as PowerPoint (Levels 1, 2, 3), Excel, Access Database, and Media Player are some of the courses needed for the clinician.

Conclusion

In this project, I have attempted to identify and create the information contained within it as comprehensively as possible for answering the question of: What knowledge is required by an Advanced Practice Nurse in the position of a Sexual Health Clinician? in order to prepare an orientation curriculum. I have shown how theory has influenced the content and delivery of the curriculum. This information is by no means deemed

complete; it is representative of my project's time line and may be modified in the future. It is my hope that a new clinician will benefit in his or her knowledge acquisition and orientation experience from the information contained in this project. Perhaps this project will inform the basis of curriculum learning modules for the future development of an educational program for other practitioners of sexual health as there has been an identified need for this from other health care professionals across Canada.

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Appendix A: Sexual Health Clinician Continuing Competency Assessment[1]

Developed: August 11, 2008

Welcome to Sexual Health at GF Strong. This continuing competency assessment describes the competencies and skills that are required for success as a sexual health clinician. It can be used to guide your orientation by outlining competencies to be achieved throughout your first year of employment in Sexual Health. It will also help you to identify personal learning goals that you want to work on. Each Sexual Health Clinician and the Coordinator of Sexual Health will keep copies of this document to keep track of areas for improvement and documentation of performance standards met. This competency assessment is to be used in conjunction with the VCH RN Continuing Competency Assessment.

Name:

Date reviewed:_____ Reviewer:_____

Date reviewed:_____ Reviewer:_____

Date reviewed:_____ Reviewer:_____

[1] From *Sexual Health Clinician Continuing Competency Assessment* (pp. 1–13), by Sexual Health Rehabilitation Service, 2008, Vancouver, BC: GF Strong Rehabilitation Centre. Copyright 2008 by GF Strong Rehabilitation Centre. Adapted with permission.

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CNA Rehabilitation Nursing Certification Exam Guide

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VCHA/Fraser Health/UBC/UVic RN/RPN Educator Career Pathway Level 1 – 4 (2007)

Legend
1 – Meeting consistently
2 – Continuing to develop
3 – Needing assistance/support
4 – Is not meeting (see comments)
5 – No opportunity

1. RESPONSIBILITY AND ACCOUNTABILITY

Professional Conduct

Competency	6 months	1 year	2 years
Demonstrates professional behaviour by: e.g arriving on time, taking appropriate break times, calling in sick.			
Demonstrates professional behaviour by dressing appropriately for work: eg professional attire that is sensitive to the intimate topics discussed with clients, family members and the health care team.			
Conducts self in a professional manner. For example: role modeling for colleagues, students and others, respectful interactions with clients, families and all members of the healthcare team.			
Recognizes and respects client diversity and needs.			
Accepts accountability for own actions and decisions.			
Utilizes services provided for employees e.g pastoral care, Critical Incident Debriefing, Employee Family Assistance Program, Employee and Workplace Health and Safety.			
Maintains client confidentiality at all times according to VCHA policy.			
Comments:			

Scope of Practice

Competency	6 months	1 year	2 years
Practices within level of competence and seeks appropriate guidance and resources when required.			
Practices in a manner consistent with legal and professional standards, VCH and Sexual Health Rehabilitation Service (SHRS) policies/standards/protocols and guidelines.			
Practices within the established mission, vision, values, objectives of VCH and the SHRS.			
Understands the goals of sexual rehabilitation nursing (e.g. maximum functional ability, optimal sexual health, adaptation to illness or disease).			
Demonstrates knowledge of the role and scope of rehabilitation nursing and the SHRS.			
Understands the role and scope of practice of other health care team members.			
Assists the Sexual Health coordinator and other members of the SHRS with administrative activities and optimal use of resources, providing input re budget and staff allocation, consistently completing workload management statistics, assisting and participating in workload decision-making, and in developing sexual health policies or standards.			
Identifies appropriate orders/directions, works collaboratively at establishing understanding before respectfully questioning inappropriate directions/orders.			
Comments:			

Safety

Competency	6 months	1 year	2 years
Notifies appropriate health care team members of concerns about changes in client health status (emotional, physical), clearly and in a timely manner.			
Applies principles of workplace health and safety including body mechanics, safe work practices and prevention and management of aggressive behaviour.			
Applies principles of infection control at all times e.g hand washing, biohazardous waste management and disposal, sharps disposal.			
Demonstrates an ability to use correct lifting techniques and transferring strategies when moving clients.			
Recognizes and reports actual and potential safety issues to clients, themselves and others e.g. faulty equipment.			
Recognizes incompetent/unsafe practice by other health care team members and follows up appropriately e.g talk to person, report to appropriate supervisor, incident report.			
Maintains CPR certification			
Describes responsibilities in all types of code situations at both GF Strong site and Echelon e.g. role of sexual health clinician, numbers to call.			
Understands delegated medical tasks and the responsibility of the sexual health clinician.			
Coordinates and participates in quality improvement and risk management activities for assigned areas .			
Assists in developing recommendations and changes to policies, procedures or protocols regarding safety.			
Maintains own wellness and physical ability to perform the duties of the Sexual Health Clinician.			
Comments:			

2. BODY OF KNOWLEDGE

Evidence-Based Practice

Competency	6 months	1 year	2 years
Takes initiative to seek out information from available sources e.g. textbooks, guidelines, articles, internet research, staff, etc.			
Shares knowledge with colleagues, students and other health care team members as appropriate.			
Applies evidence-based information to specific client care situation appropriately: • Principles of Rehabilitation Nursing including skin and wound care, bowel and bladder management, positioning and mobility • Sexual Health Framework theory and principles • Principles related to a client/family centered care model • Stages of development from adolescence to older adulthood • Sexual orientation, gender identity and expression • Body image • Communication and relationship theory • Normal and abnormal sexual response (male, female) • Neurophysiology of sexual functioning • The impact of disability, illness, aging and hospitalization on sexuality (including concerns about autonomic dysreflexia and pain). • Diagnostic testing related to sexual functioning • Fertility, pregnancy, contraception, sexually transmitted infections			
Demonstrates knowledge and application of principles when administering medication or providing information about medications to clients: drug actions, side effects, interactions and age-related physical changes and their impact on medication absorption, metabolism and excretion.			
Comments:			

Communication and Collaboration

Competency	6 months	1 year	2 years
Uses appropriate communication skills to resolve differences and conflicts, seeks guidance when necessary.			
Uses empathic approach with clients and families.			
Communicates and works effectively as a team member of the SHRS as well as within the interdisciplinary team.			
Collaborates with other Sexual Health clinicians, Sexual Medicine physicians and other members of the health care team to plan and provide care.			
Recognizes the impact of actions and decisions on clients, families and health care team members.			
Able to organize and prioritize work in collaboration with others and on own.			
Demonstrates knowledge of and uses effective communication techniques in discussing sexuality both in one-on-one situations and in groups.			
Identifies the difference between therapeutic and social communication with clients.			
Demonstrates keyboarding skills, basic windows and Word skills and use of the intranet and internet.			
Demonstrates the ability to obtain online information as needed for client care, communication and research (VCH intranet and other databases).			
Demonstrates the ability to use Powerpoint to develop a presentation.			
Demonstrates the ability to file patient reports and letters via dictation in a timely manner.			
Demonstrates the ability to write effective letters regarding clients to physicians and other care providers.			
Maintains client records as per VCHA policy.			
Comments:			

3. APPLICATION OF KNOWLEDGE

Collects relevant information

Competency	6 months	1 year	2 years
Utilizes a variety of techniques in collecting client information e.g. physical assessment, observation, interviewing techniques and interpreter services.			
Collects data from a variety of other sources e.g. lab data, diagnostic tests, documentation and other health care team members and family members.			
Performs sexual health assessments in a timely fashion using sexual health framework, knowledge and skill in doing a physical assessment, and an understanding of the client's condition.			
Assesses sexuality including: sexual function, medical co-morbidities, medications, values and beliefs, cultural belief, developmental stage, use of contraception, history of abuse, understanding of the effect of injury or disability on sexual function and reproduction, readiness and priorities.			
Assesses impact of common rehabilitation concerns: limited mobility, pain, motor and sensory impairment, changes to bowel and bladder function, potential for AD, muscle strength, balance, tone, range of motion, hand function, spasticity, tremors, depression, grief, body-image changes, disinhibition, attention, proprioception, memory.			
Assesses psychosocial functioning including: adjustment to disability, impact of the disability, relationship concerns, role adjustment, and risk of abuse.			
Assesses and understands the influence of the following on sexual health: cultural or religious values and beliefs, emotional response, family dynamics, life experience of the client.			
Assesses cognitive factors including impulsiveness, disinhibition, memory, and judgment.			
Able to assess for drug and alcohol use, history of abusive relationships or negative sexual experiences, and suicidal ideation or history.			
Applies principles of sexual health practice such as readiness and neutrality during assessment.			
Applies counselling techniques during assessment - supportive relationship, accurate information, empathy, opportunity to express feelings and clarify issues.			
Identifies and responds to relevant findings.			
Comments:			

Planning Care

Competency	6 months	1 year	2 years
Considers individual client needs (psychosocial, physical, safety, emotional needs, etc).			
Applies evidence-based knowledge from a variety of disciplines when providing care e.g. pathophysiology, psychology, pharmacology.			
Applies evidence-based knowledge of common rehabilitation conditions and impact on sexuality when providing care e.g. SCI, TBI, MS, Stroke, Arthritis.			
Applies evidence-based knowledge of concomitant conditions such as: diabetes, CHF, CAD, depression, COPD.			
Identifies actual and potential problems by analyzing data.			
Identifies and sets priorities when planning/providing care for a client.			
Uses critical thinking and problem-solving skills in clinical decision-making.			
Plans and implements care to assist individuals, couples and family members to understand and manage the sexual consequences of their disability.			
Uses strategies for talking about sexual issues – asking permission, ensuring privacy, general to specific, normalizing, neutral language etc.			
Communicates effectively with the client and family to define goals and develop a care plan.			
Comments:			

Implementation

Competency	6 months	1 year	2 years
Uses the PLISSIT model when providing information and care.			
Assist clients and significant others in enhancing their understanding of sexuality within the context of their readiness, priorities and perspectives.			
Makes appropriate clinical decisions, reassesses and acts appropriately.			
Uses effective time management skills, organizes care, manages a full client workload and requests assistance when necessary.			
Consults with and makes appropriate referrals to other members of the health care team.			
Supports and encourages client self-care and health promotion.			
Considers the potential for autonomic dysreflexia when making recommendations about sexual activity or stimulation or assisting with vibrostimulation.			
Demonstrates safe administration of medications in (oral, sublingual, intracavernosal, intra-urethral, subcutaneous.			
Assesses for and intervenes with clients with compromised airways (assistive coughing, use of ambu-bag and suction).			
Demonstrates the ability to perform urinary catheterization and collect specimens .			
Selects sexual health interventions to enhance and support sexual function by encouraging client to adopt healthy sexual practices to meet his or her needs considering client readiness and priorities. Offer education in areas such as: positioning, STI, dysreflexia, sexual communication, assistive devices and methods, contraception and bowel and bladder considerations.			
Discusses sexual changes with client e.g managing sexual behaviour, social-sexual skills, body image, partnership concerns, building and maintaining relationships, reproductive changes.			
Assists client in identifying what sexual health means to them and supporting them in their choices.			
Assists client to clarify their values and beliefs about sexuality and sexual health and the impact of those beliefs on their adaptation to illness or disability.			
Demonstrates knowledge of different types of pain (chronic, neurogenic, phantom) and uses pain management strategies to enhance sexuality.			
Comments:			

Evaluation

Competency	6 months	1 year	2 years
Monitors progress of clients towards goals.			
Uses critical thinking and analysis to assess the effects of interventions and adjusts care accordingly.			
Comments:			

Documentation

Competency	6 months	1 year	2 years
Maintains clear concise accurate and timely records of client care as per Sexual Health and VCH policy.			
Comments:			

4. CODE OF ETHICS

Competency	6 months	1 year	2 years
Demonstrates respect for individual values, beliefs and culture.			
Identifies personal beliefs, values and assumptions.			
Recognizes how clinician's personal values and beliefs related to sexuality and sexual activity may influence the provision of care.			
Recognizes the importance of confidentiality regarding client sexuality.			
Understands and applies privacy legislation.			
Understands ethical issues related to sexual health, sexuality, illness and disability.			
Applies an ethical decision-making framework when appropriate.			
Supports informed choices that the client and family make.			
Demonstrates an understanding of the legal issues related to providing sexual health care (e.g. providing information to minors, consent, guardianship legislation).			
Demonstrates an understanding of the unique issues related to professional boundaries and sexual health nursing (increased opportunity for perception of intimate relationship, need for clear role definitions, awareness of clinician and client vulnerabilities).			
Demonstrates recognition of the differences between social and professional relationships.			
Comments:			

5. PROVISION OF SERVICE IN THE PUBLIC INTEREST

Competency	6 months	1 year	2 years
Applies principles of teaching and learning to provide health related information to meet the sexual health needs of clients, families and care providers e.g. assesses learning needs, selects appropriate delivery method and evaluates education			
Plans and provides educational sessions to small and large groups of clients or care providers using theories of adult education. (see educator pathways document).			
Develops educational programs based on a specialized body of knowledge, informal case conferences, workshops and academic presentations.			
Demonstrates expertise and provides leadership in sexual health practice through reviewing literature on sexual health, attending inservices and conferences, and consulting with health care professionals.			
Provides informal education and support to care providers by consulting on individual cases, providing suggestions or recommendations.			
Contributes to the development of the body of sexual health knowledge through reflective practice, the development of clinical guidelines and outcome measures.			
Understands research process and methodology.			
Participates in sexual health research by identifying research questions, seeking grants, collecting and analyzing data.			
Attends committees as required to facilitate communication with care providers or community groups.			
Advocates on behalf of the sexual health service.			
Advocates for increased resources for community sexual health care and promotes the most equitable access to appropriate resources.			
Advocates for health care professionals to have adequate education and resources to provide sexual health care in their care settings.			
Advocates for the development of sexual health care policies and guidelines.			
Identifies appropriate admissions to sexual health and recommends alternative resources to clients not appropriate for admission.			
Facilitates continuity of care as clients move from acute phase to rehabilitation and into the community.			
Facilitates relationships within the sexual health service, VCHA and the larger community by providing presentations, developing linkages and resolving issues.			
Comments:			

6. SELF-REGULATION

Competency	6 months	1 year	2 years
Maintains competencies in skills required for sexual health practice eg intracavernous injection, sexual health assessment, sperm retrieval clinic as appropriate.			
Recognizes areas requiring development and seeks relevant learning opportunities.			
Assesses own clinical practice and participates in performance reviews.			
Participates in ongoing educational activities, applies new knowledge to clinical situations and shares information with other clinicians.			
Recognizes stressors unique to sexual health nursing and identifies coping strategies to maintain well-being.			
Engages in continuing professional development e.g inservices, conferences, committees and research.			
Comments:			