Understanding nurses' perceptions of sexual health and function in people requiring haemodialysis

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Understanding nurses' perceptions of sexual health and function in people requiring haemodialysis

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Abstract

Background: Sexual dysfunction is common for adults receiving chronic haemodialysis; however, renal nurses seldom discuss this topic with patients.

Objectives: This study aimed to identify renal nurses' attitudes towards providing sexual healthcare and to determine their confidence in discussing sexual dysfunction with adults who are receiving haemodialysis.

Design: An online cross-sectional study.

Participants: Renal nurses across Australia and New Zealand ($n = 65$) who were members of the Renal Society of Australasia provided direct care to adults receiving haemodialysis.

Measurements: Two questionnaires measuring (1) the frequency of sexual health discussions, levels of knowledge and competence, barriers to discussing sexual dysfunction and views on accountability (Van Ek survey) and (2) communication, practical knowledge, and attitude (sexual health educator for professionals scale) were used. Demographic characteristics were also collected.

Results: Most participants were females (60%) with postgraduate qualifications (61.4%). The average nephrology nursing experience was 13.10 ± 9.14 years. Most renal nurses identified as having positive attitudes (77.2%) about providing sexual healthcare and were confident in communicating with patients about sexual concerns (42.9%), although many nurses (64.35%) rarely did so. Less than one-half (48.6%) indicated feeling competent to discuss sexual dysfunction, and less than one-third (30%) had sufficient knowledge about sexual dysfunction. Barriers were lack of practical training (74.2%) and insufficient time (57.1%). Younger nurses (≤45 years old) and male nurses were significantly more confident in discussing sexual health matters.

Conclusions: Overall, renal nurses had positive attitudes towards discussing sexual health concerns with patients however they rarely did so.

KEYWORDS
haemodialysis, renal nurses, sexual dysfunction

INTRODUCTION

Sexual dysfunction-related symptoms such as a lack of interest in sex and difficulties with sexual arousal have been commonly reported by adults receiving haemodialysis (HD) treatment (Almutary et al., 2016) and for some, the symptom is distressing and often difficult to manage (Wang et al., 2019). According to Pyrgidis et al. (2021), 74% of women with kidney failure reported sexual dysfunction that caused personal distress, and when women started HD, over 80% reported some form of sexual dysfunction that significantly impacted their lives. The types of sexual dysfunction symptoms are very similar in men but also include ejaculation and erectile dysfunction. It is estimated that 80% of men with kidney failure receiving HD have experienced distress due to sexual dysfunction and an inability to enjoy sexual interaction (Cirakoglu et al., 2021). Sexual dysfunction is distressing for both sexes and can significantly impact not only the individual but other adults who have a sexual relationship with a person with kidney failure (Keskin et al., 2019; Yodchai et al., 2018). Sexual dysfunction can have harmful consequences on an individual's confidence and self-esteem, whilst damaging intimate relationships as the individual struggles to manage the pressures of HD treatment (Cho & Shin, 2016; Cohen et al., 2015). It is for these reasons that sexual dysfunction should be regularly discussed and addressed by renal nurses.

LITERATURE REVIEW

Renal nurses have an important role in providing care to help adults manage the challenges of kidney failure. Discussing sensitive issues such as sexual dysfunction can be difficult for renal nurses for many different reasons. Previous literature indicates that renal healthcare providers receive little or no training in discussing sexual dysfunction and often feel hesitant to talk with patients for this reason (Green et al., 2012). The lack of training in initiating conversations about sensitive matters made some renal nurses feel unprepared and ill-equipped to discuss sexual dysfunction with patients (Yodchai et al., 2018). Existing research has already identified confusion about whose role it is to discuss sexual concerns as some renal health providers felt it was not their responsibility to address sexual dysfunction (Fennell and Grant, 2019; Green et al., 2012; Van Ek et al., 2018). Similar results are evident in other studies involving nephrologists, renal social workers, and transplant surgeons (Hough et al., 2018; Van Ek et al., 2015) in which confusion about responsibilities and obligations often left the patients' sexual concerns being overlooked altogether.

Another barrier to discussing sexual concerns is lack of time, but this is not only specific to nephrology nursing. Nurses working in other health areas such as cardiology, identified that competing demands throughout the day prevented them from discussing sensitive matters (Karani & McLuskey, 2020; Zhu & Wittman, 2022). Finding a private and secure location to discuss sexual concerns can be a challenge for nurses as most patients are not likely to reveal and discuss sensitive information about their sexual concerns within a public and open space (Fennell & Grant, 2019). In a previous study, Yodchai et al. (2018) found that many renal nurses identified there was a lack of private and suitable places for discussions about sexual function to occur.

A further barrier is with renal nurses themselves, as issues with nursing comfort prevented discussions about sexual issues with patients (Green et al., 2012; Hough et al., 2018). Conservative attitudes of nurses towards providing sexual healthcare can impede the levels of comfort as some nurses report sexual concerns of the patient are private issues (Arikan et al., 2015; Hough et al., 2018). Some nurses use humour to discuss sexual concerns with patients as this can enhance the nurses' levels of comfort and help establish a rapport with the patient (Hough et al., 2018; Mckie et al., 2021). Making a therapeutic connection with the patient first was identified as important in discussing sexual concerns and enhancing nursing comfort levels (O'Connor et al., 2019; Yodchai et al., 2018).

There are only a few studies that have explored renal nurses discussing sexual dysfunction and providing sexual healthcare (Green et al., 2012; Hough et al., 2018; Van Ek et al., 2018; Yodchai et al., 2018). Overall, these studies have found that renal nurses are unsure of their role in addressing sexual concerns, feel unprepared due to a lack of training, and encounter workplace and personal barriers in discussing sexual dysfunction with adults receiving HD (Mckie et al., 2021). Therefore, there is a need to examine renal nurses' discussion of sexual dysfunction with patients, to ensure that patient sexual concerns are not overlooked. This study sought to identify renal nurses' knowledge and attitudes towards providing sexual healthcare and to determine levels of confidence in discussing sexual dysfunction in adults receiving HD.

METHODS

Design

The study used a cross-sectional design and is reported according to the strengthening the reporting of observational studies in epidemiology (STROBE) statement (Von Elm et al., 2014; see Supporting Information S1: Table S1).

Setting and participants

Registered and enrolled nurses working in either Australia or New Zealand who were providing direct care to adults receiving HD were recruited via the Renal Society of Australasia (RSA) between July 2021 and October 2022. A registered nurse (RN) has a Bachelor of Nursing qualification (Nursing and Midwifery Board of Australia [NMBA], 2023). Enrolled nurses are registered health professionals who have completed a diploma-level qualification such as a Diploma of Nursing and must always work under the supervision of a registered nurse (NMBA, 2023). The RSA has approximately 2000

members, although there was no publicly available information about how many registered and enrolled nurses from Australia and New Zealand would be eligible for the study. The RSA was responsible for inviting members to complete the online survey using their routine communications with members and the bi-monthly RSA Communique e-news. Further promoting and advertising of the study was done regularly via the RSA social media platform (Facebook and Twitter) and at local conferences.

Data collection

The survey was divided into three sections. The first collected demographic information (age, gender, highest qualifications, length of nephrology nursing experience, and workplace location). The second was the Van Ek survey, a 38-item instrument developed for renal healthcare professionals seeking information about the frequency of sexual dysfunction discussions, levels of knowledge and competence, barriers to talking about sexual concerns with patients, and views on accountability (Krouwel et al., 2015; Van Ek et al., 2015; Van Ek et al., 2018). This survey contains 36 multiple-choice and two open-ended questions.

The third section was the sexual health education for professionals scale (SHEPS) developed by Ross et al. (2018). The SHEPS is a 115-item instrument used to measure health professionals' confidence in communication, practical knowledge, and attitudes towards providing sexual health. There are three subscales in the SHEPS that measure (1) communication, (2) practical knowledge, and (3) attitudes and beliefs. For this study, the SHEPS was modified to 42 items. Some questions were removed as the questions sought responses about domestic abuse, termination of pregnancy, contraception, and masturbation, which were not consistent with the aims of the current study. Responses in subscales one and two are measured using a 10-point Likert scale from 'not confident' to 'very confident', and the last subscale was measured using a 10-point Likert scale from 'strongly disagree' to 'strongly agree'. In total, the online survey took approximately 10 min to complete.

Data analysis

Responses were imported from LimeSurvey® to SPSS version 29 for analysis (IBM Corp, 2020). Univariate descriptive statistics were used to analyse the demographic data using frequency distributions of categorical variables. These included age brackets, highest qualification, nursing position, the area of work within renal services, types of employment, gender, private or public hospital and country of residence. Frequency and descriptive analysis were performed on the results of the survey. Mann–Whitney *U* test was used to test differences between demographic characteristics, the Van Ek survey, and the SHEPS. Spearman Rank Correlation test was used to also calculate any possible correlation between years of renal nursing experience, the Van Ek survey, and the SHEPS. Missing data were managed by activating the exclusion by case pairwise function within SPSS, as surveys with some missing responses could still be used for item analysis (Pallant, 2020).

Ethical considerations

Human ethics approval was granted by Griffith University. An information sheet highlighting the aim and purpose of the study was provided when the survey was opened by participants. When participants started the survey, implied consent was gained. Anonymity was maintained as there was no identifiable information collected from participants.

RESULTS

Demographic characteristics

Sixty-five renal nurses completed the survey, and most of the participants were females (60%) with half being over 46 years of age (50%). The average of years of nephrology nursing experience was 13.10 ± 9.14 years. Further demographic characteristics are presented in Table 1.

Questions were asked about how often renal nurses discussed sexual dysfunction with patients (Table 2), and the results varied depending on the patient's age and gender. As measured by the Van Ek survey, over half of the nurses (78.6%) never discussed sexual dysfunction with patients who were older than 76 years. Almost half of the nurses (42.9%) reported that they never talked about sexual concerns with patients aged 16–35 years. Many nurses (62.9%) never discussed sexual dysfunction with female patients, compared with 48.6% who never talked about sexual dysfunction with male patients (Table 3). More than half of the nurses (64.3%) never discussed sexual dysfunction with a new patient, and over two-thirds (72.9%) never discussed sexual dysfunction in a subsequent follow-up session either.

Renal nurses rated their level of knowledge about sexual dysfunction. Only some nurses (15.7%) indicated minimal levels of knowledge, 30% of nurses indicated sufficient levels of knowledge, and 34.3% only had some knowledge about sexual dysfunction. When levels of competence were measured, less than half (48.6%) felt competent to discuss sexual dysfunction with patients. Almost all participants (84.3%) reported that they had never received any ongoing workplace training related to discussing sexual dysfunction with renal patients; however, most nurses still agreed (75.7%) that sexual dysfunction became worse with the commencement of HD treatment (see Supporting Information S1: Table S2).

In the Van Ek survey, participants received a list of possible barriers that could discourage them from discussing sexual concerns. Most participants reported insufficient practical training (74.2%) followed by barriers related to the patient's culture and religion (72.8%) as reasons for not engaging in discussions about sexual

TABLE 1 Participant characteristics.

	n (%)[a] *M* ± SD
Gender (*n* = 64)	
Women	42 (60%)
Men	22 (31.4%)
Years of experience in renal nursing (years; *n* = 63)	13.10 ± 9.14
Age (*n* = 64)	
≤45 years	29 (41.5%)
≥46 years	35 (50%)
Religion (*n* = 65)	
Religious	14 (20%)
No religion	47 (66.9%)
Prefer not to answer	2 (2.9%)
Other	2 (2.9%)
Ethnic background of the nurse (*n* = 65)	
Caucasian	35 (50%)
Other	30 (42.8%)
Highest level of qualification (*n* = 62)	
Bachelor's degree	19 (27.1%)
Postgraduate degree/diploma, Master's degree/PhD	43 (61.4%)
Employment status (*n* = 63)	
Full-time employment	45 (64.3%)
Part-time/casual employment	18 (25.7%)
Current nursing position (*n* = 65)	
Enrolled nurse	2 (2.9%)
Registered nurse	38 (54.3%)
Other than a registered nurse	25 (35.9%)
Location of work (*n* = 64)	
Queensland	17 (24.3%)
New South Wales	29 (41.4%)
Australian Capital Territory	9 (12.9%)
South Australia	2 (2.9%)
Western Australia	1 (1.4%)
Victoria	3 (4.3%)
Northern Territory	1 (1.4%)
New Zealand	2 (2.8%)
Area of work (*n* = 74)[a]	
In-centre HD unit	59 (84.3%)
Other than HD unit	15 (21.3%)

Abbreviations: HD, haemodialysis; *M*, mean; *n*, number; SD, standard deviation.

[a]May differ as some questions were not answered consistently; some were omitted.

[b]More than one answer was allowed.

concerns (see Supporting Information S1: Table S3). In addition, over half of the participants (57.1%) reported they did not have enough time to discuss sexual dysfunction with patients. Conversely, most participants reported sexual dysfunction as not being a problem for the patient and was rated the lowest barrier by renal nurses (5.7%). Only 10% stated someone else was accountable for discussing sexual dysfunction with patients, whereas (15.7%) of nurses agreed a sense of shame was a barrier to having discussions about sexual dysfunction. A small number of nurses, one-fifth (20%) considered sex as a private issue, whereas 27.1% of participants felt uncomfortable talking to patients about sexual dysfunction.

Questions in this same survey inquired about renal nurses' views on accountability and the responsibility of discussing sexual dysfunction with adults receiving HD. Participants were asked to indicate who was accountable for discussing sexual dysfunction. Over 60% of participants agreed the dialysis nurse was accountable, followed by the nephrologist (32.9%), transplant surgeon (24.3%), and social worker (20%). Interestingly, an overwhelming number of participants (82.9%) said there were no existing guidelines or policies in their renal unit about discussing sexual dysfunction or the delegation of accountability for talking about sexual dysfunction with patients (see Supporting Information S1: Table S4).

Levels of confidence in discussing sexual dysfunction were measured by the SHEPS, confidence in communication subscale (Ross et al., 2018). Nearly half of the nurses (42.9%) were confident in communicating with patients aged 41–65 years, whereas some nurses (35.7%) were confident communicating with patients aged 18–40 years. Over a quarter of nurses (27.2%) were also confident when providing sexual healthcare to patients who were identified as lesbian, gay, bisexual, transgender, intersex, queer, or asexual (LGBTIQA+). Over 40% of nurses reported they were not confident in communicating with patients with a physical disability (44.9%), whereas almost half of the participants (47.2%) were not confident when providing sexual healthcare to patients with religious convictions about sex. About one-third of nurses (32.8%) did not consider themselves confident enough to converse with patients who had liberal beliefs about sex (see Supporting Information S1: Table S5).

Similar results were evident in confidence levels of practical knowledge when providing sexual healthcare (see Supporting Information S1: Table S6). The results show only 14.3% of nurses were very confident about their levels of practical knowledge when providing sexual healthcare to patients aged 18–40 years; however, 41.4% were confident with patients aged 41–65 years and 37.1% with patients >65 years. Only 12.9% of nurses were not very confident about their level of practical knowledge when providing care to patients whose gender was the same as the nurse, compared with patients whose gender was different to the nurse (18.6%). Nearly a quarter of nurses (21.4%) were also not very confident about their level of knowledge in providing sexual healthcare to patients who required more specialised sexual health treatment.

Renal nurses had positive attitudes towards discussing sexual dysfunction, as measured by the SHEPS attitudes and belief subscale (Supporting Information S1: Table S7). Nearly half of the nurses

TABLE 2 Van Ek survey: Discussing sexual dysfunction with patients.

	Never, *n* (%)*	In less than half the cases, *n* (%)*	More than half of the cases, *n* (%)*	Always, *n* (%)*	Not applicable, *n* (%)*
How often:					
Do you discuss sexuality with a new patient?	45 (64.3%)	16 (22.9%)	0	1 (1.4%)	1 (1.4%)
Do patients express sexual complaints spontaneously?	39 (55.7%)	22 (31.4%)	1 (1.4%)	0	10 (14.3%)
Is the partner of the patient present while discussing sexuality?	40 (57.1%)	8 (11.4%)	4 (5.7%)	0	10 (14.3%)
Do you discuss sexuality with patients during follow-up?	51 (72.9%)	8 (11.4%)	1 (1.4%)	0	2 (2.9%)

Note: **n* (%) differs because the questions were not answered consistently; some were skipped or forgotten.

TABLE 3 Van Ek survey: Age and gender of patients.

How often do you provide information regarding sexual dysfunction to a patient in relation to their age and gender?	Never, *n* (%)*	Sometimes, *n* (%)*	Regularly, *n* (%)*	Often, *n* (%)*
Patient's age				
16–35 years	30 (42.9%)	25 (35.7%)	3 (4.3%)	2 (2.9%)
36–50 years	36 (51.4%)	22 (31.4%)	1 (1.4%)	2 (2.9%)
51–65 years	47 (67.1%)	12 (17.1%)	0	2 (2.9%)
66–75 years	51 (72.9%)	9 (12.9%)	0	1 (1.4%)
76 years and older	55 (78.6%)	4 (5.7%)	0	1 (1.4%)
Patient's gender				
Women	44 (62.9%)	16 (22.9%)	1 (1.4%)	0
Men	34 (48.6%)	24 (34.3%)	3 (4.3%)	0

Note: **n* differs because the questions were not answered consistently; some were skipped or forgotten.

(42.9%) strongly agreed that sexual problems were serious issues that needed to be addressed. Just over half of the nurses (57.1%) strongly agreed that being trained in providing sexual healthcare was important, and 48.6% indicated they would use training in their practice if they had it. Additionally, 42.9% of nurses strongly agreed they wanted to be a resource in the future for patients with sexual health concerns. Interestingly, only two nurses (2.95%) strongly agreed that they felt uncomfortable providing sexual healthcare to patients.

Further analysis was conducted to identify differences between demographic characteristics, the Van Ek survey, and the SHEPS (see Table 4). A Mann–Whitney *U* test found significant differences between demographic characteristics although gender and age of the nurse showed no statistical significance. The ethnicity of the nurse was significant ($p < 0.05$), as those who identified as Caucasian indicated higher levels in the frequency of discussions ($M = 19.60$) than those who identified as not Caucasian ($M = 11.67$, $U = 60$). Employment was another significant aspect ($p < 0.05$), as nurses employed part-time had significantly higher rates of frequency in discussions with patients ($M = 32.68$) than those nurses employed full-time ($M = 22.78$).

Within the SHEPS communication subscale, significant gender differences were apparent ($p < 0.05$), with male nurses showing significantly higher confidence in communicating *($M = 33.64$)* than female nurses ($M = 23.59$, $U = 217.5$). The age of the participants was significant, as nurses aged 45 years and younger had higher levels of confidence in communication ($M = 33.40$) than nurses 46 years and older *($M = 22.41$, $U = 215$)*. Ethnic group was again significant, as nurses who identified as Caucasian had a lower level of confidence ($M = 17.09$) in communication compared with those who identified as not Caucasian ($M = 25.41$, $U = 213.5$).

Within the SHEPS practical knowledge subscale, a Mann–Whitney *U* test also indicated significant differences between genders ($p < 0.05$), with male nurses showing higher levels of confidence

TABLE 4 Differences between demographic information, Van Ek survey, and SHEPS.

	Van Ek survey	SHEPS: Communication	SHEPS: Practical knowledge	SHEPS: Attitudes and beliefs
	Mean rank (*n*)	Mean rank (*n*)	Mean rank (*n*)	Mean rank (*n*)
Gender				
Women	25.12 (30)	23.59 (33)	20.16 (34)	29.40 (35)
Men	26.08 (20)	33.64 (21)	37.68 (17)	25.55 (20)
Mann–Whitney *U* test	288.5	217.5	90.5	399
Standardised test statistic (*Z*)	−0.228	−0.2.291	−3.971	0.891
p value	0.820	0.022*	<0.001*	0.373
Age				
≤45 years	24.42 (25)	33.40 (25)	30.09 (23)	27.20 (25)
≥46 years	26.58 (25)	22.41 (29)	22.61 (28)	28.67 (30)
Mann–Whitney *U* test	339.5	215	228	395
Standardised test statistic (*Z*)	.525	−2.561	−1.781	.351
p value	0.600	0.010*	0.075	0.725
Religion				
Religious	23.47 (31)	28.47 (33)	27.27 (33)	30.29 (34)
Not religious	28.82 (19)	25.98 (21)	23.67 (18)	24.29 (21)
Mann–Whitney *U* test	357	314.5	255	279
Standardised test statistic (*Z*)	1.262	−0.568	−0.829	−1.404
p value	0.207	0.507	0.407	0.160
Ethnic group				
Caucasian	19.60 (25)	17.09 (27)	14.43 (23)	17.65 (27)
Other	11.67 (9)	25.41 (11)	23.91 (11)	24.05 (11)
Mann–Whitney *U* test	60	213.5	197	198.5
Standardised test statistic (*Z*)	−2.054	2.094	2.598	1.630
p value	0.041*	0.035*	0.008*	0.108
Education				
Bachelors	26.25 (16)	29.18 (17)	27.62 (17)	27.72 (18)
Higher than a bachelor	24.39 (33)	25.20 (35)	24.41 (33)	27.39 (36)
Mann–Whitney *U* test	284	343	316.5	328
Standardised test statistic (*Z*)	0.427	0.888	0.738	0.076
p value	0.669	0.374	0.460	0.939
Employment				
Part time	32.68 (11)	14.82 (14	9.81 (13)	23.57 (15)
Full time	22.78 (38)	30.80 (38)	30.49 (36)	28.36 (38)
Mann–Whitney *U* test	124.50	429.5	431.5	336.5
Standardised test statistic (*Z*)	−2.029	3.376	4.478	48.792
p value	0.042*	<0.001*	<0.001*	0.291

TABLE 4 (Continued)

	Van Ek survey	SHEPS: Communication	SHEPS: Practical knowledge	SHEPS: Attitudes and beliefs
Position				
RN	22.36 (32)	27.32 (34)	26.37 (31)	25.38 (22)
Higher than an RN	27.50 (15)	23.35 (17)	19.41 (16)	27.14 (18)
Mann–Whitney *U* test	292.5	244	174.5	317.5
Standardised test statistic (*Z*)	1.201	−0.900	−1.652	.421
p value	0.230	0.368	0.098	0.673
Location of work				
Not in-centre HD	29.43 (15)	22.44 (18)	19.06 (18)	30.16 (19)
In-centre HD	23.81 (35)	30.03 (36)	29.79 (33)	26.86 (36)
Mann–Whitney *U* test	321.50	233	172	383
Standardised test statistic (*Z*)	1.251	−1.671	−2.466	.754
p value	0.211	0.095	0.014*	0.451

Abbreviations: FT, full time; HD, haemodialysis; PT, part time; RN, registered nurse; SHEPS, sexual health professional scale; *U*, Mann–Whitney test; Z, standardised test statistic.

*$p < 0.05$.

in practical knowledge of sexual healthcare ($M = 37.68$) than female nurses ($M = 20.16$, $U = 90.5$). Caucasian nurses also reported significantly lower confidence in their practical knowledge of sexual healthcare than non-Caucasian nurses ($M = 14.43$ vs $M = 23.91$, respectively, $U = 197$). Type of employment was statistically significant, as nurses employed full-time had higher levels of confidence in practical knowledge ($M = 30.49$) compared with those employed part-time ($M = 9.81$, $U = 431.5$). In addition, there was a significant difference in terms of age, as nurses aged 45 years and younger had higher levels of confidence in practical knowledge ($M = 30.09$, $U = 228$) than nurses 46 years and older ($M = 22.64$). Nurses working in-centre HD also had higher confidence in their levels of practical knowledge of sexual healthcare ($M = 29.79$) compared with nurses working in areas that were not in-centre HD ($M = 19.06$, U = 172). Further analysis was conducted to assess possible relationships between the Van Ek survey, SHEPS subscales, and years of renal nursing experience, but there was no correlation.

DISCUSSION

This study is one of the first to identify that nurses working in HD units have positive attitudes towards providing sexual healthcare, and over half of nurses also believed sexual problems were serious issues that should be addressed. Further, in the study, very few nurses indicated personal discomfort in providing care to adults with sexual issues. Interestingly, few renal nurses considered 'sex as a private issue,' and over half of the nurses felt no shame in discussing sexual health matters with patients. These results suggest renal nurses are not bound by feelings of shame or hesitancy when discussing sexual concerns with patients. Discussing sexual issues is important for both patients and nurses as it demonstrates person-centred care and allows the patient to feel their sexual concerns are not being overlooked (Åling et al., 2021; Ross et al., 2021; Zhang et al., 2020).

The results of this study suggest that renal nurses have sufficient levels of confidence in providing sexual healthcare but rarely discuss sexual dysfunction with patients. The study found that younger nurses had higher levels of confidence in their sexual health knowledge compared to older nurses. Several studies have found that younger nurses may have more open-minded and liberal attitudes about sexual issues that are not bound by traditional views about sex (Annerstedt and Glasdam, 2019; Rees et al., 2021; Thys et al., 2019). However, Potts (2021) found the opposite, as nurses 46 years and older were likely to be more confident and engage in conversations about sexual concerns with rehabilitation patients. Fackler (2019) and Markowski et al. (2020) also suggested that older nurses have broader life experience and the ability to manage difficult conversations, although this was not the situation with this current study of renal nurses.

This study also found that nurses from other ethnic backgrounds were more likely to be confident when providing sexual healthcare. These results are different to previous applications of the SHEPS (Ross et al., 2018; Zamboni & Ross, 2020); however, in the other studies, there were varied levels of confidence and not all the participants were nurses (Ross et al., 2018; Ross et al., 2021; Zamboni & Ross, 2020). The implementation of additional resources and education for kidney healthcare professionals may assist some

nurses to discuss sexual concerns more confidently regardless of ethnic background.

The study found that renal nurses did not discuss sexual health matters with patients, and the findings are similar to the Van Ek et al. (2018) study of Danish renal nurses. In other areas of nursing, such as cardiology, nurses also rarely discussed sexual concerns as well and experienced similar types of barriers (Bdair & Maribbay, 2020; Hoekstra et al., 2012; Wang et al., 2019). Hoekstra et al. (2012) found that if sexual concerns were discussed, it was likely to occur in the follow-up subsequent conversation as opposed to the first initial interaction in cardiac nursing (Hoekstra et al., 2012; Karani & McLuskey, 2020).

Nursing knowledge and competence regarding sexual dysfunction are also important components when providing care to adults with kidney failure. Unfortunately, this study identified that only some nurses felt they had sufficient levels of knowledge and competence in discussing sexual dysfunction. Although most undergraduate nursing programs provide education about the effects of chronic disease on sexual function (Bekman et al., 2023; Prize et al., 2023), the results of this study indicated that renal nurses may require more specialised education about how to discuss sexual concerns with patients (McKeaveney & Dumanski, 2024). Other researchers have identified the important link between nursing knowledge, competence, and the delivery of specialised education, as those who have received it tend to be more willing to address the sexual concerns of the patient (McGrath et al., 2021; Ussher et al., 2022; Schaller et al., 2020).

In the current study of renal nurses, the barriers to discussing sexual dysfunction were a lack of practical training, insufficient time, and patients' culture, religion, language, and ethnicity. The same barriers have also been identified with rehabilitation nurses, as some nurses avoided discussing sexual issues as they feel ill-equipped and unprepared (Fennell & Grant, 2019; Pascual et al., 2021). Other barriers, such as a lack of time are certainly not new, as nurses from other health areas have struggled with time management as well, and often prioritise 'the basics' such as wound care management, medications administration, and personal care over discussing sexual concerns (Fennell & Grant, 2019; Hill & Neylon, 2023).

Other barriers found in this study were patients' culture, religion, language, and ethnicity, and these prevented nurses from engaging in discussions about sexual matters. Cultural diversity between a nurse and a patient is a recognised barrier in discussing sexual health concerns (Bdair & ConsTantino, 2017; Karani & McLuskey, 2020; Mangolian et al., 2021). There are many challenges in discussing sexual concerns with patients who are from culturally diverse and linguistic backgrounds, which may result in nurses avoiding discussions about sexual concerns for fear of being inappropriate with the patient (Bdair & Maribbay, 2020; Karani & McLuskey, 2020; Mangolian et al., 2021). Other areas of nursing experience similar barriers based on culture. For instance, cardiac nurses consider patients' culture, religion, language, and ethnicity to be barriers to providing sexual healthcare, as the nurse may be unsure whether the patient is open to discussing sexual concerns (Ezhova et al., 2020; Zhang et al., 2020).

Limitations

This study does have limitations. First, the sample size was small despite a prolonged recruitment time, which may restrict the generalisability of the results. The study surveyed only a small number of renal nurses who were RSA members; nurses who were not a member were excluded. In addition, only two participants were from New Zealand. There were some limitations with the instruments used in this study as most answers in the Van Ek survey and SHEPS were multiple-choice and some participants may have exhibited the tendency to 'agree' with statements. Some of the terms used in the instruments may also have caused confusion as several questions used the term 'sexuality' as opposed to 'sexual healthcare.' The original SHEPS had 115 items, which was reduced to 42 items in this study; this made it difficult to compare the results of our study to other studies that have used the SHEPS instrument (Ross et al., 2018; Ross et al., 2021; Zamboni & Ross, 2020).

IMPLICATIONS FOR CLINICAL PRACTICE

The findings of this study may provide insight for renal nurses who are unaware of the impact of overlooking discussions about sexual dysfunction. The implications of this study for nursing practice may include the introduction of nurse-specific actions in addressing sexual concerns tailored to the HD unit. Examples could include a section within the patient's monthly care plan that prompts renal nurses to ask about sexual concerns. The inclusion of predetermined questions within the care plan may allow renal nurses to ask about sexual concerns without having to construct the questions, making conversations about sexual dysfunction easier. In addition, the inclusion of a sexual function assessment within care plans may create a pathway for reporting patient sexual concerns and discussing sexual dysfunction more frequently. Within clinical practice, creating a suitable environment for discussing sexual concerns is important, as this study has identified that there are many patient and environmental barriers.

CONCLUSION

This study identified that renal nurses rarely discuss sexual dysfunction and only some had sufficient knowledge about sexual dysfunction despite positive attitudes towards providing sexual healthcare. Some renal nurses had sufficient levels of confidence but still did not discuss sexual concerns with patients. Almost all nurses felt no shame or embarrassment in addressing the sexual

concerns of the patient, however, renal nurses lacked the knowledge and competence to discuss sexual dysfunction. Furthermore, while an absence of practical training in discussing sexual dysfunction was identified, almost all nurses welcomed the opportunity for further training in this area.

AUTHOR CONTRIBUTIONS

Amanda L. Mckie: Conceptualisation; methods; formal analysis; writing—original draft. **Amornrat Saito**: Data interpretation; review; editing and final approval of the manuscript. **Theresa Green**: Data interpretation; review; editing and final approval of the manuscript. **Ann Bonner**: Conceptualisation; methods; data interpretation; review; editing and final approval of the manuscript.

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CONFLICT OF INTEREST STATEMENT

The authors declare no conflict of interest.

DATA AVAILABILITY STATEMENT

The data that support the findings of this study are available in the supplementary material and from the corresponding author upon reasonable request.

ETHICS STATEMENT

The study was approved by the Griffith University Research Ethics Committee (GU Ref No; 2021/470). The study conformed to the National Statement on Human Experimentation by the National Health and Medical Research Council, Australia. A secure online survey was used, and the participants were provided with information about the study before they started the survey. Clicking to the next page indicated consent to participate in the study.

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SUPPORTING INFORMATION

Additional supporting information can be found online in the Supporting Information section at the end of this article.

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