RESEARCH ARTICLES

Using the Theoretical Framework of Acceptability to understand the acceptability of e-training for nurse led prevention of unwanted sexual behaviour in Australia's residential aged care services

AUTHORS

MEGHAN T WRIGHT BScAdvGlblChal(Hons)[1]
DAISY E SMITH BA AppSc (Psych)[1]
CHELSEA S BAIRD BMed(Sci), MBBS(Hons), FRACP[1]
JOSEPH E IBRAHIM MBBS, PhD, FRACP[1]

1. Health Law and Ageing Research Unit, Department of Forensic Medicine, Monash University, Melbourne, Victoria, Australia.

CORRESPONDING AUTHOR

DAISY E SMITH, Health Law and Ageing Research Unit, Department of Forensic Medicine, Monash University, 65 Kavanagh Street, Southbank Victoria 3006, Australia. Email: daisy.smith@monash.edu

ABSTRACT

Objective: The aim of this study was to evaluate the acceptability of one specific e-training (intervention) for prevention of unwanted sexual behaviour in Australia's residential aged care services using the Theoretical Framework of Acceptability.

Background: Aged care staff are of fundamental importance in unwanted sexual behaviour incident management and prevention. The research team developed and implemented an evidence-informed intervention designed to increase awareness, promote collaborative practice, and improve prevention and management of such incidents in aged care. Current acceptability of training on this topic is yet to be studied despite it being recognised as a key factor for successful implementation and translation into practice.

Study design and methods: This is a qualitative, cross-sectional study employing semi-structured telephone interviews with actively working enrolled and registered aged care nurses who had completed the intervention. Acceptability of the intervention was measured with the Theoretical Framework of Acceptability. Of the 36 participants that signed the consent form, 18 completed interviews. One participant was excluded from analysis as they did not complete all modules of the intervention.

Results: Analysis revealed favourable evaluation in all seven domains of the Theoretical Framework of Acceptability, finding high acceptability of the intervention amongst all participants. The intervention aligned with participant's values and the content was perceived to fill a knowledge gap. This is showcased in participants unanimous belief that it would be helpful for all front-line aged care staff to receive the intervention frequently. Although participants showcased high acceptability of the intervention, participants recommended that sexuality content be included before detailing unwanted sexual behaviour, and that this content inclusion may increase awareness and understanding of unwanted sexual behaviour.

 https://doi.org/10.37464/2020.394.762

Conclusion: Participants reported this e-training to be highly acceptable. They believed it has potential to improve attitudes and awareness of incidents in aged care. However, favourable results may reflect a personal interest with the topic, for example, the content aligned with their personal values, experience, and beliefs. More research is needed to understand both the acceptability and the efficacy of the training short and long-term.

Implications for research, policy, and practice: This study indicates that larger scale national staff training on this topic is possible and considered necessary by the sample. Future national policy should explore the inclusion of this topic in the curriculum standards. Future research should focus on evaluating the efficacy of the training in changing attitudes, awareness and influencing professional practice.

What is already known about the topic?

- Known prevalence of unwanted sexual behaviour in aged care suggests most nursing staff will be required, at some stage, to provide care to a resident who has been a target, or exhibitor of unwanted sexual behaviour.
- Previous studies of this pilot intervention indicate that it provides a useful model and curriculum of specific topics to guide development of training on unwanted sexual behaviour initiatives nationally and internationally.
- Acceptability of healthcare interventions is a critical measure in facilitating their implementation and in this instance, capacity of the aged care workforce to be trained on unwanted sexual behaviour.

What this paper adds

- E-training about prevention of unwanted sexual behaviour is acceptable to aged care nurses.
- E-training filled an existing program gap in education provision and addressed current staff knowledge deficits that aged care nurses perceived as important for better resident care and reducing work related stress.
- Lack of prior learning about intimacy and sexuality hampered optimal learning about prevention of unwanted sexual behaviour.

Keywords: sexual violence, online learning, qualitative, interviews, aged care, aged care nurses

OBJECTIVE

The aim of this study was to evaluate the acceptability of an e-training course (intervention) for prevention of Unwanted Sexual Behaviour (USB) in Australia's Residential Aged Care Services (RACS) using the Theoretical Framework of Acceptability (TFA).

BACKGROUND

Prevention and management of USB is a global challenge. Unwanted sexual behaviour encompasses both criminal aspects of sexual assault (commonly described as sexual violence) and 'unwelcome sexual behaviour' (e.g., such as unwelcome sexual conversations and comments).[1]
A major barrier to addressing this challenge, especially in older vulnerable populations, is an underling and incorrect assumption that USB does not occur in older persons. In Australia, an estimated 50 incidents occur in RACS (also known as long-term care, social care, and nursing homes) every week across the nation.[2] Internationally, the prevalence of USB in long-term care as reported by residents is approximately experienced by <1% with major implications for the victim-survivors, families, and the community.[3]

Addressing USB in older vulnerable populations is particularly challenging as it remains the most under recognised and under reported form of elder abuse internationally.[4] Additionally, globally there is a lack of proactive large scale multi-dimensional integrated and effective strategies which have undergone long-term evaluation.[5] In Australia, USB in RACS is largely unaddressed with the exception of the requirement for aged care providers to adhere to mandatory reporting obligations for accreditation and funding.[2] This approach is inadequate as it does not address the aged care staff's lack of awareness of USB, inability to recognise incidents and limited expertise to offer survivors appropriate support.[1, 6]

Strategies that improve front-line healthcare personnel awareness and competence are of fundamental importance in USB incident management and prevention.[7] Training of staff in healthcare settings improves their awareness, confidence, and skills to respond to sexual assault survivors.[8-10] There is a paucity of training for aged care staff addressing USB and limited empirical research describing the effectiveness of the available training.[1] In response to this gap, our research team developed and implemented an evidence-informed e-training (intervention) designed to increase awareness, promote collaborative practice, and improve prevention and management of resident-to-resident USB incidents in RACS.[11]

Affective Attitude	Burden	Ethicality	Intervention Coherence	Opportunity Cost	Perceived Effectiveness	Self-efficacy
How an individual feels about taking part in an intervention	The perceived amount of effort that is required to participate in the intervention	The extent to which the intervention has good fit with an individual's value system	The extent to which the participant understands the intervention and how it works	The extent to which benefits, profits, or values must be given up to engage in an intervention	The extent to which the intervention is perceived as likely to achieve its purpose	The participant's confidence that they can perform the behaviour(s) required to participate in the intervention

Prospective acceptability	Concurrent acceptability	Retrospective acceptability
Prior to participating in the intervention	Whilst participating in the intervention	After participating in the intervention

FIGURE 1: THE THEORETICAL FRAMEWORK OF ACCEPTABILITY CONSTRUCTS AND THEIR DEFINITIONS[13]

Acceptability of an intervention is a key factor for successful implementation and translation into practice.[12] The Theoretical Framework of Acceptability (TFA) uses seven different constructs (Figure 1) to explore the real-world barriers and facilitators for an intervention.[13] The TFA framework also reflects the extent and appropriateness based on anticipated or experienced cognitive and emotional responses to the intervention.[13] This framework has been applied to evaluate a wide variety of western healthcare educational interventions.[14,15]

Therefore, this study will investigate the acceptability of the USB in RACS intervention using the TFA.

STUDY DESIGN AND METHODS

STUDY DESIGN

This qualitative, cross-sectional study used semi-structured telephone interviews with actively working enrolled and registered RACS nurses to examine the acceptability of the USB in RACS intervention. Participants were asked questions around their experience and perceptions of the intervention *"Preventing unwanted sexual behaviour in residential aged care services"* (interview questions Appendix 1). Interviews were conducted in November and December 2020 and are described in accordance with the consolidated criteria for reporting qualitative studies (COREQ Appendix 2).

INTERVENTION

A self-directed e-training was developed by the research team to aid aged care nurses to better detect, manage, and prevent incidents of resident-to-resident USB in RACS (curriculum guide, Appendix 3). An overview of the intervention learning aims is provided in Figure 2. In brief, the course comprised five learning modules addressing the following topics relating to USB between residents: definitions and identifying characteristics of USB, management of incidents, targets and resident exhibitors, prevention strategies and handling and disclosing of information relating to USB incidents. It concluded with a clinical case study which consolidated learning drawing on content from all modules. The intervention was available online to participants for two weeks and had to be completed in that period (Group 1: 21 Sept – 5 October 2020; Group 2: 12–26 October 2020).

SETTING AND SAMPLE

Figure 3 details Australian RACS resident and workforce population rates and demographics in Australia. The study was conducted in Melbourne, Australia. Eligibility for participation was not restricted to this location. Participants were selected from the target population if they had met the following requirements, (a) actively working in Australia as an enrolled or registered nurse in a RACS, (b) had completed all five modules and (c) also completed the pre-test and post-test evaluation survey, therefore a relationship was established prior to this study. Two-weeks after the post-test survey end date, participants were contacted via email and/or telephone inviting them to participate in the evaluation interviews and to select a time for their interview. Interviews were then conducted approximately two to three months after they had completed the intervention. Appendix 4 details the complete study timeline. Participants were not provided with any incentives or reimbursement to participate at any point of the research. As the interviewer was one of the coordinators of the intervention, participants were clear about their interest in the project.

ETHICS APPROVAL

Ethics approval was obtained (Project ID: 23702, see Appendix 5). All participants were emailed a plain language information sheet. Signed consent forms were required to be returned to the research team via email in order to participate in the interviews.

INTERVIEW ITEM DEVELOPMENT

The research question guiding the development of interview items was *"what was the overall acceptability with the interventions content, structure and delivery, and how could it be improved?"* Interview items were developed, and pilot

Intervention Module	Intervention Learning Aims
Module 1 – Defining Unwanted Sexual Behaviour in RACS	• Identify misconceptions about older peoples' sexual expression and experience of unwanted sexual behaviours. • Define unwanted sexual behaviour and understand how the different sub-categories are determined. • Define and identify Commonwealth of Australia criteria for 'reportable incidents' of unwanted sexual behaviour in aged care.
Module 2 – Identifying characteristics of Unwanted Sexual Behaviour in RACS	• Describe and identify the common risk factors for the occurrence of unwanted sexual behaviour in residential aged care. • Understand how unwanted sexual behaviour presents, impacts and could be prevented in a person with cognitive impairment in residential aged care. • Identify the major barriers to detecting and prosecuting incidents in residential aged care.
Module 3 – Detection, Management and Support in Incidents of Unwanted Sexual Behaviour in RACS	• Identify physical, behavioural, emotional and psychological indicators of unwanted sexual behaviours in residential aged care. • Identify management techniques of suspected, witnessed and disclosed incidents of unwanted sexual behaviours in residential aged care. • Explore incident management techniques for target's who are cognitively impaired. • Review documentation requirements for incidents and legal investigations.
Module 4 – Managing Resident Exhibitors and Prevention strategies of Unwanted Sexual Behaviour in RACS	• Identify techniques to manage resident who are exhibitors of unwanted sexual behaviour. • Identify techniques for monitoring sexual expression in residents. • Identify strategies for preventing a resident engaging in unwanted sexual behaviour.
Module 5 – Handling and Disclosing Information Concerning Unwanted Sexual Behaviour in RACS	• Define and describe information that is personal, private and confidential. • Understand the privacy and confidentiality obligations for aged care staff and others when managing incidents of unwanted sexual behaviour. • Review and understand the role of substitute decision makers during incidents of unwanted sexual behaviours.

FIGURE 2: INTERVENTIONS LEARNING MODULES, MODULE TITLES AND CORRESPONDING LEARNING AIMS

Australian RACS resident population rates and demographics	Aged care workforce populations and demographics
The term 'residential aged care services' ('RACS') is used in accordance with the Australian Government Department of Health ('Department of Health') definition. This refers to special-purpose facilities which provide accommodation and other types of support to residents over 65 years old, including assistance with day-to-day living, intensive forms of care, and assistance towards independent living. Such services are provided to people who can no longer live independently.[2] In Australia in 2019-2020, there were 2,722 RACS operated by 845 approved RACS providers. In 2019, 244,363 people received permanent residential aged care (RAC) at some time during 2019, this representing an increase of 1,751 from 2018–19.[16]	The most recent aged care workforce survey estimates over 366,000 workers in RAC with more than 240,300 in direct care roles. Estimates include nurses 22,455 nurses and approximately 154,000 personal care workers. Females make up most of the RAC workforce (87%) and RAC staff are also generally older (45-65 years+, 55.2%).17 Additionally, the average ratio of direct care workers to operational places in Australia is 0.78. Registered nurses report spending less than 1/3rd of their work time caring for residents, whereas 46% of enrolled nurses spent more than 2/3rds of their time on direct care tasks in a typical shift.[17]

FIGURE 3: BACKGROUND INFORMATION ON OCCUPANCY RATES AND WORKFORCE POPULATIONS' DEMOGRAPHICS

tested internally by the primary researchers (JI, DS, MW) prior to an external review by colleagues not connected with the research project to evaluate whether the questions were appropriately expressed to measure the items of interest (Appendix 1). The research team was predominantly female (*DS,MW*), tertiary educated (*JI, DS, MW, CB*) in biological (*MW*) and social sciences (*DS*), and geriatric medicine and health science (*JI, CB*) researchers.

DATA COLLECTION

All interviews were digitally recorded by a portable audio recorder by one researcher (*MW*). Questions contained nine open-ended follow-on prompts (Appendix 1). Interviews were recorded on an audio device over the phone and transcribed using a professional transcription service. Face-to-face interviews were not conducted due to COVID-19. Field notes were taken during and after interviews. Transcripts were returned to participants for optional review of inaccuracies, and no feedback was received. Participants were instructed to notify (*MW*) of any desired revision.

The length of interviews ranged between 22 and 65 minutes. Interviews were conducted between 23 November and 14 December 2020, with one researcher (*MW*) and one interviewee present. There were 591 minutes of interview data collated, totalling 222 pages of transcript analysed.

DATA ANALYSIS

The TFA Framework[13] previously described was used to deductively guide the analysis of this study. Two researchers (*DS, MW*) independently and concurrently conducted the analysis of transcribed interviews using NVivo12. Per deductive analysis of TFA, the seven overarching constructs were used to generate themes (Table 1). Coding was conducted independently by the two researchers (*DS, MW*) to enable investigator triangulation[18], thematic discussion, resolve any discordance, and reach consensus.

RESULTS

TABLE 1: OVERVIEW OF THEMES, SUBTHEMES, EXAMPLES OF IDENTIFIED NARRATIVES, AND CORRESPONDING TFA CONSTRUCT

TFA Construct & Broad Themes		Sub-Themes	Supporting quotes	Temporal perspective
ETHICALITY	**Participants value education**	Intervention content relevant & interesting	*"I should have read this when I was doing my training the same time that I was learning about wounds and blood pressure and hygiene, I should have learned about this… [It is] A very important topic. It's a topic that comes up a lot." (P18)* *"It [the course] really fits into my workspace. It fits in with my role as an RN, an educator, as a care coordinator and now as a site manager. The course was interesting… I feel more confident now" (P5)*	RA
		Self-development	*"I'm someone who really likes to do trainings and things like that, I like to always learn stuff." (P2)*	PA
	Participants value their occupation	Person centred care	*"We [the students in this course] are leaders …that tend to take the role a little bit more seriously rather than just a pay-check but are there [in aged care] because this is what we love to do... We see [residents] as people rather than an abstract construct." (P3)*	CA
	Participants agree with intervention topic	Incidents occur in RACS	*"Oh, [unwanted sexual behaviour] is a big problem already… it's something we need to seriously look at" (P16)"* *"I get lots of questions from the managers…about what's going on with the facility, and how to deal with … lots of obviously physical abuse and sexual abuse" (P1)*	PA
AFFECTIVE ATTITUDE	**Workplace attitudes to USB**	Ageism & Sexism	*"Staff are quite aghast that elderly people might have any sort of sexual desire or identity…and will say…well, we didn't see it, or did it happen? Or "Oh she's got dementia" you know, fobbing it off." (P12)* *"You want to do the right thing, but you are sometimes just limit because the family wants something, and the resident wants something." (P14)*	PA
		Taboo Topic	*"I think it's a hard conversation that no one wants to have." (P17)*	PA
		Incidents stressful & complex	*"a challenge where you have people with quite significant cognitive impairment sharing accommodation with other people, so that's going to be a problem, and addressing that is always going to be a problem" (P16)*	PA
	Past experiences with USB	Poor management	*"I worked at another facility …and I had … a reportable incident and it was allegation of rape. The manager at that facility said, "You've got 24 hours to report don't worry about it, we'll do it tomorrow." And I wasn't satisfied with that. So…I moved facilities…[and] have taken this course." (P3)* *"We've been brushing a lot of this under the carpet because they've had dementia". (P16)*	PA
		Incident classification & reporting confusion	*"We've also got lots of different cultures here, so what one person feels is appropriate, another person doesn't" (P10)* *"I felt I really didn't know where we stood and what to do, because you're thinking, "What sort of consent is this? What's marriage? Who's got the say? And how do we find out? Can we just call the police?" (P13)"*	PA
		Reactive management	*"But they [RACS staff] are not all that proactive." (P12)*	PA
	Attitude towards other training	Topic neglected	*"I don't think it's [USB topic] addressed adequately within the enrolled nursing training package." (P15)* *"I've never done any official training other than mandatory reporting… it [reporting training] wasn't to that level [that the current intervention provided] … the education that I've had is more on the RN level where you report it to the management, and you make sure that the hierarchy is followed" (P10)*	PA
		Intervention needed	*"You [RACS nurses] just don't have the resources. But people like you, if you bring it to light, you help us get resources." (P17)* *"it's good initiative, the course for nurses...we don't have specific training…we need to improve a lot." (P14)*	RA
BURDEN	**Workforce strain**	COVID-19	*"I think COVID's had an impact in aged care just period." (P9)*	PA
		Lack of industry resourcing	*"Because it is, it's a bloody hard job. It's the hardest thing I've ever done, aged care. And it's just so frustrating. Because you just don't have the resources. But people like you, if you bring it to light, you help us get resources." (P10)*	RA
		Low-staffing levels	*"We are so understaffed it is dangerous. Residents are becoming incontinent because we can't get there to take them to the toilet. (P14)*	PA
		Time burden	*"It was quite a bit of information. it would be good if there were a bit more in-between" (P17)*	CA
		Change fatigue	*"It's important to understand that there's a lot of stress on aged care at the moment, so the staff are not as open to new things as they probably were a year or so ago" (P10)*	RA

TABLE 1: OVERVIEW OF THEMES, SUBTHEMES, EXAMPLES OF IDENTIFIED NARRATIVES, AND CORRESPONDING TFA CONSTRUCT (CONTINUED)

TFA Construct & Broad Themes		Sub-Themes	Supporting quotes	Temporal perspective
BURDEN (continued)	**Burden of topic**	Not distressing	*"I felt safe. I knew that the resources were there, and you guys were there, and you were very good at letting the learner know that." (P17)* *"I think the support behind the course was above and beyond" (P16)*	CA
INTERVENTION COHERENCE & SELF-EFFICACY	**Intervention operation**	High understanding, & high ability	*"It [the course] was all really interesting. I actually redid it twice. I went through the whole thing twice." (P12)*	RA
		Minor IT issues.	*Besides the IT that was a bit frustrating …No, I can't really point out anything that could be changed really, no. (P2)*	RA
OPPORTUNITY COST	**Perceived future opportunity costs**	Challenge cultural beliefs	*"But personal care workers sometimes [come from different] cultural backgrounds, [are] sometimes very young …and it can be really hard for them to cope with all these sensitive matters. The course might be too hard for them." (P6)*	RA
		Challenge values	*"Lots of staff won't care because they think "Old people don't behave like that"." (P4)*	PA
PERCEIVED EFFECTIVENESS	**PRE-intervention**	Poor confidence	*"Very limited [confidence to manage USB before the intervention]. I was having been confident because I knew my organisation would have given me the support, I needed to handle the situation, but I didn't have much confidence in my own ability, but yeah." (P18)* *"Probably about 2 out of 10 [confidence to manage USB before the intervention] …I knew nothing. and I would have found it very confronting" (P11)*	PA
		Poor awareness	*"[Before the intervention] I think it [unwanted sexual behaviour] probably could have happened in front of me and I might not have even truly recognised it for what it was." (P11)*	PA
	POST-intervention	Improved awareness	*"I'm more aware. I've done the course, I'm more aware of it [unwanted sexual behaviour]" (P17)*	RA
		Improved knowledge and attitudes	*"I learned a lot from the course, and I thank you very much...having the knowledge [from the course] was good, because before the course, I would have probably been laughing with the others. Because I just, I would not have known. So no, I was well-prepared, and I thank you for that." (P11)*	RA
		Did not retain all key learning objectives	*I've forgotten the... I think there is a list on every page of the online training of the section of people you can call but I didn't write them down, wasn't there? (P7)*	RA
		Improved & changed behaviours	*"I don't know what I'd have said or done had I not had the knowledge that you guys provided." (P11)* *"From a clinical point of view, I feel like I'm able to action it a lot quicker. If I saw someone do that and I thought, "That's unusual," I go and I do a urinalysis, do some further testing, delirium screening. I feel like I'm more proactive within my role because of the course." (P18)* *"At least now I've got a real strategy for if an event occurs, I've sort of worked it out in my mind how I'd approach it and hoping to get the best results." (P12)*	RA
		Poor prevention knowledge retention	*"Well, I think with prevention it's something that, it doesn't really occur to you until something [an incident] happens." (P4)*	RA
	Feedback	Mandatory, annual training for all staff	*"Something that everybody should do at least yearly, and certainly when they first start. When everyone starts, I have to do their manual training and their food handling and all of that sort of stuff. And it should be right in there with them." (P11)* *"Oh, look, I think it should be mandatory. … We have in our facility…two registered nurses, two enrolled nurses and the rest are [personal care workers]. So, they would benefit immensely. They're the hands-on people, they're the ones that are working with our resident's day in and day out." (P4)*	RA
		Sexuality training	*"As kind of a starter, so it'd be good to have sexuality in aged care, and then the whole" (P17)*	RA

Legend: CA = Concurrent Acceptability; RA = Retrospective Acceptability; PA = Prospective Acceptability

PARTICIPANTS

Of the 39 participants that completed the post-test survey for the intervention 18 completed in-depth interviews. Data saturation occurred at interview eight. Participants were majority female identifying (13/18, 72.2%), aged between 35-64 years (13/18, 72.2%), with over six years of experience (14/18, 77.8%) and most had not completed any training for prevention or management of sexual violence in the previous 12-months (13/18, 72.2%) (Table 2). Only one participant was excluded as they did not complete all modules of the intervention. No repeat interviews were carried out.

TABLE 2: PARTICIPANT CHARACTERISTICS, INCLUSIVE OF: SEX, AGE, YEARS WORKING IN RACS, AND PREVIOUS SEXUAL VIOLENCE TRAINING UNDERTAKEN

	n (%)
Sex	
Female	15 (83.3)
Male	3 (16.6)
Age Group (years)	
≤ 34	3 (16.6)
35–44	5 (27.7)
45–54	4 (22.2)
55–64	4 (22.2)
≥ 65	2 (11.1)
Years working in RACS	
≤ 5	4 (22.2)
6–10	6 (33.3)
11–15	3 (16.6)
≥ 16	5 (27.7)
Sexual violence training	
Yes, external education provider at employer's request	1 (5.5)
Yes, external education provider at my own initiative	1 (5.5)
Yes, internal/in-house training	1 (5.5)
Yes, self-directed	2 (11.1)
No	13 (72.2)
Total	**18 (100)**

QUALITATIVE FINDINGS

Participants spontaneously referred to six of the seven TFA constructs. Only *opportunity costs* were not spontaneously identified by participants, however, it was acknowledged when asked if they believed other RACS nurses and/or personal care workers would express interest in the intervention.

Findings are presented below for each TFA construct and their corresponding broader themes. Supporting statements from interviewees and interview themes are presented in Table 1.

ETHICALITY

This construct centres on the extent to which the intervention was perceived to be a good fit with the participants' value system. *Ethicality* was commonly expressed in interviews in the following three broad themes. First, participants value education because they value self-development or the course content. Second, participants value their occupation, and third, participants value the USB subject matter.

Values Education

All participants reported valuing education through either a retrospective appreciation of the course, or a prospective motivation to engage with it. The intervention content was deemed as relevant and interesting and participants valued the opportunity to learn about USB. Many participants also prospectively valued their own self-development expressing their motivation to continuously improve their knowledge and skills in an array of areas (e.g., dementia care) which incentivised them to undertake the intervention.

Values Occupation

Participants expressed the intervention aligned with their commitment to delivering 'person-centred care' and positive sentiment toward their professional role irrespective of their overall job satisfaction in the workplace. Participants presented as willing to learn anything that would make them better carers, often referring to the needs of their residents as more important than their personal comfort. The sincerity of this sentiment was evident through respecting and promoting the rights of residents, including their right to consensual sexual expression, and their dedication to improve resident care despite the strains faced by the sector (further discussed in the construct *'burden'*).

Participants Valued the Intervention Topic

The vast majority of participants expressed prospective acceptability of the intervention through their belief that USB in RACS is a problem, therefore signifying that the topic aligns with their values. Participants also valued their own comfortability in being able to hold open and honest dialogues about consensual sexual intimacy in RACS between residents.

AFFECTIVE ATTITUDE

This construct is concerned with the participant's feelings and attitudes about participating in and completing the intervention. All participants reported very positive feelings about the intervention. It was also found that prospective attitudes to the topic influenced acceptability of the intervention. Three broader themes were: workplace attitudes to USB, past experiences of USB in RACS, and lack of available training regarding USB.

Workplace Attitudes towards USB

Participants expressed their attitude toward USB in RACS often clashed with workplace values. For example, some participants detailed discordance between family and RACS staff, or between RACS staff, in relation to consensual sexual expression (e.g., the prevention of consensual sexual expression), or the credibility of someone with a cognitive impairment (e.g., dismissing sexual violence if a cognitively impaired resident is the survivor or exhibitor). As noted in '*ethicality*', participants advocated and wished to promote sexual safety. Participants also noted that USB is a taboo topic and recognised that attitudes towards sexuality and USB may be influenced by a sector-wide lack of awareness on the topic. For example, the inability to refer to sexual acts or genitals and using incorrect terminology may serve as a barrier to detection and management of USB or consensual sexual practices. The majority of participants reported that USB is a complex and stressful issue, especially when it involves residents with a cognitive impairment. These experiences motivated participants to complete the intervention.

Past Experiences with USB in RACS

Participants often provided examples of poorly managed USB incidents. Many participants noted there is confusion amongst RACS staff regarding what constitutes consensual activity and incidents that are reportable to the regulator. This was often illustrated by participants describing incidents that occur between persons with cognitive impairment, or incidents that occur between married residents. When discussing these incidents, participants were confused by constructs such as capacity to engage in sexual activity and whether consent is implied by matrimony. Some also noted that confusion around capacity resulted in the prohibition of consensual intimacy between residents or the failure to prevent and protect a resident survivor if the perpetrator was a spouse.

All participants described reactive rather than proactive management strategies, such as monitoring suspected or alleged resident exhibitors. Monitoring was the most common and relied upon prevention technique employed, despite frequent discussions detailing the time constraints and poor staffing ratios frequently experienced (described in *'burden'*). Participants often discussed that monitoring residents allowed them to prevent an incident but did not detail any additional preventative measures to avert another attempt by the resident exhibitor. Just as concerning, were the participants that did not express an understanding that the intended victim might have still required emotional support after a resident exhibitor's unsuccessful attempt. Interestingly, participants did not discuss the utilisation of external support services for resident survivor, exhibitor, or incident management, despite this being prominent throughout all module content. Lack of discussion relating to the use of external support services during incident management indicated to the interviewer that the importance of such collaboration was perhaps not understood. This was also suggested during participants discussion of ill-effective, reactive management measures discussed in *'Perceived Effectiveness'*.

Lack of available training on USB

All participants had a positive attitude towards the intervention. Participants stated the training was valuable as most had not received formal training about USB in RACS. Participants also reported that the existing training addressing elder abuse did not adequately address USB in RACS. The elder abuse training was too broad and/or too focused on mandatory reporting requirements. Participants proposed these factors contribute to poor workplace attitudes towards the topic, as well as poor USB incident detection, management, and prevention. Participants emphasised that more in-depth USB incident management and prevention education is needed as they experienced with the e-training. Furthermore, they considered it should be made mandatory for nurses practising in RACS.

Whilst some expressed transferring learned knowledge from the intervention to their workplace peers, most participants preferred a facility wide roll out of the intervention. Participants implied that dedicated professional development regarding USB was needed rather than "informal learning' (i.e., learning through modelling, peer observation, and practice).

BURDEN

The construct *burden* references the perceived amount of effort that is required to complete the intervention. Discussions focused on workforce strain, and the emotional burden of the intervention topic.

Workforce Strain

Participants spoke often of the current strain on the sector due to the recent Royal Commission into Aged Care Quality and Safety's findings, historical and continuous poor staff-resident ratios, the increasing complexities of resident care needs, and the impact of COVID-19. Although all participants believed the intervention was relevant and necessary, some expressed this workforce strain and "change fatigue" as a barrier to staff recruitment and capacity to complete the intervention. In contrast, some participants expressed that the intervention could reduce their current stressors by providing RACS staff with effective resources to address existing gaps.

Emotional burden of USB

None of the participants expressed that the content was a distressing learning experience. Some participants expressed the online environment and support from intervention facilitators made the topic less burdensome and that they

felt safe and supported. Further, most participants found it rewarding to learn a person-centred approach to USB. The majority made a clear distinction between their emotional response to managing an incident in their facility (which was stressful) and receiving education on the topic (which was empowering).

INTERVENTION COHERENCE & SELF-EFFICACY

All interviewees mentioned their ability to complete the intervention online (*self-efficacy*) which corresponded to their understanding of how the intervention worked (*intervention coherence*). As the interviews were completed post-intervention, all participants referenced or implied throughout the interviews their understanding of the intervention's purpose, how it operated, and were able to perform all mandatory tasks. These topics were discussed through the broader theme of *intervention operation.*

Intervention Operation

Most participants believed the intervention required little improvement. Most could not offer any comment when asked to identify elements of the intervention that they did not understand or could not complete. None of the participants disagreed with any of the intervention content, nor did they consider it was beyond their capacity to successfully complete. Feedback offered focused on the IT platform's functionality, suggesting that minor changes to the useability and design would increase engagement and improve the acceptability of the intervention.

OPPORTUNITY COSTS

None of the participants expressed that any benefits, profits or values were forfeited by themselves in order to complete the intervention. Participants were asked to speculate about how others may view these domains.

Perceived future opportunity costs

Some participants mentioned that the content presented in the intervention may challenge values and beliefs of some staff who come from different backgrounds or less experienced staff. For example, some participants stated that some colleagues do not believe that older people are sexually active or that they can be victim-survivors of USB and, some staff have difficulty discussing sensitive matters.

Few participants opined that for some RACS staff how they value the topic would not be offset or balance the cost of undertaking the intervention (e.g., time off work or days off).

PERCEIVED EFFECTIVENESS

It was not possible to test the actual efficacy of the intervention within this research. Rather, as per the TFA, this construct aimed to understand the extent to which the intervention was perceived by participants as likely to achieve its purpose. Closely related to participant's views on *affective attitude*, *ethicality* and *intervention coherence*, participants believed the intervention helped them improve their attitude, awareness, knowledge, and practice. The broader themes discussed were pre-intervention knowledge, attitudes and skills, post-intervention knowledge, attitude, and skills, and intervention feedback.

Pre-Intervention knowledge, attitudes, and skills

Prior to completing the intervention, many participants described poor awareness of the topic and poor confidence in detecting and managing incidents. This was often expressed as a consequence of inadequate training, poor collaboration between specialist services and a general lack of valuable resources. Some participants confessed previous poor attitudes to the topic prior to intervention completion, including lack of awareness of the magnitude and seriousness of incidents in RACS, or limited understanding of the trauma that residents with dementia may experience.

Post-Intervention knowledge, attitudes, and skills

Participants self-reported benefits at personal and workplace levels. Participants self-reported an improvement in their personal practice and also felt able to extend and transfer knowledge to other staff in their workplace. Participants' self-reported attitudes towards USB in RACS improved due to the knowledge acquired during the intervention. All participants expressed an increased confidence in either detecting, managing, and/or reporting incidents. Few participants reported an increased confidence to prevent USB. Some participants noted that the intervention prompted reflection on and/or a change to their current practice. Examples included improved attentiveness to resident behaviours, implementing new prevention techniques such as sexuality assessments and, reviewing workplace policies regarding USB. Interestingly, some participants' approach to USB remained reactive; that is, reporting incidents and monitoring alleged/suspected resident exhibitors, rather than the proactive approach advocated throughout the intervention.

Participant Feedback

Commonly discussed improvements included providing more information on sexuality in older people within the intervention content and that there be an annual mandated USB training for *all* staff, especially for more junior staff.

Expanding the intervention content to including more information regarding consensual sexuality in older people was believed by some participants to prevent the occurrence of USB or would help them distinguish between consensual verse non-consensual sexual activity. This distinction was often raised as a complex task, especially where cognitive impairment and capacity to consent issues were involved.

All participants noted that to increase the sector's capacity to address USB, aged care staff in differing roles (especially personal care workers) need to receive training on this topic. Most considered mandatory training of staff would be beneficial for both residents and the RACS. All participants believed that mandatory training would help to achieve the intervention's aims. Other feedback included making content more interactive using additional case studies and audio-visual material.

DISCUSSION

STATEMENT OF KEY FINDINGS

This study assessed the acceptability of an e-training intervention regarding USB in Australia's RACS using the TFA framework. The outcome was a favourable evaluation in all seven domains, finding high acceptability of the intervention amongst all participants. It aligned with participant's values and the content was perceived to improve participants' knowledge and attitudes towards incident management. Most compelling, was that all participants stated that it would be helpful for all front-line RACS staff to receive the intervention and that it should be mandatory. Participants considered the intervention empowering by increasing their confidence in addressing a stressful workplace issue.

INTERPRETATION

Similar to other studies, participants described the current workplace climate as highly pressured. This is in part reflecting increased workload and stress due to COVID-19 as well as recent and chronic workforce shortage. These factors may result in the intervention not being prioritised within RACS.[19] This environment acts as a barrier to acceptability of the intervention at the sector level however, participants overcame this as they considered the subject matter as a high priority at a personal and professional level.

The majority of participants considered the aged care workforce as a whole has a substantial gap in USB knowledge. This may contribute to the dismissive attitudes and reactive approaches to managing incidents of USB. All participants noted that the intervention felt empowering, filled knowledge gaps, helped to prepare staff to manage USB, and as a result relieved this as a workplace stressor. The participants individually were highly motivated to learn and change practice which outweighed any barriers to completing the intervention.

In other studies, with RACS nurses, professional development was seen as a prerequisite for quality care.[20] The intervention fills an existing clinical education void in the sector which may have led to a more favourable response about the content being relevant as there were not any comparable interventions.[20] The flexible online delivery was highly acceptable to participants. This is consistent with these platforms for healthcare professionals generally being perceived as reducing the *burden* and *opportunity cost* of the intervention.[21]

Participants considered their overall awareness of USB in RACS improved post-intervention and expressed hope that this would lead to improved care for residents in the future. They expressed a preference for the intervention to occur more frequently and be required to complete earlier in their professional development.

Whilst all participants reported increased confidence in detecting, managing and/or reporting incidents, some were only able to detail reactive protective measures. This was disappointing as proactive prevention measures were an aim of the intervention (Appendix 3). Perhaps it is unrealistic to consider improving knowledge regarding proactive preventative measures could be achieved as many studies have highlighted that more than a single intervention is required to encourage cross referrals between organisations and to address the lack of prevention knowledge.[22-24] Collaboration between RACS staff, health professionals, and sexual violence experts is required to effectively manage all aspects of incidents. Inadequate collaboration between services creates major limitations in managing and supporting older survivors of sexual violence.[22]

A gap identified in the intervention by participants was the need for the provision of foundational information about sexuality in older people. Indeed, there is a paucity of empirical research about the sexual health needs of RACS residents and whether these are proactively or routinely assessed or supported by staff. What is known is that the sexual health needs of residents are usually only reviewed in response to an occurrence of incidents of sexually disruptive behaviour.[25] Further, existing taboos around the sexuality of older people may hamper the identification of USB.[26] Finally, an exploratory study in RACS setting affirmed that education about LGBTI older adults reduced misconceptions and empowered staff to provide more holistic care to residents.[27] Our study highlighted that staff's self-reported lack of knowledge about sexuality impacts their ability to manage USB especially when attempting to distinguish between consensual and non-consensual sexual activity.

GENERALISABILITY

As with all qualitative study generalising findings to anyone or any group is fraught. The traditional views about the purpose of qualitative studies are to explore the dimension of a problem rather than generalisability.[28] Interpreting whether the assessment of acceptability could be reflective of the views of nurses from other countries should be made with caution as the study did not have *a prior* intention to investigate generalisability. An additional caveat is this intervention was designed for the aged care staff in the context of the healthcare, regulatory, and legal system in Australia.

STRENGTHS AND LIMITATIONS

To our knowledge, this is the first study to assess the acceptability of an USB in RACS e-training intervention. Limitations inherent to qualitative research are present, in addition the interviewees were a self-selected, convenience sample. This likely results in a more favourable response. Participants may have undertaken the intervention as it aligned with their own values regarding USB in RACS or experienced a need for such intervention. Research with more diverse participants, experience, and personal values would be useful for future research studying the acceptability of such an intervention.

CONCLUSION

Participants reported this intervention to be highly acceptable and it has potential to improve attitudes and awareness of USB in RACS. More research is needed to understand the effect on medium- and long-term outcomes such as better incident management, enhanced resident wellbeing, and reduction in USB. Future research should assess the short and long-term efficacy of the e-training in managing and reducing incidents of USB in RACS.

IMPLICATIONS FOR RESEARCH, POLICY, AND PRACTICE

All front-line healthcare professionals have a role to play in USB prevention and management.[29,7] Known prevalence of USB in aged care suggests most nursing staff will be required, at some stage, to provide care to a resident who has been a target, or exhibitor of USB. The intervention has two key attributes of being readily accessible and acceptable to participants, that facilitate large scale staff training.[8]

The intervention has the potential to contribute to improving the sector's response to incidents by empowering nurses to improve residents' care. Additional strategies will be required to augment the benefits of training such as policy reform, provision of resources, and legal and regulatory changes.[30] Future adaptations of the intervention that may increase *perceived effectiveness* and acceptability is the inclusion of content about sexuality and intimacy.

Future research requires exploration of this topic and how it impacts professional behaviours in short and long-term practice. Also worthy of exploration is whether mandatory training, as recommended by the participants, impacts on the acceptability and learning outcomes and organisation culture.

Acknowledgements: We thank the participants who contributed their time and wealth of knowledge to these interviews.

Funding Support: This work was supported by the Department of Health and Human Services, Seniors, Ageing and Aged Care Branch, Health and Wellbeing Division, Victoria, Australia and the Department of Forensic Medicine, Monash University.

Declaration of conflicting interests: The authors are affiliated with or employed by the Department of Forensic Medicine, Monash University, which is also a funding source. The authors have no other potential financial or personal interests that may constitute a conflict of interest.

Disclaimer: The views and opinions expressed in this article are those of the authors and do not necessarily reflect the official policy or position of any agency or departments of the Australian Federal Government, the State Government of Victoria, Monash University, the Victorian Institute of Forensic Medicine or the Coroners Court of Victoria.

REFERENCES

1. Smith D, Wright M, Ibrahim J. Aged care nurses' perception of unwanted sexual behaviour in Australian residential aged care services. *Australis J Ageing.* 2022;41(1):153-9. Available from: https://doi.org/10.1111/ajag.13014
2. Australian Government. Royal Commission into Aged Care Quality and Safety Final Report. Canberra. 2021. Available from: https://agedcare.royalcommission.gov.au/publications/final-report.
3. Yon Y, Ramiro-Gonzalez M, Mikton C, Huber M, Sethi D. The prevalence of elder abuse in institutional settings: a systematic review and meta-analysis. *Eur J Public Health.* 2019;29(1):58-67. Available from: https://doi.org/10.1093/eurpub/cky093
4. Band-Winterstein T, Goldblatt H, Lev S. Breaking the taboo: sexual assault in late life as a multifaceted phenomenon—toward an integrative theoretical framework. *Trauma Violence Abuse.* 2021;22(1):112-24.
5. Koga C, Tsuji T, Hanazato M, Takasugi T, Kondo K. Types of elder abuse and dementia onset among older adults in Japan: a 6-year longitudinal study from the Japan Gerontological Evaluation Study. *Arch Gerontol Geriatr.* 2022;100:104656.
6. Australian Government, KPMG. Prevalence Study for a Serious Incident Response Scheme (SIRS). Canberra. 2019. Available from: https://www.health.gov.au/resources/publications/prevalence-study-for-a-serious-incident-response-scheme-sirs
7. Gino S, Bo M, Ricciardelli R, Alù M, Boschi I, Carnevali E, et al. Evaluation of critical aspects in clinical and forensic management of sexual violence: a multicentre Ge.F.I. project. *Forensic Sci Int.* 2020;314:110-387. Available from: https://doi.org/10.1016/j.forsciint.2020.110387
8. Du Mont J, Solomon S, Kosa D, Macdonald S. Development and evaluation of sexual assault training for emergency department staff in Ontario, Canada. *Nurse Educ Today.* 2018;70:124–9. Available from: https://doi.org/10.1016/j.nedt.2018.08.025
9. Kennedy K, Vellinga A, Bonner N, Stewart B et al. How teaching on the care of the victim of sexual violence alters undergraduate medical students' awareness of the key issues involved in patient care and their attitudes to such patients. *J Forensic Leg Med.* 2013;20(6):582–7. Available from: https://doi.org/10.1016/j.jflm.2013.06.010

10. Smith J, Ho L, Langston A, Mankani N, Shivshanker A, Perera D. Clinical care for sexual assault survivor's multimedia training: a mixed-methods study of effect on healthcare providers' attitudes, knowledge, confidence, and practice in humanitarian settings. *Confli Health*. 2012;7(1). Available from: https://doi.org/10.1186/1752-1505-7-14
11. Smith DE, Wright MT, Pham TH, Ibrahim JE. Evaluation of an online course for prevention of unwanted sexual behaviour in residential aged care services—a pilot study. *Int J Older People Nurs*. 2021;17(1).
12. Moore G, Audrey S, Barker M, Bond L, Bonell C, Hardeman W, et al. Process evaluation of complex interventions: Medical Research Council guidance. *BMJ*. 2015;350:1258-h1258. Available from: https://doi.org/10.1136/bmj.h1258
13. Sekhon M, Cartwright M, Francis J. Acceptability of healthcare interventions: an overview of reviews and development of a theoretical framework. *BMC Health Serv Res*. 2017;17(1). Available from: https://doi.org/10.1186/s12913-017-2031-8
14. Toomey E, Flannery C, Matvienko-Sikar K, Olander EK, Hayes C, Heffernan T, et al. Exploring healthcare professionals' views of the acceptability of delivering interventions to promote healthy infant feeding practices within primary care: a qualitative interview study. *Public Health Nutri*. 2021;24(10):2889–99. Available from: http://doi.org/10.1017/S1368980020004954
15. Gerbild H, Areskoug-Josefsson K, Larsen C, Laursen B. Acceptability of Health Professionals' address of sexuality and erectile dysfunction – a qualitative interview study with men in cardiac rehabilitation. *Sex Med*. 2021;9(3):100369.
16. Department of Health. 2019–20 Report on the operation of the Aged Care Act 1997. Canberra. 2020. Available from: https://www.gen-agedc aredata.gov.au/www_aihwgen/media/ROACA/20366 -Health-Report-on-the-Operation-of-the-Aged-Care-Act- 2019%e2%80%932020-accessible.pdf
17. Australian Government, Department of Health. 2016 National aged care workforce census and survey—the aged care workforce, 2016. Canberra. 2017. Available from: https://gen- agedcaredata.gov.au/www_aihwgen/media/Workforce/The- Aged-Care-Workforce-2016.pdf
18. Noble H, Heale R, Triangulation in research, with examples. *Evid Based Nurs*. 2019;22:67–68. Available from: https://doi.org/10.1136/ebnurs-2019-103145
19. Galanis P, Vraka I, Fragkou D, Bilali A, Kaitelidou D. Nurses' burnout and associated risk factors during the COVID-19 pandemic: a systematic review and meta-analysis. *J Adv Nurs*. 2021;77:3286-3302. Available from: https://doi.org/10.1111/jan.14839
20. Page M, Pool L, Crick D, Leahy R. Empowerment of learning and knowledge: appreciating professional development for registered nurses in aged residential care. *Nurse Educ Pract*. 2020;43:102703. Available from: https://doi.org/10.1016/j.nepr.2020.102703
21. Bennett-Levy J, Perry H. The promise of online cognitive behavioural therapy training for rural and remote mental health professionals. *Australas Psychiatry*. 2009;17:121-4. Available from: https:// doi.org/10.1080/10398560902948126
22. Bows H. Practitioner views on the impacts, challenges, and barriers in supporting older survivors of sexual violence. *Violence Against Women*. 2018;24:1070–90. Available from: https://doi.org/10.1177/1077801217732348
23. Mann R, Horsley P, Barrett C, Tinney J. Norma's Project: a research study into the sexual assault of older women in Australia. Australian Research Centre in Sex, Health and Society. 2014. Available from: https://elder-mediation.com.au/resources/Sexual_Assault_Older_Women_Australia.pdf
24. Centre for Research on Families and Relationships and NHS Health. Older women and domestic violence in Scotland: ". . . and for 39 years I got on with it." Scotland. 2004. Available from: http://www.womenssupportproject.co.uk/userfiles/file/uploads/DMOlderReport.pdf
25. McAuliffe L, Bauer M, Fetherstonhaugh D, Chenco C. Assessment of sexual health and sexual needs in residential aged care. *Australas J Ageing*. 2014;34:183-188. Available from: https://doi.org/10.1111/ajag.12181
26. Malmedal W, Iversen H, Kilvik A. Sexual abuse of older nursing home residents: a literature review. *Nurs Res Pract*. 2015;902515. Available from: https://doi.org/10.1155/2015/902515
27. Petrie N, Peta S. Cook catering to sex, sexual, and gender diversity: An exploratory study on the effects of LGBTI awareness training on aged care staff in Tasmania, Australia. *J Gay Lesbian Soc Serv*. 2018;31:19-34, https://doi.org/10.1080/10538720.2018.1548329
28. Carminati L. Generalizability in qualitative research: a tale of two traditions. *Qual Health Res*. 2018;28(13):2094-2101. Available from: https://doi.org/10.1177/1049732318788379
29. Yaffe J, Wolfson C, Lithwick M. Professions show different enquiry strategies for elder abuse detection: implications for training and interprofessional care. *J Interprof Care*. 2009;23:646–54. Available from: https://doi.org/10.3109/13561820902886279
30. Wright M, May A, Ibrahim JE. Recommendations for prevention and management of sexual violence in residential aged care services. Melbourne: Health Law and Ageing Unit, Department of Forensic Medicine. 2019. Available from: https://agedcare.royalcommission.gov.au/system/files/2021-02/RCD.0013.0013.0061.pdf