

# JANUARY 2006 Network Newsletter

## Provincial Coordinator Update

I hope everyone had a joyful and restful holiday season! It has been a busy fall and winter so the rest was well deserved.

### Paediatric Update

We continue to develop the pediatric program across the province. On the provincial level, Tanya Smith, Pediatric Coordinator is working with the Regional Pediatric Program Coordinators and clinicians. They are developing a peer review system across the province for clinicians involved in the examination of children who are suspected of being sexually abused/assaulted. Peer review will provide the opportunity for clinicians to increase their skill/knowledge in the examination of children, as well as to obtain feedback about their own documentation & interpretation of findings. Our hope is to develop a peer review system that is accessible, easy to use and of benefit to the clinicians. Currently, telehealth sessions are being organized and led by various programs on clinical issues relating to pediatric sexual assault. We hope you are finding them useful. Your Program Coordinator will have the schedule of upcoming sessions.

### HIV Report

This report was submitted to the Ontario Women's Health Council in December. The report is the summary of the HIV PEP research project that was carried out across the province. It is our hope that the findings will provide the basis for supporting the continued funding of HIV prophylaxis for our clients. Thanks again to all of you for your hard work throughout the project, to our principle investigators - Dr. Mona Loufty and Dr. Anita Rachlis - and to the Centre for Research in Women's Health (*Dr. Janice DuMont, Terri Myhr, Heather Humphries and Terri Leeke*).

### Client Feedback

We are currently working on developing a mechanism for obtaining client feedback about the care provided by our programs. It is important and essential for us to know we are providing a service which is meeting our client needs. Feedback from clients will enable us to strengthen our service where needed, or to validate that we are doing what we intended. This will be implemented in a few months.

### IAFN Conference Chair

I am pleased to let you know that I'm the Conference Chair for the International Association of Forensic Nurses (IAFN) Annual Scientific Assembly for 2006 being held in Vancouver September 27-October 1, 2006. Our theme is *Forensic Nursing: A Global Response to Crime, Violence and Trauma*. The IAFN provides an opportunity for forensic nurses in any field to share ideas, information and to obtain knowledge. Presently there are 2,700 members representing 18 countries. I think about 100 members are Canadian. The website is [www.forensicnurse.org](http://www.forensicnurse.org) I like being a member of this organization for various reasons, two being that I learn about the services provided in other countries, and keep up to date on research & activities in this field. Although I believe the IAFN needs to increase its international perspective, I think we need to increase our membership and participation in the organization to encourage this to happen. Check out the website, become a member, and consider submitting an abstract to present a session at the Vancouver conference. The deadline is **January 31, 2005**. The RNAO does provide some funding for nursing education.

**Sheila Macdonald R.N.**  
**Provincial Coordinator**

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## 5 YEARS LATER... Routine Universal Screening

In the year 2000, I formed the Violence Issues Committee at the Cornwall Community Hospital. Our first and main objective was the implementation of screening for domestic violence. Putting practice before policy, we did everything possible to get it going in the ER and we succeeded. Our compliance rates were low at times, between 20 – 65% of all screenable patients being screened, but our determination and beliefs never daunted for a moment. Now 5 years later - we are as determined as ever - having much more experience under our belt, a new amalgamated hospital, and a hospital policy on Routine Universal Screening (RUS):

1. RUS will be implemented to improve care provided to victims of intimate partner violence by recognizing & referring patients to appropriate resources
2. RUS will be done by specially trained staff who:
  - Screen all women and men over the age of 12 for partner abuse
  - Are knowledgeable about the dynamics of woman abuse, and its impact on abused women and their children
  - Are skilled in responding effectively to disclosures of abuse
  - Are knowledgeable about community resources for abused women and their children

The policy goes on to explain the procedure. If anyone would like a copy, please let me know.

We are now in the process of implementing the screening hospital wide. We are beginning with the ER at both sites and will then move through the other nursing departments by priority. This is a tedious procedure as it is hard to train many nurses at once due to short staffing and scheduling. It is our belief that this new task cannot be asked of nurses without offering support, so we are present in the department throughout and following the training to offer support.

What I have learned from this process is:

1. Start with a multidisciplinary committee so the process is not only the responsibility of the Care/Treatment Centre
2. Set a hospital policy in place
3. Seek out advocates in the different departments before training
  4. It's the 'little things' you'll forget, so before you design your training, practice screening and see what you need (*you'll touch on all kinds of issues*): documentation, how to alert the Team if someone wants help but it's not an emergency; how to keep stats; where to put information in the department; who to call and for what – and many other interesting goodies that are better in place before you need them. Of course, you may be surprised that not everyone in your hospital knows about your program...
5. The need for repetition of information and expectations
6. PATIENCE, STAMINA, AND PERSEVERANCE

I congratulate the committee that I have worked with for over 5 years in being forward thinking enough to commit to the extremely hard work of putting this in place. It is a procedure that necessitates changing attitudes. To quote personal development guru Steve Pavlina: "*The willingness to do what is difficult is like having a key to a special private treasure room.*"

**Sarah Kaplan, Coordinator**  
**Cornwall PA/SA Team**

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### Sonhatsi:wa - 'True Self' ... A BOOK OF HEALING

A unique book has been published by Ganohkwasra Family Assault Support Services. In this book, First Nation's (*Onkwehon:we*) people share their courageous healing journeys from sexual trauma to discovering their 'true self'. I attended the book launch in September and immediately felt the strength it took for these individuals to come forth with their stories. It really opens your eyes to what some people endure, and can conquer.

\**Sonhatsi:wa* is the name of the sexual assault program at Ganohkwasra Family Assault Support Services. This a word in the Mohawk Language refers to the true self. It was also chosen for the book title as it best describes the transformation that happens when individuals work through their sexual traumas.

This book tells of the journeys taken by ten *Onkwehon:we* people from lives traumatized by sexual violations to discovering their true self, connecting to the real being they were originally created to be, without trauma, pain, hurt and anger, without all of life's negative distractions. 'These are true, 'heart-stories' of change, courage, hope, inspiration and love.'

If you would like a copy of this book, please contact: Lee-Ann Blackbird, Ganohkwasra Family Assault Support Services, P.O. Box 250, Ohsweken, ON, N0A 1M0 - (519) 445-4324

**Donna Creighton,  
Brantford SA/DVCT**

### Incapable/Unconscious Patients ... CONSENT TO TREATMENT

#### **POLICY:**

A forensic examination of a sexual assault client is not considered 'treatment' under the Health Care Consent Act. This means a substitute decision maker (*SDM*) cannot consent to it on behalf of the patient. The collection of forensic evidence is not addressed by the Health Care Consent Act (*HCCA*) as its collection is not related to the direct provision of care and treatment. Further, the Sexual Assault Forensic Evidence Kit (*SAEK*) guidelines states, 'Forensic evidence collection is not considered to be a medical treatment, therefore any legislation regarding CONSENT TO MEDICAL TREATMENT does *not* apply. The SAEK is used to document the collection of *physical evidence* that may assist in the investigation of a sexual assault.

Emergency treatment under the HCCA is treatment administered for the purpose of saving a life, *not* for gathering information. Therefore the policy of this corporation is that only the patient who is assessed to be *capable* for this purpose can consent to a sexual assault exam for forensic purposes. A substitute decision maker cannot consent to a forensic examination on behalf of an incapable patient. Once forensic evidence has been collected - with consent from the capable victim - if the patient is considered to be incapable for the purpose of PHIPA, the SDM can consent to the disclosure of the forensic evidence under the disclosure rules set out in PHIPA.

#### **EXCEPTION:**

There may be cases where it would be considered an emergency - to be determined on a 'case by case' basis in consultation with administration and, where necessary, legal counsel. For example, when the victim is a child (*less than 16 years old*) and the suspect is a family member with ongoing access to the child. Stopping the subject by collecting forensic evidence is necessary to protect the child.

#### **References:**

1. Personal Health Information Protection Act, 2004
2. Health Care Consent Act, 1996

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3. Child and Family Services Act
4. Guidelines and Procedures for a Coordinated Approach to Child Sexual Abuse/Assault in Windsor Essex County

**Joanne Barbera, Program Manager** (*acting*)  
Windsor SATC

## ONE OF OUR OWN... Support Lori

On December 6<sup>th</sup> in cities and towns across Canada, people held memorial services, candlelight vigils, prayers and other events to mark what we call 'The Montreal Massacre'. Sixteen years ago Marc Lepine murdered 14 promising young women at L'Ecole Polytechnique in Montreal because of their gender. This year's remembrance ceremonies were particularly painful for Southwestern Ontario nurses, as they continue to mourn the loss of Lori Dupont - one of their own. Lori was the Amherstburg nurse who was stabbed to death by her ex-partner - an anesthetist - on November 12th, 2005 in the Recovery Room of Hotel Dieu Grace Hospital Windsor where she worked.

The Chatham-Kent Sexual Assault Crisis Centre, along with Lori's mother, is petitioning the Legislative Assembly of Ontario to conduct a full and public inquest into Lori's murder. The Coroner's office appointed the Domestic Violence Death Review Committee (DVDRC) to examine her death, but the DVDRC does *not* have the mandate to examine the aspects of her murder that pertain to the workplace. The DVDRC will *not* conduct a public review.

Lori's mother says, "*Our only salvation at this time is in the hope that out of this tragedy some positive changes will be forthcoming in the legal system and in the workplace...Lori must not become another statistic. That would be unbearable and unforgivable.*"

If you are aware of this petition, please add your name to show your support in honour of Lori.

**Linda Murray, Coordinator**  
Charham-Kent SA/DVTC

## FOR YOUR INFORMATION...

### Upcoming Events

◆ **Sexual Assault Nurse Examiner Training**

*Feb 20-24, 2006*  
Toronto

◆ **Pediatric Social Work Clinician Training**

*February 27, 28, March 1 (1/2 day)*  
Keynote speaker: Geri Crisci MSW  
Arranged through your Program Coordinator

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## ◆Pediatric Medical/Forensic Clinician Training

*March 30-31, 2006*

Keynote speaker: Dr. Lori Fraser

Arranged through your Program Coordinator.

## ◆Annual Conference for SA/DV Treatment Centres

*May 25 & 26, 2006*

Kingston, ON

Details forthcoming