Provincial Coordinator Update

Greetings! I have just returned from a leave of absence. Naturally I get the coldest, wettest summer to be off. Despite that, it was enjoyable. Thanks to everyone who helped cover some of my responsibilities while I was away.

As I have not been at work in five months, I asked my assistant Janelle to provide an update on what has been happening around the Network. Below is her report.

I have had the opportunity over the past five months to view the Network and its activities from a different perspective, and I appreciate and want to acknowledge the excellent work you are doing. This has been a rewarding and beneficial time for me. I would like to thank everyone who supported me, and kept me up to speed on all the information within the programs (*something Sheila usually does*), and the Ministry. I also want to welcome Sheila back.

In Memory

Time has definitely flown by, and so much has happened. I would first like to express my deepest sympathies to the family and friends of Lise-Anne Labelle who recently passed away. Lise-Anne was the Coordinator of the Niagara Regional Sexual Assault/Domestic Violence Program. Lise-Anne was first a nurse on the team, then stepped up to fill the role as Coordinator.

SANE Training

The SANE Training took place September 27 – October 1, 2004, and it was the largest group to date…44 Nurses!! Thanks to all our SANE trainers for their ongoing participation and commitment to the program. Your efforts are greatly appreciated. Clinical enhancement is what keeps us on the cutting edge. The next SANE Training will be February 3 – 7, 2005 in Toronto.

Anniversary

Congratulations to the Women's College Sexual Assault / Domestic Violence Care Centre in Toronto which is celebrating 20 years of service in November. The SA/DVCC first opened its doors in 1984 and was the first Centre established in Ontario. Manager Deidre Bainbridge and the Team of nurses, physicians and social workers continue to provide excellent clinical service as well as leadership in research and academic studies. *Well done!!*

Our Network is made up of beautiful, capable women and men who are always ready to step up at any time. As we move forward into another hectic year, let's remember that life is unpredictable and extremely precious. Reward yourselves when necessary, and take breaks when needed. Embrace the New Year in good spirits!

Janelle Noel
Assistant to Provincial Coordinator

&

Sheila Macdonald R.N.
Provincial Coordinator

Changes for the Best... FOR OUR SAEKs

In August I met with the Receiving Office Manager & some of the scientists from the Centre of Forensic Sciences (CFS) to review the Sexual Assault Evidence Kit (SAEK) & make any changes since the kits were going to tender. Here are the results of that meeting:

When Jamie Ferrell was in Burlington she spoke on the importance of epithelial cell transfer. She suggested that when 'touching', or 'rubbing' of genitalia took place, nurses should do a swab in the affected area to see if epithelial cells were transferred from offender to victim. I asked the scientists about the possibility of collecting a DNA specimen in this way and was told the CFS will only examine a swab with body fluid on it. Saliva, semen, blood, and emesis are the fluids they examine for DNA.

I learned the CFS encouraged police departments to only submit swabs they felt were relevant to the case - so the entire kit might not be submitted as evidence. I asked what would happen if, during the investigation, new information surfaced which may lead to other testing being required. The scientists felt the police would not discard any evidence until a case had been completed.

I also learned how important it is to include the 'desiccant' in the pouch with the buccal swab (**Step 11**). The 'desiccant' is what helps to maintain the integrity of the specimen. Interestingly, the brand new kit we opened for this meeting did *not* have a 'desiccant' in it. We wondered if this might be the reason the 'desiccant' was not being included with specimens. We plan to add this to the instructions on the front of the envelope.

One comment received from nurses was that there was no envelope to place the drop sheet from **Step 1** into. It's perfectly acceptable to use the envelope labelled **Step 1** for this purpose. I would suggest placing the label with the identifying kit number on the drop sheet *after* it has been folded back up when the client completes undressing.

We also talked about the specimen box in **Step 6**. There are concerns that even though this box does have a forensic seal, (*one of two included in the kit*), only one end of the box can be securely sealed. We are hoping to provide two (2) seals for this box when the new kits are available so both top and bottom will have a numbered seal. Currently some nurses put orange seals on the box bottom.

I asked why - if the patient states there was no alcohol or drug use at the time of the assault - do the instructions read '...regardless of history the following sample should be collected: **6-1** blood for alcohol/drug(s) analysis'. It was explained that the window of opportunity to capture this type of evidence is so small, that it's best for a specimen to be available should it ever become an issue. The scientists also stated that it was most helpful if it was noted on page 3 of 4 'why' a specimen was *not* completed.

If nurses want to submit anal swabs for testing, they should do so. These can be included under **Step 4 -** skin swabs. However, anal swabs will not confirm that anal penetration has occurred. That is why rectal swabs should be done. That's also why it's recommended that the area be cleansed with distilled water before the swab is collected. This eliminates the chance of fluid leakage from the vagina.

We also recommended including a space for the kit number on the diagram sheets. Nurses completing the forms sometimes overlook this. This will eliminate confusion by providing a consistent way to identify which documents belong with which kit. Another useful suggestion was that individual Centres store *photocopies* of the forms. This way, if an error is made when completing the forms, a new form is available for the nurse to use. This will eliminate the need to open a new kit just to get a copy of a form - which is *quite* costly.

The tender process is a long process and we are not sure when the new kits will be available. I hope by the time you read this, that Centres have a full complement of forensic kits available for use.

Nancy DiPietro, Manager
Burlington SA/DVTC

SANE In Kitchener…CENTRE FOCUS

The Waterloo Region Sexual Assault/Domestic Violence Treatment Centre is nearing the completion of its 1st year with our Sexual Assault Nurse Examiner (SANE) program in place. While the concept and implementation seemed straightforward enough, the transition and the subsequent approvals offered challenges. Our Team is fortunate to have a knowledgeable and supportive team of 12 physicians - 2 of whom advised around making the medical directives reflective of our community & Centre needs.

Two nurses participated in the comprehensive SANE training provided by the Ontario Network in Toronto. Our draft set of medical directives was presented to the Nursing Practice and Professional Practice Committees at the hospital. Our Medical Advisor presented the directives to the Medical Advisory Committee. All three committees approved the medical directives.

With all of the approvals and course work in place, we put our knowledge into practice. A Team physician who works at a sexual health clinic offered to supervise us performing a number of speculum examinations at the clinic. Finally, 2 of our physicians supervised our ability to collect sexual assault evidence using professional patients. Now we were ready to practice as SANEs! We went 'live' as SANE. nurses in December 2003 -- assuming responsibility for the care of the client.

The benefits of the SANE response were immediately felt. While the benefits to clients were gratifying, we were most pleased with the unexpected personal rewards. As professionals we were able to utilize our nursing assessment and implementation skills to their fullest. Our decision-making skills became fine-tuned with the autonomy provided by our new role.

To date, our Centre has two practising SANE nurses. As our community - and the need for our services - continues to grow, our goal is to encourage more of our nurses to take the SANE training. With the ongoing support we've received from our Team, hospital administration, community and other Centres, and with the fundamentals in place, we look forward to continuing to provide our clients with specialized care.

Val Johnston – Warren, SANE Nurse
Cathie Cullen, SANE Nurse
Kitchener SA/DVTC

Nurturing Nurses…...STAFF RETENTION

When we first opened, there was little work for graduating nurses. Currently, however, we don't have enough nurses to replace those retiring. This, unfortunately, places programs like ours - staffed with on-call nurses - at a distinct disadvantage. In listing the barriers to taking on this work, it becomes apparent what direction needs to be taken to improve staffing:

1. Nurses are paid $3 per hour to be on-call for our program. Not only is that a pitiable amount of money, but it prevents them from taking on other work that pays their regular hourly wage. As well, they can't be available for 8 hours following an on-call shift because they need the time to complete a case if it happened late in the shift. Essentially, this means they're donating *personal* time to the program in addition to their commitment.
2. Hours on-call do not count toward seniority. So a nurse can dedicate herself for years without received professional credit. This prevents her from accessing other jobs where seniority counts.
3. Call-back hours, by virtue of being premium hours, do *not* count as pensionable hours.
4. Nurses who work for the program without another unionized position, can sometimes take call for a whole month, not get called in, and actually owe money from their own pocket for union dues - as the on-call pay is less than the dues!
5. Nurses who work only on-call are not officially eligible for education leave. It's up to individual Coordinators to grant leave from their budgets for professional development.
6. If nurses on-call have other part-time positions within their hospital, there are all sorts of restrictions imposed on them regarding the scheduling of their shifts.
7. Part-time and on-call nurses have no provisions in the collective agreement guaranteeing their day of pay for court appearances. It's done at the discretion of the Coordinator who must contend with budgetary constraints & issues around precedent setting for the hospital.

These are but some issues nurses on-call face when they accept this work - and they are told at the outset, so they're aware of what they're getting into. As Coordinators, we expect them to be dedicated and professional no matter what the time of day, meticulously accurate in their documentation, and skilled in 3 separate areas of competency (*physical assessment, crisis counselling and forensics*). We expect them to keep up to date and to do their work with grace.

I would like to recommend that we all take a serious look at these issues and resolve to do something as a Network to better the working conditions for our nurses. Perhaps it's time to look in a concerted fashion at how staffing can be accomplished to meet program needs, while at the same time providing an environment in which nurses will choose to stay. Every year, we lose experienced and qualified nurses because they've gained expertise with us, and then move on to greener and more serene pastures. The time is *now*

as the nursing job market continues to pose a challenge for us. Nurses are dedicated to the cause and want to do this work because they have the best interests of survivors in mind. Let's make it easier for them to do it!

Halina Siedlikowski, Coordinator
Ottawa SATP & DVP

Battling Bullying…IN THE SCHOOLS

In October, Linda Fisher MSW and I attended the Family Violence Prevention Fund's bi-annual conference in Boston. I will share with you some notes I took during a session on bullying.

Bullying is the most common, serious problem of the school-age child. Ten percent of all children are bullied (*some research shows rates of 15% but 10% is accepted as a reliable minimum*).

A child is bullied when he/she is exposed repeatedly to negative acts by another child or group of children. Bullying may involve direct action (*hitting, shoving, taunting, teasing*) or indirect action (*avoiding, social exclusion, spreading rumours*). It may take different forms in boys and girls.

Bullying is a traumatic childhood experience with effects which persist into adulthood. Children who bully frequently are more likely as adults to: drink alcohol, use tobacco, have lower academic achievement, and have more aggression and anti-social behaviour, including criminality. Children who are bullied frequently are likely as adults to: have more health complaints and symptoms, as well as anxiety, depression and poor self esteem, are at increased risk for unhealthy dieting and eating disorders, and more likely to skip work or feign illness.

The *traditional* view is that bullying is a developmentally 'normal' aspect of children's growth and social relations. This is supported by comments, 'boys will be boys' and 'girls are mean'. This train of thought leads many adults to believe that bullying is inevitable acceptable behaviour, and a growth experience or rite of passage.

The *new* view is that bullying is primarily a problem created by adults through modelling of bullying behaviour, acceptance of bullying as normal, inaction or inadequate action when bullying occurs, and by exposing children to social systems - especially schools - in which bullying is implicitly accepted.

The modern era of understanding bullying began with the work of Dan Olweus, a psychologist in Norway, in the 1970s. Olweus found that school is the most common site for bullying incidents. He developed a systemic 'bullying prevention program' with the goal of changing the culture of schools, while involving administrators, teachers, staff, parents and children. Olweus believed successful implementation of a bullying prevention program requires a change in what we have always believed about childhood bullying.

I think we will hear a great deal more about bullying in the future. Even now, any education in both school settings and workplaces receive much higher attendance when advertised as bullying instead of as human rights or harassment.

Anne Finnigan, Coordinator
London SA/DVTC

Surviving SARS...CENTRE IN CRISIS

The past year was unprecedented for our Scarborough hospital SACC. As the first Ontario hospital to encounter SARS, we've seen firsthand: our vulnerability, our strength, and the resilience of our staff and our clients.

On March 7th, 2003, a 44-year-old male was admitted to the Grace site Emergency Department experiencing serious respiratory problems. He had SARS, contracted from his mother who'd recently returned from a Hong Kong vacation.

A staff member noted the man had just buried his mother, which prompted the newly appointed head nurse of the Critical Care Unit, Agnes Wong, to recall an article in a Chinese newspaper about a Hong Kong father and daughter who died of an unusual form of pneumonia. Infection control officers quickly isolated patients with respiratory distress, but not fast enough. In all, 44 people died in Canada, hundreds of others became ill.

Our SACC/DV program was not spared from tragedy: Dr. Nestor Yanga caught SARS early in the outbreak and died in August of 2003. A casual RN at the Grace site fell ill - her life now revolves around medical appointments, a full rehabilitation program, and being studied on a personal and professional level.

The Grace site Emergency Department closed on March 23rd of last year. All staff in the hospital during the previous 2 weeks went home under quarantine. General Division took emergency and in patients from the Grace Division. We quickly negotiated with police and York Central SACC to redirect emergency sexual assault clients. However, when York Central received a medical transfer from the Grace diagnosed with SARS, this too closed. Women's College Hospital (WCH) then came to the rescue. All victims from

York Central and Scarborough were redirected to WCH. While Grace Emergency remained closed to sexual assault cases until the July 1st weekend, nurses and physicians remained on-call.

Many SACC nurses who *didn't* work at Scarborough Hospital were also directly affected. The Team public health nurse was pulled from the 'Baby's Best Start' program to follow-up on patients in the community who registered at Scarborough Hospital during the critical time. A SACC nurse at Toronto General volunteered to work in the isolation unit set up for SARS patients. When patients at the North York General mental health unit contracted the disease, a SACC nurse there was quarantined for 21 days.

The resilience of the clients and dedication of the counsellors was notable. Many day treatment programs were closed - deemed 'non-urgent'. However, a hunt for external counselling facilities brought community support: office space at the mental health outpatient clinic, right on the bus route. Counsellors flexed time with clinic staff and other community agencies at this space. All had to go through SARS screening, wearing a mask for appointments with clients. On the plus side, there was free parking, transit access, shopping, and a Thrift Store in the plaza.

When we returned to the Centre in July, our client numbers slowly returned to normal levels but everyone agrees that the community spot was a therapeutic change for clients and staff.

The volunteer website students were also at the hospital for a meeting just before SARS was diagnosed. Two students fell ill within the critical period and were also quarantined at home for 1 week missing classes and at least two exams.

We resumed our full hospital program in the summer, and are back to normal levels of service...but will always remember the winter of 2003 as one of trepidation, dedication, caring, and resilience.

Shirley Broekstra, Coordinator
Scarborough SACC

FOR YOUR INFORMATION

- The Women's 'Health Matters' Forum and Expo

January 14 & 15, 2005
Metro Convention Centre, Toronto
More details at womenshealthmatters.ca

- Paediatric Training

January 19, 20, & 21, 2005
Holiday Inn on King, Toronto (Mirvish Theatre District)

- Annual Conference for SA/DV Treatment Centres:
  '*Working on the Edge*'

April 14 & 15, 2005
Delta Chelsea Hotel, Toronto
Speakers include:

Author Babette Rothchild (*The Body Remembers: The Psychophysiology of Trauma and Trauma Treatment* & *The Body Remembers Casebook: Unifying Methods and Models in the Treatment of Trauma and PTSD*)

Author Rebecca Campbell (*Evaluating Services for Survivors of Domestic Violence and Sexual Assault*)