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ORIGINAL ARTICLE

Sexual harassment or disinhibition? Residential care staff responses to older adults' unwanted behaviours

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Abstract

Background: The ethical complexity of residential care is especially apparent for staff responding to residents' inappropriate sexual expression, particularly when directed towards care workers as these residents are typically frail, often cognitively impaired, and require ongoing care.

Objectives: To explore staff accounts of how they made meaning of and responded to residents' unwanted sexual behaviours directed towards staff. This exploration includes whether staff appeared to accept harassment as a workplace hazard to be managed, or an unacceptable workplace violation, or something else.

Methods: These qualitative data are drawn from a national two-arm mixed method study in Aotearoa New Zealand undertaken in 35 residential care facilities. Semi-structured interviews were conducted with 77 staff, residents and family members. Interpretive description was used to analyse the data.

Results: Staff had numerous ways they used to respond to behaviours: (1) minimisation, deflection and de-escalation, where staff used strategies to minimise behaviours without requiring any accountability from residents; (2) holding residents accountable, where staff to some degree addressed the behaviour directly with residents; (3) blurred boundaries and complexities in intimate long-term care, where staff noted that in a context where touch is common-place, cognitive function was diminished and relationships were long-term, boundaries were easily breached; (4) dehumanising and infantilising residents' behaviours, where staff appeared to assert control through diminishing the residents' identity as an older person. It was evident that staff had developed considerable practice wisdom focused on preserving the care relationship although few referred to policy and education guiding practice.

Conclusions: Staff appeared to be navigating a complex ethical terrain with thoughtfulness and skill. Care workers seemed reluctant to label resident behaviour as sexual harassment, and the term may not fit for staff where they perceive residents are frail and cognitively impaired.

Implications for practice: Policy, education and clinical leadership are recommended to augment practice wisdom and ensure staff and resident safety and dignity and to determine how best to intervene with residents' unwanted sexual behaviours.

KEYWORDS
dementia, disinhibited behaviour, nursing, older adults, residential care, Sexual harassment

1 | INTRODUCTION

The ethical complexity of residential care is especially apparent for staff responding to residents' inappropriate sexual expression, particularly when directed towards care workers (Grigorovich & Kontos, 2020; McAuliffe & Fetherstonhaugh, 2020; Nielson et al., 2017). This article explores the meaning-making by care staff about sexual advances by residents and provides an overview of why this topic is complex in this context. An over-arching consideration is that any sexual expression by older adults is readily problematised leading to a conflation of concern about any sexualised expression. Ageism impacts the conflation of the way a range of sexual behaviours are interpreted. Although a growing body of literature affirms the importance of a person-centred approach to older people living in residential care, inclusive of older people's sexual expression (see, e.g., Aguilar, 2017; Rowntree & Zufferey, 2015), this is contentious for many reasons. Attention has been drawn to the readiness with which older people's sexual expression is dismissed; treated with disgust and as non-normative behaviour (Doll, 2013; Simpson et al., 2017). Staff, residents and family members' reactions to older people's sexual expression are amplified in the residential care context as older people lose their privacy on entering the communal world of residential facilities (Bauer et al., 2014; Villar et al., 2014). Their intimate and sexual lives are readily exposed in what is the workplace of the staff. Additionally, there is ample evidence that few facilities internationally have actively implemented policies, education and clinical leadership processes to ensure a climate affirming people's sexual rights while upholding a duty of care and staff wellbeing (see, e.g., Cook et al., 2018; Shuttleworth et al., 2010). Discerning this balance is complex as many people living in residential care have degrees of cognitive impairment, although many with dementia go undiagnosed (Dyer et al., 2018).

These gaps in implementing policy, education and leadership are significant as the majority of those in caregiver roles providing direct care in facilities have limited educational qualifications and will default to their tacit sense of what is right, primarily informed by personal and religious views (Burrow et al., 2018; Cook et al., 2017). Nielson et al. (2017) also note that in the absence of policy-informed guidance, care staff assumed personal responsibility for managing residents' behaviour. It is therefore not surprising with this confluence of factors that the literature also draws attention to the problem of inappropriate sexual expression, including staff sexual harassment. However, there is debate about the extent to which inappropriate behaviours are a manifestation of the above issues: loss of privacy; ageist assumptions and staff reacting without clear guidance. Nevertheless, the literature raises concerns that healthcare workers

What does this research add to existing knowledge in gerontology?

- Direct care staff commonly have long-standing care relationships with residents and endeavour to resolve residents' behavioural issues in ways that preserve inter-personal connectedness.
- Staff take frailty and cognitive impairment into account when making sense of residents' behaviours and typically select interventions, such as distraction, that uphold residents' dignity.
- Staff draw on practice wisdom and an ethic of care when choosing how to respond to sexual harassment from residents.

What are the implications of this new knowledge for nursing care with older people?

- Nurses and care staff will benefit from education to destigmatise the ageism surrounding older people's sexuality in the residential care context, to discern the difference between sexual expression and sexual harassment.
- Nurses require the skills to implement and role-model appropriate interventions when residents engage in staff sexual harassment.
- Nurses need awareness that staff have subjective responses to sexual harassment by frail, cognitively impaired older adults; while some may be unconcerned, others may experience distress, requiring active support.

How could the findings be used to influence policy or practice or research or education?

- Policy, education and leadership are needed to ensure that staff experience safety in their workplace by knowing how to respond to and report sexual harassment and plan ongoing care.
- Educational programmes ideally draw from the practice wisdom of direct-care staff to avoid assumptions about their (in)ability to respond to residents.
- Further research is warranted to consider whether the generic concept of sexual harassment is fit for purpose in the residential care context when caring for frail and cognitively impaired older adults.

in this sector are a vulnerable workforce who experience endemic levels of harassment (Grigorovich & Kontos, 2019; Villar et al., 2020).

However, in the residential care context, there is contestation about how unwanted sexual behaviours are categorised. The definition of sexual harassment has several components. It involves gender-based behaviour that may manifest in unwanted sexualised behaviour. Sexual harassment is a broad term encompassing workplace behaviour that recipients experience as unwanted and offensive, leading them to feel uncomfortable or unsafe (Viglianti et al., 2018). The definition also includes non-sexual derogatory behaviour towards people based on their gender, or their non-compliance with gender norms (Herbenick et al., 2019). Nurses, who constitute a feminised workforce, report high levels of sexual harassment, which impact workplace stress and satisfaction (Lu et al., 2020). Sexual harassment ranges from sexual remarks to unwanted touch and sexual invitations, through to sexual assault (Villar et al., 2020). The #MeToo movement has drawn international attention to the ongoing pervasiveness of sexual harassment (Ross et al., 2019). However, the movement's focus on narrow prototypes of offenders, who are portrayed typically as male and in positions of authority and influence over the lives of women do not align readily to the residential care context. Frail, and often cognitively impaired older adults, living in residential care, do not fit this prototype. Indeed, analysis of their unwanted sexual behaviours is commonly not defined in the scholarly and policy literature as sexual harassment, but rather as inappropriate sexual behaviour (see, e.g., Nielson et al., 2017). Hayward et al. (2012) noted that staff also had a gendered perception of behaviours; that sexualised approaches by women residents were more likely to be interpreted as flirtatious, whereas male resident behaviours were more likely to be called inappropriate sexual behaviours. Burgess et al. (2018) found that staff in the assisted living context did not consider inappropriate behaviours to be harassment if they did not feel threatened. Also, lower levels of harassment from residents may be considered part of the job (Grigorovich & Kontos, 2020). Although Grigorovich and Kontos (2020), in their Canadian ethnographic study in a single care home, argue that behaviours should be considered harassment regardless of whether the resident has cognitive capacity, this is a contested view. Nielson et al. (2017), in their Danish study with 39 care staff, found that staff were reluctant to adopt this term because they believed the label demeaned cognitively impaired residents and they preferred to preserve residents' dignity by referring to such behaviours as disinhibited. Their study led to the researchers questioning whether the term, sexual harassment, was useful in this context, especially as staff did not appear to find it helpful in the way they understood and responded to behaviours. Burgess et al. (2018) noted that the close emotional ties staff had with residents also impacted on staff propensity to discount multiple minor episodes of behaviours usually associated with sexual harassment. Clifford Simplican (2015) argues that dependency is complex and can include violence; that caregivers are at risk when abuse is discounted due to the assumption it is unintentional.

The context of residential care differs from that of hospital settings in that for residents it is usually their permanent, legal home. Villar et al. (2020) note that there is limited literature that considers how staff manage sexual harassment, particularly in the long-term care context where staff typically have relationships with residents that may span months to years. Our study goes some way to address this gap. The overarching aim of the wider research project from which the current data are drawn was to explore how people think about sexual consent in the residential care context for older adults. This exploration necessitated consideration of unwanted actions. Our goals were (1) to analyse how people (staff, residents and family members) are making decisions in practice about sex and intimacy in aged care; (2) to use this information to inform the literature on ethical theory and discourses on consent and wellbeing. For a detailed overview of the entire study, see Henrickson et al., 2020. This article aims to explore staff accounts of how they made meaning of and responded to residents' unwanted sexual behaviours directed towards staff. This exploration includes whether staff appeared to accept harassment as a workplace hazard to be managed, or an unacceptable workplace violation or something else. We were particularly interested to consider whether these accounts highlighted a vulnerable workforce, and/or whether staff accounts appeared to illustrate agency and skilful decision making in navigating challenging behaviours.

In Aotearoa New Zealand, there are laws that support adults' rights to sexual expression; protect staff and residents from sexual harassment and ensure proxy decision makers are consulted where an adult is cognitively impaired. These laws include the Crimes Act (1961); the Homosexual Law Reform Act (1986); the Protection of Personal and Property Rights Act (1988); the Human Rights Act (1993); the Employment Relations Act, 2000; the Health and Disability Services (Safety) Act (2001); the Prostitution Reform Act (2003) and the Marriage (Definition of Marriage) Amendment Act 2013. Although laws and policy guidance are in place (see, e.g., Worksafe, 2018), there are no standardised national guidelines for staff in residential care to assist them in how to interpret this information to develop specific policies, leadership and education about residents' sexual expression and unwanted sexual behaviours.

2 | DESIGN

These qualitative data are drawn from a national two-arm mixed method study in Aotearoa New Zealand. Thorne's (2016) methodological approach, interpretive description, was used. This methodology draws from factual material and social constructionist analysis to aid the investigation of the 'messy' world of healthcare. The social constructionist paradigm focuses on how meanings are created, sustained, negotiated and interrupted (Burr, 2015).

2.1 | Procedure and participants

Purposive sampling was used to recruit a national sample of staff, residents and residents' family members from large, medium and

small care providers. This article focuses primarily on staff interviews. The research team provided an introductory presentation about the study for staff at each facility. Senior staff then provided fliers to residents and family members and posters were visible in the facilities. Residents either contacted the team directly or via a family or staff member. The qualitative arm consisted of semi-structured interviews conducted between October 2018 and October 2019 with participants recruited from 35 residential care homes. Project staff conducted 61 interviews with 77 participants recruited from the participating facilities. Interviews were conducted at a time convenient for the participants, in a safe, uninterrupted venue in the facility. Interviews were completed as follows: staff, 36 interviews, residents, 26 interviews with 28 people (couples interviewed together); family members, 12 interviews with 13 people. In this article quotations are identified by an initial letter indicated staff (S), or resident (R) and a participant's number. The gender of the participants completes the quotation identification (e.g. S1F is a staff interview, and this participant was female). What follows are examples of the questions asked that elicited the data within the article:

Resident question: Have you ever noticed people living here who are engaged in amorous or sexual behaviour that seems unwanted by the other person? How was this situation managed?

Staff question:: What intimate relationship and/or sexuality/sexual expression issues would be of concern for you? Can you give some examples from your experience? When you think about what you are likely to do in a complicated situation, what is the most likely to influence you: Education you have received? Your own values and beliefs? Thinking about what your colleagues might think or do in this situation? Or something else?

2.2 | Ethical considerations

The study was approved by a University Human Ethics Committee. Participation was voluntary. Participants were informed about the study; respect for confidentiality and anonymity were discussed, and written consent was obtained before interviews. The ethics committee was satisfied that the research team had demonstrated expertise in sexuality research.

2.3 | Data analysis

Audio-recorded interviews were transcribed. Thematic analysis, guided by Braun and Clarke's (2006) six steps of data analysis, was undertaken to identify key themes. These steps involve the following: initial data familiarisation; assignment of preliminary codes; search for patterns across the dataset; clustering themes; naming themes; report writing. To ensure rigor with inter-rater reliability, the research team independently read and coded all transcripts (Liamputtong, 2013). All team members then reviewed others' coding and through meeting and dialogue collectively developed themes (see Table 1).

3 | RESULTS

None of our participants mentioned formal processes for reporting and managing unwanted sexual attention from residents towards staff. Residents' behaviours encompassed verbal sexual innuendoes; attempts to kiss, fondle and grab staff; masturbation while receiving care and demands for intercourse. The following themes highlight the strategies staff used to respond to these behaviours and the meanings that guided their interventions, or lack thereof: (1) minimisation, deflection and de-escalation, where staff used strategies to minimise behaviours without requiring any accountability from residents; (2) holding residents accountable, where staff to some degree addressed the behaviour directly with residents; (3) blurred boundaries and complexities in intimate long-term care, where staff noted that in a context where touch is common-place, cognitive function was diminished and relationships were long-term, boundaries were easily breached; (4) dehumanising and infantilising residents' behaviours, where staff appeared to assert control through diminishing the residents' identity as an older person. Of note across the dataset, staff reported unwanted sexual behaviours that were initiated by women and men and therefore did not neatly reflect the gender power relations highlighted in the wider literature about the sexual harassment of women healthcare workers.

3.1 | Minimisation, deflection and de-escalation

Staff gave numerous examples of where residents made comments and jokes that involved sexual innuendoes directed at staff where staff used deflection and distraction:

> I was asking resident, “Where are you going; are you going for a walk?” She said, “Yes, why don't you come with us?” I said, “No, I have to work”. She said, “So, I could find some other guy out there, and we can do a threesome”. I said, “No, you just go for a walk. Don’t find any other guys there.”
>
> (S2F)

Evident in the above quote is the staff member's low-key response which normalised the content and did not alert the resident that the proposition was inappropriate. In the following quote a staff member provided another account of an innocuous intervention that addressed the problem without addressing the behaviour directly with the resident:

TABLE 1 Coding to develop themes

Codes	
• Low-key response—verbal • Low key response—physically stopping behaviour • Distraction • Humour • Re-directing attention • Familiarity with/predictability of resident behaviours	Theme 1: minimisation, deflection and de-escalation
• Clear, incisive intervention • Physical (e.g. removing hands) and verbal correction • Stating boundaries • Senior staff leadership	Theme 2: holding residents accountable
• Routine intimacies between staff and residents (hugs and kisses) • Longevity of relationships • Cognitive impairment • Normal reactions or not? - challenges in staff determining meaning while providing intimate cares (e.g. resident erection when showering)	Theme 3: blurred boundaries and complexities in intimate long-term care
• Staff demeaning residents' sexual expression • Staff infantilising residents	Theme 4: dehumanising and infantilising residents' behaviours

> We did have one lady who, when the entertainers come in, she would be dancing with people and she'd put her hands all over people's bottoms, and many of the residents resented that. What we would do, is one of the staff members would dance with her, so that she was occupied, and she wasn't behaving inappropriately with other people, and if you held her hands and danced, she was quite happy with that. So, it was only a matter of managing it so that it wasn't upsetting anybody.
>
> (S13F)

Here again the staff had devised an intervention that protected staff and residents and appeared to preserve the inclusion of the resident while preventing her from sexually harassing people. In the wider literature, the recipient of harassment typically experiences distress at the behaviour. It was notable across our dataset that where residents' behaviours were non-aggressive and staff associated the residents' actions with dementia, participants typically did not describe distress, and in the instance below, the staff member interpreted the behaviour as misdirected love:

> ***Q: What intimate relationship or sexual expression issues would be of concern for you that you might see in the residents?*** A: Possibly with some of the men; they have approached me in sexual ways, yes. We did have one man here that had bad dementia and he wanted me to go to bed with him, so I just said, "Oh no, I can't do that; that is not allowed," and that sort of thing, and we [staff] just brushed it over.
>
> Q: Any other examples where sexual expression has been problematic?: A: Not problematic, but I think what it is, is sometimes you get some residents where they're quite loving and they're used to cuddling and loving. We've got one man here that if he goes to give you a kiss he aims for your lips, to kiss on your lips, so we just turn our head sideways and things like that. (S30F)

The following quote is a striking example of how a staff member dismissed sexual harassment including the risk of sexual assault because of her over-arching knowledge of the resident. This was even though this resident was not cognitively impaired but had been consuming alcohol:

> I went in to give him his medication, and he just up, threw me on his mattress, and [said], "Oh come darling, you know I love you," and away it went. I was saying, "Oh come on poppa; this is not on, you should know that now." It took a couple of minutes, but then it was just all over. I was not frightened by him, because I knew him. and I knew he would not hurt a fly. It might have just been his mind, just having a tick about sexualities or whatever. But I was not frightened by him, and in all honesty, I never reported it, because I didn't want him to get into trouble. But as I say, if I had been frightened or really threatened; yes, I would have done something, but he wouldn't hurt a fly. He was a kind, really gentle man.
>
> (S11F)

The above quote also highlights that the staff member used her own relational knowledge about the resident, her subjective interpretation and her preference that the issue was not escalated, to come to her decision not to report the behaviour. The data indicate that staff used minimisation, deflection and distraction to foster

long-term caregiving relationships with residents. This preference appeared to be the case regardless of whether the person was cognitively impaired.

3.2 | Holding residents accountable

The extended quote below is included as it is an example of the leadership evident in the dataset, where the nurse manager held the resident accountable and worked relationally to make it possible for staff to continue a relationship with the resident. The context was that a nurse manager had been told by her staff of healthcare assistants that they were fearful of working with a resident because they felt harassed while showering him because he masturbated:

> I thought, "We're not going to put up with that." Anyway, he's in the shower and I knock on the door and say, "Hello, it's [Name] here. May I come in?" "Yes." I made sure he had a robe on. I said, "Now look, we've had this problem. I know you'll understand what I'm going to say, but our lovely girls [staff] here are feeling a little concerned, because they would like to feel like when they care for you that they're caring for this lovely gentleman, who they like in the terms of dad or father; and the things that father does are quite different to things that a lover or a husband would do." I said, "So, what I would like from you is the assurance, that as long as you're going to be here – and we love you here – could you please make the effort to not bring your penis out and introduce it to the girls. You're perfectly capable of washing it yourself, and they don't want to handle it, and they don't want to examine it or anything else." This is how I said it to him. "Oh. I am still allowed to stay here?" "On the condition that this doesn't take place again." It never has. The girls were so relieved. She [the healthcare assistant] was standing outside the bathroom door. She said, "Thank you, thank you."
>
> (S3F)

What is interesting in the above quote is that the manager planned her intervention and chose not to fully confront the resident about the harassment by naming the behaviour as such, but instead appeared focused on both protecting her staff and making an ongoing care-giving relationship with the resident possible. The manager described the future relationship she expected the resident to have with the staff.

In contrast, a resident described witnessing a staff member taken by surprise by a resident's groping, who vigorously rebuked the resident:

> We were in the dining room and she [healthcare assistant] leant over to pass this person a plate of food and the man was sitting in a wheelchair, he put his hand up her dress, and she slapped it away, because it wasn't just a pat. He tried to put his hand up and she told him off in front of everyone. He was embarrassed as hell; he never did that again. He got a shock because she's a really quiet woman. Her mother had just died, and this bloody bugger did that. Everybody just told him to stop it; yelled out, "Don't do that you dirty bugger."
>
> (R6F)

This example illustrates the power that physically vulnerable residents have to sexually harass staff. It also indicates that calling out the behaviour particularly with cognitively intact residents may be an effective strategy.

3.3 | Blurred boundaries and complexities in intimate long-term care

Across the dataset staff, residents and family members described warmth and friendliness—a type of intimacy—between staff and residents, due to propinquity and longevity of the relationships. For example the term, family, was commonly used by staff to describe their relationships with colleagues and residents. Hugs and kisses were commonplace. A family member commented on the intimate touch she observed residents seeking routinely:

> There were people who were very tactile with us; like when we visited there were particular older women who would want to come and give you a hug or sit next to you and pat your hand. Physical touch was something they were obviously really craving… You could see that the staff in the dementia care place did make an effort to do things; like they'd massage people's hands, or they'd be brushing their hair. So, there were things they were doing to try and make sure that people were experiencing touch.
>
> (F5F)

This routine closeness appeared to mitigate offence taken by staff when they perceived that residents had crossed a boundary, but also posed a dilemma for staff as to how to keep themselves safe while being emotionally present for residents:

> We've got a very charismatic male caregiver who everybody loves, and a lot of the female residents would fall in love with him, and he felt quite vulnerable at times being alone with those people, because at one stage, two of the female residents were having quite florid fantasies which sort of became real to them. This staff member batted for the other team anyway [was gay]; so there was no way any of it was true, but just that whole [situation] now when you sit with a

> resident and they're upset, if you take their hand or hold them, or you just rub their shoulder; how does that look for somebody going past if it's a male staff member with a female resident. You've got that whole [question of] how free are the staff members to touch, and provide love and care?
>
> (S7F)

Providing intimate cares for residents was a key area where at times staff were uncertain about the meaning of residents' behaviour—whether it was an expression of a legitimate need or of sexual harassment. In the following quote the residents' erections per se did not mean the staff member felt threatened or uncomfortable:

> It's like our males, we being caregivers and we're cleaning around their private parts, they still have that feeling, and some of them can be rude but you learn to divert it somewhere else or you just ignore what they're saying and just carry on. You go and do [shower] a male and he gets an erection, and you think, "Oh, my god". But he can't help it; he can't help it. That to me, so he's still got his sexual needs.
>
> (S9F)

The above example shows a staff member managing the blurred boundaries and confusion about the meaning of the behaviour through normalising, diversion and deflection.

3.4 | Dehumanising and infantilising residents' behaviours

Another coping strategy apparent in the dataset was staff dehumanising residents through mocking any sexual expression as deviant:

> I know that [older] people are sexual beings and that they're out there having sex; just because it's revolting to me, doesn't mean that it's revolting to everybody else. We'll joke in the nurses' station about how in the old days the nun would hit it [male erection] with a ruler, and we'll joke about that, and what happens inside the nurses' station stays in the nurses' station.
>
> (S7F)

The above view is problematic numerous ways: if all sexual expression by older adults is viewed with disgust, then how possible is it to recognise inappropriate behaviours? Also, it is a risk that role-modelling this view of residents' sexual expression is then carried by staff into their care relationships.

Significantly, some staff described the strategy of infantilising residents in ways that meant staff perceived residents were neither responsible for their actions nor a threat. In the quote below the staff member described a resident who wanted to hug and rub himself against staff. This participant appeared to minimise the behaviour through infantilising—'he was quite sweet'—while also affirming the importance of boundaries:

> He was really overt - he was a really big man; never been married. I used to give him a hug and used to have to, "Right, that's enough." He was quite sweet, but the caregivers did get a bit upset, because he used to brush himself on them and things like that, so I just explained, "You need to set your boundaries with him and let him know that was he's doing is inappropriate." He did respect that.
>
> (S22F)

The above staff member appeared to advise her staff that they were responsible for setting boundaries, rather than the resident being responsible for holding a boundary.

4 | DISCUSSION

The purpose of this article was to explore staff accounts of how they made meaning of and responded to residents' unwanted sexual behaviours directed towards staff. Apparent across the dataset were examples of staff for the most part using their own life skills, values and beliefs to intervene (or not). Although from an outsider position it is possible to view these participants as part of an oppressed and vulnerable workforce in need of consciousness-raising about sexual harassment, the participants did not appear to perceive themselves this way. The key reasons staff did not typically perceive themselves as victims were that they did not experience the residents' harassment as intentional, for the most part, and they had strategies to address the behaviour, on their own behalf and to protect colleagues who felt unable to address the behaviours. The meaning staff attributed to the behaviour appeared to impact directly on the felt sense of a negative personal impact (or not) on the staff member. The profile of residents living in care facilities differs significantly from the profile of those who sexually harass in other workplaces. The combination of resident frailty and cognitive diminishment, the staff's duty of care to provide intimate physical care, and the staff's sense of knowing the residents and being known all add to the conundrum of how staff might best respond (Nielson et al., 2017). These points are explored below.

This study echoes the literature exploring sexual harassment in the residential care context; staff described making decisions based on their personal judgement, rather than with reference to workplace policies and reporting processes (Burgess et al., 2018; Grigorovich & Kontos, 2019; Nielson et al., 2017; Villar et al., 2020). However, this point also is the case for staff responses to expressions of intimacy and sexuality more generally; most commonly facilities internationally operate without a seamless flow from policy to staff education, clinical leadership and facilitated ethical deliberation in these

areas (see, e.g., Cook et al., 2018). We argue that it is not possible to address sexual harassment in this environment without first addressing the facility culture and climate towards older adults' sexual expression. It is only by stripping away ageist assumptions and challenging disgust at any sexual expression that staff will be enabled to make distinctions between appropriate and inappropriate sexual behaviours (Cook et al., 2017, 2018; McAuliffe & Fetherstonhaugh, 2020). We consider that sexual harassment policies and educational programmes must be shaped specifically for the residential care context, where clinical leaders juggle a duty of care for frail, and often cognitively compromised residents as well as responsibility for staff wellbeing.

There is contention surrounding the argument of whether residential care staff are a vulnerable and victimised group. Also contested is the question of whether sexual harassment carries the same weight of meaning independent of whether recipients experience threat and perpetrators have cognitive intentionality. Grigorovich and Kontos (2019) argue that both are the case. They contend that the predominantly female workforce in residential care has internalised structural oppression to the point that they are unable to recognise sexual harassment. They also consider that sexual harassment should be named as such no matter the cognitive capacity of residents. McAuliffe and Fetherstonhaugh (2020) take a more moderating view. They argue that while it is important to ensure staff safety and to recognise and address sexual harassment, what is appropriate or not is often unclear; that the interpretation is subjective, and that cognitive capacity is a relevant consideration. This subjective interpretation was evident in these data.

As researchers, we are reluctant to write off staff tolerance of sexual harassment as merely evidence of traditional femininity, self-sacrifice and structural and cultural positioning. Staff accounts appeared to indicate that for the most part they did not experience helplessness and a sense of loss of control; they had devised strategies to intervene. This evidence indicates that in any education provided, facilitators must recognise and respect that staff already have a skill set that can be built on with facility-wide systems and processes. This view is supported by research into the decision-making processes by caregivers in residential care who have limited education (Anderson et al., 2005; Burrow et al., 2018; Gray et al., 2016). These studies identified that although these workers are stigmatised and at the bottom of the care hierarchy, they perceived they had competency in their decision making and skills. In the absence of formal education, these authors contend that caregivers primarily drew on 'mother wit' (prior personal expertise in caring for those who are vulnerable yet may behave problematically), and the golden rule (picturing oneself in a similar situation and responding accordingly). Another factor evident in the current study that we consider educators must acknowledge is that staff typically have complex relationships with residents that are not distinctly positive or negative and that may include reciprocal affection. In this study staff commonly used the metaphor of family to describe their relationships with residents and therefore education that 'others' perpetrators of harassment, treating them as solely bad is likely to unhelpful for staff. A more nuanced appreciation, such as that offered by Clifford Simplican (2015) may be most useful; one that recognises the complexities in the intimacy of caregiving with those who are vulnerable, disinhibited and can cause harm.

We concur with Molterer et al. (2020), who provide a useful framework for interpreting the actions of residential care staff both as actions grounded in practical, experiential wisdom and as actions in the context of care relationships: Care 'is enacted through different care practices that are either inspired by a "professional logic of care" that aims for justice and non-maleficence in the professional treatment of residents, or by a "relational logic of care," which attends to the relational quality and the meaning of interpersonal connectedness in people's lives'. (Molterer et al., 2020, p.1). Their argument is that good care is a result of a negotiation between these different logics of care, through a 'tinkering' process involving intuitive deliberation, situated assessment and affective judgement. Therefore, one way of understanding what staff are doing when they appear to minimise, de-escalate or deflect certain behaviours is that staff are prioritising the maintenance of interpersonal relationships over concerns grounded in justice, and that this choice is not necessarily a mistake that staff are making—rather, staff are 'tinkering' with different moral goods, and drawing on their experience to make decisions about which goods to prioritise in a given context.

The study has some limitations. Initially, we planned to randomise selection of the sites. However, recruitment challenges required us to modify this strategy as many facility managers declined the participation request. It is likely that people who were comfortable with the topic of sexuality agreed to participate. Staff will have selected the examples of interactions with residents they chose to give. For example it is interesting that the only reactive, angry response of a staff member to a resident provided was recounted by a resident.

5 | CONCLUSION

Our study led us to consider that staff appeared to be navigating a complex ethical terrain with thoughtfulness, skill and creativity. Although the examples provided highlighted the vulnerability of staff, we do not accept the wholesale explanation that these workers responded from a place of internalised oppression, of which they were unaware. This position discounts the practice wisdom staff may hold, and which we encourage policy makers and educators to harness. We consider that any policy and education development must be designed in consultation with direct-care staff, to ensure that the intimate knowledge caregivers have of the complexities, dilemmas and relational values are considered. Leaders need to work with direct-care staff to determine how to name unwanted behaviours. Both institutional leaders and care workers seem reluctant to label resident behaviour as sexual harassment, because sexual harassment carries connotations of shame, blame, guilt and culpability, and the term may not fit for staff where they perceive residents are

cognitively impaired. However, care workers may nevertheless experience the behaviour as sexual harassment and they may still experience the harm, and therefore policies, education and leadership role-modelling will augment practice wisdom. Our study highlighted that broader education and research about ageing, intimacy and sexuality are integral to addressing sexual harassment in the residential care context.

6 | Implications for practice

Clinical staff have practice wisdom that warrants appreciation and consideration when determining how best to make sense of and intervene with residents' unwanted sexual behaviours. Policy, education, and clinical leadership are recommended to enhance clinical judgment, ensuring staff and resident safety and dignity are foregrounded.

CONFLICT OF INTEREST

The authors declare there are no conflicts of interest.

AUTHOR CONTRIBUTIONS

Catherine M. Cook, Vanessa Schouten, Mark Henrickson and Sandra MacDonald contributed to all stages of the research process and the article preparation. Narges Atefi contributed to project management, data collection and analysis.

DATA AVAILABILITY STATEMENT

The data that support the findings of this study are available on request from the corresponding author. The data are not publicly available due to privacy or ethical restrictions.

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