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ARTICLE

The complexities of implementing an LGBT inclusion scheme in residential care: sharing knowledge, overcoming opposition and producing in- and exclusion

Roos Pijpers and Krystel Honsbeek

Institute for Management Research, Radboud University, Nijmegen, The Netherlands
Corresponding author: Roos Pijpers; Email: roos.pijpers@gmail.com

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Abstract

A growing number of organisations in residential care for older people are working towards safe and inclusive environments for LGBT residents. In the Netherlands, these efforts are supported by an LGBT inclusion scheme called 'Pink Passkey'. Drawing on critical organisational diversity studies, the paper understands inclusion as 'accomplished' in interactions across difference, and as always inherently partial (*i.e.* exclusion-producing). Qualitative methods are used to study the implementation process of the Pink Passkey in two nursing homes during one year. In sum, the paper contributes evidence of positive change associated with the use of the Pink Passkey as an inclusion scheme characterised by a long-term, open-ended and comprehensive approach. Compared to fixed-term projects and stand-alone measures described in previous LGBT ageing literature, an inclusion scheme helps to gain sustained attention to sexual and gender diversity (despite gaps in the implementation process), to normalise it more and to overcome opposition (though this does not disappear). The inclusion accomplished is, indeed, partial: bisexual, transgender and other gender non-conforming identities are less represented than gay and lesbian identities. Also, there is an emphasis on residents' agency to disclose LGBT identities and preferences, which excludes involuntary same-sex sexual expressions caused by disinhibited behaviour. The paper ends by suggesting disinhibited behaviour in older LGBT adults as an issue of interest to the wider literature on LGBT ageing, given the increasing prevalence of dementia and Parkinson's disease. Here, the role of care professionals who are able to understand and respond to bodily cues that echo struggles with otherness merits further consideration.

Keywords: LGBT inclusion scheme; residential care; critical organisation diversity studies; The Netherlands

Introduction

A growing number of organisations in residential care for older people in the Netherlands are working towards safe and inclusive environments for lesbian,

gay, bisexual, transgender and intersex (LGBTI) residents. They are supported by an inclusion scheme called Pink[1] Passkey (*Roze Loper* in Dutch), promoted by COC Netherlands, one of the oldest LGBTI advocacy organisations in the world. While it is up to care organisations themselves to devise a way to use the Pink Passkey, COC Netherlands recommends paying attention in policies, communication, activities and staff training on a regular basis (Linschoten and Boers, 2014; Meijsen, 2016). The aim of this paper is to understand the scope and limits of the Pink Passkey in creating awareness in organisational structures and daily care provision. To this end, the paper presents the results of a one-year qualitative study into the process of implementing the Pink Passkey in two nursing homes of a large care organisation.

The paper contributes to a growing but still limited body of academic research on attention and practical action with respect to LGBT inclusion in residential care. Most of this literature has focused on attitudes of managers and care-giving staff (Hinrichs and Vacha-Haase, 2010; Neville *et al.*, 2015; Willis *et al.*, 2016; Ahrendt *et al.*, 2017; Simpson *et al.*, 2018; Caceres *et al.*, 2020), suggesting that, in the absence of attention to sexual and gender diversity, organisations and staff tend to understand the best way of supporting LGBT residents and clients is to avoid any differentiation between residents. An adjacent debate, on knowledge and attitudes of nursing staff with respect to aged sexuality (*e.g.* Bauer *et al.*, 2007; Mahieu *et al.*, 2016; Simpson *et al.*, 2017*b*; Roelofs *et al.*, 2019), discusses LGBT residents and clients from the perspective of 'diverse sexualities' (Mahieu *et al.*, 2016: 619), arguing that there is much room for improvement with respect to knowledge and attitudes concerning sexual and gender diversity more generally. The few studies on preferences *and* experiences of older LGBT care receivers show that a 'one-size-fits-all' approach (*see also* Westwood, 2016) stands in the way of disclosure. To encourage openness in LGBT care receivers, these studies have suggested that care-givers be more explicit and proactive in signalling their own openness towards, or interest in, LGBT issues (Grigorovich, 2016; Willis *et al.*, 2016; Pijpers, 2022).

To our knowledge, only a handful of studies have investigated practical action to develop alternatives to a 'one-size-fits-all' approach (Hafford-Letchfield *et al.*, 2018; Leyerzapf *et al.*, 2018; Sussman *et al.*, 2018; Willis *et al.*, 2018). The studies by Hafford-Letchfield *et al.* (2018) and Willis *et al.* (2018) reflect on the results of the Care Home Challenge, a one-year action research project carried out in six care homes of a large care organisation in the United Kingdom (UK). In this project, advisors from local LGBT communities worked with care home managers to identify barriers to and possibilities for LGBT-friendly care provision. Starting out from low levels of awareness in the six care homes, through advisory sessions and the provision of visual material, this awareness has been increased. Due to work pressure and what was perceived as an underlying 'quiet' reluctance to engage with the topic, community advisors struggled to get managers' attention and involvement in training sessions. To achieve change, the authors see merit in distributing leadership roles between managers and 'locally appointed LGBT champions' (Hafford-Letchfield *et al.*, 2018: 318). Sussman *et al.* (2018) provide an overview of practical action in 32 care homes across Canada on the basis of telephone interviews with administrative staff. They show that a majority of these

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care homes invest in training programmes, while smaller numbers engage in LGBT thematic programming, regular contacts with LGBT networks, inclusive language and a strategic policy approach (Sussman *et al*., 2018). Leyerzapf *et al*. (2018) highlight experiences with so-called 'Pink Salons', meeting activities for LGBT residents and members from the wider LGBT community, in three Dutch nursing homes with a Pink Passkey. Participants appreciate the social contact with like-minded people, but they also feel the Salons lead to 'hypervisibility' (Leyerzapf *et al*., 2018) of particular, namely 'out and proud' LGBT-community identities, unintentionally emphasising differences. Therefore, many participants prefer mixed activities, which they see as more likely to challenge heteronormativity and prejudice.

The present paper contributes to this literature by studying an LGBT inclusion scheme, as a particular form of working towards safe and inclusive environments in residential care. An inclusion scheme differs from an action research project in that it is a long-term investment in organisational change, unconnected to specific project periods. The Pink Passkey, moreover, is a relatively open-ended approach (*see* above). While goals and means are broadly specified, no outcome and impact measures are predefined. Further, inclusion schemes like the Pink Passkey encourage organisations to build commitment in strategic policies and across the organisational hierarchy, in addition to taking practical action. In principle, this also represents a comprehensive approach to LGBT inclusion, which merits a study on its own.

The paper uses a conceptualisation of inclusion borrowed from critical organisational diversity studies (Gagnon and Cornelius, 2000; Roggeband and Verloo, 2006; Zanoni *et al*., 2009; Ahmed, 2012; Dennissen *et al*., 2019; Zippel and Ferree, 2019; Janssens and Steyaert, 2019*a*, 2019*b*; Dobusch, 2021). Contributions to this literature:

> …share … a non-positivistic, non-essentialist understanding of diversity – as well as the socio-demographic identities subsumed under this term – as socially (re) produced in ongoing, context-specific processes. Crucially, they underline how such processes and the resulting understandings both reflect existing unequal power relations within a given context and contribute to maintaining, resisting and/or transforming them. (Zanoni *et al*., 2009: 10)

With respect to inclusivity policies and measures, focusing on equality in access, resources and recognition, this literature has suggested that organisational structures and contexts stand in the way of (fuller) inclusion. Roggeband and Verloo (2006: 628), for example, have argued that 'conditions of liquidity', *i.e.* a constant change and replacement of positions and individuals occupying them, hamper organisational change. Dobusch (2021) argues that inclusivity often presupposes the ability to build and enjoy social relationships, whether in teams of colleagues, in interactions with organisational leaders, in diversity groups or in recruitment and promotion procedures. However, not all employees have or desire social relationship skills and therefore risk not being recognised and/or not feeling in place (Dobusch, 2021). This presumtion may also unintentionally downplay attention to other skills, such as productivity and creativity.

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Further, inclusivity policies and measures have been shown to be ineffective in integrating the concerns and aspirations of individual employees with those of organisational leaders (Gagnon and Cornelius, 2000). This, crucially, points to the inherent difficulty of having measures that are supposed to address unequal power relations solicited or approved by those in power (Zanoni *et al.*, 2009). Consequently, they are often unsuccessful in addressing actually existing inequalities (Ahmed, 2012; Dennissen *et al.*, 2019). Drawing on social practice theory, Janssens and Steyaert (2019*a*: 526) explain the limitations of inclusivity instruments through the 'hierarchical, racialized and male gendered' doings and sayings (also known as social practices) that constitute everyday organisational contexts.

This same practice focus, however, has recently redirected analytical attention to organisational inclusion, which, in comparison to inclusivity, is more about the ability to be yourself and to flourish. Janssens and Steyaert (2019*b*: 1157; *see also* Dobusch, 2021) argue that inclusion is accomplished ('produced') in routine-based, embodied interactions, to be precise, when interactions across difference are actively and constantly encouraged, which challenges and suspends norms and helps to build affective bonds. Understood as a layered social practice, it is easier to acknowledge inclusion as always partial and as potentially having exclusionary consequences (Dobusch, 2021).

Inspired by this conceptualisation, we posit that as an inclusion scheme, the Pink Passkey (a) is implemented in, and as part of context-specific processes of (re)producing sexual and gender diversity, and (b) is contributing to positive change or, in the vocabulary of social practice theory, transformation (Shove *et al.*, 2012), when inclusion is accomplished partially, in daily interactions whether or not directly related to Pink Passkey activity. This understanding allows us to study accomplishments with respect to issues such as distribution of leadership roles, thematic programming and staff training. In addition to previous research, we also take into account mixed, or rather general activities, as well as daily care provision, notably nursing and expressive therapy. The focus on expressive therapy corresponds well with social practice theory's emphasis on body and materiality, alongside ideas and attitudes (Janssens and Steyaert, 2019*a*).

The Pink Passkey: an LGBT inclusion scheme for aged care in the Netherlands

Across the Netherlands, there are over 160 care spaces with a Pink Passkey, most of them nursing homes, but increasingly also home care divisions and social care organisations (*see* Figure 1). The two nursing homes under study are located in the city of Den Bosch. The Pink Passkey is also applied in Germany (*Regenbogenschlüssel* in German) by care organisations in the city of Frankfurt. In the UK, a similar scheme called Pride in Care, supported by Care England, is offered by LGBTI advocacy organisation Opening Doors London.

The first Pink Passkeys were awarded in 2008, in the form of a celebration at the care home that received the award, with music, speeches and pink decoration, by a group of activists from a local chapter of COC Netherlands. In

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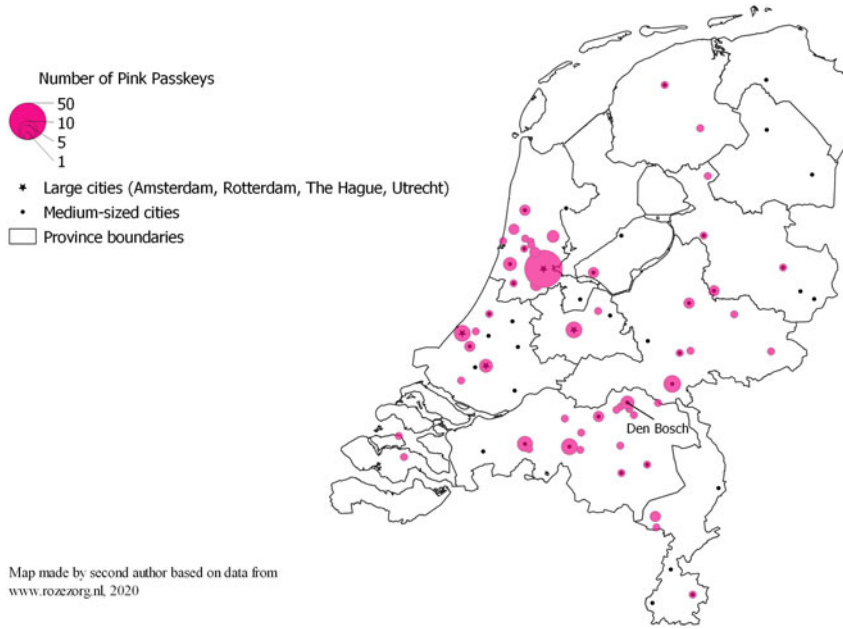

Figure 1. Nursing homes with a Pink Passkey in the Netherlands.

those days, it was seen mostly as an incentive for care organisations with an interest in working on LGBT issues. Since then, the Pink Passkey has professionalised in three ways. First, it has evolved into a formal co-operation between COC Netherlands and ANBO, an advocacy organisation for older people. Second, it is now offered as a quality certificate: in order to obtain a Pink Passkey, organisations need to go through an auditing procedure which is repeated every three years. This procedure mostly checks if levels of attention are maintained. Obtaining a Pink Passkey involves a preparation and lobby process initiated by Pink Ambassadors, local volunteers of COC Netherlands working on outreach to care organisations. Third, the Pink Passkey is included in a national register of social interventions[2] (Meijsen, 2016), and is backed up by documents with instructions (Linschoten and Boers, 2014; Meijsen, 2016) and an evaluation report (Kluit, 2016). The evaluation report was based on focus groups with residents, including small numbers of openly lesbian and gay residents, in five nursing homes with a Pink Passkey, and found that the Pink Passkey does make some residents feel more safe and at home, while others do not experience a marked difference. Themed activities help to create and maintain a certain degree of tolerance, which, however, also masks an ongoing disinterest among the majority of heterosexual residents, or lasts for a brief period of time only (Kluit, 2016). When staff who have been assigned or have taken on responsibility for implementing the Pink Passkey leave, *i.e.* the implementation shows signs of liquidity (Roggeband and Verloo, 2006), there is a risk that Pink Passkey activity comes to a standstill.

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Research approach

To study LGBT inclusion as a social practice co-shaped by the process of implementing the Pink Passkey, we opted for a qualitative research approach. Qualitative methods are used in to understand learning and change in health organisations (Bosio *et al.*, 2012). The research in the two nursing homes was carried out by the second author between September 2017 and June 2018. The analysis of the data and writing of the paper were carried out by the first author.

The empirical research consisted of participant observations and follow-up in-depth interviews covering a broad range of actors, activities and forms of daily care provision. Consent was obtained verbally from both the organisational key figures who introduced her to chairs of meeting, activity leaders, team leaders and therapists, and from these actors themselves. The participant observations took place during themed and general activities, staff training, nursing shifts and music therapy. One non-participant observation was performed during a therapy session of a medical care clown. Medical clown care is a paramedic care practice aimed at mitigating agitation, fear and loneliness using creative therapy forms such as magic and puppetry. In addition, participant observations took place at meetings of a diversity team and other meetings related to the implementation of the Pink Passkey. In total, the second author observed for 55 hours. All observed meetings and activities were recorded and transcribed verbatim, while also observational fieldnotes were taken. The second author was always formally introduced by the meeting chair or activity leader, and verbal consent was sought from participants. Permission for participant observation during nursing shifts was granted after obtaining ethical clearance in the form of a 'certificate of conduct'. Participation during nursing shifts consisted of assisting nursing staff with washing and dressing residents at one of the psychogeriatric wards, and engaging in staff interaction in dressing rooms and during coffee breaks. These interactions were recorded as well; fieldnotes were taken afterwards. Therapy sessions were not recorded; during these sessions, only fieldnotes were taken. All observations were accompanied by an observation guide.

The follow-up in-depth interviews aimed to discuss additional insights and experiences as well as tentative findings about how inclusion is practised or accomplished (Hitchings, 2012). Interviews were held with seven individuals: a spiritual counsellor, an external consultant specialising in organisational change, a psychologist specialising in aged sexuality, an internal consultant specialising in expressive therapy, a member of a team of social carers, a medical care clown and a music therapist. The interviews were accompanied by an interview guide, and were recorded and transcribed verbatim. In transcriptions and fieldnotes, residents appear either anonymously or with pseudonyms such as 'Mr A' or 'Mrs Z'. Staff and volunteers appear with their first and last name and their initials. To ensure confidentiality and anonymity, all recorded and written material was stored on an encrypted data server.

The data were processed using the qualitative analysis program Atlas-Ti, version 8. The authors applied template analysis (King, 2004; Brooks *et al.*, 2015), a particular version of thematic analysis (Braun and Clarke, 2006, 2021), which entails an iterative approach of going back and forth between preliminary themes and

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codes. Template analysis allows for the initial definition of themes which are likely to be useful for the analysis (Brooks *et al*., 2015). In this case, an example of an initially defined theme was reluctance, or opposition, to engage with the Pink Passkey, which resonates findings from the literature review (Hafford-Letchfield *et al*., 2018) and emerged readily from a first read through the dataset. The iterative approach is first applied to a sub-set of the data in order to create an initial 'template' for the analysis of all the data (Brooks *et al*., 2015). With the reviewing of this template, themes are redefined and new themes are generated. In this case, the analysis started with the interview data, and was then broadened to include the observation data. Eventually, three overarching themes remained, which will be discussed in detail in the next section. The first theme is named 'formal and informal knowledge sharing'. This theme includes processes of knowledge sharing in the context of the formal organisational structures supporting the Pink Passkey; as well as informal knowledge sharing in the context of daily care provision not related to Pink Passkey activity. The second theme is named 'opposition from managers and volunteers'. This theme describes continuity and change in opposition against training or activities offered in the framework of the Pink Passkey, and identifies 'overcoming opposition' as a context-specific process (Zanoni *et al*., 2009) on its own. The third theme is named 'the Pink Passkey as a construct of in- and exclusion'. This theme was identified by considering findings in the light of the argument that inclusion policies, measures and underlying ideas produce exclusion in and by itself (Dobusch, 2021). In particular, we will argue that the implementation of the Pink Passkey in the two nursing homes privileges some LGBT identities and orientations and same-sex sexual expressions over others.

To enhance the quality of the analysis, member-checking was applied (Jonsen and Jehn, 2009). A Dutch-language summary of the themes and specific findings associated with these themes was discussed with two staff members, the spiritual counsellor who participated in various research activities and a strategic policy officer, in June 2020. This member check also provided an update of the embedding of the Pink Passkey in organisational structures. Simpson *et al*. (2017*a*) have drawn attention to the challenges in researching intimacy and sexuality in residential care settings. These are about having to deal with the moral claim that the 'oldest' old should not be asked about sensitive issues like these, and with convictions about the oldest old not being interested in nor wanting to open up about intimacy and sexuality. In the present research, while these claims and convictions were found in volunteers (*see* below), this did not complicate the research itself.

Finally, we decided to include staff interpretations of expressions of residents with major cognitive problems, such as advanced dementia. This follows Tronto's (1993, 2013) argument that caring well requires people to be able to respond to the care they receive. However, in the case of people who are no longer able to respond verbally, '[o]thers in any particular care setting will also be in a position, potentially, to assess the effectiveness of the caring act(s)' (Tronto, 2013: 23). An ethical issue related to this approach is that staff interpretations may be coloured by the research aims and notions presented to them. In the present research, staff had not linked these expressions to same-sex orientations before, let alone to labels such as gay or lesbian.

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Formal and informal knowledge sharing

The most important entity responsible for 'phasing in' the Pink Passkey, both in individual nursing homes and in the wider care organisation, is the above-mentioned diversity team. At the time of the research, there was one team consisting of managers, actors who were invested from the start, such as the spiritual counsellor, and policy and communication staff. By 2022, the diversity team is led by a member of the Board of Governors and is supported by local teams representing different geographical catchment areas.[3] Themed activities organised under the flag of the Pink Passkey are included in the annual budget of nursing homes. Policy-wise, the Pink Passkey has been positioned in one of the organisation's strategic visions. This is featured on the website of the organisation.[4]

In the two nursing homes under study, a group of staff and volunteers called Pink Ambassadors, named after the Pink Ambassadors affiliated with COC Netherlands, is working on implementation in themed programming and daily wellbeing activities (participant observations of meetings with Pink Ambassadors, March and June 2018). The role of Pink Ambassadors was created with a view to sharing the ideas underlying the Pink Passkey more widely within the nursing homes (interview, spiritual counsellor, January 2018). This shows how responsibility with respect to implementation is divided between managers and locally appointed LGBT champions (Hafford-Letchfield *et al.*, 2018). During the research period, three themed activities were organised (for a short description, *see* Table 1).

The activities are open to the wider public and indeed many visitors come from the wider neighbourhood and the local LGBT community (participant observation of music performance, March 2018). At least one current resident has opted for one of the nursing homes because of the Pink Passkey activity there (participant observation of diversity team, March 2018). This is an intended effect of the Pink Passkey which has also been found in other care organisations with a Pink Passkey (Kluit, 2016). However, the share of visitors from, and concomitant hypervisibility (Leyerzapf *et al.*, 2018) of the local LGBT community at the themed activities also raised discussion (participant observation of diversity team meeting, March 2018). Part of this discussion was the question whether or not to organise Pink Salons at the nursing homes. While this issue was unresolved at the end of the fieldwork period, it was eventually decided against: since the primary goal of themed activities is awareness-raising, they remain primarily directed at residents, staff and volunteers.

Pink Ambassadors also intervene through the use of playful and colourful materials on special days (various participant observations with Pink Ambassadors and volunteers). Examples are boxes of sugar sweet hearts accompanied by a thought-provoking text card featuring the logo of the Pink Passkey on Valentine's day, flowers and text cards on International Day against Racism and Discrimination, and pink-coloured cakes on Pink Saturday. Efforts are also made to raise awareness during daily coffee moments. Pink Ambassadors support other staff and volunteers in doing so, *e.g.* by preparing a list of discussion topics (participant observations with volunteers, February 2018 and Pink Ambassadors, March 2018). Themed activities and low-level interventions were not evaluated

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Table 1. Themed activities observed during fieldwork period

Themed activity	Short description
Music performance	A collective of six female musicians from the city of Den Bosch who write songs with light-hearted feminist lyrics performed at one of the nursing homes. The performance was introduced with a short speech about sexual diversity. The collective wrote a song on the theme of being in the closet in the nursing home especially for the occasion.
Photo exhibition	On display were photographs of older LGBT-identifying citizens of the city of Den Bosch. Each photo was accompanied by a short text about the life history of the person who was pictured. The exhibition toured various nursing homes of the care organisation.
Film screening	The film *Four Minutes* was screened in one of the nursing homes. Set in a prison, this film tells the story of the intimate bond between two females, an elderly piano teacher and a talented inmate. After the screening, there was an informal discussion with drinks. The activity was co-organised with the local chapter of COC Netherlands.

(as argued above, the implementation of the Pink Passkey is not usually accompanied with outcome and impact measurement, which means there is no clear expectation of their impact on awareness). However, residents as well as staff and volunteers do refer to them during the activities and meetings where the second author observed, suggesting that some degree of inclusion is accomplished here (Janssens and Steyaert, 2019*b*; Dobusch, 2021).

Further, knowledge about sexual and gender diversity is disseminated via a diversity workshop with attention to the lifecourse histories and associated care needs of older LGBT people offered by the external consultant, and a staff training about intimacy and sexuality offered by the psychologist. In this training, sexual diversity is casually included, *e.g.* as a background to PowerPoint slides, and by using gender-inclusive language (participant observation of staff training, March 2013). Both the workshop and the training have only reached a relatively small number of staff (interviews, external consultant, February 2018 and psychologist, March 2018). This is partly the case because the size of the organisation, which features 30 nursing homes and many teams of care-givers. It is also partly the case because of reluctance and opposition, which is discussed in the next section.

Examples of informal knowledge sharing in the context of daily care provision were provided by personal care-giving and nursing staff. No-one among this staff that the second author talked to during the participant observations of nursing shifts was aware of the training opportunities. However, they contributed various experiences with openly lesbian or gay residents (participant observations of nursing shifts, May 2018). They recalled a (now deceased) lesbian woman who preferred not to be washed by a male care-giver, a preference they always tried to accommodate. The resident, in her turn, accepted the fact that she sometimes needed to wait for personal care a little longer. Another resident opened up about her interest in women after a care-giver herself had been open about her relationship with another woman. Further, they reported experiences with residents with dementia who show challenging sexual behaviour, such as masturbating in shared spaces or making sexual advances towards fellow residents or care staff. Several examples were given of

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male residents who had made sexual advances towards male care-givers. These examples concerned both men who were known to have a male partner and men who were or had been married to a woman (participant observations of nursing shifts, May 2018; interview, psychologist, March 2018; interview, internal consultant, December 2017). The fact that these same-sex sexual expressions are not linked to same-sex orientations or labels such as gay, lesbian or bisexual (*see* above) resonates the notion of 'practical cultural competences' (Van Herwaarden *et al*., 2021). These are competences to respond promptly to a situation where (cultural) difference plays a role without reflecting on underlying values and emotions. Later in the paper, we will discuss a case where staff called in 'analytical' cultural competences (Van Herwaarden *et al*., 2021), *i.e.* competences to analyse and reflect on these values and emotions. We argue that drawing on practical cultural competences alone inadvertedly collapses responsiveness to difference into a 'one-size-fits-all' approach (Westwood, 2016). Through calling in analytical cultural competences, by contrast, staff are more likely to accomplish inclusion (Janssens and Steyaert, 2019*b*).

However, since formal knowledge sharing has a limited reach, informal/embodied knowledge and practical cultural competences are not always complemented or supported with analytical cultural competences. This indeed suggests that the inclusion of LGBT identities, orientations, *etc*., is partial at best (Dobusch, 2021). At the same time, staff have first-hand experiences with residents who are explicitly negative about staff members who are either openly gay or whom they think might be gay (participant observations of nursing shifts, May 2018). As will be shown in the third empirical section, staff experiences with discrimination are taken seriously within the organisation, which is a prerequisite for the implementation of inclusivity schemes (Gagnon and Cornelius, 2000). Unfortunately, the data do not allow us to conclude whether the implementation of the Pink Passkey has helped to prevent discrimination (*see* Ahmed, 2012; Dennissen *et al*., 2019).

Opposition from managers and volunteers

Secondly, the analysis provides further insight into the forms of reluctance and opposition to initiatives to promote LGBT-friendly care environments. It shows, for example, how exactly 'quiet' reluctance (Hafford-Letchfield *et al*., 2018) underpins managers' arguments to keep off staff training:

> It's an opposition that is framed as we are not going to do anything with it because we are so busy. And I understand work pressure in care, I know they are busy, and I know priorities have to be made. And then the priority is to have a workshop about wound care, and there isn't any room for discussion about how this [sexual diversity] might be seen as a theme of wellbeing. So that is really very difficult. That is opposition framed as work pressure – I experienced this myself last summer – like, our staff members do not need to be trained in this issue, they are so open, they don't need training. Now it's really very difficult to break through that, because it's hard for me to say it is needed. Because I don't know these people at all. But to really claim that this isn't needed, this is not an issue here, everyone is accepting of everyone here. Yes if that is said, then for me that is opposition …

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> And yet, you need those managers and those team managers to get to the staff. (Interview, external consultant, February 2018)

On the one hand, the work pressure in care homes is a valid argument not to (be able to) prioritise staff trainings. On the other hand, the strength of this argument, and the hierarchical organisational practices (Janssens and Steyaert, 2019*a*) that support it, make it even more difficult to discuss the issue of staff openness towards and acceptance of LGBT diversity and verify the mentioned claim ('it isn't needed').

The findings further draw attention to reluctance and opposition from the side of volunteers. To our knowledge, the research published to date has not taken into account the role of volunteers in the transformation of practices around LGBT inclusion. In the Netherlands, nursing home staff and residents are supported by an estimated 100,000 volunteers (De Jong, 2020). By 2022, the one nursing home had 120 volunteers and the other had 70; both places had about a dozen less than before the outbreak of COVID-19. The demographics of the volunteer workforce have not changed; the majority in the one nursing home are aged over 60 and two-third are females; while the majority in the other nursing home are aged over 70, and fewer than a dozen are males. Like the residents, volunteers dominantly come from the local neighbourhood. Volunteers are involved in well-being activities, ranging from daily coffee moments to weekly or irregularly themed programming, and in one-to-one contacts with residents. Convincing volunteers about the possible benefits of the Pink Passkey has been a struggle in its own right. At the audit before obtaining the Pink Passkey, the council of volunteers reported a mostly negative and sceptical attitude towards the Pink Passkey (interview, spiritual counsellor, January 2018). This attitude reflected an underlying idea that sexual and gender diversity is a 'societal issue', and not an issue for a nursing home:

> Many volunteers don't have faith in it at all, they think the Pink Passkey is ridiculous and say things like 'our residents are not into this at all, they don't find it interesting at all. Two men dancing [themed activity predating the research in the nursing home were two men had danced together], nobody wants to go there'. Well, the room was packed with people, but no-one wanted to go there [cynical undertone]. There was a very strong opinion about what should be part of care and activities and what not. And that this societal issue is not relevant for these people who in fact only want to be pampered or play bingo and the like. This kind of feeling you got from those volunteers. (Interview, spiritual counsellor, January 2018)

Although it is not fully clear why there was such a strong disassociation with the topic of sexual and gender diversity and the alleged needs of nursing home residents, a possible explanation could lie in the fact that the majority of volunteers were socialised in the heydays of the welfare state and might see nursing homes as places where the 'oldest old' are to be cared for, without being confronted with a societal issue such as LGBT emancipation. In the case of the 'two dancing men', it is also possible that the manifest contestation of gender norms was confrontational for volunteers themselves. What may have surfaced, then, following

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Janssens and Steyaert (2019*a*), are ageist, heteronormative and gendered social practices, reproduced by a faction of a sizeable group within the organisation.

During the fieldwork period, two dedicated meetings for volunteers were organised to informally discuss the topic of sexual and gender diversity. At these meetings, volunteers told each other about gay and lesbian family and their struggles for (self-)acceptance. In this way, perceptions of what residents would (not) need and like were counterbalanced with voices of volunteers reconsidering (some of) their own dislikes and prejudices (participant observations of volunteer meeting, February 2018 and June 2018). These meetings also made clear that themed activities have made positive impressions as well. This was the case, for example, with an activity where young people were invited into the nursing home to talk about their coming out (participant observation of volunteer meeting, February 2018). Another strategy used to curb the dismissive attitude among volunteers is to involve the volunteer council of the organisation in events and meetings, and to introduce or present the Pink Passkey together with the council (interview, spiritual counsellor, January 2018). This suggests that responsibility to achieve change may be extended to volunteers as well (*see* Hafford-Letchfield *et al*., 2018).

Overcoming opposition, so the findings suggest, has become easier because of accomplishments in terms of rehearsing arguments, talking to individuals and groups, sharing stories and also lobbying. The Pink Passkey has been applied in the wider care organisation since 2012, and in the two nursing homes since 2016, where the preparation and lobby process took a year and a half, partly due to opposition (interview, external consultant, February 2018). At the time of the research, the diversity team was lobbying in yet other nursing homes and met with opposition yet again (participant observation of diversity team, March 2018). By 2020, however, 16 out of 30 nursing homes of the organisation had obtained a Pink Passkey. Also, new managers and staff in a co-ordinating role continue the work of their predecessors (interview, external consultant, February 2018). According to one manager, 'this pink [thing] belongs to the [nursing] home' (participant observation of diversity team, March 2018), indicating that, for her, the means and ends associated with the Pink Passkey have gradually become more normal. These accomplishments suggest that, at the time of the research, conditions of liquidity (Roggeband and Verloo, 2006) did not pose a major barrier to the continuity of the implementation process.

The Pink Passkey as a construct of in- and exclusion

Echoing Dobusch's (2021) line of reasoning about how inclusion policies, measures and underlying ideas inherently produce exclusion, the third theme draws attention to the context-specific processes (Zanoni *et al*., 2009) of in- and exclusion related to the implementation of the Pink Passkey. The analysis shows there are two such processes of in- and exclusion. The first follows from an intentionally broad interpretation of the Pink Passkey, using it to address a broad range of diversity issues (hence the diversity [*sic*] team and the representation of sexual diversity as one of several 'diversities' on the website of the organisation). The broad interpretation was pioneered initially by the spiritual counsellor, after oftentimes having been asked and having asked herself whether the Pink Passkey might be too specific

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given incidences of prejudice and discrimination within the nursing homes (interview, spiritual counsellor, January 2018). These victimise care-givers, nurses and medical doctors of colour, as well as some groups of residents, such as people with brain damage and people without family or visitors (interview, internal consultant, December 2017). Also people who first move into the nursing home face a certain risk of not being accepted by residents who are sometimes all too quick to judge (interview, internal consultant, December 2017).

The analysis suggests that the broad interpretation of the Pink Passkey may limit the ability to express bisexual, trans and intersex identities. Exemplary of how this ability may be limited in the process of implementing the Pink Passkey is a recurring conversation activity led by the spiritual counsellor. This conversation activity is structured around a central theme, introduced by means of a text or story, and contains liturgical elements such as prayer, music, candles and objects that materially represent the central theme. Two out of six conversation activities in which the second author took part were themed 'being yourself'. Attention was paid to the topic of sexual diversity as part of this theme. This unfolded as follows:

> Anna [counsellor] kicked off the first 'being yourself' conversation activity by putting a vase with wild flowers on the table. She tells the participants there must be at least five types of grass in there, and that seeing them together allows you to spot the differences between them. The participants look at the flowers in amazement. They try to name these and other grasses. Anna proceeds by showing a candle with pictures of five loaves of bread and two fish on it, upon which one of the participants summarises the Bible story about Jesus sharing the food among thousands of followers yet there is enough for everybody. Anna and other participants discuss the Bible story where Jesus gives his friends courage by telling them his Father's house has many rooms. Then, she asks participants what having a place, or being yourself, means to them. Responses vary from being listened to, to not being yourself when you are often ill and in need of care. When I am asked, I include in my answer that I can be myself when my feelings for other women are accepted. After a general discussion about parents' struggles to accept a homosexual child, Anna gently but directly invites one participant to tell about her gay son. This participant tells the others that her late husband and her son himself have struggled with acceptance, but that it is alright now. Her story encourages another participant to talk about her lesbian friends, while a third talks about her transgender grandchild. Other participants ask questions, nod in agreement, or listen quietly. (Fieldnotes, second author, participant observation of conversation activity, 4 June 2018)

Moving conversations to the topic of sexual diversity requires substantial moderation skills, both in terms of narrowing down the topic and in terms of making people feel safe enough to share a story (participant observation of conversation activities, 4 and 18 June 2018). In this process, bisexual and trans identities were only casually referred to, and intersex was omitted (participant observation of conversation activities, 4 and 18 June 2018). In the absence of proper moderation, however, conversations might not touch upon sexual diversity at all.

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During the other 'being yourself' conversation activity, the topic was brought into dialogue with issues of faith and religion. The two nursing homes are located in an area where the Catholic South of the Netherlands borders on the Protestant North, and some residents still vividly remember how they were not allowed to interact with children from 'the other' faith (participant observation of conversation activity, 18 June 2018). Other residents have experienced first-hand how difficult it was to date, let alone marry, a Catholic if you were a Protestant, and *vice versa* (participant observation of conversation activity, 18 June 2018). Residents use these examples to compare past and present: if what used to be deviant then has become accepted or normalised today, the same normalisation process might apply to sexual diversity (participant observation of conversation activity, 18 June 2018). Through encouraging interaction across difference in this way (*see* Janssens and Steyaert, 2019*b*), residents began to reinterpret norms around sexual diversity, and to voice empathy and understanding for people who struggle(d) with their sexuality. This example shows how the broad interpretation of the Pink Passkey accomplishes inclusion of LGBT identities by forging links with other diversities, albeit in very general terms. This, again, may imply that some sexual and gender identities may not be touched upon.

The second context-specific process of in- and exclusion follows from the emphasis on encouraging openness about LGBT life histories, identities and orientations, whether through themed activities (*see* Table 1), low-level interventions or staff training. The analysis of the observation and interview material involving expressive therapists points, once more, to *involuntary* same-sex sexual expressions caused by disinhibited behaviour, *e.g.* in a resident with Parkinson's disease:

> A few years ago, I visited a ward every week, and the staff there asked me to think along about a man who responded to staff in a weird way. They were not sure what to make of it. In the role of medical care clown, you see a bit more of people. When I approached this man, I just saw his gaze followed a male care-giver, I had seen that … As a medical care clown, you try to sense how far you can go with somebody, how close you can get. Are we going to do something, we are not going to do anything. So in the end he wanted to go outside; fine. Outside we were alone. That man was physically confined to a wheelchair, but mentally he was still quite capable of expressing himself … As soon as the care-giver was gone, he looks at me and he says, 'I think you understand it. That's such a nice care-giver'. So then I talked to him about have you had these feelings before. Then he said he was decently married and that he had had feelings for a long time, but that he had never been able to do anything with them. And now he was confronted with his feelings in a really harsh way. (Interview, internal consultant, also active as a medical care clown, December 2017)

According to medical-psychological dementia literature, expressive therapy offers people ways of re-engaging with positive emotions (Kontos *et al.*, 2016; Moreno-Morales *et al.*, 2020). Medical clown care, moreover, has been associated with responsiveness to culture and diversity (Rämgård *et al.*, 2016). More specifically, Beausoleil (2017) has argued that performers and therapists whose expertise it is to be responsive to bodily cues, whether from audiences or clients, have practical

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and analytical competences to accomplish inclusion in situated encounters such as the ones discussed here. This is because they are able to use their own bodies to 'tune into sensory cues' (Beausoleil, 2017: 309), drawing on a repertoire of (bodily) strategies to begin and carry on with such encounters.

> Tina [medical care clown] wears a pink legging, a patterned skirt with golden lining, and a pink and white striped shirt. She carries a green handbag, with three fake flowers peeping out. She looks decidedly different from how people would normally dress. Subtly, she makes contact with one of the residents at the ward, retaining this resident's attention by taking a large pearl necklace out of the green bag. She then moves along with the resident to a small indoor garden, responding to her utterings both verbally and non-verbally. Later, she puts the pearl necklace on another female resident, who responds by saying that a certain John also loves jewellery. She sounds sad. Then, after a brief pause, she shows Tina her bracelet ('look!'), adding that her mother also loves jewellery. After another pause, during which the resident observes Tina wobbling about, Tina points at the necklace and the resident exclaims how lonely she sometimes was, and how sad she could feel. She and Tina exchange looks. Tina asks if it's off her chest. The resident responds 'yes, and glad to'. (Fieldnotes, second author, observation of medical care clown, October 2017)

Comforting potential was also observed when one of the music therapists experimented with playful ways of tweaking the traditional gender roles echoed in the old-style songs sung with residents (participant observation of music therapy, November 2017). Like the medical clown, she attentively sounded out with whom she could make contact, moving her body towards and away from people (participant observation of music therapy, November 2017).

The interviewed expressive therapists were never introduced to the Pink Passkey (interviews, medical care clown, October 2017 and music therapist, November 2017). This is likely the case because Pink Passkey activity is mostly oriented towards residents who are cognitively able and willing to express their LGBT preference or identity, and much less towards involuntary same-sex expressions by residents with dementia and Parkinson's disease. This suggests that the Pink Passkey is somewhat narrowly focused on accomplishments in the area of encouraging openness, ignoring some of the implications of disinhibited behaviour.

Conclusion

This paper studied the scope and limits of the Pink Passkey, an LGBT inclusion scheme for organisations in residential care in the Netherlands in two nursing homes of a large care organisation. In doing so, the paper contributes to the academic literature on LGBT inclusion in residential care by studying the scope and limits of an LGBT inclusion scheme; a long-term, open-ended and comprehensive approach to work towards safe and inclusive environments. To begin with, we would like to suggest that the conceptualisation of inclusion used in this paper, drawing on critical organisational diversity studies, is a contribution in itself. In this conceptualisation, inclusion is seen as a partial 'accomplishment' (Janssens

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and Steyaert, 2019*b*; Dobusch, 2021) located in context-specific processes of (re) producing sexual and gender diversity – an accomplishment that may, therefore, even be exclusion-producing. In this way, it is possible to appreciate inclusion schemes for encouraging interactions across difference, generating new meanings, resources and skills (Shove *et al*., 2012) along the way, despite maybe not enabling all to whom the scheme's goals might apply to feel oneself and to flourish. We feel this conceptualisation helps to appreciate the complexities inherent in any form of practical action to work towards safe and inclusive environments.

The main conclusion of the research is that the long-term investment in change has resulted in knowledge, awareness and commitment being shared relatively widely, also across the organisational hierarchy. The chances of attention to sexual and gender diversity coming to a standstill have been reduced. This process is marked by a particular distribution of responsibility, which is not limited to managers, Pink Ambassadors and other invested actors, but is extended to residents and volunteers in meetings and activities. Through sharing stories, people begin to realise that the topic of sexual and gender diversity may have more resonance than initially thought. In the process of implementing the Pink Passkey, interactions across difference have indeed helped to align norms and create conviviality. Beyond hypervisibility produced in themed programming, personal stories greatly help to understand sexual diversity as a normal aspect of everyday life in the nursing home.

The open-endedness specific to the Pink Passkey as an inclusion scheme features a broad interpretation, taken to challenge prejudice and discrimination in general. On the one hand, this broad interpretation was shown to support awareness and understanding of sexual and gender diversity, *e.g.* by inviting people to relate to locally relevant examples of difference and deviance from the past. It appears to have been helpful in making the Pink Passkey more acceptable. On the other hand, given the effort it has been shown to take interactions around diversity in a broader sense to sexual and gender diversity, the broad interpretation may well have contributed to the fact that bisexual, transgender and other gender non-conforming identities are less represented than gay and lesbian identities.

While the Pink Passkey is implemented as a comprehensive approach, with organisational commitment supporting practical action, there are limitations to its reach. Due to the size of the organisation and structural capacity issues, the latter argument in some cases masquerading opposition, not all personal care-giving and nursing staff have been reached. However, sexual diversity is inherently a part of nursing, through contact with openly lesbian and gay residents, but also through disinhibited same-sex sexual behaviour and rejection of gay colleagues. For the expressive therapists involved in the research, the Pink Passkey was altogether new. Here, there is a poor integration of practical and analytical cultural competences.

In sum, the paper contributes evidence of positive change, or transformation, associated with the use of LGBT inclusion schemes characterised by a long-term, open-ended and comprehensive approach. Compared to previous literature on fixed-term projects and stand-alone measures and activities, an inclusion scheme helps to gain sustained attention to sexual and gender diversity (despite gaps in the implementation process), to normalise it more and to overcome opposition

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(though this does not disappear). The inclusion accomplished is, indeed, partial, and multifaceted, and, in some ways, random. Future research is to find out whether the open-endedness of the Pink Passkey is found in other schemes as well, and whether more inclusion is produced in the case of schemes where outcomes and impact are more clearly defined.

To the wider LGBT ageing literature, the paper contributes insights to the issue of disinhibited behaviour caused by dementia and Parkinson's disease. The examples provided in the paper suggest an interesting avenue for further research. In the wider literature, it has been pointed out that older LGBT adults with dementia may express hidden needs or show signs of depression or agitation related to discrimination and self-silencing in the past (Fredriksen-Goldsen *et al.*, 2018; Jacobs *et al.*, 2020). In our wider research on attention to sexual and gender diversity in nursing homes, we learned about a resident with advanced dementia who had transitioned in later life. This resident now displayed severe agitation, asking loudly about what had happened to her body, with staff feeling incapable of comforting her. Also in these cases, involvement of professionals who are able to understand and respond to bodily cues that echo struggles with otherness (*see* Tronto, 1993, 2013) may prove very helpful.

The generalisability of the research is limited: given the efforts it takes to spread awareness and address opposition in nursing homes even with a Pink Passkey, it is not likely that levels of inclusion are as high in other places. What is more, while the progress made by the various Pink Ambassadors paved the way for the second author to do this research, having talked to several dozens of residents, staff members and volunteers, she contributed to the creation of awareness herself. In terms of generalisability, then, the findings may be biased towards positive change or transformation (Willis *et al.*, 2018).

Based on the conclusions, the main recommendation to nursing homes and care organisations is to develop low-threshold training programmes that are accessible for all staff and volunteers. For homes and organisations without access to a mature inclusion scheme, offering a one-day training on the issues faced by older LGBT adults is still preferable to doing nothing (Westwood and Knocker, 2016). To overcome capacity issues (and opposition) in nursing homes and organisations, it might be more productive to invite one or two members from a larger number of teams to trainings, and have these members take on an informal Pink Ambassador role within their team. In this way, more care-giving staff can be given the opportunity to expand their embodied experiences with some formal background knowledge. Training materials should resonate the work and expertise of expressive therapists. In addition, a more structured approach can be developed to encourage the sharing of stories by and about (former) residents, while retaining confidentiality.

Competing interests. The authors declare no competing interests.

Ethical standards. In 2015, at the time of submitting the research proposal to the Netherlands Organisation for Scientific Research (NWO) and the Scientific Advisory Board of the Institute of Management Research, ethical approval was not required, and no ethic committees were instituted. In the paper, it is explained how permission and consensus were obtained, and confidentiality and anonymity ensured.

Notes

1 In the Netherlands, the adjective 'pink' is commonly used for all things and events associated with the LGBTI community, dating back to the liberation movement of the 1970s. 'Pink' is arguably still more commonly used than 'queer', especially in older generations. The adjective 'pink' has a positive connotation.
2 This register distinguishes between social interventions that are 'well-described' (aims and means are described clearly), 'well-substantiated' (based on coherent theoretical ideas and empirical findings) and 'evidence-based' (Gelinck *et al.*, 2018). The Pink Passkey is included as a well-described intervention.
3 The local teams are led by Pink Ambassadors – this role is now adopted across the care organisation. Also, an organisation-wide Pink Ambassador with paid hours has been appointed.
4 The website is not cited because the care organisation wishes to stay anonymous.

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