

IMPROVEMENT OF SEXUAL ASSAULT NURSE EXAMINER SERVICES
AT A COMMUNITY HOSPITAL

by

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DEDICATION

This paper is dedicated to my husband and daughter for supporting me through this journey and encouraging me to follow my dreams. To my father for giving me a passion for learning and to my mother for helping me become a nurse. Thank you also to my people, who have taught me to take the small steps and allow the big things to happen.

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ABSTRACT

Sexual violence affects a large portion of the population, and impacts survivor's short-term and long-term mental and physical health. Negative healthcare experiences following an assault may increase the person's trauma. The purpose of the Sexual Assault Nurse Examiner (SANE) is to assure that patients reporting sexual assault receive timely, competent and compassionate care by a trained individual. SANE programs can be difficult to fund and retention of Nurse Examiners is difficult. At a community hospital in a rural state, a SANE performed a microsystem assessment. Using servant leadership, the SANE advocated to improve services to patients reporting sexual assault and gained support from administration and the community.

CHAPTER ONE

INTRODUCTION

Background

Sexual violence is an unfortunate but very real fact of life in our society. In fact, it seems to be a problem as old as human existence. It is referenced in the Bible, mythology and throughout the arts and literature. Sexual violence encompasses a wide array of abuses, from sexual harassment and stalking to sexual assault. Sexual assault includes any physical contact of a sexual nature that is not wanted by the victim and can range from fondling to penetration with varying levels of physical violence associated (National Institute of Justice, 2010). While this is a worldwide problem, this paper will focus on the problem as it is in the United States. It is also recognized that anyone can be assaulted – no matter his or her gender or sexual orientation. Men are victims of assault, and some women are perpetrators of assault. Unless specified, this paper will focus on what is known to be the most common type of sexual violence: a male assaulting a female (Black et al., 2011).

It is estimated that 68% of assaults are never reported to the police. (Rape, Abuse & Incest National Network, 2015). As such, it can be difficult to understand the full scope of this problem. Out of all violent crime, sexual assault carries the greatest shame and stigma and many victims not only hide what happened from their loved ones but also do not report to any type of authority (Campbell, Wasco, Ahrens, Sefl & Barnes, 2001). Some victims never tell anyone and others only tell friends or family. Some victims tell

counselors or seek medical care and/or report it to law enforcement. To better estimate the true prevalence of sexual assault, the Centers for Disease Control (CDC) conducted the National Intimate Partner and Sexual Violence Survey. This is a nationwide survey that assessed both the lifetime incidence and the past-year incidence of stalking, intimate partner violence (IPV) and sexual violence. The survey discovered specifics about the type of violence and the long and short-term impacts the victim feels resulted from the violence (Black et al, 2011). The 2010 survey found that nearly one in five U.S. women had been raped in her lifetime, while one in 71 men reported having been raped in his lifetime. These statistics translate to approximately 22 million U.S. women and 1.6 million men in the United States having a history of being raped (Black et al, 2011). Sadly, many people are subject to multiple types or incidences of sexual violence in their lifetime. In a study of 140 women who reported having been assaulted, the average number of experiences of sexual victimization in their lifetime was 2.65 (Perilloux, Duntley & Buss, 2012). Considering the small percentage of victims who report their assault to law enforcement, it is not surprising that most rapists will never spend a day in jail for their crime (RAINN, 2015). Even for individuals who do report to law enforcement and attempt criminal proceedings, the rate of cases going to trial and resulting in conviction is low. Campbell et al. (2014) found that even in cases where the victim had received a medical forensic exam and reported to the police, in 90% of cases no legal action occurred.

Victims of sexual assault suffer many physical consequences. In the immediate aftermath of an assault there can be an overwhelming feeling of a loss of body integrity

with the sensation that their body has been severely injured, even though there may not be, and usually isn't, serious bodily harm (Campbell et al., 2001). Mild physical injuries can include bruising, abrasions and pain. More significant but less common injuries include lacerations of the skin, strangulation, head injuries and fractures. Another concern in the immediate period is the possibility of contracting a sexually transmitted infection (STI) or becoming pregnant as a result of the assault.

After the immediate period there are other physical consequences to assault. In addition to having suffered one act of violence, "approximately two of three individuals who are sexually victimized are revictimized" (Classen, Palesh & Aggarwal, 2005, p. 124). Some victims report engaging in risk taking behaviors such as drinking, drug use, promiscuity and a general lack of consideration for their physical safety (Office of Justice Programs, 2015). Both women and men with a history of sexual violence "were more likely to report frequent headaches, chronic pain, difficulty with sleeping, activity limitations, poor physical health and poor mental health" than those without such history (Black et al., 2011, p. 3). In addition, women were more likely to report asthma, irritable bowel syndrome and diabetes if they had a history of violence (Black et al., 2011). Not only does the victim of sexual violence suffer serious physical consequences in the immediate period, they are subject to a lower level of physical well being for the rest of their lifetime.

The emotional and psychological consequences of sexual assault can be devastating. Immediately following the assault many victims experience numbness, disbelief and disorientation. Several experience fear of further harm, fear of the reactions

of others, and shame over their inability to protect themselves or prevent the assault from happening. It is not uncommon for victims to engage in self-blame, trying to figure out what they did wrong to cause the assault to happen. Some feel anger towards their assailant or those who did not help them. Some who do not have full memory of the assault (due to the effects of trauma, intoxication, strangulation or head injury) struggle with not knowing the details of what has happened to them. Many will experience “flashbacks, intrusive thoughts of the rape, fear, anxiety, nightmares, day-mares and the development of phobias” (Ledray, Burgess & Giardino, 2011, p. 8). Most rape survivors have a period of disruption in their daily lives and routines as they recover. They suffer lost productivity due to missing work and school or from the inability to focus on tasks. Some have to withdraw from their usual activities due to fear and anxiety. The immediate period of disorganization is significant.

More troubling are the long-term emotional and psychological effects that can occur for survivors of sexual violence. Survivors are more likely to experience depression, anxiety, suicidal ideation, withdrawal, isolation, interpersonal conflicts, and sexual dysfunction (Office of Justice, 2015). These disorders have a significant impact on quality of life and can result in a loss of normal functioning and even death. Victims often suffer from self-blame and decreased self-worth. They can have trouble viewing themselves as in control, confident and able to manage their lives. Spiritual distress can result from the breaking down of the assumptions that enable a person to go about their everyday life. These assumptions are best described by Janoff-Bulman as: the world is good, the world is meaningful and the self is worthy (Janoff-Bulman, 1992, p. 6). After

becoming the victim of a violent crime these assumptions are destroyed, and reorganizing how one views the world must take place. While these problems can be severe, one of the most serious and well-known disorders that may occur as a result of sexual violence is Posttraumatic stress disorder (Ledray et al., 2011).

Burgess and Holmstrom first recognized and reported on “Rape Trauma Syndrome,” a syndrome that was recognized as a nursing diagnosis by the North American Nursing Diagnosis Association in 1979 (Ledray et al., 2011). This syndrome involved two stages: an acute disorganization of the victim’s lifestyle followed by a long-term process of re-organization of their lifestyle. While Posttraumatic stress disorder (PTSD) was first recognized in combat veterans, it later became the term used for anyone suffering from a disorder caused by having experienced a life threatening event, and in 1980 the term PTSD came to incorporate Rape Trauma Syndrome (Ledray et al., 2011). “Rape survivors represent the largest non-combat group of individuals with posttraumatic stress disorder” (Office of Justice, Emotional Response, 2015, Para. 1). PTSD involves experiencing four aspects: re-experiencing the trauma (flashbacks, nightmares), emotional numbing (feeling detached, joyless), avoidance (changing one’s activities to avoid triggers) and increased arousal (irritability, hyper-vigilance) (Ledray et al., 2011). These symptoms occur for greater than a month and can cause significant loss of functioning and quality of life.

Clearly sexual assault is a health problem that effects too large a portion of our population. This type of violence has significant outcomes for a person’s short and long term functioning and is a contributor to poor health for the rest of the lifespan.

Importance of Response

When a victim interacts with others following an assault, the risk for and severity of these outcomes can be influenced by their responses. The self-blame and emotional distress common to survivors can be compounded if they are met with blaming attitudes, disbelief or insensitive care. Many women, anticipating these attitudes, choose never to disclose what has happened to them. Some, after experiencing negative attitudes from others, choose to limit their feeling of vulnerability by seeking no further help or assistance.

Patterson, Greeson & Campbell (2009) studied 102 adult women who had experienced sexual assault. Of those, 29 survivors did not report to formal social systems, such as medical, legal or counseling services. The reasons listed for not seeking help included anticipating rejection, anticipating disbelief, fear of being forced into legal action and feeling that no one *could* help them. Significantly, “survivors described how not seeking help was a form of self-protection against system personnel and processes they had perceived as hurtful” (Patterson et al., 2009, p. 130). These women not only had to suffer alone, they did not receive any screening, care or education on the consequences of sexual assault such as sexually transmitted infections, pregnancy, injuries or psychological problems.

Ideally, interaction with the medical system after an assault includes emotional care, physical care, education on risks, referrals for other services and forensic collection of evidence. This process is termed a medical forensic examination.

Even for those willing to seek care, the problems they may face have been well documented and have been termed “the second rape” (Campbell et al., 2001). Patients often seek care in the local Emergency Department (ED) following assault, with varying levels of care received. In the traditional care of the ED the needs of sexual assault survivors are not perceived as urgent (Littel, 2001), and victims are often subject to long wait times as patients with more physically critical needs are treated.

In order to not disturb evidence, victims may be denied food or water and not allowed to empty their bladders while they wait, sometimes for hours. “For the victim of sexual assault, the delay may result in the loss of evidence, a risk that the victim will become discouraged, withdraw her legal complaint against the perpetrator, and return home” (Girardin, 2005, p. 124).

Victims are often treated and assessed by personnel with no training in sexual assault or trauma informed care and thus often perceive blame, indifference or frustration from those they are trusting with their story. If their case does move forward legally the evidence collected may not be admissible in court and the person who collected it may resent having to testify in court on behalf of the victim (Littel, 2001). In addition, rather than receiving a coordinated response for all of their needs, victims must seek out care from many entities – a process that can be difficult even for a non-traumatized person. These hurtful interactions when seeking care may encourage victims to drop their legal cases and to avoid seeking medical or psychological help for their ailments related to the assault. Not only do victims not receive further care, they are at higher risk for health consequences from the assault. Campbell et al., (2001) reported “that victims who rated

their contact with the medical system as hurtful exhibited higher psychological and physical health distress” (p. 1253).

Nurses Address Sexual Assault

To address the problems with medical care encountered by victims, professional nurses initiated a model of care in the 1970s that has come to be called the Sexual Assault Nurse Examiner (SANE) model (Ledray et al., 2011). A SANE is a Registered Nurse (RN) who has received specialized education and training in helping victims of sexual assault when they seek care. In the past, sexual assault victims were treated by physicians who were often too busy to focus on one patient, untrained to provide the care, and who were often pulled away during the care. Additionally, physicians may have resented taking the time to testify if the case moved forward. Given that most victims of assault do not require emergency medical attention, professional nurses are appropriate caregivers for this patient population. Nurses are trained in treating patients with sensitivity and nurses who are educated to become a SANE receive specialized education in trauma informed care. In addition, SANEs stay with the patient and provide all the care needed (assessment, education, support and documentation) with little interruption (Ledray et al., 2011).

The benefits of a SANE educated nurse to the legal aspects of sexual assault have been documented. Sexual assault evidence kits collected by a trained SANE are more likely to be complete with higher quality evidence and fewer mistakes or chain of custody issues that can affect the case (Corum & Carroll, 2014; Littel, 2001). In court,

documentation by a trained and experienced examiner increases the validity of findings and decreases the chances an examination will be dismissed as invalid. In addition, trained SANEs can “present victims with a positive first impression of the community response system, increasing the likelihood that they will cooperate with law enforcement and prosecution” (Littel, 2001).

By having a healthcare worker who can collaborate with law enforcement, the victim’s experience can be more streamlined and the legal investigation more complete. SANEs recognize that testifying in court, even years later, is part of their care of the patient. In addition, SANEs have training in testifying and can become experienced and valuable witnesses. In some communities implementation of a SANE program increased reporting of assaults, increased filing of charges, increased plea bargains (saving individuals the financial and emotional costs of a trial) and resulted in higher conviction rates (Crandall & Helitzer, 2003; Campbell, Patterson & Bybee, 2011).

The medical benefits of having a SANE treat patients following sexual assault are significant. When treated by a SANE patients are more likely to receive education on their risk of pregnancy and STIs, medication to prevent pregnancy and STIs, Human Immunodeficiency Virus (HIV) counseling, information on care of injuries and post assault care such as a shower and a change of clothes (Campbell et al., 2006). A standard of care in SANE programs is the encouragement of follow up care for full sexual health screening and further education in the weeks following the assault.

Small communities may have grassroots organizations called Rape Crisis Centers or Sexual Assault Counseling Centers. Many of these organizations provide free

counseling for victims of assault, support in navigating the legal system and offer coordination with the local hospital to have an advocate present when a patient receives a forensic examination. Victims treated in SANE programs are more likely to receive referrals for community services such as crisis counseling (Campbell et al., 2006).

The emotional care provided by a SANE can be one of the most important aspects of care. The initial response of healthcare providers can significantly influence a victim's confidence and ability to seek care. Being treated with respect and dignity is vital to helping the survivor receive the care they need. In studying the services provided by SANEs, Campbell, Townsend et al. (2006) found that SANEs helped patients by providing full explanations of each step in the examination, being "sensitive to the victim's emotional state by talking in a soothing tone of voice, not using medical jargon, reflecting a calm demeanor, moving through the examination at a pace comfortable for the victim, and reminding the victim that they were now safe" (Campbell et al., 2006, p. 394). "SANE nurses strive to preserve their patients' dignity, ensure that victims are not re-traumatized by the evidentiary exam, and assist victims in gaining control by allowing survivors to make the decisions throughout the evidence collection process" (Campbell, Patterson & Lichty, 2005, p. 317). In a study of client satisfaction in a Canadian program, patients reported they were treated with respect, were supported and cared for and did not feel judged (Du Mont, Macdonald et al., 2014). One survivor's statement clearly shows the impact of this approach:

For a horribly humiliating experience your staff did a great job in comforting, respecting, [and] explaining things. Not judging and certainly not forcing any procedure on you that you were not willing to do. I thank you for being there through a terrible time. (Du Mont et al., 2014)

Receiving supportive care in the immediate period following the assault can decrease the emotional and psychological consequences of sexual assault. In reviewing psychological and sociological issues contributing to the development of Posttraumatic Stress Disorder in rape survivors, Chivers-Wilson (2006) found that increased levels of distress immediately following the assault are correlated with the development of PTSD and other pathologies. In addition, perceived positive support and giving back control to survivors are important in healthy recovery from this trauma (Chivers-Wilson, 2006). In contrast to the potential trauma of traditional ED care, women who were given medical forensic care by trained professionals following an assault “felt they were not being judged and were provided the time and attention warranted by their circumstances” (Du Mont, 2009, p. 777) and that the examination, while difficult to go through, created a feeling of empowerment that served them (Du Mont, 2009).

Local Problem

The focus of this paper is to describe improvements made in the care of sexual assault patients at a non-profit community hospital. The hospital is part of a larger healthcare organization in a rural state and is part of a rapidly growing community. The organization includes treatment centers, clinics, assisted living facilities and two hospitals. The primary hospital is an 86-bed facility that includes an Emergency Department (ED), an Intensive Care Unit, a Labor and Delivery Unit and a level II Neonatal Intensive Care Unit. The hospital is rated a Level III Trauma Center.

This hospital did not have a formal Sexual Assault Nurse Examiner program, or a formal SANE leader. As such, it was difficult to provide consistent services to patients reporting sexual assault, and to address the need for an experienced group of Sexual Assault Nurse Examiners. The hospital was experiencing a high turnover among SANEs who expressed dissatisfaction with the lack of an organized program and support. Patients were frequently subject to long wait times while the ED tried to contact a SANE who may or may not be able to come from another hospital unit or from home. Many patients ended up receiving care by a nurse who felt forced to perform the sexual assault exam or who was untrained in caring for these patients. The growing community population had resulted in a busy ED and the strain of having to perform these examinations or find a SANE was increasing.

With a growing community population and a perceived increase in the number of patients reporting sexual assault in the ED, an opportunity for improvement was noted. This hospital had a culture of patient satisfaction and progress towards best practice. In addition, the hospital was moving towards magnet status, a status that includes best practices in nursing services, excellence in the delivery of nursing services and promotion of quality (American Nurses Credentialing Center, 2008).

CHAPTER TWO

INTENDED IMPROVEMENT

Study Question

How can this rural community hospital effectively address the healthcare of victims of sexual assault, while also meeting the needs of the select group of professional nurses with SANE education? The Director of Nursing for the Emergency Department selected a professional nurse with SANE education (the author) to lead this initiative.

Batalden et al. (2007) reported that in order to effectively lead a microsystem a leader must “observe the actual context of work,” “determine the need for new services,” “take timely action,” and “share information in a format that connects to taking action” (Batalden et al., 2007, p. 55-59). This change could best occur through the efforts of a SANE who was at the bedside and understood the struggles that the patients and nurses were facing.

Microsystem Assessment

The first steps in the nursing process are to first assess and then to diagnose any problems that are present. Prior to 2010 no attempt had been made to assess the frequency with which patients requested sexual assault forensic examinations, the efficacy of the examinations or the satisfaction of healthcare workers providing the examinations. Other unknown factors were the impact on community partners and

problems encountered by the nurses who provided the care to patients who had been sexually assaulted.

In their book, “Quality by Design,” Nelson, Batalden and Godfrey define a microsystem as “a small group of people who work together on a regular basis to provide care to discrete subpopulations of patients” (Nelson, Batalden & Godfrey, 2007, p. 7). Looking at a unit of care as a microsystem provided a model to assess the system and discover opportunities for growth or change. One way to assess a microsystem is using the five Ps: the purpose, patients, professionals, processes and patterns of the microsystem (Nelson, Batalden & Godfrey, 2007). The author used the five Ps approach to evaluate and describe the services provided to patients reporting sexual assault.

The Purpose

The purpose of this project is to ensure that patients reporting sexual assault receive timely, competent and compassionate care by a trained Sexual Assault Nurse Examiner (SANE).

The Patients

In 2010 the author and a colleague initiated a roster of patients who were treated for sexual assault in the ED. The author used the roster to quantify the need for SANE services.

Patients enter into care through one of three ways: contacting law enforcement, contacting victim advocacy or arriving at the Emergency Department seeking medical evaluation. Patients may report being assaulted just hours prior to the hospital visit or up

to days prior to receiving care. SANE services are appropriate for a patient who either has visible injuries or who may have DNA or trace evidence on their body. Outside of this window, SANEs would not be routinely involved in the care of these patients. Our county has a Sexual Assault Response Team (SART). This team provides for a coordinated response to ensure that the patient is offered all of the services that are available to them. When a patient reports first to the hospital, the hospital facilitates contact with a victim advocate and a detective if the patient desires. Accordingly, when a person reports first to law enforcement the victim will be helped to access medical and advocacy resources if desired.

The majority of the patients go home under their own care. Occasionally patients are in police custody and they are discharged back to police custody. Adolescents may be discharged in the care of their parents. Rarely is a patient admitted for inpatient care. Victim advocates from local sexual assault resource centers respond to each examination and provide support to the patient. Prior to discharge the advocate and the SANE discuss with the patient their comfort in going home and any safety concerns that may be present. The patient is also encouraged to identify their own support systems and to access them to aid in the initial recovery period.

Patients are encouraged to maintain contact with their victim advocate for assistance with navigating the legal process. Advocates are also able to be with the patient for all interactions with law enforcement if desired. The community has two local advocacy agencies that offer free counseling to the primary victim (the patient) and to secondary victims (family, friends) of sexual assault. The SANEs call the patient within

the first week following the assault to see how they are doing, if they have any questions and to encourage a medical follow up visit three weeks following the assault. The patient is given phone numbers upon discharge so that they may contact the SANE, the advocate and the law enforcement agency involved if they have questions or concerns.

The hospital has not yet conducted any satisfaction surveys of patients reporting assault to assess the patient's perception of our care. Anecdotally, many patients are very grateful at the end of the examination and express thanks to the SANE with hugs and tears. Quantitative and qualitative data on the perception of SANE services is an area to explore in the future.

The Professionals

The author attended the standard 40-hour SANE training in May of 2010 and began performing examinations in the local ED. Early in the course of this work, the author became aware of the difficulty in retaining staff in the role of a SANE. The hospital had several professional nurses who had been educated and experienced as SANEs who requested to be removed from the responsibility. Among the additional nurses who were trained in 2010, only the author remained after one year's time. By initiating conversations about relinquishing the role of SANE, the author learned the following reasons were common: emotional stress, disorganized equipment and supplies, lack of comfort with the camera, lack of updated training offered, lack of experience and skill, the stress of being called when they were unable to perform the examination and the guilt experienced in not being available.

The volume of examinations at the community hospital was such that there was not a predictable need for a SANE and the frequency is sporadic. It was not uncommon to have weeks go by without an examination, nor to have several examinations in one week. Consequently, all of the SANEs work full-time in other departments, and generally complete exams in their spare time. Occasionally the nurses' home unit has a low census so that the SANE can be pulled to complete an examination. However, this may cause stress for the staff of the home unit.

The primary supporting department for SANE examinations was the Emergency Department. All of the examinations occurred within that department and patients who had been assaulted were admitted through that department. If patients had medical needs they were treated by the ED providers and nurses before, during or after the forensic examination. The SANEs consulted the ED providers for medication and lab orders.

Other departments involved were the home units of the SANEs and the house supervisor department. The home departments were affected by having to adjust their staffing and in the payroll process. The house supervisors are nurses who are responsible for patient care and patient flow throughout the hospital. In the absence of a readily available SANE, the house supervisor was responsible for helping the ED adjust to staffing changes so an ED nurse could complete the examination.

Outside of the hospital, the work of the SANEs directly affected the processes of law enforcement and prosecution. When a forensic examination had not been performed or had been delayed vital evidence was lost. In addition, without the care and support of

a SANE trained nurse the patient may be more likely to avoid other community involvement, including the legal system.

The professionals who worked most closely with the SANEs were the victim advocates. The advocates are on call 24 hours a day every day of the week and respond quickly to the report of a patient being in the ED. The majority of examinations are performed with the advocate, SANE and patient working together. The advocate is solely there for the patient in making sure that their voice is heard, helping with decision-making, accessing resources, providing for comfort needs and safety planning for discharge.

The Processes

The process of an examination includes the following parts: medical care and treatment, documentation of injuries, collection of DNA and trace evidence and emotional support.

Table 1. Processes of a forensic examination on a sexual assault patient.

<u>Medical Care and Treatment</u>	<u>Documentation of Injuries</u>
1. Consent for examination 2. Blood work and other medical screenings as indicated 3. Injury evaluation and treatment 4. Medications to prevent sexually transmitted infections and pregnancy 5. Medications for pain and nausea 6. Discharge teaching	1. Full body examination, including genital area if applicable 2. Forensic photography of any visible injuries, with patient consent 3. Documentation on paperwork provided in the Sexual Assault Evidence Collection Kit

Table 1. Processes of a forensic examination on a sexual assault patient, continued.

<u>Collection of DNA and trace evidence</u>	<u>Emotional Support</u>
1. Swabbing areas of reported contact (e.g., mouth, vagina, neck, anus)	1. Obtaining consent step by step
2. Sticky tape lift from head hair and pubic hair	2. Thorough explanations of the rationale for each step
3. Collection of patient's head hair and DNA from buccal swabs	3. Opportunity for the patient to share what happened to them with supportive people
4. Collection of any debris from body	4. Help with decision making (whether to disclose to others, report to law enforcement)
5. Collection of any applicable clothing	5. Addressing any physical, emotional or safety concerns
6. Collection of blood and urine for suspicion of drugging	6. Counseling on STI, pregnancy and HIV risk
	7. Understanding of sexual assault dynamics and effects

The Patterns

One of the most consistent patterns the author observed was an overall increase in the number of patients reporting assault since 2010. Another pattern was the lack of retention of SANE staff. Among the many RNs who had received SANE education both before and after the author, the author was the only SANE remaining at this hospital with more than two years experience in the field. In addition, a pattern of days of the week with the most examinations has been noted.

Contrary to old myths, most people are not raped by a stranger. Nationally, the CDC reports that approximately 86% of rape victims knew their assailant (Black et al, 2011). Local data supports this trend.

Drug facilitated sexual assault (DFSA) is an increasingly recognized problem across the United States. The term DFSA refers to a sexual assault in which the victim

was rendered vulnerable by drugs or alcohol and was unable to either consent to sexual activity, or defend himself or herself from an aggressor (Ledray et al., 2011). DFSAs occur through the voluntary ingestion of alcohol or drugs or through involuntary, or surreptitious drugging. Much of the public has heard of “date rape drugs,” such as Rohypnol or gamma – hydroxybutyric acid (GHB) being used by perpetrators to induce amnesia and drowsiness in their victims. In fact, there are many available drugs that can be used to facilitate a sexual assault such as prescription pain medications, allergy medicines and sleep aids. The most common drug implicated in sexual assaults, however, is alcohol (Ledray, 2001). Alcohol use is common in our society, and binge drinking is somewhat expected in portions of our population. Alcohol can decrease one’s perception and increase impulsivity. As a result people can end up in vulnerable situations that they would avoid if they were sober. Reasons to suspect DFSA include loss of memory, feeling of being paralyzed during event, late reporting, continued intoxication, dilated or constricted pupils, changes in vital signs and intoxication that does not seem appropriate for the amount of alcohol ingested. Concerns for DFSA have been increasing in the community. The state crime lab supplies a kit for a SANE to collect blood and urine for analysis in those cases. In addition, the local police department offers a specialized kit that can provide results faster than the state based testing allows.

As noted previously, the majority of sexual assault victims do not sustain serious physical injuries. The amount and type of injuries a victim sustains is a matter that can influence perceptions of a victim’s experience and influence legal outcomes. In the

literature, the rate of physical injury varies from 44.7% up to 65% and the rate of ano-genital injury from 20% to 53% (Read, Kufera, Jackson & Dischinger, 2005; Riggs, Houry, Markovchick & Feldhaus, 2000; Sugar, Fine & Eckert, 2004). Victims are more likely to report their assault and more likely to have a criminal case move forward if they sustain visible injuries.

Some SANE programs will use methods other than the naked eye to assess for injury in the ano-genital area. These methods include a magnifying instrument called a colposcope and the use of Toliudine blue dye, a substance that highlights areas of injury for better visualization. Advances in digital photography now allow magnification of injuries to facilitate identification, decreasing the importance of colposcopy. The local program uses only observation and digital photography.

Historically, some patients have avoided seeking medical care for the fear of having to report to law enforcement. In 2005 the state created a program by which patients can have their forensic examination paid for without having to involve law enforcement at the time. This allowed patients who didn't feel comfortable making a legal report to have evidence collected for later use and receive medical care without having to make the decision to report under duress.

Leadership Theory

The leadership theory used for this project was that of servant leadership. "Patients can feel vulnerable as they place their lives in the hands of the healthcare system in times of desperate need" (Trastek, Hamilton & Niles, 2014, p. 374). Health

care providers are in a position of trust: their patients rely on them to provide safe care and the organization relies on them to deliver that care. “A strong leader enables teams to function safely” and to improve the quality of care within the organization (Trastek et al., 2014, p. 376-377).

Servant leadership is a principle that was coined by Robert Greenleaf in 1977 with the publication of his book “Servant Leadership.” The author explored the need for a different vision of leadership in our institutions and he puts forth the idea of one who is a servant first, and then is inspired to lead. Service is not a new principle and has been attached to the profession of nursing for a long time. Greenleaf elevates the term “servant” and places the servant not in a subservient role but in an enlightened, authentic and fulfilling role as leader. He highlights many principles of servant leadership and states that all leadership begins with “the initiative of an individual” (Greenleaf, 1977, p. 28). Servant leaders are able to use listening, understanding, imagination, acceptance, empathy, foresight, persuasion, awareness and perception to influence others towards common goals. Servant leaders know when and how to withdraw in order to “reorient oneself,” gain insight and perceive the big picture, and ask, “How can I use myself to serve best?” (Greenleaf, 1977, p. 33). With the use of a servant leaders’ vision and persuasion “power is used to create opportunity and alternatives so that individuals may choose and build autonomy” (Greenleaf, 1977, p. 55). Servant leadership is very much about growing people, both patients and care providers, and helping them reach their potential. “This model relies on building competence in relationships and requires leaders to actively identify opportunities to enhance employee capabilities” (Neill &

Saunders, 2008, p. 399). Howatson-Jones (2004) noted that this model, in contrast to traditional power models of leadership, requires interdependence and emotional empathy. Servant leaders “serve something beyond themselves as well as the people they lead and with whom they share time” (Waterman, 2011).

Servant leadership has many benefits when used in the healthcare system. Nursing by definition includes caring for others, and many who are drawn to nursing are naturally suited to the role of servant leadership. In addition, the changing role of healthcare to include the patient as a team-member lends itself to this style.

When applied to healthcare delivery, servant leadership is appealing on a deeper level because the application is based on the dignity and self-worth of all people and emanates from the democratic principle that a leader’s power is generated from those who are led. (Neill & Saunders, 2008, p. 396)

Waterman (2011) identified benefits of servant leadership including improving performance, developing followers, showing commitment to the community, valuing people and seeking to “improve care through encouragement and facilitation, rather than through power and authority” (Waterman, 2011, p. 26). Huber et al. (2007) discuss the growing need in healthcare systems to engage and develop staff in order to build a work environment that is capable of delivering excellent care. “Without motivated and involved multidisciplinary staff, a microsystem cannot achieve the exceptional outcomes of which it is capable” (Huber et al., 2007, p. 107). In today’s world with the pressure on healthcare systems to deliver high quality care with less waste, servant leadership is an excellent model to employ. “When someone else believes in you it is one of the most powerful gifts to receive and inspires you to push the limits to achieve greater things” (Mahon, 2011, p. 5).

“Nursing, as the largest health care workforce involved in direct patient care, is central to the formulation and implementation of effective organizational approaches to address many patient safety and quality care challenges” (Davis-Ajami, Costa & Kulik, 2014, p. 17). Appropriate leadership styles and strategies can help to identify, define and address some of the gaps in quality that face our healthcare system. Using servant leadership theory, one can influence, engage and provide resources to the staff to help them use best practices in caring for patients at a local level. Using the principles of servant leadership, the author began to identify areas for improvement at this community hospital.

CHAPTER THREE

PROJECT OUTCOMES

MethodsAssessment

It was difficult to assess the needs of patients reporting sexual assault because little data were available locally. When it became clear that local perceptions about sexual assault may not be accurate and that the data were inconsistent, the author developed a system whereby the author was informed of all patients who reported sexual assault. This enabled accurate tracking of data for this patient population.

The high turnover of SANEs and the stress noted when a SANE was unavailable made it clear that this microsystem could use improvement. The author communicated with former SANEs to discover their reasons for not continuing in the work. In addition, discussion with the Emergency Department nurses identified the impact of not having SANEs on call. The work of trying to find a SANE was reported to be stressful, and worse was having to manage this time-consuming examination themselves. Some expressed the concern of doing an examination with high legal importance without adequate training and experience. Others reported the embarrassment of caring for a patient who was aware the nurse seemed uncertain of what they are doing.

The author made a personal commitment to continue this work. There would be nothing gained by ending up with a condition called “burn out” and leaving the hospital system and all of its patients with no experienced SANE or leader. It was clear that care

of self would be important to remaining in this work in order to serve the need of the community. The author reviewed her own priorities, abilities and support systems. This project had significant personal importance to the author. However, placing family, health and the pre-existing full-time job as higher priorities would allow the continued well-being needed to continue with this work. Personal care included rest, nutrition, exercise, and relationships with people who enriched the author. Through these efforts the author was able to sustain her personal commitment to this project over years.

The SANE services were included in the ED budget, with no separate budget. No attempt to quantify the cost of these services had been made or the expenses of maintaining trained SANEs. Previously nurses were responsible for all or part of the financial responsibility of getting SANE training. This system led to nurses opting out of training or resenting having to pay for the training. The SANEs who paid for their own training did not feel an obligation to continue to provide coverage for the ED. In order to provide up to date training for SANEs and increase their satisfaction and commitment a dedicated budget for SANE training and service would be needed.

The hospital had a union contract, and in order to have SANEs on call the hospital would be required to pay SANEs union wages. Without being on call, there was no guarantee that when a SANE was needed one would be available. This system resulted in increased wait times for the patients, increased work for the ED nurses and patients sometimes being cared for by a nurse without training specific to their care. All of the SANEs had other employment and many had families or were taking classes. Without

having 24/7 call coverage the hospital was relying on luck to provide coverage for these patients.

The author joined the local Sexual Assault Response Team (SART) in 2012. The SART, an interdisciplinary team, is comprised of prosecutors, detectives, law enforcement officers, victim advocates and medical responders to sexual assault. The group meets monthly. The goal of the team is to improve the coordination of services to provide victim-centered care to those reporting assault in our community. On this team sexual assault cases are reviewed and issues discussed among the members to improve service to victims. It became apparent that the lack of a timely, trained and competent response in the ED was affecting the hospital's community partners. Victim advocates expressed that many victims found the wait times difficult and some were treated in a manner that was perceived as callous. In addition, many patients were aware of an untrained nurse's discomfort and lack of skill in caring for them, an issue that increased the discomfort of an already uncomfortable experience. Law enforcement officers often experienced delays in getting details of the examination and therefore delay in securing evidence at other crime scenes related to the incident. The County Prosecutors found that there was room for improvement in quality and admissibility of the evidence collected. In addition, problems with continuing victim engagement hindered many case's progression through the legal system. The assessment made it clear that the current state was not leading to the best outcomes for our community partners.

A useful tool in an evaluation of a potential project is performing what is known as a SWOT analysis. SWOT is an acronym for Strengths, Weaknesses, Opportunities

and Threats and is an assessment that looks at “all aspects of the system” and can assist in identifying “internal and external aspects that may positively or negatively affect the project” (Harris, Roussel, Walters & Dearman, 2011, p. 53).

Table 2. SWOT Analysis of Hospital Sexual Assault Services.

STRENGTHS	WEAKNESSES
- existing physical facility for use - support of ED staff/house supervisors - most supplies free from state crime lab - provides a vital community service - committed SANE leader - hospital’s mission statement focuses on community health and quality of life	- lack of experienced SANEs - inconsistent volume and frequency of examinations - organizing position may not be justified - hard to get experience with low volume - likely to not be financially profitable
OPPORTUNITIES	THREATS
- no immediate competition - some reimbursement available for examinations - strong multi-disciplinary support - possible grant money available - heightened awareness of the problem of sexual assault at this time	- need administrative support - need continued support of ED manager - may be low on priorities if financial needs of organization not met

These assessments made it clear that there were some primary problems including lack of funding for training and call, lack of formal recognition and leadership, and lack of formal organizational support. The system in place was not working well for anyone: the ED staff, the SANEs, the advocates, the law enforcement agencies, the prosecution and most importantly, the victims. There were also many positive opportunities for

change, as evidenced by a strong community partnership, a willing leader, increasing organizational support and an identified need.

Implementation

Having a broad understanding of the community needs and resources as well as an understanding of the hospital's needs, the author began work to improve the areas that could be improved. The author began to work with the ED manager to organize supplies. Information was gathered on where to obtain additional supplies. A rolling cart was provided by another department and put into use with supplies organized in drawers for easy access. The cart was checked every few weeks to ensure supplies were kept up to date.

In order to function as a leader in patient care, it is important for the leader to have a solid knowledge base, skill base and experience. "Health care providers rely on their professional peers to relay important scientific and health care delivery developments" (Trastek et al., 2014, p. 377). In an effort to gain skill, the author participated in examinations as frequently as possible. The author attended an additional formal SANE training in a neighboring city to update her knowledge. At this training the author met other SANE leaders from around the state. The author visited the local facility where examinations were performed and observed how supplies were organized, how the program was staffed and how they conducted orientation for new SANEs. In addition, a contact was made with the state crime lab. This connection enabled clarification of questions about evidence collection. Relationships established with community partners

through the SART allowed a greater understanding of what the patients face before and after the examination process. This knowledge has proven useful in counseling patients when they are in the ED and in addressing concerns.

Membership in a professional organization provides nurses access to many resources to improve knowledge and practice. The International Association of Forensic Nurses is the primary professional organization for SANEs. This organization provides access to the newest research as well as an online community forum in which SANEs of all experience levels and from different communities can ask questions and receive answers. The author joined this organization and used the resources to increase her knowledge.

An attempt was made to hold regular SANE staff meetings in which supplies and techniques could be reviewed and practice with the camera could be performed. The camera was labeled with simple directions to make it easier to use. Unfortunately, attendance at the meetings was difficult due to many different schedules requiring coordination. The meetings were not successful. Many of the SANEs did not demonstrate engagement in the work or a desire to be part of the team.

Through the establishment of community partnerships, the local police department expressed their interest in having SANEs on call and their ability to share grant money to make it possible. The data collected confirmed that more patients requested examinations on Fridays, Saturdays and Sundays and providing coverage for a SANE on those days would likely result in the greatest improvement in timely response to patients. This grant money enabled nurses to be available at a moment's notice and to

be paid for their availability. Interestingly, the availability of pay for being on call did not increase the SANEs willingness to take call shifts. Despite being paid to be on call it was difficult for many nurses to commit to call shifts above their regular work. In addition, the general lack of commitment to the program may have contributed to this outcome.

The author worked with a representative from a local foundation to apply for private grant money to fund training and call pay. Grant money was received and was used to send three new SANEs and the leader to training in 2013. At this point the author began interviewing potential SANEs prior to their training to discuss the logistics of the job and their reasons for being interested in this work. The hope was to use the grant money to train nurses who would be more likely to continue performing examinations.

Outcomes

By 2014 there were many sustained improvements. The supplies continued to be stocked and organized in a way that made the work easier to perform. A cumbersome process involved in transferring the photographs from the camera to a CD to be submitted to the police was improved through collaboration with the local law enforcement agency. The new process eliminated many steps, allowing the photo memory card to be given directly to law enforcement and a new card used for every patient. The SANE leader gained experience and skill and became a source of information for the community partners through her reading, connection with the professional organization and networking with other SANE programs in the state.

An unanticipated benefit occurred with some staffing changes in the Emergency Department. The arrival of a new ED physician with significant forensic experience and a new Director of Nursing for the ED offered new perspectives and commitment to continuing the program. The ED physician was able to offer a 40-hour SANE training at the hospital to train four more SANEs in November of 2014. Of the four SANEs, one was a hospital employee who performed many examinations in 2015 and became a valuable member of the team. One community nurse who joined the training is in the process of being hired to the team. The other two nurses did not continue to do the work after orienting on an examination. A continued difficulty was noted: when a new SANE completed training but was unable to orient during an examination for months, they often dropped out of the program.

The staffing problem persisted, with many SANEs not able to give up their free weekends to take paid call, or to be available at a moment's notice during the weekdays. When one of the two primary SANEs was not available, the ED physician performed examinations. Occasionally, an examination was still performed by ED staff. Despite the continued difficulties, there was a decrease in wait times for patients from 2014 to 2015. In November of 2015 the ED physician provided an abbreviated SANE course to four more nurses.

The lack of organization was becoming more apparent on a higher level. Issues of how to handle medical records were brought up by staff, SANEs, detectives and the prosecutors. Many SANE programs store photos and records themselves due to privacy concerns and questions were raised about how best to handle this matter in the

community. In addition, it is recommended that programs have case reviews for quality improvement and continuing education. Without a formal leader and access to records, there was no one to facilitate this process. In addition, it came to light that the medical bills for victims of sexual assault had not been handled effectively. In the absence of a formal program leader, there was no one to resolve these issues.

The International Association of Forensic Nurses offers an online course entitled “SANE Sustainability.” This course offers information and potential solutions to SANE leaders in regards to the frequently encountered problems in establishing and maintaining SANE programs, a nationwide problem. The ED manager and author decided to use some of the remaining grant funding to allow the author to attend this course that discusses staffing, legal issues, training issues and many other aspects of leading a SANE program.

In 2015, the members of the local Sexual Assault Response Team requested to meet with the hospital administration to garner support for a more formal SANE program. A meeting was arranged with hospital administration and SART members. In preparation for this meeting, the author collected data on SANE programs throughout the state. Programs ranged from small to large and from having no formal organization to being highly organized. Programs were asked about their program structure, leadership, function, call pay, scheduling and quality measures as well as about the volume and frequency of examinations. Comparison data on the size of the associated city and hospital was included in the report.

The author also prepared a list of the benefits of SANE programs to the health of patients and to the health of the community. Included in this were the difficulties and stressors experienced by all staff involved when there was no SANE available.

Lastly, the author prepared three potential proposals for moving forward with providing care for sexual assault patients. These proposals were: to continue as it had been, to make SANE services part of the routine ED care with ED nurses providing the care, or to establish a formal program of a small group of SANEs who are enabled to provide the care needed. A list of pros and cons of each option was provided for discussion. In addition, ways to increase the volume of examinations to justify the financial investment were discussed including assisting in assault examinations for the pediatric population and documentation of injuries from physical abuse cases of all ages. Many surrounding communities brought their patients to the hospital for examinations and the idea of advertising the availability of these services to those organizations was offered by the ED manager.

At the meeting members of the SART included the county prosecutor, victim advocates, and local detectives. The members were able to share with the hospital administration how the lack of timely response to victims of assault was affecting their abilities and outcomes. The information on the benefits of SANE programs, what surrounding communities were doing and the three program options were presented. After the meeting, the hospital administration stated their intention to support the organization of a SANE program and support of the third option, a small, formalized group of SANEs. This type of approach had the potential benefit of increasing quality of

examinations as well as increasing satisfaction of the SANEs. With the volume of exams, having a smaller number of practitioners meant that each SANE would perform enough examinations each year to gain skill and experience. They would be able to develop relationships with community partners. The money that had been used to train a large number of SANEs could be more effectively used to offer training and education to a small number of committed SANEs more frequently. When SANEs were valued members of a team, the SANEs would have more reason to stay up to date on information and involved in the program. With SANEs on call 24 hours a day, seven days a week the stress to the ED staff, house supervisors, SANEs, advocates, detectives, and patients would be decreased. To begin solving the organizational concerns, the author was offered a part-time position to serve as the program coordinator, an offer that was accepted.

There were drawbacks to this approach. Establishing this type of program would require more organization at the beginning as issues of hiring, call schedules and training were established. Two of the potential SANEs were not hospital employees and the hospital administration would have to develop a means to hire them for this work. In addition, the financial drawbacks were clear. The hospital would be paying a large amount of money for what is, comparatively, a small amount of actual service. In addition, there was no decision made to change the nurses' time commitment to their primary units to increase their ability to take call.

CHAPTER FOUR

DISCUSSION

Summary of Current State

At the end of 2015 the SANE program coordinator interviewed and hired a team of SANEs, including one who was already performing examinations. Four of the new SANEs had attended the abbreviated course provided by the ED physician at our facility. Team members were asked to sign a letter of commitment to the program that requested at least a one year commitment, attendance at meetings and taking a number of call shifts per month. In addition, the letter emphasized the importance of providing these services to our community and the desire for coverage being consistent. The program coordinator reviewed with the SANEs the days of the week or month they could best take call and addressed concerns that were voiced. In addition, times of the year when the SANE would be unavailable due to travel or personal reasons were gathered in order to prepare in advance for coverage.

Establishing the new program involved collaboration between the program coordinator, ED manager and director of nursing. The issues discussed included call pay, benefits, hiring the community SANEs and other concerns that were present.

As of this writing, the hospital SANE program has held two staff meetings, one per month, with excellent attendance and participation at both. Each meeting has included case reviews, protocol discussions and emotional support. Practice and help with the camera has also been provided. In addition, the Program Coordinator provided

research articles or other pertinent information to each SANE to take home for review. Thus far, the new team of SANEs displays a high level of commitment and engagement in the team.

Due to past experience, the author had concerns about getting four new SANEs experience with examinations before their engagement lagged. This concern proved to be somewhat unfounded as the program performed ten adolescent/adult examinations in the first nine weeks of the year. Many of these examinations were attended by a new SANE who was able to gain exposure and skill soon after their training. A decision was made by the program coordinator to allow the new SANEs to decide when they could take call on their own. A balance would need to be present between supporting the new SANEs and the need for call coverage. Feeling pushed into such difficult work could make a SANE feel overwhelmed. Knowing this, the author made a commitment to be as available as she could to provide coverage until all staff felt comfortable taking call shifts.

The community partners had expressed interest in having an improved level of documentation in cases of intimate partner violence, child physical abuse and child sexual abuse. The skills needed for these tasks are SANE skills, and this work could increase the experience of the SANEs as well as increase the value of the program to the hospital and community. Most SANE programs perform pediatric examinations and all 40-hour SANE trainings include pediatric information. In addition, 40-hour pediatric specific SANE trainings are offered and recommended.

The hospital relied on the pediatricians on call to provide coverage for acute sexual and physical assault examinations in children. With an increasing volume of pediatric examinations requested and the addition of new pediatricians to the hospital, it became clear that the physicians did not receive enough training or experience to feel comfortable collecting evidence and performing forensic photography for these cases. A majority of pediatricians indicated that they would not be comfortable performing an examination that required evidence collection or photography on their own. It was clear that our services to child victims of violence could be improved. A decision was made that the best practice for our pediatric population would be to have a pediatrician and SANE work together on these cases and this was communicated to the pediatricians and ED staff. This commitment would be possible with 24 hour SANE coverage.

The emotional strains of this job can be significant. The author has made a point of considering emotional support part of the job of leading this program. Checking in with all the SANEs periodically and offering support and encouragement following examinations is an ongoing process. In addition, written thank you notes or acknowledgments will be used to express appreciation and support to the staff. The hospital participates in an Employee Assistance Program through which staff can receive five free sessions of counseling in the community. Information on how to access this program has been shared with the new SANEs and use of this service encouraged.

Financial Considerations

By state law a provider of medical forensic exams can receive reimbursement of \$600 per patient for providing this service. This money is either received from the state's Department of Justice Forensic Rape Examination Payment Program (FREPP) or from the law enforcement agency involved if the victim is moving forward with criminal charges. Having a reimbursement for a portion of or all of the examination is an advantage in operating this program.

The expenses for a routine forensic examination are the ED charge, medications and the salary of the SANE. The ED charge provides for the room, computer system and registration, medical screening examination and other equipment and supplies. Some patients may also receive laboratory testing, non-routine medications and diagnostic imaging such as X-rays or CT scans for injury.

Previously, no effort had been made to quantify the costs and payments for sexual assault examinations at our hospital. To better understand the financial considerations of running this program the author made connections with other departments in and out of the hospital. The program coordinator met several times with staff from the billing department to iron out the issues of previously un-reimbursed sexual assault examinations and to determine a process to increase communication about who the payer is for a particular examination. In addition, bills for examinations were reviewed to determine the costs of an examination to the payer. The author will review billing for all examinations at the end of a year to determine how frequently an assault patient needs a higher amount of care and what the average cost of that care is. This will provide a

year's data on this aspect of the cost of the program to compare with funds received. If examinations are frequently costing more than the \$600 allowed amount an effort can be made through the hospital, grant money and the community partners to find funding for the overage. The Coordinator also met with staff from the City's billing department to establish a system for the hospital to be reimbursed for call pay that is covered by the local police department's grant money.

Quantification of the salary expenses of the program will be made. The author is tracking examination hours, meeting hours, trial hours and call hours for the year 2016 to enable the salary cost of the program to be identified. To aid in this, the ED manager worked with the hospital human resources department to establish separate pay codes to be used for SANE call and SANE examination time.

The author will continue to work with the hospitals' foundation in an attempt to raise money to offset some of the costs of the program. A neighboring program has had success with raising a significant portion of their needed funds and is willing to share information with our program on their accomplishment. The program will continue to seek private grant money as well.

Future Considerations

In this new program, there are many continued opportunities for growth and improvement. With a formal SANE program coordinator in place further assessment, planning, implementation and evaluation of our services can be performed.

In any patient service it is important to measure the quality of the services provided and the satisfaction of the people those services cater to. Surveying patients for comments on their experience could bring to light information that could help us improve our practice. In addition, surveys of the patient advocates, law enforcement officers and prosecutors could highlight successes and areas for development. Evaluating statistics to see if more patients are engaged in the criminal process, more charges are filed and more cases result in convictions could be of interest to the community. More importantly, studying the rate at which our patients seek follow up medical and emotional care and what could be done to increase a patient's willingness to seek aftercare would be vital information to improve our patients' long and short-term well-being. Working more closely with the primary follow up agencies can facilitate a smooth transition for our patients.

Long patient wait times and being cared for by a non-SANE were frequent problems that highlighted the need for a more formal program. At the end of one year, evaluating patient wait times and how many cases are done by a non-SANE will be a valuable quality indicator. In addition, a satisfaction survey of ED nurses and providers could be performed to identify any deficiencies or problems with the system.

One of the primary problems the hospital faced was retention of SANEs. In this light, it will be important to determine if the changes made will result in an improvement in retention of staff. As of 2016, we have a program staffed with two experienced SANEs, four new SANEs and one experienced SANE who is not able to begin working until mid-year. This gives us a total of seven SANEs plus our physician medical director.

Evaluating how many SANEs are working at six months and twelve months after establishing a more formal program with paid call will be useful information. In addition, interviewing departing SANEs on their reasons for leaving the program will continue to highlight areas for improvement.

Through remaining private grant funding, the program will be able to send the four new SANEs to the statewide 40-hour SANE training this spring at no cost to the nurses. This will be an excellent opportunity for further timely training and engagement in this work. As we move into offering pediatric services it will be necessary to have the five SANEs who have not been trained specifically in pediatrics to attend a pediatric SANE training in the next two years. Finding the best way to fund continuing training for our SANEs will be an important piece of a sustainable program.

Most established SANE programs have a process of peer review in place. Many state programs have the leader review every case's documentation and photography to provide a formal evaluation of quality. In addition, peer review of cases as a group is performed for ongoing education and improvement. The International Association of Forensic Nurses has many tools that can be used to aid in the peer review process. Establishing formal peer review will be an important part of legitimizing and improving our services.

Conclusion

Sexual assault is a problem that affects a large portion of our society and has significant long and short-term health effects. The care that patients receive when they

report to the hospital can influence their outcomes. Historically the care received has often perpetuated the victim's trauma, but the Sexual Assault Nurse Examiner model of care can improve the patient's experience and future health. Through the use of servant leadership, including self-care, the author has remained committed to improving services for patients reporting sexual assault at a non-profit community hospital in a rural state. Self-improvement and development including membership in the local Sexual Assault Response Team and membership in a professional organization have enabled this nurse to become a local expert in the care of these patients. Understanding of the issues involved in caring for these patients both locally and nationally has enabled improvement in the quality of services and the possibility of this local hospital creating a sustainable SANE program with experienced, skilled nurses providing the standard of care to patients reporting sexual assault.

REFERENCES CITED

- American Nurses Credentialing Center. (2008). *Magnet Recognition Program Overview*. Retrieved from:
<http://www.nursecredentialing.org/Magnet/ProgramOverview>
- Batalden, P.B., Nelson, E.C., Johnson, J.K., Godfrey, M.M., Huber, T.P., Kosnik, L. & Ashling, K. (2007). Leading Microsystems. In E.C. Nelson, P.B. Batalden, & M.M. Godfrey (Eds.), *Quality by Design: A Clinical Microsystems Approach* (p. 51-68). San Francisco, CA: Jossey-Bass.
- Black, M.C., Basile, K.C., Breiding, M.J., Smith, S.G., Walters, M.L., Merrick, M.T., Chen, J., & Stevens, M.R. (2011). *The National Intimate Partner and Sexual Violence Survey (NISVS): 2010 Summary Report*. Atlanta, GA: National Center for Injury Prevention and Control, Centers for Disease Control and Prevention.
- Campbell, R., Bybee, D., Townsend, S.M., Shaw, J., Karim, N. & Markowitz, J. (2014). The Impact of Sexual Assault Nurse Examiner Programs on Criminal Justice Outcomes: A Multisite Replication Study. *Violence Against Women*, 20 (5), 607-625. Doi: 10.1177/1077801214536286
- Campbell, R., Patterson, D., & Bybee, D. (2011). Using Mixed Methods to Evaluate a Community Intervention for Sexual Assault Survivors: A Methodological Tale. *Violence Against Women*, 17 (3), 376-388.
- Campbell, R., Patterson, D. & Lichty, L.F. (2005). The Effectiveness of Sexual Assault Nurse Examiner (SANE) Programs: A Review of Psychological, Medical, Legal, and Community Outcomes. *Trauma, Violence and Abuse*, 6 (4), 313-329.
- Campbell, R., Townsend, S.M., Long, S.M., Kinnison, K.E., Pulley, E.M., Adames, S.B., & Wasco, S.M. (2006). Responding to Sexual Assault Victims' Medical and Emotional Needs: A National Study of the Services Provided by SANE Programs. *Research in Nursing and Health*, 29, 384-398.
- Campbell, R., Wasco, S.M., Ahrens, C.E., Sefl, T. & Barnes, H.E. (2001). Preventing the "Second Rape": Rape Survivors' Experiences With Community Service Providers. *Journal of Interpersonal Violence*, 16, 1239-1259. Doi: 10.1177/088626001016012002
- Chivers-Wilson, K.A. (2006). Sexual assault and posttraumatic stress disorder: A review of the biological, psychological and sociological factors and treatments. *McGill Journal of Medicine*, 9, (2), p. 111-118.

- Classen, C.C., Palesh, O.G. & Aggarwal, R. (2005). Sexual Revictimization: A Review of the Empirical Literature. *Trauma, Violence & Abuse*, 6 (2), 103-129. Doi: 10.1177/1524838005275087
- Corum, V. & Carroll, J. (2014). Forensic Analysts' Perspectives: Sexual Assault Kits Under the Microscope. *Journal of Forensic Nursing*, 10 (1), 50-57. Doi: 10.1097/JFN0000000000000002
- Crandall, C. & Helitzer, D. (2003). *Impact Evaluation of a Sexual Assault Nurse Examiner Program* (NIJ Document No: 203276; Award Number 98-WT-VX-0027). Albuquerque, NM: Albuquerque SANE Collaborative.
- Davis-Ajami, M.L., Costa, L. & Kulik, S. (2014). Gap Analysis: Synergies and Opportunities for Effective Nursing Leadership. *Nursing Economics*, 32(1), p. 17 – 25.
- Du Mont, J., Macdonald, S., White, M., Turner, L., White, D., Kaplan, S. & Smith, T. (2014). Client Satisfaction With Nursing-led Sexual Assault and Domestic Violence Services in Ontario. *Journal of Forensic Nursing*, 10, (3), 122-134. Doi: 10.1097/JFN.0000000000000035
- Du Mont, J., White, D. & McGregor, M.J. (2009). Investigating the medical forensic examination from the perspectives of sexually assaulted women. *Social Science & Medicine*, 68, 774-780.
- Girardin, B.W. (2005). The Sexual Assault Nurse Examiner: A Win-Win Solution. *Topics in Emergency Medicine*, 27, (2), 124-131.
- Greenleaf, R. 1977. *Servant Leadership*. Mahwah, PA: Paulist Press.
- Harris, J.L., Roussel, L., Walters, S.E. & Dearman, C. 2011. *Project Planning and Management: A guide for CNLs, DNP's, and Nurse Executives*. Sudbury, MA: Jones & Bartlett Learning.
- Howatson-Jones, I.L. (2004). The servant. *Nursing Management*, 11 (3), 20-24.
- Huber, T.P., Godfrey, M.M., Nelson, E.C., Johnson, J.K., Campbell, C. & Batalden, P.B. Developing Professionals and Improving Worklife. In Nelson, E.C., Batalden, P.B. & Godfrey, M.M. (Eds.), *Quality By Design: A Clinical Microsystems Approach*. (pp. 106-123.
- Janoff-Bulman R. (1992). *Shattered Assumptions: Toward a New Psychology of Trauma*. New York, NY: The Free Press

- Ledray, L.E. (2001). *The role of the sexual assault counselor/advocate*. Washington, DC: US Department of Justice, Office for Victims of Crime.
- Ledray, L.E., Burgess, A.W. & Giardino, A.P. (2011). *Medical Response to Adult Sexual Assault: A Resource for Clinicians and Related Professionals*. St. Louis: STM Learning.
- Littel, K. (2001). *OVC Bulletin. Sexual Assault Nurse Examiner (SANE) Programs: Improving the Community Response to Sexual Assault Victims*. Washington, DC: Office for Victims of Crime.
- Mahon, K. (2011). In praise of servant leadership – Horizontal service to others. *Canadian Association of Critical Care Nurses*, 22 (4), p. 5-6.
- National Institute of Justice. (2015). *Rape and Sexual Violence*. Retrieved from: nij.gov/topics/crime/rape-sexual-violence/Pages/welcome.aspx
- Neill, M.W. & Saunders, N.S. (2008). Servant Leadership: Enhancing Quality of Care and Staff Satisfaction. *Journal of Nursing Administration*, 38 (9). 395-400.
- Nelson, E.C., Batalden, P.B. & Godfrey, M.M. (2007). *Quality by Design: A Clinical Microsystems Approach*. San Francisco, CA: Jossey-Bass.
- Office of Justice Programs, Office For Victims of Crime. (2015). *SART Toolkit: Put the Focus on Victims*. Retrieved from: <http://ovc.ncjrs.gov/sartkit/>
- Patterson, D., Greeson, M. & Campbell, R. (2009). Understanding Rape Survivors' Decisions Not to Seek Help from Formal Social Systems. *Health and Social Work*, 34 (2), 127-136.
- Perilloux, C., Duntley, J.D. & Buss, D.M. (2012). The Costs of Rape. *The Archives of Sexual Behavior*, 41, 1099-1106.
- RAINN (Rape, Abuse & Incest National Network). (2015). *Statistics*. Retrieved from: <https://www.rainn.org/statistics>
- Read, K.M., Kufera, J.A., Jackson, M.C. & Dischinger, P.C. (2005). Population-based study of police-reported sexual assault in Baltimore, Maryland. *American Journal of Emergency Medicine*, 23, 273-278.
- Riggs, N., Houry, D., Long, G., Markovchick, V. & Feldhaus, K.M. (2000). Analysis of 1,076 Cases of Sexual Assault. *Annals of Emergency Medicine*, 35, (4), 358-362.

- Sugar, N.F., Fine, D.N. & Eckert, L.O. (2004). Physical injury after sexual assault: Findings of a large case series. *American Journal of Obstetrics and Gynecology*, 190, 71-76.
- Trastek, V.F., Hamilton, N.W. & Niles, E.E. (2014). Leadership models in health care – a case for servant leadership. *Mayo Clinic Proceedings*, 89 (3), p. 374-381.
- Waterman, H. (2011). Principles of ‘servant leadership’ and how they can enhance practice. *Nursing Management*, 17 (9), 24-26.