Recommending Practice Development for Registered Nurses in Remote Northwest Territories, Canada Through Participation in Sexual Assault Nurse Examiner Education

by © Meghan Sweetnam

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Abstract

Background: Registered nurses (RNs) providing care in remote Northwest Territories (NT), Canada must be dedicated to providing person-centred care to a largely indigenous population. The risk of sexual assault (SA) for Indigenous women is three times higher than that of non-Indigenous women; however, women in the NT do not receive the specialist care of a sexual assault nurse examiner (SANE). Furthermore, as colonial approaches to healthcare are identified, Indigenous epistemologies, such as *etuaptmumk* and *Piliriqatigiinniq,* are increasingly utilized to inform care of Indigenous peoples. **Purpose:** To recommend a practice development project which would provide an opportunity for RNs to acquire SANE education and become the primary care providers for women presenting to the emergency department (ED) in the post-SA period. **Methods:** To preface the proposal, a literature review and stakeholder consultations were prepared. Rogers' Diffusion of Innovation theory, emancipatory practice development, and local and global Indigenous epistemologies were utilized to direct the proposal. **Results:** The literature review and stakeholder consultations provided support for implementing RN-led post-SA care in the ED. Accordingly, a project proposal was conceived as a way of proposing, implementing, and evaluating Indigenous-informed, person-centred, RN-led post-SA care in the ED. **Conclusion:** This project exhibits the advanced nursing competencies of direct comprehensive care, health system optimization, education, research, and consultation and collaboration. The proposed project will inform nursing practice development, encourage transformational practice development, and improve patient care in the post-SA period.

Keywords: practice development, sexual assault nurse examiner, remote nursing

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I would like to acknowledge my nursing colleagues at the Inuvik Regional Hospital for their feedback and encouragement as I finished the project. It is easy to become singularly focused at times, and my colleagues reminded me of the holistic nature of nursing practice, as well as the importance of teamwork. In particular, Sue Clarkson and Debbie MacDonald acted as nursing mentors to me, both in clinical practice and in academic pursuit, for the duration of this project, and I would be remiss in not acknowledging them specifically.

I must acknowledge the expertise of the Indigenous elders and community members in assisting me with this project. As a non-Indigenous settler in the community of Inuvik, at the juxtaposition of the Gwich'in Settlement Area and Inuvialuit Settlement Region, I am forever grateful for the kindness and patience extended towards me as I navigate decolonizing my nursing practice. It is my hope that through further collaboration, we will be able to make great strides in the Beaufort Delta region of the Northwest Territories in working toward decolonizing healthcare and working together as a team.

Finally, I would like to thank my fiancé, Moses, my daughters, Natalie and Bethany, and my mother, Charlene, for keeping the family afloat while I worked full-time, completed my studies part-time, and carried two babies through a global pandemic. This project is dedicated to my daughters, who will grow to have strong Indigenous and non-Indigenous family values. It is

my hope that my *paniik* will grow into a world where their cultures compliment each other, and where they can contribute to their community in the tradition of both their families.

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Recommending Practice Development for Registered Nurses in Remote Northwest Territories, Canada Through Participation in Sexual Assault Nurse Examiner Education

Practice development, as a method of encouraging change in the nursing profession, is relatively new when compared to the profession itself. Practice development is not synonymous with professional development; rather, practice development seeks to advance patient care, evidence-based nursing, nursing theory, and nursing knowledge by merging clinical practice, education, and research into organized action (Chambers et al., 2013). In short, practice development specifically focuses on tangible changes in individual practice as a way of encouraging global changes in nursing practice. Ultimately, these changes will propel the nursing profession closer to person-centred practice.

In Inuvik, Northwest Territories (NT), the Inuvik Regional Hospital (IRH) serves the Beaufort Delta and Sahtu regions, which are the two northernmost and regions of the NT. In these remote regions, 78% of the inhabitants self-identify as Canadian First Nations, Inuit, or Métis, with the largest ethnicities identified as Gwich'in First Nation, Dene First Nation, and Inuvialuit (Beaufort Delta Health & Social Services Authority [BDHSSA], n.d.; Bureau of Statistics, Government of the Northwest Territories [BSGNWT], 2016). Healthcare is directed to the community's nearest health facility, and IRH is the regions' only hospital. Victims of sexual assault (SA) present to the IRH emergency department (ED), where post-SA care is administered by a physician with a registered nurse (RN) to assist. Notably, the risk of SA was nine times higher in the NT than in the rest of Canada (Statistics Canada via Cooke, 2016). In many EDs across Canada, post-SA care is led by an RN with sexual assault nurse examiner (SANE) education. Implementing a similar SANE-led program at IRH has the potential to increase the effectiveness of post-SA care, and align with the values of person-centred practice. At this time,

implementing a SANE-led post-SA care program would require a practice change for the ED RNs at IRH. The aim of this project, then, was to propose a practice development project for ED RNs at IRH to obtain SANE education. The overarching aim of this project, however, was to achieve better outcomes for Indigenous women experiencing SA by encouraging practice development in ED RNs in an effort to foster person-centred practice.

Practicum Goal and Objectives

The overall goal for this practicum project was dynamic throughout the project as the processes of research and community consultations were completed. Initially, the goal of this project was to develop a proposal outlining a change of practice for ED RNs at IRH whereby RNs were trained to complete post-SA examinations and requisite follow-up care. Yet, at the conclusion of the practicum, the goal for the project evolved into developing a proposal to encourage practice development in IRH RNs via completing post-SA care education as a means for improving the care for Indigenous women in the post-SA period.

To complete the proposal, three objectives were established:

1. To collaborate with key stakeholders to develop a culturally relevant, evidence-based action plan to facilitate the expansion of IRH RNs' roles to encompass post-SA care responsibilities.
2. To complete an integrated literature review to establish evidence, and to facilitate the proposed practice development.
3. To develop a proposal for implementation of the practice development for IRH RNs.

Overview of Methods

To accomplish the practicum goal and objectives, a literature review and consultation plan were developed by the author.

Literature Review

The literature review was imperative at the outset of devising the practicum proposal. Topics researched included the guiding framework for the proposal, establishing the effectiveness of RN-led post-SA care, detailing the various care program models and evaluation, and implementing practice change.

Methods

Three research databases (CINAHL, PubMed, and Google Scholar), as well as Google search engine, were searched using a combination of search terms, yielding several thousand publications. Global inclusion criteria included articles published after the year 2000, and articles published in English. As much as possible, articles focusing on rural and remote Canadian programs were selected for assessment. To guide the final selection, the Critical Appraisal Tool (CAT) from the Public Health Agency of Canada (PHAC) was employed to categorize publications as a descriptive study, analytic study, or literature review, and to assess each for relevance and rigor (PHAC, 2014). Additionally, two Indigenous frameworks were utilized for reviewing the literature: firstly, *etuaptmumk*, a Mi'kmaq First Nations framework, was reviewed to honour the perspective of the Gwich'in First Nation. Additionally, *Pilriqatgiinniq*, a Canadian Inuit framework, was reviewed to honour the perspective of the Inuvialuit.

Results

A final total of 14 articles was included for review, and categorized into four themes. Themes included: guiding Indigenous frameworks, effectiveness of SANE programming, program design and evaluation, and implementing practice change using Rogers' Diffusion of Innovation theory.

Guiding Indigenous Frameworks. As a means of honouring Indigenous epistemologies, *etuaptmumk* and *Pilriqatgiinniq* were reviewed to assist in integrating the literature. Chatwood et

al. (2015) call on researchers to employ *etuaptmumk*, or "two-eyed seeing". When considering concepts, the researcher must consider knowledge from the western perspective using one eye, and from an Indigenous perspective using the other eye. By utilizing both eyes as is intended, the researcher employs a holistic worldview. *Pilriqatgiinniq*, a Canadian Inuit research framework, is employed for health research and is informed by four concepts. Firstly, *innuqatigittiarniq* (respect for others) is emphasized when building relationships between people in order to build respect between researcher and research participant (Healey & Tagak Sr., 2014). Secondly, *unikkaaqatigiiniq* (story telling) is emphasized to remind researchers of the largely oral history of the Canadian Inuit (Healey & Tagak Sr., 2014). When considering information, it is imperative that a western researcher understand that oral history is informed knowledge, and indeed, centuries of knowledge can be communicated in one story. *Pilriqatiggiinniq* is also informed by *iqqaumaqatigiinniq* (all thoughts into one), which emphasizes a holistic worldview and encourages the researcher to consider all domains (physical, spiritual, emotional, etc.) (Healey & Tagak Sr., 2014). The final concept guiding knowledge generation in the *Pilriqaatiggiinniq* framework is *pittiarniq* (technical and moral good). Approaching research with humility and respect is necessary for understanding the Inuit worldview (Healey & Tagak Sr., 2014). Thus, when reviewing the forthcoming literature, both *etuaptmumk* and *Pilriqaatiggiinniq* were considered in an effort to honour Indigenous epistemologies.

Efficacy of SANE Programming. The literature review demonstrated that SANE programs were considered effective in relation to two highlighted clinical outcomes: patient satisfaction with nurse-led post-SA care and influence on the flow of the ED (Du Mont et al., 2014; Du Mont et al., 2017; Sampsel et al., 2009; Stermac & Stipe, 2009). Notably, however, Indigenous patients were less likely to rate their post-SA care as good or excellent when

compared to non-Indigenous women (Du Mont et al., 2017). This difference may point to a lack of Indigenous-informed, culturally appropriate care, which is of particular importance when considering the current project.

Program Design and Evaluation. Two primary program designs were highlighted in the evidence: a healthcare-focused program, and a combination healthcare/forensics-based program. From the literature review, it was evident that patients presenting for post-SA care preferred a healthcare-focused program, pointing to the value of specially trained individuals completing care in the post-SA period (Logan et al., 2006; Martin et al., 2007). The literature review also highlighted several program evaluation parameters, including patient satisfaction, patient psychological well-being, and patient understanding of the medico-forensic process (Campbell et al., 2008). These parameters provided guidance when considering the evaluation of the current project.

Implementing Practice Change. Evidence for the utilization of Rogers' Diffusion of Innovation theory was examined as a means of encouraging nursing practice change. From the literature, it was determined that employing Rogers' theory was a reasonable method of encouraging change in nursing practice. Bowen et al. (2012) noted successful implementation of a delirium-screening tool into routine practice in a US-based intensive care unit. By employing the five stages of Rogers' theory (knowledge, persuasion, decision, implementation, and confirmation), the researchers noted that, by the conclusion of the study, 85% of patient screening tools were completed (Bowen et al., 2012). In addition to an organized implementation plan, Watson-Wolfe et al. (2014) and Guilbert (2014) noted the importance of making change relatable to nurses via consulting, and including nurses in the proposed practice change.

After concluding the literature review, the author determined that there was sufficient

evidence for implementing a SANE-led post-SA program in the ED. The author also noted that a healthcare-based program is preferred by patients, and considered this research finding when approaching consultees during the consultation process. Finally, in order to effect change in the ED, the author noted the relevance of Rogers' Diffusion of Innovation theory. To approach ED RNs with a practice change utilizing the five steps of Rogers' theory would increase the chance of success for the proposed practice change. The aforementioned points were amalgamated when considering the consultation phase of the project, which is described in the following section.

Consultations

When designing the proposed program, a consultation period was undertaken to ensure the proposed program met the needs of the providers and the clients. In fact, when considering the needs of the clients, employing the guiding Indigenous frameworks demonstrated that meeting the client's physical and emotional needs was imperative, but also the spiritual and cultural needs. As such, a multi-faceted consultation plan was developed as a means of considering the holistic needs of the proposed clients.

Methods

At the outset of the consultation process, five objectives were identified:

1. To identify potential advantages and disadvantages to implementing the proposed program.
2. To assist in designing the role of the RN in the proposed program.
3. To assess for current cultural barriers to accessing healthcare in the post-SA period, and to identify strategies to mitigate these barriers.

4. To identify culturally appropriate training for the nurses when completing post-SA examinations with Indigenous clients (specifically, Gwich'in and Inuvialuit clients).
5. To identify ways of knowing specific to Gwich'in and Inuvialuit cultures, and to implement these ways of knowing when designing the program.

Nine participants were contacted for consultation. Prior to sending out the surveys, each participant was categorized into one of three groups based on their purpose for inclusion: cultural representative, team design, and existing program design. All completed surveys were also examined for secondary inclusion into one of the aforementioned groups. For example, some consultants were experienced in team design, but could also provide expertise as a cultural representative. As such, these consultants aided in enriching the data collection process.

Results

Of the nine potential participants, five participants completed and returned the written surveys (56% response rate). Three surveys corresponded to the team design role, one survey corresponded to the cultural ambassador role, and one survey corresponded to the existing program design role. Three overarching themes were identified from the completed surveys: nurse as trusted entry point to care, a culture of silence and under-reporting of SA, and challenges unique to northern care.

Nurse as Trusted Entry Point to Care. This theme was alluded to on all five surveys. It was noted that, when properly educated, nurses have the necessary knowledge, skills, and judgement to complete post-SA care. Furthermore, nurses also have many other qualities that contribute to effective post-SA care, such as compassion and integrity. This overwhelming support for nurses as post-SA care providers was echoed in the literature review; Du Mont et al.

(2014) noted that 98.6% of 920 surveyed individuals rated their nurse-led post-SA care as good or excellent. Extrapolation of the evidence from both the literature review and consultations revealed that nurses were satisfactory providers of post-SA care, and in fact, nurse-led care could be considered as a viable alternative in the IRH ED.

A Culture of Silence and Under-Reporting of SA. This theme was alluded to by respondents familiar with the population of the IRH ED. Respondents noted that women in the Beaufort Delta region may under-report SA due to cultural barriers such as distrust of the healthcare system, and fear of the judicial system. The respondents also noted that these barriers may be mitigated by the development of a nurse-led post-SA care team. From the literature, there has been evidence that marginalized individuals under-report SA due to a fear and mistrust of the dominant society's medical and legal system. Tillman et al. (2010) note that African American women often under-report SA because of past negative experiences with the medical system. This theme highlighted the importance of culturally-relevant care to encourage Indigenous women to report SA; as such, a culturally-informed program was identified as imperative in an effort to supersede the cultural of under-reporting SA.

Challenges Unique to Northern Care. Most respondents identified high staff turnover and a lack of consistent staff as barriers to successfully implementing nurse-led post-SA care. Many staff are non-Indigenous, and travel to the Beaufort Delta from out-of-territory. The high rate of locum providers contribute to lack of trust in medical care from the residents of the Beaufort Delta/Sahtu. Mitigating this distrust has been highlighted by encouraging more Indigenous providers (Kulig et al., 2013). This theme also pointed to the importance of culturally-relevant care, and the presence of Indigenous providers in the post-SA care period.

In preparing the final proposal, considering evidence from the literature review and

consultations was imperative. The literature review highlighted the success of similar programs in other jurisdictions, provided guidance for program design and evaluation, and finally, outlined the procedure for encouraging and implementing nursing practice change. The consultation process provided valuable local input; local input that was strongly alluded to as imperative in the individual consultations. At the conclusion of the literature review and consultation process, the author integrated the information into a proposed nurse-led post-SA care program, which will be detailed in the following sections.

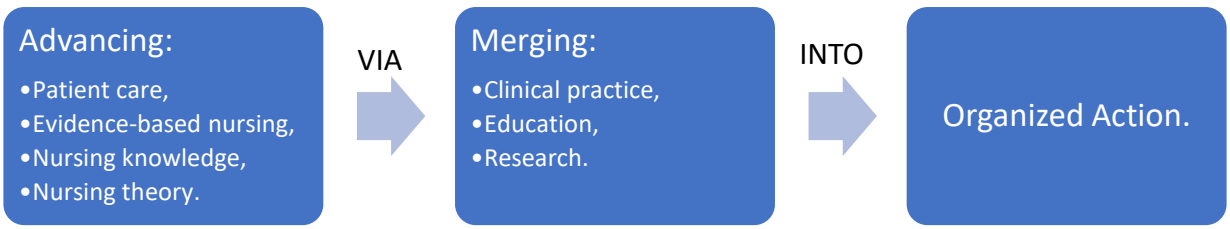
Overview of the Proposed RN-led Post-SA Practice Development Program

Implementing a person-centred, culturally-safe program in the IRH ED requires a multi-faceted approach. Actual implementation was beyond the scope of this project; rather, a proposal detailing the implementation of this practice development project is described in the forthcoming sections.

At the outset of the proposal, and after the literature review, it was determined that the proposed project would benefit from nursing practice development as opposed to nursing practice change. While seemingly identical, practice development focuses on the "human factors" of healthcare (McCormack, 2014, p.638). As illustrated in the following figure, the goal of practice development is advancing patient care, evidence-based nursing, nursing knowledge, and nursing theory by merging clinical practice, education, and research (Chambers et al., 2013).

Figure 1.

Diagram depicting the process of practice development.



Note. The above diagram depicts the flow of practice development from initial goals to final action.

Practice development is less concerned with the idiosyncrasies of a nurse's individual practice, and more concerned with developing the nurse. To properly incorporate practice development into the proposed project, a review of the literature was conducted in an effort to examine how practice development has been used in other settings. In studies by Chambers et al. (2012), Burley et al. (2019), and Hardiman and Dewing (2019), employing emancipatory practice development as a means of encouraging change proved successful in three different projects. In each project, nurses underwent emancipatory practice development activities to transform their practice into a more person-centred approach. Evidence for transformation was measured by the researchers and corroborated by nursing colleagues. With respect to the current project, practicing from a person-centred paradigm requires a cultural shift in programming to honour and respect the majority Indigenous population. This shift must be completed via practice development.

Development Team

To implement nurse-led post-SA care in the IRH ED, and thus, practice development, a comprehensive multidisciplinary team will be required to initiate the change in the current practice model. Representatives from the Government of the Northwest Territories (GNWT) management, nurse educators, Indigenous government representatives, licensing body representatives, allied healthcare, and frontline service providers, with the author as coordinator, will liaise to initiate the development of nurse-led post-SA care in the IRH ED. Roles and responsibilities of each representative will be well defined to smoothly develop and implement the project.

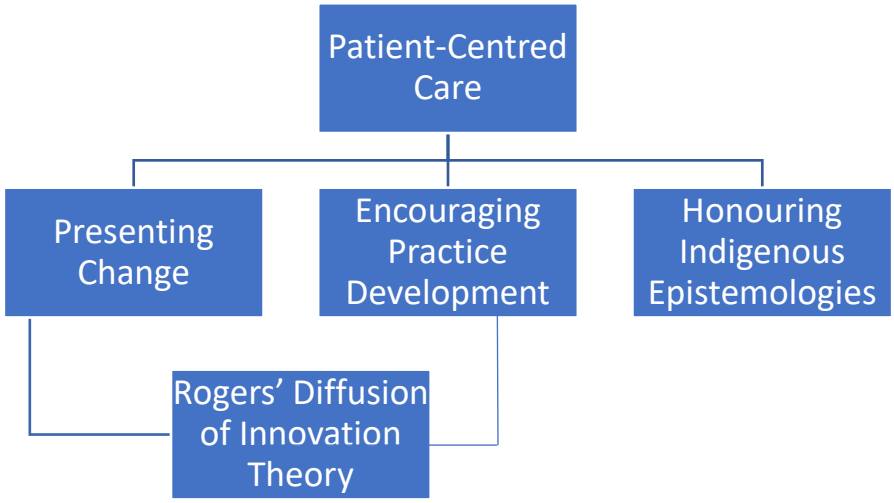
Program Development

Implementing the program requires consideration to the post-SA exam education required for the nurses, as well as the implementation of the person-centred model of care. Importantly, while the project initially concerned only ED RNs, further research into program models, as well as cost-effectiveness in Canada's North, determined that any RN with an interest in post-SA care could participate in the program. There are two avenues for obtaining post-SA exam education: firstly, nurses can achieve SANE designation through a comprehensive certification program offered by the British Columbia Institute of Technology (BCIT) (BCIT, n.d). Secondly, nurses can obtain post-SA care education through the International Association of Forensic Nurses (IAFN), but would not be designated as SANEs (IAFN, 2021). For the proposed program, it will be essential that at least one to two nurses achieve SANE designation as "change champions"; however, the rest of the team could be composed of nurses with post-SA exam education.

Implementing the person-centred model of care will require three actions: presenting change, encouraging practice development, and honouring Indigenous epistemologies. Presenting the proposed change in practice will be structured using Rogers' Diffusion of Innovation theory's five-step approach. Once the proposed practice change is agreed upon, the nursing team members will initiate practice development by beginning emancipatory practice development activities such as entrance interviews and contextual preparation (Hardiman & Dewing, 2019). Finally, both actions must be presented with attention to Indigenous ways of knowing so that the result honours Indigenous persons as the primary stakeholders in IRH's person-centred care model. A schematic diagram is presented in Figure 2.

Figure 2.

A diagram illustrating the multifaceted approach to achieving person-centred care in the IRH ED.



Note. The above schematic diagram illustrates the three actions required to initiate patient-centred care in the IRH ED: presenting change, encouraging practice development, and honouring Indigenous epistemologies.

Encouraging Change

Examining the status quo and organizational policies currently in place revealed four sectors where change must take place to successfully implement the proposed project: the organization's leadership, education, funding, and policy and practice. With respect to leadership, the consultation process revealed strong support for nurse-led post-SA care. Challenges to this support included a high staff turnover in management, but could be mitigated by strong support from permanent, long-term frontline staff. As aforementioned, nurses involved in the project must engage in education relating to post-SA care. Furthermore, the nurse educator must be supportive of the proposed change. Funding will require re-allocation of healthcare dollars when compared to the current model. To successfully implement nurse-led post-SA care, one nurse with the requisite education must be scheduled for each shift and redeployed from their primary position to post-SA care on an as needed basis, thereby eliminating on-call pay. Thus, the more nurses who can be recruited for the team, the better the chance of implementing

the role change. Finally, policy and practice development must be undertaken in order to delegate post-SA care to nurses with the supervision of physicians. This is a lengthy process as medical directives are drafted and presented to the various committees for approval; nevertheless, implementing nurse-led post-SA care is in the best interest of the patient, and working towards person-centred care is the goal of healthcare providers. There is support for the proposal in the evidence obtained from the literature review, as well as from the consultees during the consultation process; with the development team in place, it is possible that this task can be completed.

Evaluating Change

To evaluate the success of the program, and of the practice development project, several parameters must be examined. At the beginning of the project, data regarding the number of SA presentations to the IRH ED, the number of SA presentations to outside agencies without presentation to the ED (i.e. RCMP), the number of repeat presentations, the length of stay, and staff entrance interviews must be collected. This data must again be collected at six months and one year post-program implementation in an effort to determine if the program was successful. Furthermore, as the program evolves, appropriate space for collecting information regarding patient satisfaction and well-being will be created. Patient satisfaction with the program will be the most effective parameter of determining the success of the program, while staff exit interviews will be the most effective parameter of determining the success of practice development.

Building the Profession: Advanced Nursing Practice Competencies

The preceding project was an example of several advanced nursing competencies as defined by the Canadian Nurses Association (CNA). Firstly, the project contributes to optimizing

health systems as an example of person-centred care (CNA, 2019). Specifically, this project "advocates for clients in relation to care, the health system and policy decisions" (CNA, 2019, p. 31). By advocating for nurse-led post-SA care, the author is advocating for person-centre care as it is evident in the literature that patients prefer healthcare-based, specialist-provided care in the post-SA period (Logan et al., 2006; Martin et al., 2007). Furthermore, by framing the program using an Indigenous lens, the project will be relevant to the majority Indigenous population of the IRH ED; continuing collaboration with Indigenous health advocates will make the program increasingly relevant to patients.

This project also contributes to the advanced nursing competency of education (CNA, 2019). The project serves as an example of enhancing the knowledge of nursing and other colleagues, as well as fostering growth in organizational culture (CNA, 2019). The impetus of the program as a practice development project for IRH RNs will encourage transformational change among the nurses at IRH; transformational practice development is defined as the practice development of one nurse affecting many (Manley & McCormack, 2003). This project, then, advocates for an organizational culture where change towards person-centred practice is encouraged. In this way, the project satisfies the education competency as defined by the CNA. Furthermore, the CNA encourages advanced practice through applying research and current best practice (CNA, 2019). This project demonstrates that nurse-led post-SA care is an effective means of delivering post-SA care, and indeed, is preferred by patients. By thoroughly examining the existing literature for nurse-led post-SA programming, and innovatively advocating for the programming to include practice development, this project has the potential to contribute to the research canon.

Finally, this project contributes to the advanced nursing competency of leadership (CNA,

2019). This project identifies a gap in service provision, and also contributes a means of addressing this gap at the clinical and organizational level. More importantly, by deconstructing the current model of care, and reframing service provision from a decolonized perspective by employing Indigenous epistemology, this project has the potential to effect systems-level change by contributing to the overall decolonization of healthcare.

Recommendations and Future Activities

In order to propel this project into fruition, the proposal must be presented to the development team described in preceding sections. Prior to this presentation, however, it would be prudent for the author and other interested parties to begin post-SA care education. It is recommended that at least one or two IRH RNs achieve SANE designation, which can take as long as one year of course work, plus clinical hours. Beginning this process prior to the presentation of the proposal will demonstrate dedication to learning and may lend additional credibility to the project.

Additionally, more research is needed into emancipatory practice development as a delivery model for encouraging practice change. Further academic research would be beneficial, and several experts have been identified throughout the course of writing this proposal who could lend their expertise to emancipatory practice development delivery in the clinical setting. To effect real and lasting transformational change, emancipatory practice development is the most appropriate avenue to take; as such, further research will only propel the proposal forward.

Finally, further collaboration with Indigenous representatives is necessary. While preliminary research has been completed with respect to Indigenous epistemologies, none of the identified ways of knowing are specific to the peoples of the Beaufort Delta and Sahtu regions. Furthermore, no specific ways of knowing were identified during the consultation process. As

such, cross-consultation with more elders and experts in the field of education may be warranted. To deliver this program such that it then delivers person-centred care to the people of the northernmost communities in the NT, partnership with Indigenous communities is crucial.

Conclusion

The practicum project described throughout this report was conceived as the author noted a gap in service provision relating to post-SA care in the IRH ED. The integrative literature review revealed that SANE-led post-SA care is effective, and indeed, the consultation process noted that nurses have the knowledge, skills, judgement, compassion, and integrity necessary to lead post-SA care. In order to effect real change in nursing practice, emancipatory practice development was proposed as a means of encouraging transformational change. The ultimate goal of this proposal was initially to advance nursing practice in the clinical domain by delegating post-SA care to the ED RNs. Yet, as the course evolved, the overarching goal of the project became improving the experience of women in the post-SA period. As the majority of the population in the catchment are of IRH self-identify as Indigenous, it was imperative that the project be guided by Indigenous ways of knowing. In this way, a culturally safe and culturally relevant program can be implemented that it representative of person-centred care. To encourage person-centred care in nursing practice, then, nursing practice development was essential. It is the author's sincere hope that the program is implemented in the IRH ED, and the process for doing so involves presentation of the proposal to a development team comprised of allied healthcare, nursing management, and other key stakeholders. Ultimately, buy-in for the proposed project relies on the organization's dedication to person-centred care. With the current climate leaning toward healthcare professionals seeking to decolonize their individual practices, it would

be wise for all practitioners to seek out practice development principles and initiate the process of moving toward person-centred care. This project provides a tangible avenue for this journey.

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Appendix A—Literature Review

Recommending Practice Development for Registered Nurses in Remote Northwest Territories, Canada Through Participation in Sexual Assault Nurse Examiner Education: A Review of the Literature

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Abstract

Background: Risk of sexual assault in Indigenous women is three times greater than in non-Indigenous women; in the Beaufort Delta and Sahtu regions of Canada's Northwest Territories, 78% of residents self-identify as Indigenous. At present, there is a lack of dedicated programming for post-sexual assault care at the Inuvik Regional Hospital (IRH), the healthcare facility servicing this area. **Purpose:** To examine the feasibility of implementing sexual assault nurse examiner (SANE) training for the IRH emergency department nurses. **Methods:** Three research questions were developed and researched using three databases. Themes were identified in the literature and the publications were categorized accordingly. **Results:** Fourteen publications were included for review. **Conclusion:** Three overarching themes were identified in the literature review: effectiveness of SANE programming, SANE program design and evaluation, and the implications of enacting nursing practice change using Rogers' Diffusion of Innovation Theory. The overall review was framed by Indigenous epistemology, including *etuaptmumk* (seeing with both eyes) and the Canadian Inuit research framework, *Piliriqatigiinniq.*

Keywords: sexual assault, nursing, Northwest Territories, Rogers' Diffusion of Innovation, *etuaptmumk, Piliriqatigiinniq*.

Recommending Practice Development for Registered Nurses in Remote Northwest Territories, Canada Through Participation in Sexual Assault Nurse Examiner Education: A Review of the Literature

In the Northwest Territories (NT), the risk of sexual assault (SA) was nine times higher than in the rest of Canada in 2011 (Statistics Canada via Cooke, 2016). Furthermore, Du Mont et al. (2017) note that Indigenous women experience sexual violence at three times the rate of non-Indigenous women (115 per 1000 Indigenous women versus 35 per 1000 non-Indigenous women). In the Beaufort Delta region of the NT, the Inuvik Regional Hospital (IRH) serves approximately 6700 residents of the Beaufort Delta, and a further 700 residents in the northern Sahtu communities of Colville Lake and Fort Good Hope (Beaufort Delta Health & Social Services Authority [BDHSSA], n.d.; Bureau of Statistics, Government of the Northwest Territories [BSGNWT], 2016). Approximately 78% of the population in the Beaufort Delta and northern Sahtu self-identify as First Nations, Inuit, or Métis (BSGNWT, 2016). Given the high risk of SA in the NT, coupled with the high risk of sexual violence in Indigenous populations, it follows that emergency department registered nurses (ED RNs) in the NT must be prepared to undertake post-SA care on a regular basis.

Implementing a sexual assault nurse examiner (SANE) program in the IRH ED has the potential to increase the effectiveness of post-SA care for the Beaufort Delta and northern Sahtu populations. Currently, a SANE program is operating at the territorial hospital in Yellowknife (Stanton Territorial Hospital). Nevertheless, uncomplicated post-SA presentations in the Beaufort Delta and northern Sahtu do not necessitate transfer to the territorial hospital, and thus, assessment, evaluation, and treatment of affected individuals are conducted by physicians with ED RN assistance in Inuvik. Evidence has established that SANE programs are effective with

respect to client satisfaction with care, and to a lesser extent, cost-savings for the hospital. As such, a literature review of SANE program effectiveness follows to establish the relevance of a SANE program for the IRH ED. Furthermore, to help guide implementation of the proposed new program, a review of existing program designs in other facilities will be completed. As part of this review includes the identification of how existing programs measure their success, program indicators will be collected. Finally, realizing a SANE program in the IRH ED calls for a practice change for the existing ED RNs. Adopting change is not simple, nor is it intuitive. In order to ease the transition between the existing practice and the proposed practice, Rogers' Diffusion of Innovation change theory is utilized as a guiding theory for practice change. As such, a review of this change theory, and its successful implementation in other instances of practice change is warranted.

The overall proposal for a practice change involving the establishment of a SANE program will be guided by a theoretical framework that respects and honors Indigenous epistemology. As noted, 78% the population in the Beaufort Delta and northern Sahtu identifies as Indigenous, and because Indigenous women are three times more likely to experience sexual violence than non-Indigenous women, successful implementation of any program addressing post-SA care must be guided by Indigenous ways of knowing. Therefore, a review of pertinent Indigenous ways of knowing is necessary and will serve as a guiding framework for this literature review and overall proposed practice change.

Theoretical Framework: Indigenous Ways of Knowing

The Beaufort Delta and northern Sahtu regions are traditionally populated by the Gwich'in, Dene, and Inuvialuit peoples; Gwich'in and Dene peoples self-identify as Canadian First Nations, while the Inuvialuit self-identify as a culturally and ethnically unique subset of the

Canadian Inuit. As a guiding framework for the Canadian First Nations, *etuaptmumk* (seeing with two eyes) was identified as a culturally relevant way of knowing. When researching issues relevant to First Nations peoples, one of the researcher's eyes must examine data from the western perspective, and the other eye must examine data from an Indigenous perspective (Chatwood et al., 2015). By using both eyes equally, the researcher is able to resolve any potential conflict between western and Indigenous epistemologies. With respect to this literature review, and overall proposal, it is thus imperative to review literature from both western and First Nations perspectives; in this way, the proposed program will be culturally relevant, and employ culturally safe care for the majority Indigenous population.

The Canadian Inuit have developed an independent research framework called *Piliriqatigiinniq*, which informs health research in Canadian Arctic communities (Healey & Tagak Sr., 2014). The model encompasses four concepts: firstly, *inuuqatigiittiarniq* (respect for others) is utilized to direct the building of relationships between people. As relationships between people are strengthened, the larger community is strengthened (Healey & Tagak Sr., 2014). Thus, when conducting research, or implementing projects, the researcher must clearly articulate the intentions and motivations behind the research or project. This transparency contributes to respect, and the strengthening of relationships.

Pilriqatigiinniq is also informed by *unikkaaqatigiiniq* (storytelling) (Healey & Tagak Sr., 2014. The Inuit have a strong oral culture, and employ storytelling as a way to share knowledge, values, morals, skills, and histories. As a western researcher, then, it is important to be cognizant of storytelling as informed knowledge; centuries of knowledge can be communicated in one story, which influences data collection (Healey & Tagak Sr., 2014). *Pilriqatigiinniq* is also informed by *iqqaumaqatigiinniq* (all thoughts into one), which emphasizes a holistic worldview.

Thus, when conducting research or implementing a project, knowledge and utilization of holism is imperative to successful collaboration with the Inuit (Healey & Tagak Sr., 2014). Finally, *Pilriqatigiinniq* is informed by *pittiarniq* (being good). *Pittiarniq* emphasizes technical and moral good, and emphasizes one's behavior. It is imperative that one must be humble, and respectful of the unique rights of all things; by "doing good", one will embody this concept (Healey & Tagak Sr., 2014).

It is important to note that the aforementioned Indigenous epistemologies are not specific to the Beaufort Delta or northern Sahtu regions, but are employed as a global framework to honour Canadian Indigenous epistemologies. As research is conducted into specific Gwich'in, Dene, and Inuvialuit ways of knowing, the guiding framework for this project will be altered to be more specific to the Beaufort Delta and northern Sahtu regions.

Method

Three research questions were developed for the literature review:

1. What is the effectiveness of SANEs or SANE-led response teams, especially in relation to working with Indigenous population?
2. How are smaller SANE programs designed & evaluated?
    a. What cultural indicators influence a Canadian Indigenous woman's willingness to present for post-SA care?
    b. What specific cultural indicators influence Gwich'in, Dene, and Inuvialuit knowledge of SA and the requisite follow-up care?
3. How is Roger's Diffusion of Innovation Theory used in the implementation of a professional practice change?

Three separate literature searches were conducted to address the three questions. CINAHL, PubMed, and Google Scholar were utilized to search for peer-reviewed literature, and the Google search engine was accessed for grey literature. Global inclusion criteria included articles written in English, and articles published between 2000 and present. As much as possible, Canadian publications and publications focusing on rural and remote settings were targeted for assessment. For the first question, search terms included “sexual assault nurse”, “forensic nurse”, “SANE”, “effectiveness”, “Canada”, “successful”, “finance”, “budget”, and “cost” in combination. Each database yielded greater than 100 articles; articles selected for further perusal were chosen based on the global inclusion criteria. Search terms for the second question included “SANE program”, “design”, “evaluation”, and “review”. Similarly, each database yielded greater than 50 articles; the global inclusion criteria were then applied to select articles for further perusal. Finally, search terms for the third question included “Rogers’ Diffusion of Innovation theory”, “Rogers’ Diffusion of Innovation model”, “nursing” and “nursing programs”. The CINAHL database yielded 107 articles, the PubMed database yielded 58 articles, and Google Scholar yielded 54,300 articles. As before, the global inclusion criteria were applied to select articles for further perusal. To guide final article selection, the Critical Appraisal Tool (CAT) from the Public Health Agency of Canada (PHAC) was utilized to screen each article based on whether the article specifically addressed the aforementioned research questions (PHAC, 2014). Once it was determined that an article was relevant to the current research, each article was classified as a descriptive study, analytic study, or literature review, and then evaluated based on the criteria included in each critical appraisal tool (PHAC, 2014).

Results

A final total of 14 articles were selected and organized into categories for review: five articles pertaining to the effectiveness of SANE programs, five articles pertaining to program design and evaluation, and four articles pertaining to implementing practice change. The categories were identified based on the key research questions, and articles were relegated to a category based on the previously mentioned search criteria.

Effectiveness of SANE programs

The effectiveness of SANE programs generally focused on two outcomes: clinical outcomes and "other" outcomes (i.e. criminal prosecution of perpetrator, and program outcomes [such as cost-effectiveness]). For the purposes of this review, two clinical outcomes were highlighted: patient satisfaction with SANE-led care, and effect of SANE-led care on emergency department flow. Cost-effectiveness of SANE programs was also reviewed. In an initial study, Du Mont et al. (2014) examined patient demographics and satisfaction in 1484 participants (1425 women, 54 male, 5 transgender) across 30 of 35 SA/domestic violence centres in Ontario from 2009 to 2011. Of the initial sample, 920 participants completed a researcher-developed Client/Guardian Satisfaction Survey; 98.6% of the 920 individuals rated their care as good or excellent on a four-point Likert scale (Du Mont et al., 2014). In a follow-up to their initial study, Du Mont et al. (2017) specifically examined the same data for demographics and satisfaction with post-assault care in the Indigenous population. The data were first examined by the Indigenous research team member, then compared to that of non-Indigenous women (Du Mont et al., 2017). When demographics were considered in the results examination, Du Mont et al. (2017) found that Indigenous women were more likely to be assaulted between 12 and 18 years of age, present to the centre with a police presence, and were less likely to rate the care they received as good or

excellent (95.7% of Indigenous women versus 99.1% of non-Indigenous women).

Both studies by Du Mont et al. (2014, 2017) had moderate relational value to the current proposal. Both studies were conducted in Canada, and the more recent study specifically addressed Indigenous females. Several limitations were evident in each article; firstly, Du Mont et al. (2014) did not include their statistical analysis, nor a succinct explanation of their method. Furthermore, the questionnaires developed by Du Mont et al. (2014) may not be valid or reliable for other populations, as they were only tested for the population in question. Finally, a four-point Likert scale, while acceptable, does not include a "neutral" option. An overwhelming statistic of 98.6% satisfaction with post-assault care leads the reader to question whether a "neutral" option may have better reflected the patients' actual feelings towards the care received (Du Mont et al., 2014; Du Mont et al., 2017). The published statistic could reflect response bias, where the participants felt pressure to respond in a way perceived as favorable to the researchers. A 'neutral' option may have allowed the respondents to reflect their true feelings, while also alleviating some of the pressure of the response bias.

Sampsel et al. (2009) gathered data about patient demographics, assault characteristics, forensic examination results, and treatment protocols in two Ontario EDs before and after a SANE program implementation. The authors noted that after SANE program administration, the time from presentation to the emergency department and examination decreased, sexually transmitted infection (STI) prophylaxis prescription increased, physicians performed more pelvic examinations, and the overall number of patients presenting to the ED after SA increased (Sampsel et al., 2009). Similarly, in an examination of 466 post-SA cases in a Toronto area ED, Stermac & Stirpe (2009), noted no difference in demographics between patients directed to a SANE (n=210) and patients directed to a physician (n=256). Stermac & Stirpe (2009) noted that

physicians were more likely to see post-SA patients who had experienced trauma or physical coercion, but that service interruptions were more likely during physician exams (25.1% of physician exams versus 20% of SANE exams). Furthermore, SANE-led examinations were shorter in duration, and the time to a SANE exam was shorter than the time to a physician exam (3.25 hours versus 4 hours). As is evident, both studies demonstrated an improvement in ED flow, where post-SA patients were examined quicker, the examinations were shorter, and fewer interruptions occurred when examined by a SANE.

Sampsel et al. (2009) studied participants relevant to the current population, but some potential cases may have been missed; ICD-9 codes were studied for inclusion, and individual variation in coding SA examinations may have led to missed cases. Furthermore, Sampsel et al. (2009) did not control for confounders, which could affect the interpretation of the success of the SANE program. In their study, Stermac and Stirpe (2009) did not describe the study methodology, nor the data collection, which raises doubt in the study results. If the study cannot be duplicated, the methodology was weak, or the data collection was inappropriate, the results of the study cannot be utilized with confidence (PHAC, 2014). Thus, while preliminary research illustrates that SANE programs are effective at improving ED patient flow, based on the aforementioned studies, further research is necessary to determine the veracity of these findings.

In a literature review examining the effectiveness of SANEs on several variables, Nathanson et al. (2016) employed rapid evidence methodology and searched major online peer-reviewed databases and grey literature. The authors discovered one study noting the cost-effectiveness of SANE examinations when compared to forensic physician examinations, but also note that the data for the study were incomplete (Nathanson et al., 2016). The literature review conducted by Nathanson et al. (2016) was comprehensive, but failed to search for peer-

reviewed articles or grey literature in languages other than English. Furthermore, the overall focus of the study was Australian, where forensic physicians perform examinations, and to inform pediatric SANE policy. Although the literature review did not exclude adult SANE programs, the overall relatability of the evidence to the current population is moderate because the current population of interest are adults, and general physicians (not specialists) perform examinations (Nathanson et al., 2016; PHAC, 2014). Nevertheless, the authors drew the appropriate conclusions based on the evidence, which indicates that while SANE programs may be more cost-effective than forensic physician examinations, more study is required to make a definitive conclusion, especially in relation to general practitioner versus SANE examinations.

Evidence garnered from the research indicates that SANE programs are considered successful in relation to the highlighted clinical outcomes: patient satisfaction with SANE-led care, and effect of SANE-led care on emergency department flow. Nevertheless, there was a difference in satisfaction with SANE-led care between the Indigenous population and the general population (Du Mont et al., 2017). This difference may be due to lack of Indigenous-informed care during post-SA examinations, emphasizing the importance of an Indigenous guiding framework when assessing the current research, and implementing the proposed program in the IRH ED.

Program Design and Evaluation

Descriptions of SANE program design were varied across the literature, including health care-based programs and forensic-based programs, programs that were led exclusively by SANEs, and programs where SANEs were members of a sexual assault response team (SART). For the purposes of this literature review, health care-focused programs were examined where SANEs were either independent practitioners, or members of a greater SART.

Logan et al. (2006) presented a case study on one SANE program in a midsized city in the United States (US). The authors conducted an in-depth interview with the program manager (a SANE), and also evaluated the characteristics of patients treated in the program (n= 444 patients). The SANE program presented in the current study was a joint effort between the police, state attorneys, a rape crisis centre, the state university, and county government. The program was administered out of the police station, but the examination centre was located in a level one trauma facility; SANEs were contracted on a one-year basis to provide 24-hour coverage, every day of the year. In this program, SANEs were members of a greater SART and focused on evidence collection and documentation, STI prophylaxis, and counselling for the post-SA patient (Logan et al., 2006). On evaluation of the program, the authors noted that SANE program education was pertinent for high school and college students, as well as poor and marginalized citizens, as these demographic groups constituted the majority patient population. Furthermore, program evaluation noted the importance of collecting patient demographics to direct program resources based on client trends, and also noted a high number of patients who had been re-victimized (Logan et al., 2006). The authors recommended increased counselling services beyond that provided for the presenting event, a discovery that was made as a result of tracking patient demographics.

In a literature review examining health care-related interventions for women after SA, Martin et al. (2007) described several SANE programs. The literature review discussed 30 publications with a majority US focus. The authors categorized the publications into five groups: SA training for clinicians, surveys of clinicians caring for SA victims, studies comparing two modes of service delivery (SANE examiners versus physician examiners), studies focused on post-exposure prophylaxis, and follow-up reviews of patients treated and services provided in

SANE programs (Martin et al., 2007). During the literature review, the authors discovered that SANE programs with a health care focus attracted more patients, and that patients preferred a combination of medical examination and counselling post-SA (Martin et al., 2007).

The publications by Logan et al. (2006) and Martin et al. (2007) both noted patient preference for health care-focused SANE programs. The study by Logan et al. (2006) employed strong data collection methods; researchers conducted the interviews with previously validated data collection forms. Similarly, the literature review by Martin et al. (2007) addressed a clear research question, and made appropriate interpretations of their results. Unfortunately, both publications had a strong US focus, where the legal system tends to have a strong influence. Furthermore, the study by Logan et al. (2006) did not conduct a follow-up review of their results to determine whether perspectives changed after post-SA victims had time to clarify their thoughts. Furthermore, Martin et al. (2007) did not include their literature review methodology; the literature review findings could be incomplete if the methodology was not rigorous. If the review is incomplete, the findings could be inaccurate, which affects the overall conclusions drawn by the authors (PHAC, 2014).

With respect to SANE program evaluation, three overall evaluation indicators were identified: patient satisfaction (as noted in the aforementioned study by Du Mont et al., 2014), patient psychological well-being, and patient understanding of the medico-forensic process. Campbell et al. (2008) described the creation and implementation of a survey to evaluate one US-based SANE program and patient psychological well-being. The authors followed the participatory evaluation model, which emphasizes collaboration between researchers and program members. The evaluation survey was developed according to a six-step evaluation and planning process, and assessed program activities, nurse consistency, and short-term patient

psychological outcomes, identified as “empowerment”. The survey results indicated that, overall, patients felt empowered by their experiences: the patients noted that the nurses listened, exhibited care and compassion, gave clear instructions for medications, and the patients felt informed, and that they could re-connect with the program ad lib (Campbell et al., 2008). By assessing patient psychological well-being, and the subsequent results, the SANE program was deemed effective. The authors exhibited good study methodology; response bias was mitigated by having program “advocates” administer the survey on behalf of the SANEs. The advocates were trained in survey administration, and although the survey was not tested for validity or reliability, initial testing demonstrated good internal consistency (Campbell et al., 2008).

In a qualitative study by Du Mont et al. (2009), 19 women were interviewed about their understanding of the medico-forensic examination process in SANE programs across Ontario. The interview consisted of closed- and open-ended questions relating to the time of presentation to the SA program, reasons for presenting to the program, the health care received at the program, the staff-victim relations, reasons for undergoing a medico-forensic examination, prior knowledge of the collection process, and feelings about having undergone a medico-forensic examination (Du Mont et al., 2009). The overall finding of importance from the interviews was that the women felt that the health care dimension of the examination was more important than the forensic examination and collection process. Du Mont et al. (2009) noted that 26.3% of the women (n=5) believed that the medico-forensic exam was necessary to ensure that their health was not jeopardized; a further 31.5% of the women (n=6) believed that they had no choice but to undergo the medico-forensic examination. The authors noted that further education regarding the right to refuse the forensic exam, but still obtain a medical exam, was necessary. In this particular study, patient information and education was an important evaluation indicator. The

overall study did not employ a theoretical framework, which weakens the study methodology, but employed a diverse sample of women across various rural and urban Ontario centres. This leads to moderate generalizability of the study to the current population.

In a study examining program evaluation, Du Mont et al. (2018) developed a training program educating general ED staff nurses about SA patient presentation, and subsequently evaluated this program delivery. While not specifically examining SANE program evaluation, the study by Du Mont et al. (2018) employs a good evaluation framework that can be translated to SANE program evaluation. The program in the study was developed by the lead authors and delivered to ED staff across Ontario (n = 1564), both as an in-person in-service, and as an online module. When evaluating the program, the authors employed a five-point Likert scale to measure ED staff opinions on 16 statements. Overall, the ED staff valued the continuing education on SA presentations, and believed their competence increased after completing the training. Although a response bias is present, the staff completed the evaluations anonymously, which could indicate an increased reliability of the results. The authors did not test the specific data collection tool, but Likert-scale ratings are a well-accepted methodology employed in many studies; this suggests that evaluation may be conducted using the same methodology (Du Mont et al., 2018; PHAC, 2014).

From review of various SANE program designs, it is evident that the participants value health care-focused program design. This preference points to the value of specially trained medical professionals conducting post-SA care, which in turn, points to the value of SANE-led programs in locations where post-SA victims will present (such as an ED). Unfortunately, none of the articles specifically examine Indigenous patients, nor do the articles employ an Indigenous framework for examination of SANE program design. By employing *etuaptmumk* in this case, it

is evident that Western research frameworks are emphasized. It is therefore paramount to ascertain the value of these programs from an Indigenous perspective, work to design any program servicing largely Indigenous populations from an Indigenous perspective, and to evaluate the program from an Indigenous perspective. These activities must be achieved by consulting local Indigenous leaders.

Implementing Program and Practice Change

In an effort to successfully implement practice change for the ED RNs at IRH, the proposal will utilize Rogers' Diffusion of Innovation (DoI) theory as a guiding framework for change. This literature review focuses on studies directly employing DoI to facilitate change or studies employing DoI as a guiding framework.

In a study by Bowen et al. (2012), the authors directly employed Rogers' DoI to facilitate implementation of a delirium screening tool in a US intensive care unit. The authors employed the five stages of Rogers' DoI (knowledge, persuasion, decision, implementation, and confirmation) when planning the implementation of the screening tool. During the knowledge phase, the authors planned in-services for the nurses, held meetings with the physicians and residents, and created poster boards about the tool, which were displayed on the unit. During the persuasion phase, the authors identified screening tool "champions" to facilitate implementation of the tool. During the decision phase, the authors updated the poster boards with relevant information. During the implementation phase, the authors placed the new screening tool directly into the patient's chart to facilitate ease of implementation. Finally, during the confirmation phase, the authors posted the results of the study, and encouraged the continued support of the champions. The authors found that, during the study, 85% of the assessments were completed on eligible patients (159 assessments completed out of 187 potential assessments) (Bowen et al.,

2012). Feedback from the nurses indicated that the support of the champions and nursing staff was inherent to the program's success, and that ease of access to the new tool (by placing it with the patient's charting) facilitated ease of implementation. Disclosing the weekly results of the study increased the nurses' adherence to the practice change, and the authors noted successful practice change at weeks 2 and 18 following the study (85% and 88% adherence to practice change, respectively) (Bowen et al., 2012). While the study had a limited sample of only one hospital, the study methodology was sound and generalizable to the current proposed practice change. Thus, this study will be beneficial when planning the proposed practice change for the IRH ED RNs.

In a study employing Rogers' DoI as a guiding framework, Watson-Wolfe et al. (2014) examined a practice change to decrease the use of antipsychotic drugs in patients with dementia in one US facility. The authors first completed a baseline assessment of antipsychotic use in the population, then implemented an education in-service for staff about antipsychotic use. The authors found that the pre-test prescribing rate of antipsychotics was 20.3% (n= 12 of 59 residents), while RN documentation for reasons for use was 16.7% (n= 2 of 12 residents). After the in-service, the prescribing rate of antipsychotics was 15.4% (n=8 of 53 residents), while the RN documentation rate was 75% (n= 6) (Watson-Wolfe et al., 2014). The study was generally sound, but there was no explanation of the attrition rate between pre- and post-testing, nor was there adequate control of confounders (i.e. age of resident, degree of psychosis, etc.).

In a cross-sectional study employing Rogers DoI as a guiding framework, Guilbert et al. (2014) examined factors associated with practice change, delays in practice change, and strength of adoption of change in an initiative for RNs to prescribe contraception in Quebec. The authors surveyed 745 RNs and discovered that, after training, 57.3% of the RNs had implemented the

new practice of prescribing contraceptives. Of the 57.3%, 85% had implemented the change within two years of taking the advanced training, and an average of 5.6 women were started on contraceptives every month (Guilbert et al., 2014). The authors examined this practice change according to Rogers' DoI and found that shorter delays in practice implementation occurred when the RNs perceived the organization they worked for as favorable, the RNs practiced re-invention (continuing re-invention of practice), and the RNs worked for a small organization. The RNs were also more likely to implement the practice change more often when the practice was perceived as simple, and good mentorship and support were available from the organization (Guilbert et al., 2014). The authors note that Rogers DoI explains *strength* of practice change well, but does not explain the implementation of a new practice as well; however, the results of the study demonstrated that simpler practice changes were implemented more readily. The study by Guilbert et al. (2014) was well designed, with moderate sample selection, and previously validated data collection tools. Yet, the sample size was relatively small (n= 745 of 2805 eligible nurses), and self-reporting may have affected the reliability of the results.

Finally, in a literature review of implementing mobile devices into nursing education programs by Doyle et al. (2014), the authors reviewed 52 articles pertaining to implementing and evaluating practice change. Using Rogers' DoI as a guiding framework, the authors noted that applying the aforementioned phases of the DoI (knowledge, persuasion, decision, implementation, and confirmation) led to increased acceptance of change by stakeholders (Doyle et al., 2014). The literature review reviewed all major electronic databases for peer-reviewed literature, but failed to search the grey literature or non-English publications.

From the aforementioned literature, it is evident that Rogers' DoI framework is a reasonable tool for implementing practice change, and would prove beneficial for implementing

the proposed practice change. By implementing the five phases of the framework, the proposed change could be implemented with the participation of the staff nurses in the IRH ED; through their participation, the practice changes will be less foreign, and their buy-in will ensure success of the change. Fundamentally, however, the proposed changes to care must be thoroughly vetted by Indigenous leaders, in keeping with the previously described Indigenous frameworks. Practice change is specific to the healthcare team, and the patient is a member of the healthcare team. Indigenous patients require Indigenous-centred care; it is therefore imperative that Indigenous leaders are consulted prior to implementing practice change affecting Indigenous patients.

Discussion

In the preceding literature review, the overall consensus of the literature on effectiveness of SANEs and SANE-led programs was positive. Du Mont et al. (2014), Du Mont et al. (2017), Sampsel et al. (2009), and Stermac and Stirpe (2009) note that SANE programs lead to increased patient satisfaction and have a positive effect on ED patient flow, which also affects the overall patient experience. To a lesser extent, the literature, via Nathanson et al. (2016), notes that SANEs may be more cost-effective for hospital budgets than physicians when completing exams, but much more research is required in this area. Program designs focusing on health-based interventions are extensive throughout the literature, and evaluation indicators include patient satisfaction, patient psychological well-being, and patient knowledge of the process (Logan et al., 2006; Du Mont et al., 2009; Martin et al., 2007; Campbell et al., 2008). Finally, program changes guided by Rogers' DoI theory are effective (Bowen et al., 2012; Watson-Wolfe et al., 2014; Guilbert et al., 2012; Doyle et al., 2014). When implementing Rogers' DoI, it is important to focus on the stages of implementation, and to a lesser extent, the type of adopter the program is targeting.

Strengths of the evidence included in this review include a general effort to validate data collection tools and standardize data collection methods. The Canadian studies have satisfactory generalizability to the current population in terms of health care systems and societal foci (i.e. health care over justice system), but the greater Canadian population is not generalizable to the largely Indigenous population of the Beaufort Delta and northern Sahtu regions of the NT. Throughout the literature, inconsistent sampling techniques are employed, which further affects sample generalizability to the current population. Furthermore, few empirical studies have been completed, and thus, this literature review largely examines case studies and studies employing descriptive methodology.

Conclusion

The literature relating to SANEs, and programs utilizing SANEs, are diverse. Nevertheless, SANE programs are generally considered effective alternatives to physician-led models, and the literature demonstrates that Rogers' DoI theory is an effective guiding framework for implementing practice change. A SANE program in the IRH ED is a multi-factorial project with exciting implications for practice changes for ED RNs, and for better patient care in a population where SA is prevalent. The proposed project is generally supported by the literature, with evidence of program success nationally and internationally. With a theoretical framework that honors Indigenous ways of knowing, it is anticipated that the proposed SANE program will be culturally relevant, and offer culturally safe care to the largely indigenous population of the Beaufort Delta and northern Sahtu regions of the NT.

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Appendix A

Integrative Review Literature Summary Tables

Literature Review Tables

TOPIC 1A—EFFECTIVENESS OF SANES: CLINICAL INDICATORS

Name, Author, Date, Study Objective	Sample/Groups (Size, Setting, Characteristics)	Design and Methodology	Key Findings/Limitations	Strengths/Limitations	Conclusion and Rating
Du Mont et al. (2014). Client satisfaction with nursing-led sexual assault and domestic violence services in Ontario. Objective: to evaluate whether facilities offering sexual assault and domestic violence acute care services are meeting clients' needs in Ontario. Secondary objective to describe the clients accessing these	- 30 of 35 total Sexual Assault/Domestic Violence Treatment Centres (SADVTCs) across province of Ontario; led by SANEs. Some led by nurse-physician combinations. - n= 1484 participants (1425 female, 54 male, 5 transgender). Completed intake form only. - n=920 participants completed intake and satisfaction survey.	-Descriptive analysis study. -Committee formed to oversee study methodology and implementation; consisted of experts from 6 SADVT centres. -Two forms developed and implemented: Client Intake Form & Client/Guardian Satisfaction Survey. Developed based on patient rights/standards of care, but also from previous intake forms. - Implemented in a staggered fashion across the	-Descriptive statistics displayed in table form—good visual summation of findings for the large amount of data. -Most clients were women/girls (96%). - Most clients were under 45 years (92.1%). -Most clients identified as white (75.3%). -Most assailants were male (91.2%); most assaults were committed by one perpetrator (80.1%). -35.8% of clients required care in ED. 46.2% of clients were injured. -**18.1% of clients self-reported a disability (this may not be a true number, as disability was SELF-reported; could be an over- or under representation). -Only 58.4% of clients	STREGTHS: -Ethical approval from all centres where study implemented (30/35 centres in Ontario). -Authors identified affiliations, also no competing interests. -Questionnaires used in the study were developed based on client rights/standards as per the SADVTC statement of patient rights and standards of care (examples given in study methodology section). Likert scale identified as basis for satisfaction survey. - Self-admin client satisfaction survey eliminates potential for investigator bias. - Long answer questions examined for thematic components	-Strong research focus, sampling methodology. -Moderate data collection, collection strategies. -Weak statistical testing. RATING: WEAK

centres as literature describing this demographic is lacking.		province. Data collection from April 2009 to June 2011. Ongoing data entry into secure database. -Descriptive analysis from intake forms. - Long answer questions examined for thematic components (qualitative methodology).	completed an SA kit. -Most clients presented for assessment/documentation of injury (84.8%). -62.9% received crisis counseling. - 98.8% rated care as good or excellent; ~95% of clients felt believed, supported, and were treated with respect. - 98.6% felt that the care they needed was received (good measurement of needs being met). - Most dissatisfaction stemmed from long wait times, waiting with other emergency clients in waiting rooms and a lack of sensitivity in emergency staff. -Marginalized population (sex workers/homeless), First Nations, men, older adults, persons with disabilities likely underrepresented in this study because less likely to seek services. -Many clients sought care after 24hrs; recommended	(acceptable qualitative methodology). LIMITATIONS: -Retroactive data completion where applicable (sites contacted after the data collected if data incomplete). Potential for errors in data collection. - Reader referred to another article for descriptive analysis method. -Statistical analysis not included. -Marginalized population (sex workers/homeless), First Nations, men, older adults, persons with disabilities likely underrepresented in this study because less likely to seek services. -No identification about reliability/validity of data collection tools.	

			that SADVTCs create and disseminate literature that advises public about importance for timely assessment (forensic collections, etc). - Mitigating negative effects included having SANEs on staff 24/7, sensitivity training for ED staff, and private waiting rooms for SA/DV clients (as per client feedback). -Identified limitations include study being conducted in ON (may not be generalizable to rest of Canada), the population who engaged in SADVTC services may not hold same opinions as those who did not, no follow-up with clients after leaving site (no ability to assess long-term benefits).		

References:

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/JFN0000000000000035

Public Health Agency of Canada (2014). Infection control and prevention guidelines: Critical appraisal toolkit. Retrieved from: http://publications.gc.ca/collections/collection_2014/aspc-phac/HP40-119-2014-eng.pdf

Name, Author, Date, Study Objective	Sample/Groups (Size, Setting, Characteristics)	Design and Methodology	Key Findings/Limitations	Strengths/Limitations	Conclusion and Rating
Du Mont et al. (2017). A comparison of Indigenous and non-Indigenous survivors of sexual assault and their receipt of and satisfaction with specialized health care services. Objective: to examine the experiences of Indigenous women at Ontario SANE facilities, as compared to non-Aboriginal women, using earlier data collected in the 2014 study.	-n= 116 (adult Indigenous females, aged 12+). - 948 total women in the survey (>12% of the sample). -Disproportionate rate of sexual assault in Indigenous women (>12% of survey versus 4% of general population).	-Data collection tools designed by research team, piloted at two different sites, then modified as needed. -Data collected between April 2009 and June 2011. -Anonymity ensured. -Data collected in a private area or at home. -Data entered on an ongoing basis as it was received. -Analysis led by Indigenous research team member. -Fisher's Exact or Pearson's Chi-square test to analyze associations between	-Indigenous women were more likely to present to the centre with police, within 24 hours of the assault, and to a rural centre (level of significance stated for each). -Indigenous women were more likely to be between 12-18 years at the time of assault than non-Indigenous women. -Indigenous women were more likely to have been assaulted by a parent/guardian or relative than non-Indigenous women. -Indigenous women were less likely to have been made to drink or do drugs prior to the assault than non-Indigenous women. -Indigenous women were more likely to receive safety	STRENGTHS: -Good explanation of study design and methodology (better than in the previous study from 2014). -Stated p-value for level of significance. -Identification of police presence as one reason why Indigenous women present within 24hours of a sexual assault. -Appropriate use of statistical analysis for comparing two groups. -Identification of ways to improve services for Indigenous women (SANE outreach to Indigenous communities). -Appropriate identification of study limitations. LIMITATIONS: -Self-identification of ethnicity (some	-Strong identification of study methodology/design. -Strong identification of limitations of study. -Moderate use of statistical analysis (level of significance stated, but other measures of dispersion missing). -Strong control of information bias. -Moderate insurance of relevance to population in question (only one Indigenous team member completing analysis, surveys not designed with culturally appropriate information in mind). RATING:

		Indigenous and non-Indigenous data.	planning/risk assessment, and to be referred to community services for support than non-Indigenous women. -Indigenous women were less likely to rate the care they received as good or excellent than non-Indigenous women (95.7% versus 99.1%).	participants may have been missed because they did not self-declare based on fear of discrimination). -All data are from hospital settings when hospitals may not be present in some of the more rural/remote communities. - Satisfaction scores are dependent on people who chose to complete the surveys. -Likert scale dichotomy (no neutral option). -The surveys employed may not have captured the entire experience of Indigenous women as they were not designed to specifically examine the Indigenous female perspective.	MEDIUM

References:

Du Mont, J., Kosa, D., Macdonald, S., Benoit, A., & Forte, T. (2017). A comparison of Indigenous and non-Indigenous survivors of sexual assault and their receipt of and satisfaction with specialized health care services. *PLoS ONE 12*(11), 1-15. doi: 10.13071/journal.pone.0188253

Public Health Agency of Canada (2014). Infection control and prevention guidelines: Critical appraisal toolkit. Retrieved from: http://publications.gc.ca/collections/collection_2014/aspc-phac/HP40-119-2014-eng.pdf

Name, Author, Date, Study Objective	Sample/Groups (Size, Setting, Characteristics)	Design and Methodology	Key Findings/Limitations	Strengths/Limitations	Conclusion and Rating
Sampsel et al. (2009). The impact of a sexual assault/domestic violence program on ED care. Objective: To evaluate the impact of sexual assault/domestic violence program on ED flow, patient care and completeness of forensic data collection.	Inclusion criteria: 14 years and older presenting to ED, with diagnosis of sexual assault and inclusion of chart in SADV program (intervention group only). -n=61 pre-SADVP cases. -n=92 post-SADVP cases.	-Cross-sectional study design. - Descriptive statistics gathered and reported include characteristics of patient population, nature of SA, timing/duration of clinical assessment, acute medical care/follow up received, completeness of forensic data collection.	- No significant differences with respect to age, relationship to assailant, number of assailant, weapon involvement, involvement of EtOH or other drugs, or presence of semen between two groups. -MDs performed more pelvic examinations post-SADVP introduction. -No significant difference in kit completion between two groups. -Decreased time between presentation to ED and time to nurse. -Length of stay did not change between groups. -STI prophylaxis improved with SADVP implementation.	STRENGTHS: -Independent verification of data abstraction by two researchers, but researchers not blinded to study hypothesis. -Ethical approval from Queen's University. -Statistical analysis appropriate for level of data. -Validated tool employed for injury reporting. -Level of significance stated. LIMITATIONS: -Pre-SADVP charts identified by ICD-9 codes; some sexual assault cases may have been missed as they may not have been coded appropriately. -Nature of study is that of a chart review, not	-Moderate sample selection as participants representative of population, but nature of study may have affected whether all of the participants were included. -Strong control of selection bias, strong control of misclassification bias. -Only one validated tool identified (were others employed?). -Strong control of comparison/intervention groups. -Weak control of confounders (not explored in study). -Strong control of ethical conduct. -Strong generalizability of results to population of interest. RATING: MEDIUM

			-Number of patients accessing SADVP increased, but self-reported anal/vaginal penetration decreased—speculative that the media campaigns to increase awareness about any unwanted sexual advances as sexual assault were successful (SA is not limited to rape).	patient interview or self-report.	

References:

Sampsel, K., Szobota, L., Joyce, D., Graham, K., & Pickett, W. (2009). The impact of a sexual assault/domestic violence program on ED care. *Journal of Emergency Nursing, 35*(4), 282-289.

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Name, Author, Date, Study Objective	**Sample/Groups (Size, Setting, Characteristics)**	**Design and Methodology**	**Key Findings/Limitations**	**Strengths/Limitations**	**Conclusion and Rating**
Stermac & Stirpe (2009). Efficacy of a 2-year-old sexual assault nurse examiner program in a	- n= 466 women at a Toronto sexual assault care centre between Jan. 1996 and Nov. 1997. - n= 256 MD examinations; n= 210 SANE	- Cross-sectional study design. - Comparisons between groups: ANOVA & Chi-squared statistical analysis.	- Demographics: age range = 14-82 years. Mean age = 26.6 years. Unemployment = slightly more than 50%. No statistically significant difference in age, marital status,	STRENGTHS: - Moderate use of statistics with correct interpretation. - Good control of confounding variables. LIMITATIONS:	- No description of study methodology, data collection = weak study design. RATING = WEAK

Canadian hospital. Objective: To describe a SANE program at a Canadian hospital, and compare the SANE program model to a physician examiner model.	examinations. - Inclusion criteria: not identified. - Variables identified to define any characteristics between 2 clinician groups: demographic information, client presentation (injuries, drugging of victims, EtOH/drug ingestion by victims), assault characteristics (type of SA, degree of physical violence, weapon use or coercion, police involvement) treatment characteristics (SA kit completion, physical exam, length of service delivery [incl. interruptions]).		or employment status of women examined by 2 clinician groups. - Presentation: no significant differences between groups re: EtOH use/drugs, police involvement. Physician group more likely to see cases with physical trauma, higher number of injuries. - Assault: no statistical difference between assault presentation (vaginal/anal assault) between clinical groups; MDs more likely to see victims of physical coercion than SANEs. - Treatment: SA kit completion did not differ between 2 clinician groups, SANEs more likely to do “partial kits”, completion of physical exams did not differ between 2 clinician groups,	- No description of sample procurement, data collection. - Any data collection instruments not included for reader perusal. - No evidence of ethics review. - Study not necessarily representative of population of interest (urban vs. rural/remote)	

			service interruptions more likely with MD exams (25.1% vs. 20.0% of SANE exams). Time to exam significantly higher for MDs (4 hours) than for SANEs (3.25 hours). - SANE examination was shorter, after a shorter wait time.		

References:

Stermac, L. E., & Stirpe, T. S. (2009). Efficacy of a 2-year-old sexual assault nurse examiner program in a Canadian hospital. *Journal of Emergency Nursing, 28*(1), 18-23. doi: 10.1067/men.2002.119975

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TOPIC 1B—EFFECTIVENESS OF SANES: COST-SAVINGS/FINANCIAL BENEFIT

Name, Author, Date, Study Objective	Sample/Groups (Size, Setting, Characteristics)	Design and Methodology	Key Findings/Limitations	Strengths/Limitations	Conclusion and Rating
Houmes et al. (2003). Establishing a sexual assault nurse examiner (SANE) program in the emergency department. Objective: To review the requirements, objectives, and resources required when establishing a SANE program in a hospital emergency department.	N/A	- Review.	- SANE programs save approximately 20 min of physician time and 4h of ED RN time.	STRENGTHS: - Evidence-based review. LIMITATIONS: - US-based review (discusses costs directed at patients/victims).	

References:

Houmes, B. V., Fagan, M. M., & Quintana, N. M. (2003). Establishing a sexual assault nurse examiner (SANE) program in the emergency department. *The Journal of Emergency Medicine, 25*(1), 111-121. doi: 10.1016/S0736-4679(03)00159-8

Public Health Agency of Canada (2014). Infection control and prevention guidelines: Critical appraisal toolkit. Retrieved from: http://publications.gc.ca/collections/collection_2014/aspc-phac/HP40-119-2014-eng.pdf

Name, Author, Date, Study Objective	Sample/Groups (Size, Setting, Characteristics)	Design and Methodology	Key Findings/Limitations	Strengths/Limitations	Conclusion and Rating
Nathanson et al. (2016). Is there a role for paediatric Sexual Assault Nurse Examiners in the management of child sexual assault in Australia? Objective: To review the literature re: what is known about SANEs, their effectiveness (accessibility, health and legal outcomes, cost effectiveness), and to inform a policy on models of care and best practice which may be implemented in Australia.	- n= 6 studies. - Inclusion criteria: studies in previous 10 years, peer-reviewed, English language studies.	- Rapid evidence assessment methodology. - Databases: Cochrane library, PubMed, Ovid MEDLINE, EMBASE, Psycinfo, Nursing@Ovid, Campbell Collaboration, Google Scholar, DARE, PROSPERO. - Review of grey literature noted.	- 1 study noting cost-effectiveness of SANEs vs. forensic physicians, but single study/ data incomplete.	STRENGTHS: - Independent review of relevant articles completed by two authors. - Discussion of how disagreements managed. LIMITATIONS: - Sample: child sexual assault (loosely applicable to adult sexual assault). - Australian based study.	- Comprehensive literature review conducted (databases, grey literature), but no additional languages included in search. - Appropriate conclusions drawn based on evidence. - Moderate level of applicability (goal was to assess effectiveness of child SANEs, but studies examined incl. mixed pediatric/adult SANEs). RATING: MEDIUM

References:

Nathanson, D., Woolfenden, S., & Zwi, K. (2016). Is there a role for paediatric sexual assault nurse examiners in the management of child sexual assault in Australia? *Child Abuse & Neglect, 59*, 13-25. Doi: 10.1016/j.chiabu.2016.07.004

Public Health Agency of Canada (2014). Infection control and prevention guidelines: Critical appraisal toolkit. Retrieved from: http://publications.gc.ca/collections/collection_2014/aspc-phac/HP40-119-2014-eng.pdf

TOPIC 2—PROGRAM DESIGN AND EVALUATION

Name, Author, Date, Study Objective	Sample/Groups (Size, Setting, Characteristics)	Design and Methodology	Key Findings/Limitations	Strengths/Limitations	Conclusion and Rating
Logan et al. (2006). Program and sexual assault survivor characteristics for one SANE program. Objective: To examine a SANE program's development and operation; to describe the demographic, incident, and exam characteristics of victims in the program over a 5 year period.	- One SANE program in midsized US city. - n= 444 participants within the program.	- Case study. - Instrument developed and tested for review of program: closed and open-ended questions about client eligibility, staffing, program coverage, participation in a SART, documentation techniques, and resources offered. - Interview with program manager conducted by first and second authors. - Description of demographic, incident, and exam characteristics taken from specific intake form developed	- SANE program developed jointly between police, attorneys, rape crisis centre, state university, and county government. - Funded by the state and county. - Program administered out of local police division to decrease competition between area hospitals, and because police are responsible for collecting forensic information for all crimes. - SANE centre located at a Level 1 trauma facility and attached to the emergency department, but is locked and secure. - Program contracts with SANEs for	STRENGTHS: - Stated ethics approval by University. LIMITATIONS: - Reliability of data from forensic examinations occurring directly after assault. - Follow-up with victims not conducted. -	- Study participants representative of target population, especially in terms of substance consumption. - Strong data collection, but unclear details surrounding efforts to reduce information bias. RATING: MEDIUM

		for the program. -	period of 1 year to provide 24/7 coverage. - Covers one county, with approximate population of 266 000, as well as surrounding counties. - Operates as a SART—SANE, police and rape crisis volunteers respond to the hospital. - Client can decline any part of forensic or medical component. - Program focuses on evidence collection and documentation, as well as STI/pregnancy prophylaxis and counselling. - Demographic information highlights the importance of SANE program education for high school/college students, as well as minority, poor, and marginalized women. - Women are more		

			likely to report assaults by strangers or acquaintances; less likely to report intimate partner assaults. - Setting of assault usually survivor or assailant's home. - Assessing assault characteristics assists in providing education to the community about risks for assault. - Substance use higher in SANE program victims and in national household probability sample. - Recommended that SANE programs collect data about client characteristics to document client needs/trends. - High rates of revictimization among program participants suggests need to discuss more than presenting incident.		

References:

Logan, T. K., Cole, J., & Capillo, A. (2006). Program and sexual assault survivor characteristics for one SANE program. *Journal of Forensic Nursing, 2*(2), 66-74.

Public Health Agency of Canada (2014). Infection control and prevention guidelines: Critical appraisal toolkit. Retrieved from: http://publications.gc.ca/collections/collection_2014/aspc-phac/HP40-119-2014-eng.pdf

Name, Author, Date, Study Objective	Sample/Groups (Size, Setting, Characteristics)	Design and Methodology	Key Findings/Limitations	Strengths/Limitations	Conclusion and Rating
Du Mont et al. (2009). Investigating the medical forensic examination from the perspectives of sexually assaulted women. Objective: To further understand the medico-forensic exam from the perspectives of those who have been through the process.	- n= 19 women from across Ontario in different catchment areas (culturally diverse, populations range from 100 000 to 1 million). - Presented to SADVTC (sexual assault and domestic violence treatment centre).	- Qualitative. - In-depth interviews by trained interviewers. - Semi-structured, face-to-face interviews. - Closed and open-ended questions. - Interview topics = time of presentation to assault centre, reasons for going to centre, health care received, staff-victim relations, reasons for undergoing medico-forensic examination (MFE), prior knowledge of collection practices, and feelings about having undergone an MFE. - Audio-taped and transcribed verbatim. - 2 authors devised higher-order constructs: Expectations and	- Demographic information included. - Reasons to undergo MFE = systematize collection of evidence to aid in prosecuting SA cases (evidence of the assault, force assailant to take responsibility for what he did, help identify the assailant, prove the assailant's guilt, prevent the assailant from re-offending, increase feelings of safety). - Reasons: prosecution, seeking proof for family/friends. - Women identified the health care dimension as significant (fewer than half went to the centre with the intent of undergoing an MFE). Health care was more important	STRENGTHS: - Identified limitations to obtaining sample (unconnected phone numbers, women who did not wish to revisit the assault, inability to directly contact women). - Ethics approval mentioned. - Interviewers trained and provided with detailed instructions. LIMITATIONS: - Generalizability of findings. - Small sample. - No theoretical framework identified. - No reflection on researcher bias.	- No evidence of theoretical framework. - Small sample, but moderate sample selection (diversity of sample evident). - Strong explanation of study design. - Moderate generalizability (Canadian study, but focused on largely urban area). RATING: MEDIUM.

		Experiences. - 2 authors devised lower-order constructs. - Differences of opinion were resolved through discussion/consensus. - Responses identified in each construct referenced back to transcripts for context and secondary extraction of relevant quotes.	than collection of evidence (n=10). - Women felt they had positive interactions with nurse examiners (n= 17). - n= 5 women underwent the MFE to ensure health was not jeopardized (not understanding that MFE not necessary for medical exam). -n=6 women felt that they had no choice but to undergo an MFE. - n=12 women felt the MFE was physically and emotionally difficult. - But n=14 women found the experience empowering.		

References:

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. doi: 10.1016/j.socscimed.2008.11.010

Public Health Agency of Canada (2014). Infection control and prevention guidelines: Critical appraisal toolkit. Retrieved from: http://publications.gc.ca/collections/collection_2014/aspc-phac/HP40-119-2014-eng.pdf

Name, Author, Date, Study Objective	Sample/Groups (Size, Setting, Characteristics)	Design and Methodology	Key Findings/Limitations	Strengths/Limitations	Conclusion and Rating
Martin et al. (2007). Health care-based interventions for women who have experienced sexual violence: A review of the literature. Objective: To examine the evidence r/t health care-related interventions for women who experienced sexual violence.	- Initial search = 2107 abstracts, narrowed to 122. - n= 30 articles with majority focus in US. - Inclusion criteria: English/Spanish language, published between January1990 and June 2005, empirical, focused on health care services for women who had experienced sexual violence. - Re: women—could be a combination of adult and adolescent women, women and men, or clinicians serving women. - Re: health care services—hospital or clinic setting or training of	- Literature review. - Search of computerized databases (not specified). - Contacted experts for article suggestions. - Data abstraction form developed to review publications (location of study, eligibility criteria, study design/sample, intervention, measures/indicators employed in study, study results). - Studies classified into one of five groups based on focus of study and/or study design. - Categories: studies focused on SA training for clinicians (2), studies surveying	- Sexual assault training programs for clinicians were found to be warranted and helpful for the clinicians. - Not all ED have written protocols for care (true in the case of IRH), many Ed staff do not have specialized training, emergency contraception not always offered. - Males were more likely than females to have negative attitudes towards SA victims. - Practitioners who have more experience caring for SA victims often offered better quality care and more likely to view rape as a serious problem. - SANE programs are helpful in assessment/care of	STRENGTHS: - Well-categorized. - Review procedure present. LIMITATIONS: - Un-tested review procedure. - Very few empirical studies with cohorts. - Few qualitative studies.	- Review addressed clear research questions. - Moderate review methodology (databases searched unclear, non-English language articles included, unclear whether grey literature consulted). - Moderate rigor for review process. - Strong interpretation of results. - Strong relatability to current population RATING: MEDIUM

	clinicians. Other care settings (psychology clinics, etc.) excluded.	clinicians who assess/care for SA victims (7), studies comparing 2 methods of service delivery to SA victims (7), studies focusing on post-exposure prophylaxis for SA victims (5), and descriptive/follow-up studies describing patients seen and/or services provided (9).	SA victims, health care-based programs attract more victims than forensic programs do, SA victims prefer combination of medical and counseling treatment, and administration of a video may assist in reducing a woman's stress prior to the exam. - Wide range of women offered PEP (28-100%); many women did not complete PEP and did not return for follow-up appointments (usually due to side effects from PEP). - Wide range in descriptive studies characterizing patients seen/services provided. Mixed findings from all studies. No results applicable for current review.		

References:

Martin, S. L., Young, S. K., Billings, D. L., & Bross, C. C. (2007). Health care-based interventions for women who have experienced sexual violence: A review of the literature. *Trauma, Violence, & Abuse, 8*(1), 3-18. doi: 10.1177/1524838006296746

Public Health Agency of Canada (2014). Infection control and prevention guidelines: Critical appraisal toolkit. Retrieved from: http://publications.gc.ca/collections/collection_2014/aspc-phac/HP40-119-2014-eng.pdf

Name, Author, Date, Study Objective	Sample/Groups (Size, Setting, Characteristics)	Design and Methodology	Key Findings/Limitations	Strengths/Limitations	Conclusion and Rating
Campbell et al. (2008). A participatory evaluation project to measure SANE nursing practice and adult sexual assault patients' psychological well-being. Objective: To describe the process of the development of an evaluation survey of SANE practice and patient psychological well-being.	- Researchers-evaluators and stakeholders within a SANE program and its parent agency (domestic violence-sexual assault agency). - Executive director from parent agency, SANE program director, all program nurses, advocate supervisor, volunteer advocates. - All SANE patients (18 years and older) treated in the program eligible for participating, unless cognitive disability precluded understanding. Final n= 52.	- Participatory evaluation model (researchers-evaluations and program stakeholders). - Program staff directly involved in planning/conducting the evaluation. - Six-step evaluation/planning process. - Steps: Define outcomes and narrow scope, define evaluation goals and objectives, design program evaluation, conduct evaluation and collect data, analyze data/present findings, use findings for improvement. - Evaluation design: SANE patients asked to complete evaluation	- Questionnaire had two sections: program activities and nurse consistency and short-term outcomes. - Nurses consistently employed eight behaviours identified as "empowering logic". - Nurses rated consistently high on listening; slightly lower for asking whether or not patients had questions. - Patients felt nurse care/compassion, felt informed, felt that there were clear instructors for medications, and felt that they could re-contact the program with problems/concerns. - Most patients felt that they did not feel	STRENGTHS: - Reduce response bias by having advocates conduct evaluations on nurses. - Ethical approval mentioned. - SANE advocates trained in questionnaire delivery. - Process guided by evaluation framework. LIMITATIONS: - Survey developed for specific program; not tested for rigor/validity.	- Moderate sample selection (every patient contacted, but only at one US site—no information about demographics or patient diversity). - Strong control of misclassification bias (control of survey administration by trained advocates). - Survey not tested for validity/reliability, although initial testing shows good internal consistency. - Weak control of confounding. - Strong control of statistical testing. - Moderate generalizability of results. - Strong degree of implementation.

		assessment during "down-time" (after medication admin or during follow-up). - All SANE advocates trained in questionnaire delivery. - Questionnaire followed four-point Likert scale for each section to rate consistency of behaviours, and then strength of outcome.	pressure to complete the forensic kit.		RATING: HIGH

References:

Campbell, R., Patterson, D., Adams, A. E., Diegel, R., & Coats, S. (2008). A participatory evaluation project to measure SANE nursing practice and adult sexual assault patients' psychological well-being. *Journal of Forensic Nursing, 4*, 19-28. doi: 10.1111/j.1939-3938.2008.00003.x

Public Health Agency of Canada (2014). Infection control and prevention guidelines: Critical appraisal toolkit. Retrieved from: http://publications.gc.ca/collections/collection_2014/aspc-phac/HP40-119-2014-eng.pdf

Name, Author, Date, Study Objective	Sample/Groups (Size, Setting, Characteristics)	Design and Methodology	Key Findings/Limitations	Strengths/Limitations	Conclusion and Rating
Du Mont et al. (2018). Development and evaluation of sexual assault training for emergency department staff in Ontario, Canada. Objective: To assess the efficacy a program designed to increase the competence of ED staff addressing victims of SA. To compare in-person and online training modalities.	- n=1564 staff from 76 EDs across Ontario. - n= 736 staff participated in person. - n= 828 staff participated online.	- Mixed-methods. - Training addressed using Kirkpatrick's model (examines changes in participants; perceived competence in caring for victims, as well as satisfaction with content/delivery). - In-person training delivered to increase competence: context of SA, response to victims of SA, role in treating SA victims. - Training devised by lead authors and curriculum developer based on principles of adult learning. - Training guided by experts in the field. - Training delivered by program managers/coordinators. Training took between 30min and 60min. - Online training took 30min to complete.	- Statistically significant improvements from pre- to post-training. - Mean gain in competence higher for in-person training over online training. - Participants rated training positively, and rated in-person trainers positively. - Participants found the interactive nature (quizzes, modules) helpful. - Participants also felt that continued education on the topic would be valuable (more information, longer running time, handouts, more real-life case studies).	STRENGTHS: - Mentions ethical conduct (exemption). - States participation on pre- and post-training questionnaires to determine adherence to testing. LIMITATIONS: - Results based on self-reporting (response bias). - Results not generalizable over time—i.e. did the participants retain and use the knowledge?	- Participant representation largely generalizable to larger population (although may not be generalizable to current ED RN population). - Moderate control of data collection (minimal missing data, assessors trained in data collection). - Moderate control of collection tool validity (collection tool not specifically tested, but Likert scales well-established collection method). - Strong control

		- Data questionnaires for assessment developed by team: pre-training and post-training. Subjects rated 16 statements on 5-point Likert scale. - Pre-training questionnaire collected demographic information. - Post-training questionnaire collected information on 10 statements related to content/delivery of training. - Quantitative testing measured using Cronbach's Alpha and Mann-Whitney U test. - Open-ended questions coded thematically.			of statistical measures. RATING: MEDIUM.

References:

Du Mont, J., Solomon, S., Kosa, S. D., & Macdonald, S. (2018). Development and evaluation of sexual assault training for emergency department staff in Ontario, Canada. *Nurse Education Today, 70*, 124-129. doi: 10.1016/j.nedt.2018.08.025

Public Health Agency of Canada (2014). Infection control and prevention guidelines: Critical appraisal toolkit. Retrieved from: http://publications.gc.ca/collections/collection_2014/aspc-phac/HP40-119-2014-eng.pdf

TOPIC 3—IMPLEMENTING A PROGRAM/PRACTICE CHANGE

Name, Author, Date, Study Objective	Sample/Groups (Size, Setting, Characteristics)	Design and Methodology	Key Findings/Limitations	Strengths/Limitations	Conclusion and Rating
Guilbert et al. (2014). Determinants of the implementation of a new practice in hormonal contraception by Quebec nurses. Objective: To determine the factors associated with implementing a practice change (nurse-prescribed contraception), delays in implementation, and "intensity" of the implementation.	- n= 745 nurses between November 2011 and March 2012 (26.6% response rate from >2805 questionnaires). - Inclusion criteria: completed training in hormonal contraception, registered with the Quebec Nursing College, and currently worked as nurses.	- Cross-sectional study. - Conceptual framework: Rogers DOI. - Dependent variables = implementing/not implementing practice, rapidity of implementing practice after training, how many clients were started on contraception in a given month. - Independent variables = factors based on Rogers DOI, socio-demographics, marital status, level of education, location of employment, section of practice, region of	- 57.3% of respondents had implemented new practice. - 85% of these nurses had implemented the practice within 2 years of training. - An average of 5.6 women per month were started on contraception. - Nurses who worked in youth clinics, nurses who perceived innovative places of employment, cosmopoliteness, and those who perceived the intervention as "simple" were more likely to implement the new practice. - Delays in practice were attributed to earlier training and living in a remote area. - Delay was shorter	STRENGTHS: - Ethics approval stated. - Data collection described (subjects identified through provincial database—contacted by email or post with invitation letter, consent, survey, and pre-paid envelope for response; reminders sent a/p Dillman's design method). - Survey questions developed in Rogers DOI framework by researchers; validated through prior research. - Correct interpretation of statistical measures. LIMITATIONS: - Poor response rate. - Sample selection bias—self-reporting more likely for nurses who adopt the process.	- Moderate sample selection: sample not necessarily representative of population. - Reliable data collection instrument. - Adequate ethical conduct. - Appropriate use of statistics with recognition of unexplained variance. RATING: MEDIUM.

		practice.	when nurses had experiences compatible with the new practice and also practiced re-invention. Rogers influence: shorter delay associated with perception of favourable organizational structure, re-invention, and small-sized organization. - Intensity higher when nurse had previous experiences compatible with new practice, had seen the effects of the new practice, and with a perceived organizational innovativeness. Rogers influence: simple practice, good mentorship/support, observed effects of new practice, practiced re-invention, and were influenced by opinion leaders. Intensity	- Some confounding variables not explained: degree of organizational readiness, personal values, cultural norms, etc.	

			decreased when nurses perceived that the practice was voluntary. - Rogers determinants explain intensity of new practice, rather than implementation or delay in implementation. - The simpler the new practice, the more likely nurses are to adopt it (r/t implementation).		

References:

Guilbert, E. R., Robitaille, J., Guilbert, A. C., & Morin, D. (2014). Determinants of the implementation of a new practice in hormonal contraception by Quebec nurses. *Canadian Journal of Human Sexuality, 23*(1), 34-48. doi: 10.3138/cjhs.23.1-A1

Public Health Agency of Canada (2014). Infection control and prevention guidelines: Critical appraisal toolkit. Retrieved from: http://publications.gc.ca/collections/collection_2014/aspc-phac/HP40-119-2014-eng.pdf

Name, Author, Date, Study Objective	Sample/Groups (Size, Setting, Characteristics)	Design and Methodology	Key Findings/Limitations	Strengths/Limitations	Conclusion and Rating
Bowen et al. (2012). Using diffusion of innovations theory to implement the confusion assessment method for the intensive care unit. Objective: To identify barriers to practice change, and describe development strategies (specific to Rogers DOI theory) for implementing a delirium tool in an ICU.	- Initial implementation failure in an 8-bed ICU in an American hospital. - Case study: 9-bed MICU and 8-bed SICU with staff of 34 nurses in New Jersey, US.	- Case study. - Nurses attended 1 hour in-servive to gain knowledge about delirium (Knowledge Phase of DOI theory). - Poster boards available to increase staff knowledge re: delirium/ CAM-ICU (Knowledge Phase of DOI theory). - Meetings held with MDs/stake holders re: implementation (Knowledge Phase of DOI theory). - CAM Champs identified (charge nurses) and support from managers./clinical educator (Persuasion Phase of DOI theory). - Updated poster	- 85% of assessments were completed (159/187). - Interviews with nurses, manager, clinical educator identified the following: - Future in-services should include case studies on use of CAM-ICU. - Meeting with all residents/staff during one of *their* morning meetings assisted in addressing knowledge barrier. - Support of CAM champs/manager/educator invaluable and necessary for success. - Ease of access to CAM-ICU charting imperative to filling out. - Disclosing the weekly results of the assessments aided in improving adherence. - Nurses continued the CAM-ICU assessments on follow-ups at Week 2	STRENGTHS: - High degree of reliability between staff nurses and researchers on RASS scores (r= 0.97). - Reliable data collection methods using trained researchers. - ?Generalizable sample. - Moderate credibility. LIMITATIONS: - Limited sample (1 hospital). - No identification of ethical conduct.	- Weak overall study design, although credible case study. RATING: WEAK

		boards on weekly basis used to influence nurses' decision re: CAM-ICU implementation (Decision Phase of DOI theory). - CAM-ICU charting placed in patients' binders to facilitate ease of access; work flowsheets placed in binders to demonstrate use of tool (Implementation Phase of DOI theory). - Continued support from CAM Champs + leaders (Implementation Phase of DOI theory). - Continued support from all + posted results of study (Confirmation	and Week 18 (85% and 88% completion).		

		Phase of DOI theory).			

References:

Bowen, C. M., Stanton, M., & Mann, M. (2012). Using diffusion of innovations theory to implement the confusion assessment method for the intensive care unit. *Journal of Nursing Care Quality, 27*(2), 139-145. doi: 10.1097/NCQ.0b013e3182461eaf

Public Health Agency of Canada (2014). Infection control and prevention guidelines: Critical appraisal toolkit. Retrieved from: http://publications.gc.ca/collections/collection_2014/aspc-phac/HP40-119-2014-eng.pdf

Name, Author, Date, Study Objective	Sample/Groups (Size, Setting, Characteristics)	Design and Methodology	Key Findings/Limitations	Strengths/Limitations	Conclusion and Rating
Watson-Wolfe et al. (2014). Application of the Antipsychotic Use in Dementia Assessment audit tool to facilitate antipsychotic use in long term care residents with dementia. Objective: To test the effectiveness of an in-service to encourage the appropriate use of antipsychotics for nursing home residents with dementia.	- Pre-test: n= 59 residents living in facility. - Post-test: n= 53 residents living in facility. - Nursing staff: n=18. 10 attended inservice, 8 received documentation. - Nurses attending in-service scored 94.9% +/- 8.21% on post-test. Nurses not attending in-service did not take the exit test.	- Uncontrolled Before-After design. - Baseline audit completed using Antipsychotic Use in Dementia Assessment (American Medical Directors Association) documenting number of meds received and reasons for receipt. - Staff then provided with results of audit. - Educational in-service provided (voluntary). Powerpoints provided to QI/Staff Development Coordinators—disseminated info to those who did	- Pre-test prescribing rate: n=12 (20.3%). Adverse effects: n= 4 (33%). Non-phar interventions mostly documented by activities staff: n=10 (83.3%). Nursing documentation: n=2 (16.7%). - Post-test prescribing rate: 15.4%. No adverse events. Nurse documentation: 75%.	STRENGTHS: - Ethical review conducted. - Use of validated data collection instrument. - Trained staff nurse in QI/chart review. LIMITATIONS: - Voluntary attendance at in-service. - Comparison of knowledge between nurses attending in-service vs. nurses with PowerPoints not possible because latter group did not take exit test.	- Weak sample selection (self-referred and volunteer). - No control of sampling bias. - Moderate control of misclassification bias (minimal accounting for missing data—attrition? Death?). - Moderate control of information bias (assessor trained, but not blinded to groups). -Valid and reliable data collection tools. - Control of confounders not evident (winter vs. summer months? Age of participants, etc). - Easily implemented (strong feasibility).

		not attend in-service.			RATING: WEAK

References:

Watson-Wolfe, K., Galik, E., Klinedinst, J., & Brandt, N. (2014). Application of the antipsychotic use in dementia assessment audit tool to facilitate appropriate antipsychotic use in long term care residents with dementia. *Geriatric Nursing, 35,* 71-76. doi: 10.16/j.gerinurse.2013.09.002

Public Health Agency of Canada (2014). Infection control and prevention guidelines: Critical appraisal toolkit. Retrieved from: http://publications.gc.ca/collections/collection_2014/aspc-phac/HP40-119-2014-eng.pdf

Name, Author, Date, Study Objective	Sample/Groups (Size, Setting, Characteristics)	Design and Methodology	Key Findings/Limitations	Strengths/Limitations	Conclusion and Rating
Doyle et al. (2014). Integrating mobile devices into nursing curricula: Opportunities for implementation using Rogers' Diffusion of Innovation model Objective: To review studies on integrating mobile device use in undergraduate and graduate nursing curricula, and to examine the potential use of Rogers' Diffusion of Innovation Model as a framework to guide implementation.	- n= 52 articles (4 RCTs, 13 quasi-experiments, 4 qualitative, 18 descriptive, 13 mixed methods). - Inclusion criteria: English language, nursing education focus	- Literature review. - Databases: EBSCO (Academic Search Complete, CINAHL, Medline), PubMed, and Google Scholar. - Timeline: up to June 2013 (no earliest dates set). - Initial individual review, then 2 researchers independently. - Articles grouped by study methodology. - Rogers DOI used as framework to analyze implementation strategies identified in papers. - Articles then themed into best practice	- Iterative, rather than linear, process.	STRENGTHS: LIMITATIONS: - No grey literature search. - Only English language articles.	

		recommendations for incorporating mobile devices into nursing education.			

References:

Doyle, G. J., Garrett, B., & Currie, L. M. (2014). Integrating mobile devices into nursing curricula: Opportunities for implementation using Rogers' Diffusion of Innovation model. *Nurse Education Today, 34*, 775-782. doi: 10.1016/j.nedt.2013.10.021

Public Health Agency of Canada (2014). Infection control and prevention guidelines: Critical appraisal toolkit. Retrieved from: http://publications.gc.ca/collections/collection_2014/aspc-phac/HP40-119-2014-eng.pdf

TOPIC 4—THEORETICAL FRAMEWORK: INDIGENOUS WAYS OF KNOWING

Name, Author, Date, Study Objective	Sample/Groups (Size, Setting, Characteristics)	Design and Methodology	Key Findings/Limitations	Strengths/Limitations	Conclusion and Rating
Healey & Tagak (2014). Piliriqatigiinniq "Working in a collaborative way for the common good": A perspective on the space where health research methodology and Inuit epistemology come together. Objective: To add Inuit perspectives on health-related research epistemologies/methodologies to assist in informing health research in Arctic communities.			- Knowledge comes from people's histories, stories, observations of the environment, visions, and spiritual insights. - Establishing trust/accountability is part of relationship development with colleague/researcher. - Construction of knowledge must be completed in a manner that builds/sustains relationships with the environment, and is respectful of the environment. When conducting interviews, it is best to conduct them in an environment that is familiar (homes, on the land, comfortable community space). - Knowledge is sacred object—seeking knowledge is a spiritual quest.	STRENGTHS: - Well-positioned article about Inuit ways of knowing from Nunavut. - Draws on prior research from Indigenous communities (global). - Consults with local Inuit experts re: ways of knowing. - Ways of knowing are described as per Inuktitut description (decreases chance the message is lost in translation). LIMITATIONS: - Nunavut-specific; not all concepts generalizable to Western Arctic Inuit (Inuvialuit).	

			- Knowing can come from prayer/dreams, through connections with one another, living/non-living, ancestral spirits. Mind, body and spirit all involved in information gathering. - How language of knowledge is conveyed dictates understanding of the knowledge because of the shared relationships between people speaking the language. - Holistic, relational perspective is integral to Inuit ways of knowing. - Inuuqatigiittiarniq (respect for others, building positive relationships, and caring for others). Building a relationship between people strengthens that relationship, and then the community, as a whole. In health research—must clearly articulate intentions/motivations		

			for engaging in a study. - Awareness of a community context is part of acknowledging one's respect for it. - Participants must be engaged (not recruited) to participate in a project. This stems from forming trusting relationships. - Unikkaaqatigiinniq (story-telling, the power of a story, role of stories). - Inuit have a strong oral history and culture. - Story-telling is a way to share knowledge, values, morals, skills, histories, legends, and artistry. - Relational epistemology: stores are shared, not collected. - Important to present stories in their entirety, but also important to acknowledge when parts are omitted due to time/space constraints.		

			- Iqqaumaqatigiinniq (all thoughts/knowing coming into one). Holistic Indigenous worldview. - Reflecting on how ideas come together, what the ideas offer to the Inuit community and to the community of researchers/collaborators, and putting ideas in context of literature part of finding meaning/understanding. - Pittiarniq (being good) in relation to ethics. - Technical and moral excellence. - Must be based on Inuit societal values. - Being humble and respectful of the rights of all things helps Inuit maintain their relationships. - Actions are reflective of one's intention to do good (behavior emphasized). - Accountability: research must resonate with three audiences. 1.		

			General Indigenous community. 2. Non-indigenous community. 3. Indigenous scholars (best position to evaluate research). - Pilriqatigiinniq (working together for the common good). - Model developed for conducting health research in Inuit communities. - Essence of Inuit epistemology: ethics, accountability, methodology, knowledge, understandings, relationships with each other as human beings, and environments.		

References:

Healey, G., & Tagak Sr., A. (2014). Piliriqatigiinniq "Working in a collaborative way for the common good": A perspective on the space where health research methodology and Inuit epistemology come together. *International Journal of Critical Indigenous Studies, 7*(1), 1-14.

Public Health Agency of Canada (2014). Infection control and prevention guidelines: Critical appraisal toolkit. Retrieved from: http://publications.gc.ca/collections/collection_2014/aspc-phac/HP40-119-2014-eng.pdf

Name, Author, Date, Study Objective	Sample/Groups (Size, Setting, Characteristics)	Design and Methodology	Key Findings/Limitations	Strengths/Limitations	Conclusion and Rating
Chatwood et al. (2015). Approaching *Etuaptmumk*: Introducing a consensus-based mixed method for health services research. Objective: To describe Indigenous values underlying health systems stewardship.	- "Experienced researchers"	- Research Q: what indigenous values underlie health systems stewardship?	- Knowledge systems are cumulative. - Knowledge systems represent multiple generations, plus careful observation, plus trial and error learning. - Knowledge content and method of expression hold social/cultural/scientific value. - GNWT recognizes Aboriginal Traditional Knowledge as valid and essential source of information. - Etuaptmumk (two-eyed seeing). - Covers social, economic and environmental aspects. - Aims to respond to and resolve inherent conflicts between Indigenous ways of knowing and scientific inquiry forming the basis of health care.	STRENGTHS: - Good explanation of study's framework. LIMITATIONS: - Confusing and vague.	RATING: WEAK

			- Mixed methods follows concept of two-eyed seeing. - Indigenous knowledge can be framed as a mixed method. Honours common set of beliefs, values, assumptions. - Aims to enhance understanding of health research. -		

References:

Chatwood, S., Paulette, F., Baker, R., Eriksen, A., Hansen, K., Eriksen, H., … & Brown, A. (2015). Approaching *Etuaptmumk*: Introducing a consensus-based mixed method for health services research. *International Journal of Circumpolar Health, 74*, 27438. doi: 10.3402/ijch.v74.27438

Public Health Agency of Canada (2014). Infection control and prevention guidelines: Critical appraisal toolkit. Retrieved from: http://publications.gc.ca/collections/collection_2014/aspc-phac/HP40-119-2014-eng.pdf

Name, Author, Date, Study Objective	Sample/Groups (Size, Setting, Characteristics)	Design and Methodology	Key Findings/Limitations	Strengths/Limitations	Conclusion and Rating
Ferrazzi et al. (2018). Reciprocal Inuit and western research training: Facilitating research capacity and community agency in Arctic research partnerships. Objective: To describe a cross-cultural research training workshop between Inuit peoples and graduate students in Arviat and Iqaluit.	- Workshop recruitment = purposive. - Arviat: n=18; Iqaluit: n=17.	- Case study. - Training workshops held over 3 days in Arviat and Iqaluit during April and May 2017. - Presentations by elders (Arviat only), arctic researchers, Inuit research assistants, graduate students, and others. - video conferencing between UofA and other universities to Iqaluit research site. - Bloom's Taxonomy integrated with IQ (Inuit Qaujimajatuqangit). - Modified workshop framework allowed for holistic approach (story-	- Purpose of training was to encourage reciprocity and relationship building that benefits both Indigenous and non-Indigenous research communities. - High degree of satisfaction with research training workshop from exit surveys. - Participants agreed that information was useful and improved understanding of research. - Agreed that the workshops encouraged them to work as researcher or research assistant.	STRENGTHS: - Mixed-methods study incorporating Wester and Indigenous ways of knowing. LIMITATIONS: - Difficult to rate study based on accepted tools (PHAC CAT).	RATING: MEDIUM

		sharing encouraged while also meeting realistic learning objectives). - Validated relevance of lived experience. - Focus on conceptual and procedural knowledge. - Exit evaluations filled at the end of the workshop (Arviat) and at the conclusion of each day (Iqaluit).			

References:

Ferrazzi, P., Christie, P., Jalovcic, D., Tagalik, S., & Grogan, A. (2018). Reciprocal Inuit and western research training: Facilitating research capacity and community agency in Arctic research partnerships. *International Journal of Circumpolar Health, 77*, 1425581. doi: 10.1080/22423982.2018.1425581

Public Health Agency of Canada (2014). Infection control and prevention guidelines: Critical appraisal toolkit. Retrieved from: http://publications.gc.ca/collections/collection_2014/aspc-phac/HP40-119-2014-eng.pdf

Appendix B—Consultation Report

Recommending Practice Development for Registered Nurses in Remote Northwest Territories, Canada Through Participation in Sexual Assault Nurse Examiner Education: Summary of Consultations

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NURS 6660: Practicum 1

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November, 2019

Recommending Practice Development for Registered Nurses in Remote Northwest Territories, Canada Through Participation in Sexual Assault Nurse Examiner Education: Summary of Consultations

Project Overview and Rationale

It has been established that care provided by sexual assault nurse examiners (SANEs) leads to increased client satisfaction with post-sexual assault (SA) care (Du Mont et al., 2017; Du Mont et al., 2014; Campbell et al., 2005). In the Northwest Territories (NT), risk of SA was nine times higher than in the rest of Canada in 2011 (Statistics Canada via Cooke, 2016). Furthermore, Du Mont et al. (2017) note that Indigenous women experience sexual violence at three times the rate of non-Indigenous women (115 per 1000 Indigenous women versus 35 per 1000 non-Indigenous women). As approximately 78% of the population in the Beaufort Delta and northern Sahtu regions of the NT self-identifies as Indigenous, it follows that emergency nurses in this region are exposed to post-SA care on a routine basis.

From the evidence, it follows that implementing SANE care in the emergency department (ED) of the Inuvik Regional Hospital (IRH) in Inuvik, NT has the potential to increase client satisfaction with post-SA care (Du Mont et al., 2014; Du Mont et al., 2017). The IRH serves as the regional facility for eight communities in the Beaufort Delta and two-three communities in the northern Sahtu regions of the NT; prior to transfer to the territorial capital, patients are first examined in Inuvik. The goal for this practicum project, then, is to create an action plan for implementing SANEs in the IRH ED. As part of the action plan, evaluation of the new post-SA program will be ongoing, with synthesis and analysis of results after two years. This plan will be delivered to key stakeholders, including the Manager of Nursing Units and Medical Director at IRH, and health advocates from the local Indigenous governments (Gwich'in and Inuvialuit).

After presentation of the plan to the stakeholders, it is hoped that senior leadership at the Northwest Territories Health and Social Services Authority (NTHSSA) will agree to a practice change, allowing registered nurses in the IRH ED to practice as SANEs for clients who present after SA.

In an effort the implement the action plan, Rogers's Diffusion of Innovation (DoI) change theory will be utilized to facilitate practice change in the IRH ED. Rogers's theory emphasizes five steps to change: knowledge, persuasion, decision, implementation, and confirmation (Jones & Seckman, 2018; Udod & Wagner, 2018). Rogers' theory emphasizes that programs which are consistent with stakeholder values, simple to implement, can be tested for efficacy, and result in notable improvements in care are more likely to be adopted (Jones, 2018). These principles will be taken into account when preparing the change model.

As a guiding conceptual framework, I will utilize Indigenous ways of knowing, specifically, ways of knowing which honour First Nations and Inuit traditions. The Beaufort Delta and northern Sahtu regions of the NT are traditionally populated by the Gwich'in, Dene, and Inuvialuit peoples; Gwich'in and Dene peoples self-identify as Canadian First Nations, while the Inuvialuit self-identify as a culturally and ethnically unique subset of the Canadian Inuit. As a guiding framework for the Canadian First Nations, *etuaptmumk* (seeing with two eyes) was identified as a culturally relevant way of knowing. When researching issues relevant to First Nations peoples, one of the researcher's eyes must examine data from the western perspective, and the other eye must examine data from an Indigenous perspective (Chatwood et al., 2015). By using both eyes equally, the researcher is able to resolve any potential conflicts between western and Indigenous epistemologies.

The Canadian Inuit have developed an independent research framework called *Pilriqatigiinniq*, which informs health research in Canadian Arctic communities (Healey & Tagak Sr., 2014). The model encompasses four concepts: firstly, *inuuqatigiittiarniq* (respect for others) is utilized to direct the building of relationships between people. As relationships between people are strengthened, the larger community is strengthened (Healey & Tagak Sr., 2014). Thus, when conducting research, or implementing projects, the researcher must clearly articulate the intentions and motivations behind the research or project. This transparency contributes to respect, and the strengthening of relationships.

Pilriqatigiinniq is also informed by *unikkaaqatigiiniq* (story-telling) (Healey & Tagak Sr., 2014. The Inuit have a strong oral culture, and employ story-telling as a way to share knowledge, values, morals, skills, and histories. As a western researcher, then, it is important to be cognizant of story-telling as informed knowledge; centuries of knowledge can be communicated in one story, which influences data collection (Healey & Tagak Sr., 2014). *Pilriqatigiinniq* is also informed by *iqqaumaqatigiinniq* (all thoughts into one), which emphasizes a holistic worldview. Thus, when conducting research or implementing a project, knowledge and utilization of holism is imperative to successful collaboration with the Inuit (Healey & Tagak Sr., 2014). Finally, *Pilriqatigiinniq* is informed by *pittiarniq* (being good). *Pittiarniq* emphasizes technical and moral good, and emphasizes one's behavior. It is imperative that one must be humble, and respectful of the unique rights of all things; by "doing good", one will embody this concept (Healey & Tagak Sr., 2014).

It is important to note that the aforementioned Indigenous epistemologies are not specific to the Beaufort Delta or northern Sahtu regions, but are employed as a global framework to honour Canadian Indigenous epistemologies. When devising the consultation process, specific

questions were included on the questionnaires given to the representatives from the Gwich'in and Inuvialuit regarding Gwich'in and Inuvialuit ways of knowing. By consulting the representatives' knowledge of their individual cultures, it is hoped that this practicum project will also provide an initial avenue for examining the unique ways of knowing specific to the Gwich'in and Inuvialuit peoples. Furthermore, inclusion of Indigenous epistemologies will prove beneficial to incorporating the interests of the client group into the policies and procedures of nursing profession.

Methods

Consultation was necessary for this proposed action plan in order to ensure the proposed practice change meets the needs of both the providers (ED RNs) and the clients. Moreover, given the unique cultural orientation of the majority of clients inhabiting the service area of IRH, and the lack of said cultural representation in the health care field, ensuring the local Indigenous groups are equal participants in the proposed practice change was essential. The participants chosen for consultation were selected based on proximity to the proposed practice change; for example, the medical director of the hospital must first approve of delegating the task of post-SA care to RNs before any proposed practice change can occur. Furthermore, each consultant was identified to participate in an effort to meet the objectives identified for consultation. The purpose of the consultations were as follows:

1. To identify potential advantages and disadvantages to implementing the proposed program.
2. To assist in designing the role of the RN in the proposed program.
3. To identify current cultural barriers to accessing health care in the post-SA period, and to identify strategies to mitigate these barriers.

4. To identify culturally appropriate training for the nurses when completing post-SA examinations with Indigenous clients (specifically, Gwich'in and Inuvialuit clients).
5. To identify ways of knowing specific to Gwich'in/Inuvialuit cultures, and to implement these ways of knowing when designing the program.

After the participants were identified, initial contact was made via email with a brief introduction to the proposed project and to the purpose of the project in fulfilling the requirements for completing the Masters of Nursing program at Memorial University of Newfoundland. A brief face-to-face meeting was then scheduled with participants located in Inuvik in an effort to build rapport. Once the meeting was complete, and the consultants agreed to participate, an email with a letter further explaining the project, as well as the questionnaire specific to their consultant role, was sent via email (see Appendix A). If the consultants were located outside of Inuvik, an email with the same letter, as well as the questionnaire specific to their consultant role, was sent with a proposed return date of July 24, 2019.

Nine consultants agreed to participate by filling in the survey. From IRH's leadership, the medical director and manager of nursing units participated. As previously mentioned, the medical director's participation was imperative as he must first approve of delegating the care of post-SA patients to the registered nurses in the emergency department. Furthermore, the medical director would assist in designing and implementing medical directives and would contribute his expertise relating to post-SA care. The manager of nursing units directly supervises the ED RNs. Her consent to participation was necessary; firstly, she must consent to a practice change in the ED, and her approval of any program was necessary prior to presenting the proposed change to senior leadership at the NTHSSA. Furthermore, the manager was a former ED RN, and has expertise in the physician-led model of post-SA care in the IRH ED.

Two health advocates from the local Indigenous governments also consented to participate. The representative from the Gwich'in is a well-known elder and health advocate for the Gwich'in in Inuvik and the surrounding communities. Approximately 30% of Inuvik self-identifies as Gwich'in, and the consultant's cultural knowledge was acknowledged as imperative for beginning to understand an Indigenous woman's experience when presenting for a SA examination. The representative from the Inuvialuit is a nurse, and has been newly elected to the territorial government as a Member of the Legislative Assembly. Her input was identified as necessary to understanding an Inuvialuit woman's experience when presenting for a SA examination. Her cultural knowledge is extensive, and was identified as necessary for designing a culturally appropriate program to present to senior leadership.

Two nurses-in-charge at community health centres in the Beaufort Delta agreed to participate in the consultation process. In the health centres, the nurses are responsible for conducting SA examinations and also provide the requisite follow-up care. Their experiences with the current model in the health centres was identified as beneficial for designing an RN-led program in the IRH ED. Additionally, two current IRH ED RNs agreed to participate in the consultation process; these nurses fill a senior role and have extensive experience in the current model of care. The IRH ED RNs were chosen in an effort to articulate the advantages and disadvantages of the current model. Their assistance in designing a program was acknowledged as necessary as they will be working in the program; therefore, their buy-in to a change in practice was necessary in designing a successful program.

Finally, a nurse practitioner and lead of the sexual assault response team (SART) at the territorial hospital in Yellowknife was identified for inclusion. She agreed to participate in the

consultation process as a nurse with SA examiner training, and with experience in leading a SART in the NT.

Data Management and Summary of Permissions

Each survey was a written response and required no transcription. Prior to sending out the surveys, each consultant was placed into one of three groups based on their primary purpose for inclusion: cultural representative, team design, and existing program design. Each survey was also examined for secondary inclusion into one of the aforementioned groups. For example, while the Inuvialuit cultural representative's primary role was to assist in identifying ways to make the program culturally relevant, the consultant is also a nurse, and as such, could assist in role design. Additionally, while the nurse-in-charge from the Fort McPherson health centre fulfilled a primary role as to assist in role design and examination of pre-existing services, the consultant is also Gwich'in, and may identify ways to make the program more culturally relevant. Each survey was examined for correlating themes identified across the survey groups and related to the evidence in the pre-existing literature relating to nurse-led post-SA care.

This project does not require approval from the Health Research Ethics Board (see attached checklist in Appendix B). As aforementioned, each individual located in Inuvik was contacted for an initial meeting to discuss the project and their participation in consultation, and as an avenue to build rapport. Participants located outside of Inuvik were contacted by email for the same purpose. Once consent to participation was gathered, an email with an attached letter further explaining the project, as well as the survey was sent to each individual. Consent was implied by completing the survey. Data was protected by keeping the results of the survey on a password-protected computer with no indication of the person's identity. Instead, the surveys

were saved according to the role the individual filled in the consultation process (i.e. role design, cultural representative, etc.).

Analysis of Results

Of the nine consultants agreeing to participate in the survey, five consultants returned completed questionnaires: three surveys corresponded to the team design role, one survey from the cultural ambassador role, and one survey from the existing program design role. The survey from the existing program design role also screened in for team design role; similarly, the survey from the cultural ambassador also screened in for the team design role. Three overarching themes were identified from the surveys: the nurse as a trusted entry point to care, a culture of silence and under-reporting of SA, and challenges unique to isolated northern care.

The first theme, nurse as trusted entry point to care, was alluded to on all five surveys. One respondent stated, "I see the role of the registered nurse as being the main contact of the client for continuity of care… I think it is important for the client to have contact with one nurse to prevent having to retell her story each time she needs to speak to a caregiver." Another respondent stated, "… the RN is the key provider for patient comfort… Nurses triage and take sexual assault handover, as well." Finally, a third respondent noted, "I think that this [RN-led post-SA care] would be better as the nurses are able to have the time to build the trust and complete the exam…" From all surveys, it was noted that, if properly trained, nurses have the necessary knowledge, skills, and judgement to lead post-SA care, and indeed, add many other qualities, such as compassion and integrity.

This theme is related to the literature, where studies by Du Mont et al. (2014) and Du Mont et al. (2017) note overwhelming client satisfaction with SANE-led post-SA care. In an initial study, Du Mont et al. (2014) examined patient demographics and client satisfaction with

SANE-led care in 1484 participants (1425 women, 54 male, 5 transgender) across 30 of 35 SA/domestic violence centres in Ontario from 2009 to 2011. Of the initial sample, 920 participants completed a researcher-developed Client/Guardian Satisfaction Survey; 98.6% of the 920 individuals rated their care as good or excellent on a four-point Likert scale (Du Mont et al., 2014). In a follow-up to their initial study, Du Mont et al. (2017) specifically examined the same data for demographics and satisfaction with SANE-led post-SA care in the Indigenous population. When demographics were considered in the results, Du Mont et al. (2017) found that Indigenous women were more likely to be assaulted between 12 and 18 years of age, present to the centre with a police presence, and were slightly less likely to rate the care they received as good or excellent (95.7% versus 99.1% of non-Indigenous women). This differential may be accounted for due to lack of culturally appropriate care, which is important when considering the design of the proposed program. Finally, in an examination of preference between forensics-based programs, and healthcare-based programs, Campbell et al. (2008) noted that overall, patients felt empowered by their experience: the patients noted that the nurses listened, exhibited care and compassion, gave clear instructions for medications. The patients felt informed, and that they could re-connect with the program ad lib (Campbell et al., 2008).

The second theme identified in the surveys was a culture of silence and under-reporting of SA. When queried on how a woman's culture may influence her willingness to present to a healthcare provider, one respondent stated, "The culture of women in this region has been one of silence when 'bad' things happen. Therefore, when a sexual assault happens because of how they have learned to deal with things… [they] keep it to themselves and just move on…" To another question, the respondent stated, "Sexual assault from what I have witnessed and learned is to not deal with it and move on. Even sometimes to be blamed for it as though we have put our self

[sic] in this situation. It is not talked about." Another respondent stated, "I feel that sexual assaults are highly under-reported and that the development and advertisement of the RN-led post-SA team would assist more people in coming forward."

While this topic was not specifically addressed in the literature review conducted for this proposed project, this theme directly relates to barriers to health care faced by marginalized individuals. In an examination of SA in the female African American population, Tillman et al. (2010) note that African American females experience barriers to post-SA care such as secondary re-traumatization, including victim-blaming and queries about past sexual experiences. Furthermore, Tillman et al. (2010) note that African American women often stay silent about SA because of past negative experiences with the dominant society's medical, legal, and forensic system, and as a way to protect African American males, who are over-represented in the American prison system. The last two sentiments were specifically noted by one respondent, "There has always been a mistrust and a perception that the healthcare system is not understanding of the way we live… over many years this has moved into viewing the health care [system] as 'racist'". Furthermore, the respondent notes that "… [they] keep it to themselves and just move on as it is probably someone they know and don't want to cause family feuds as everyone is related or close family ties." Thus, while African American women and Canadian Indigenous women are unique ethnic groups, both experience marginalization and, indeed, similar barriers to care in many circumstances. The importance of this theme relating to the proposed project connects to the importance of culturally-informed care to encourage women to report SA and to supersede the current culture of silence.

The final theme identified in the completed surveys is challenges unique to isolated northern care. Most respondents identified staff turnover as a barrier to implementing a

permanent team of RNs dedicated to post-SA care. When queried regarding potential obstacles relating to implementing an RN-led SART, one respondent noted, “Staffing—we don’t have enough core staff and have a high turnover rate.” One respondent identified the challenges relating to cost of training and retaining qualified staff, “Education in rural and remote [communities]→ how do we [complete] education (in person, video conference, on line [sic] modules)”. Unfortunately, the literature relating to successful education practices and/or retaining qualified staff in rural and remote communities is scarce. The Government of the Northwest Territories (GNWT) has identified several programs implemented to assist in recruiting and retaining qualified nurses, allied health providers, and physicians (Government of the Northwest Territories [GNWT], n.d.). The 2015-2016 Annual Report points to the Remote Nursing Certificate Program, as well as the Targeted Academic Support Program, both of which were created to assist existing staff in achieving appropriate training for working in rural and remote communities (GNWT, n.d.). Kulig et al. (2013) note the importance of recruiting local Indigenous individuals to treat other local Indigenous individuals. While recruiting Indigenous people into the nursing profession is certainly an effective long-term plan, in the interim, perhaps having Indigenous support workers on the SART could be an effective way of mitigating this challenge. In fact, one respondent noted, “Inuvialuit women historically are always surrounded by other stronger women in crisis.” Perhaps recruiting cultural support personnel is an effective way to mitigate one of the challenges of isolated Northern care.

Conclusion

The support for the proposed project was clear in the returned surveys. Themes identified from the surveys included nurses as a trusted entry point to care, a culture of silence and under-reporting relating to SA, and challenges to isolated northern care (i.e. staffing and education).

The first theme was also echoed in the published literature, where client satisfaction with SANE-led post-SA care was clearly evident (Du Mont et al., 2014; Du Mont et al., 2017; Campbell et al., 2008). The second and third themes were not immediately evident in the literature accessed for this proposed project, but specifically point to the importance of understanding real and perceived cultural barriers to care, and the challenges of implementing a proposed project (and resultant practice change) in an isolated northern community. The results of the surveys have legitimate implications for the proposed project, and point to the importance of gathering key stakeholder support and expertise. From the consultations, it is clear that this proposed project cannot occur in a vacuum, and importantly, because of the cultural nature of care in the Beaufort Delta and northern Sahtu regions, the support and expertise of the local Indigenous groups will prove necessary.

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Appendix A
Consultant Letter and Surveys by Consultant Role

5 July 2019

To Whom It May Concern:

My name is Meghan Sweetnam, and I am a student in the Master of Nursing (MN) program at Memorial University of Newfoundland. I am currently working on a Practicum Project to fulfill the final course requirements of my MN; this project requires consultation with key stakeholders, which is why I am emailing you at this time.

The title of my project is "Proposing a practice change for emergency department registered nurses related to post-sexual assault care in rural/remote Northwest Territories, Canada". The goal of my project is to develop a program proposal that outlines the evidence for, and an action plan to implement, a practice change for emergency department registered nurses (ED RNs) at the Inuvik Regional Hospital (IRH). This practice change will mean that ED RNs will complete post-sexual assault examinations and coordinate the requisite follow-up care.

In the Northwest Territories, risk of sexual assault is nine times higher than in the rest of Canada (Statistics Canada via Cooke, 2016). From the literature, it has also been established that Indigenous women experience sexual violence at three times the rate of non-Indigenous women (Du Mont, Kosa, Macdonald, Benoit, & Forte, 2017). We also know that sexual assault nurse examiners lead to increased client satisfaction with post-sexual assault care (Du Mont et al., 2017). As a result, RN-led sexual assault response programs have been established nationally and internationally, and I believe that a program of this nature would benefit clients presenting to the IRH ED after a sexual assault.

I am emailing you a survey to ascertain your thoughts on this matter. Your responses to this survey will stored on a secure device, protected by password. Only your position, as identified in the greeting to this email, will be referred to in the consultation report. Your honest and informed thoughts are much appreciated by me in an effort to design the most beneficial program possible for clients presenting to the IRH ED after a sexual assault.

The answers to this survey would be most appreciated by July 24, 2019.

Thank you kindly,

Meghan Sweetnam

Attached: Survey Questions

Role: Cultural Ambassador/Representative (Gwich'in First Nation)

1. How may a woman's culture influence her willingness to present to a healthcare provider after a sexual assault?

2. How may a woman's culture influence her relationship with a healthcare provider after a sexual assault?

3. How is sexual assault viewed/considered in the Gwich'in culture? How is sexual assault spoken about?

4. How does a woman's gender influence her willingness to present for a sexual assault examination?

5. When implementing a sexual assault response team in the IRH ED, what education is necessary for the team with respect to Gwich'in cultural values?

6. This project is being framed by *etuaptmumk* (seeing with two eyes) as a way to honour First Nations ways of knowing (Chatwood, Paulette, Baker, Eriksen, Hansen, Eriksen… & Brown, 2015).

    a. In your knowledge, are there any specific Gwich'in ways of knowing which would influence the design and implementation of this project?

    b. How would you incorporate Gwich'in ways of knowing in this project?

7. In your opinion, what would be the benefits of a sexual assault response team led by registered nurses in the IRH ED?

8. In your opinion, what would be the disadvantages of a sexual assault response team led by registered nurses in the IRH ED?

9. In your opinion, how could any disadvantages to a RN-led sexual assault response team be managed?

10. Do you have any additional thoughts you would like to add to this survey?

Thank you/Mahsi cho for your responses.

Role: Cultural Ambassador/Representative (Inuvialuit Peoples)

1. How may a woman's culture influence her willingness to present to a healthcare provider after a sexual assault?

2. How may a woman's culture influence her relationship with a healthcare provider after a sexual assault?

3. How is sexual assault viewed/considered in the Inuvialuit culture? How is sexual assault spoken about?

4. How does a woman's gender influence her willingness to present for a sexual assault examination?

5. When implementing a sexual assault response team in the IRH ED, what education is necessary for the team with respect to Inuvialuit cultural values?

6. This project is being framed by *inuuqatiglitiarniq* (being respectful of all people), *unikkaaqatigiiniq* (story-telling), and *pilriqatigiiniq* (working together for the common good) in an effort to honour Inuit ways of knowing (Healey & Tagak, 2014).

    a. How would you incorporate Inuit ways of knowing in this project?

    b. In your knowledge, are there any specific Inuvialuit ways of knowing which would influence the design and implementation of this project?

7. In your opinion, what would be the benefits of a sexual assault response team led by registered nurses in the IRH ED?

8. In your opinion, what would be the disadvantages of a sexual assault response team led by registered nurses in the IRH ED?

9. In your opinion, how could any disadvantages to a RN-led sexual assault response team be managed?

10. Do you have any additional thoughts you would like to add to this survey?

Thank you/Quyanainni for your responses.

Role: Team Design

1. In the current model, what are the advantages and disadvantages of post-sexual assault care for adult women in the IRH ED?

2. In your opinion, what is the role of the physician on a sexual assault response team?

3. In your opinion, what is the role of a registered nurse on a sexual assault response team?

4. In your opinion, what is the role of social work/victim services on a sexual assault response team?

5. In your opinion, what are the potential benefits of a sexual assault response team led by RNs in the IRH ED?

6. In your opinion, what are the potential obstacles to a sexual assault response team led by RNs in the IRH ED?

7. What strategies could mitigate any identified obstacles (i.e. education/training, staffing, etc.)?

8. What education is necessary for RNs wishing to join a sexual assault response team?

9. What qualifications should a RN possess when joining a sexual assault response team?

10. Do you have any additional thoughts you would like to add to this survey?

Thank you for your responses.

Role: Existing Program Consultation

1. In the current model, what are the advantages and disadvantages of post-sexual assault care for adult women in the IRH ED?

2. In your opinion, what is the role of the physician on a sexual assault response team?

3. In your opinion, what is the role of a registered nurse on a sexual assault response team?

4. In your opinion, what is the role of social work/victim services on a sexual assault response team?

5. In your opinion, what are the potential benefits of a sexual assault response team led by RNs in the IRH ED?

6. In your opinion, what are the potential obstacles to a sexual assault response team led by RNs in the IRH ED?

7. What strategies could mitigate any identified obstacles (i.e. education/training, staffing, etc.)?

8. What education is necessary for RNs wishing to join a sexual assault response team?

9. What qualifications should a RN possess when joining a sexual assault response team?

10. Do you have any additional thoughts you would like to add to this survey?

Thank you for your responses.

Appendix B
Health Research Ethics Authority Screening Tool

	Question	Yes	No
1.	Is the project funded by, or being submitted to, a research funding agency for a research grant or award that requires research ethics review	☐	☐
2.	Are there any local policies which require this project to undergo review by a Research Ethics Board?	☐	☐
	IF YES to either of the above, the project should be submitted to a Research Ethics Board. **IF NO** to both questions, continue to complete the checklist.	☐	☐
3.	Is the primary purpose of the project to contribute to the growing body of knowledge regarding health and/or health systems that are generally accessible through academic literature?	☐	☐
4.	Is the project designed to answer a specific research question or to test an explicit hypothesis?	☐	☐
5.	Does the project involve a comparison of multiple sites, control sites, and/or control groups?	☐	☐
6.	Is the project design and methodology adequate to support generalizations that go beyond the particular population the sample is being drawn from?	☐	☐
7.	Does the project impose any additional burdens on participants beyond what would be expected through a typically expected course of care or role expectations?	☐	☐
LINE A: SUBTOTAL Questions 3 through 7 = (Count the # of Yes responses)		**0**	
8.	Are many of the participants in the project also likely to be among those who might potentially benefit from the result of the project as it proceeds?	☐	☐
9.	Is the project intended to define a best practice within your organization or practice?	☐	☐
10.	Would the project still be done at your site, even if there were no opportunity to publish the results or if the results might not be applicable anywhere else?	☐	☐
11.	Does the statement of purpose of the project refer explicitly to the features of a particular program, Organization, or region, rather than using more general terminology such as rural vs. urban populations?	☐	☐
12.	Is the current project part of a continuous process of gathering or monitoring data within an organization?	☐	☐
LINE B: SUBTOTAL Questions 8 through 12 = (Count the # of Yes responses)		**3**	
	SUMMARY **See Interpretation Below**	**3**	

Interpretation:

- If the sum of Line A is greater than Line B, the most probable purpose is **research**. The project should be submitted to an REB.
- If the sum of Line B is greater than Line A, the most probable purpose is **quality/evaluation**. Proceed with locally relevant process for ethics review (may not necessarily involve an REB).
- If the sums are equal, seek a second opinion to further explore whether the project should be classified as Research or as Quality and Evaluation.

These guidelines are used at Memorial University of Newfoundland and were adapted from ALBERTA RESEARCH ETHICS COMMUNITY CONSENSUS INITIATIVE (ARECCI). Further information can be found at: http://www.hrea.ca/Ethics-Review-Required.aspx.

Appendix C—Practice Development Proposal

Recommending Practice Development for Registered Nurses in Remote Northwest Territories, Canada Through Participation in Sexual Assault Nurse Examiner Education

Meghan A. Sweetnam

Faculty of Nursing, Memorial University of Newfoundland

NURS 6661: Practicum 2

Dr. W. J. Maddigan

June 21, 2021

Abstract

Background: The risk of sexual assault (SA) for Indigenous women is three times higher than that of non-Indigenous women; however, women in remote Northwest Territories (NT) do not receive the specialist care of a sexual assault nurse examiner (SANE). Furthermore, colonial approaches to healthcare are reinforced by the current model of care. As 78% of the population in the catchment are of the Inuvik Regional Hospital (IRH) identifies as Indigenous, Indigenous ways of knowing are central to decolonizing healthcare. **Purpose:** To recommend a practice development project which would provide an opportunity for RNs to acquire SANE education and become the primary care providers for women presenting to the emergency department (ED) in the post-SA period. **Methods:** To preface the proposal, a literature review and stakeholder consultations were prepared. Rogers' Diffusion of Innovation theory, emancipatory practice development, and local and global Indigenous epistemologies were utilized to direct the proposal. **Results:** A project proposal was conceived as a way of proposing, implementing, and evaluating Indigenous-informed, person-centred, RN-led post-SA care in the ED. The proposal addresses initial consultation of stakeholders to program implementation, and recommends next steps for bringing the project to fruition. **Conclusion:** The proposed program has the potential to improve care for patients in the post-SA period by implementing nurse-led post-SA care. This project will also inform nursing practice development, and encourage transformational practice development by focusing nursing practice on person-centred care.

Keywords: practice development, sexual assault nurse examiner, remote nursing

Recommending Practice Development for Registered Nurses in Remote Northwest Territories, Canada Through Participation in Sexual Assault Nurse Examiner Education

Registered nurses (RNs) total 300,669 in Canada, with 1,337 of those nurses jointly registered in the Northwest Territories (NT) and Nunavut (NU) (Canadian Institute of Health Information [CIHI], 2019; Registered Nurses Association of Northwest Territories & Nunavut [RNANT/NU, 2019). RNs constitute the largest group of healthcare providers, and in order to effectively contribute to the healthcare profession, practice development is essential. Practice development is not synonymous with professional development; rather, practice development focuses on the "human factors" of healthcare (McCormack, 2014, p. 638). Practice development specifically seeks to address advancing patient care, evidence-based nursing, nursing theory, and nursing knowledge by merging clinical practice, education, and research into organized action (Chambers et al., 2013). In short, practice development seeks to change the status quo of practice assumptions; rather than practicing the way one always has, practice development challenges one to be innovative (McCormack, 2014).

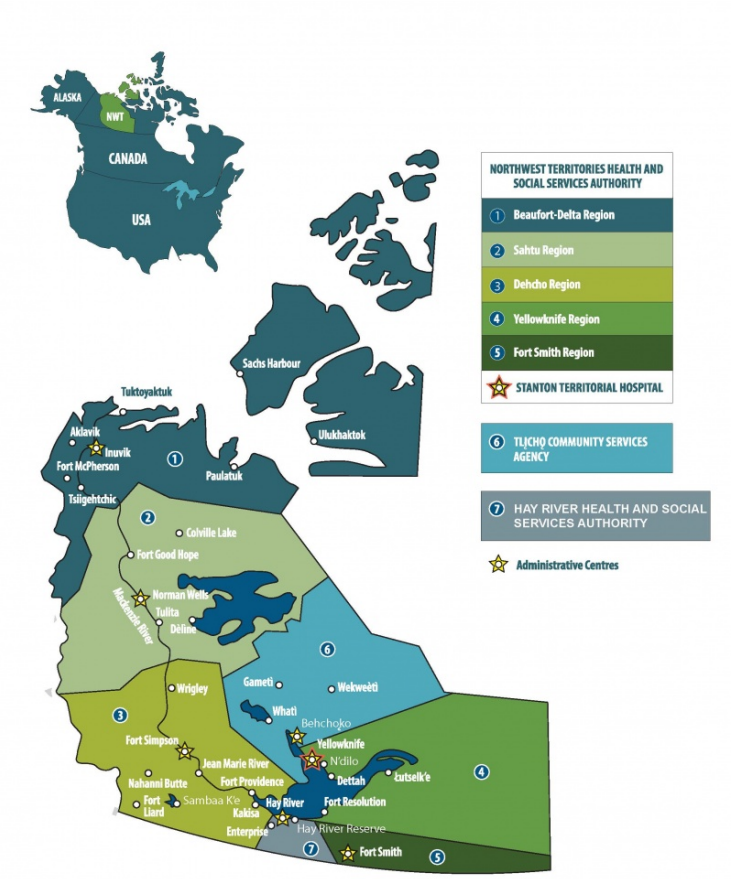
The Inuvik Regional Hospital (IRH) consists of a 14-bed inpatient unit, a 2-bed labour and delivery unit, and an 8-bed emergency department (ED). Uniquely, all nurses in the hospital are employed by the Government of the Northwest Territories (GNWT) via the Northwest Territories Health and Social Services Authority (NTHSSA). The NTHSSA is a centralized authority in Yellowknife, the territorial capital, and directs policy and procedure for all regions in the NT. The ED employs seven RNs, who work one of three shifts: day shift (0730-1930hr), evening shift (1000-2200hr), or night shift (1930-0730hr). Thus, from 1000-2200hr, there are two RNs working in ER, but from 2200-1000hr, one RN is responsible for the running of the 8-bed department, as well as acting as the after-hours supervisor for all nursing units (from 1700-

0730hr). It is imperative that the ED RN is able to work autonomously, with no direct supervision, and to the full scope of practice as outlined in the *Nursing Profession Act, 2003, c.15* (Government of the Northwest Territories [GNWT], 2010). The ED RN works with one general practice (GP) physician, and other allied health members on an on-call basis. As a team, the RN and MD assess, treat, and monitor all patients presenting to the ED.

The IRH serves approximately 6700 residents of the Beaufort Delta region of the NT, and a further 700 residents in the northern Sahtu communities of Colville Lake and Fort Good Hope (Beaufort Delta Health & Social Services Authority [BDHSSA], n.d.; Bureau of Statistics, Government of the Northwest Territories [BSGNWT], 2016). A map detailing the communities of the Beaufort Delta and northern Sahtu regions is depicted in Figure 1.

Figure 1

Map Depicting NT Health and Social Services Authorities and Requisite Communities



Note. The Beaufort Delta and northern Sahtu regions are the northernmost regions in the NT. The image is from PracticeNWT, n.d., (https://www.practicenwt.ca/en/map-nwt).

Approximately 78% of the population in the Beaufort Delta and northern Sahtu self-identify as First Nations, Inuit, or Métis (BSGNWT, 2016). All adult patients experiencing sexual assault (patients aged 18 years and older) present to their nearest healthcare facility, and care is escalated as necessary. Victims of sexual assault (SA) in Inuvik present to the IRH ED. Notably, in the NT, the risk of SA was nine times higher than in the rest of Canada in 2011 (Statistics Canada

via Cooke, 2016). Furthermore, Du Mont et al. (2017) note that Indigenous women experience sexual violence at three times the rate of non-Indigenous women (115 per 1000 Indigenous women versus 35 per 1000 non-Indigenous women). Given the high risk of SA in the NT, coupled with the high risk of sexual violence in Indigenous populations, it follows that ED RNs in the NT must be prepared to undertake post-SA care on a routine basis.

At current, the post-SA exam in the IRH ED is conducted by a physician with RN assistance. In many emergency departments across North America, routine post-SA care is led by an RN with sexual assault nurse examiner (SANE) training. In concordance with the strength of the evidence, implementing a SANE program in the IRH ED has the potential to increase the effectiveness of post-SA care for the Beaufort Delta and northern Sahtu populations. However, this program implementation would require practice development for the ED RNs at IRH. The primary goal of this proposal, then, is to recommend a practice development project for IRH ED RNs to obtain SANE education. The overarching goal in implementing this proposal is to achieve better outcomes for Indigenous women experiencing SA; the principal way of obtaining this outcome is to encourage ED RNs to first reflect on their own practice, thereby encouraging a practice change, and ultimately, practice development.

Background

The impetus for this project began as the researcher noted lengthy wait times between a victim's presentation time and time to discharge. Part of this wait time can be attributed to the nature of SA presentations: the individuals often present at night, which as previously mentioned, is a period with a low staffing ratio. From 2200hr-1000hr, the one ED RN and one ED MD must be reassigned to care for the SA victim as sexual assault is generally assigned an urgent triage score of 2. As a result, the flow of the department stops. In this case, any other

patients must wait for re-assessment, and newly presenting patients must be triaged by a nurse who is not a primary ED RN. Furthermore, IRH is driven by temporary locum staff (both RNs and MDs), many of whom do not have experience with post-SA exams because they come from larger facilities where a sexual assault response team (SART) is in place, or on-call SANEs can provide care. Most importantly, locum RNs and MDs generally do not have experience with the Beaufort Delta population, which contributes to distrust of the practitioners and re-traumatization of the victim. With respect to the last point, the project was further driven by the research of Du Mont et al. (2017) which examined the satisfaction of Indigenous women (versus non-Indigenous women) undergoing post-SA exams and noted increased satisfaction with RN-led post-SA care. This study was particularly vital to the current project as it specifically addresses Indigenous women, and approximately 78% of the population of the IRH ED self-identify as Indigenous.

Implementing a project with an Indigenous focus for Indigenous patients requires a guiding theoretical framework focusing on both First Nations and Inuit epistemology. The Beaufort Delta and Sahtu regions are traditionally populated by the Gwich'in, Dene, and Inuvialuit peoples. The Gwich'in and Dene peoples self-identify as Canadian First Nations, while the Inuvialuit are a culturally and ethnically unique subset of the Canadian Inuit population. Traditionally, and in Northern Canada especially, there has been a difficult relationship between healthcare providers and Indigenous patients, primarily stemming from a traumatic history between Indigenous populations and colonial institutions such as religious organizations and the Government of Canada. As a non-Indigenous RN in Canada's north, the author has anecdotal experience of the unequal healthcare system; as such, the author has sought to actively engage with the process of de-colonizing personal nursing practice.

In the Beaufort Delta region, there has been a long history of the colonial school system. The first missionary schools were operated by the Roman Catholic and Anglican churches; the Immaculate Conception school was opened by the Roman Catholic church in Aklavik in 1926, while the Shingle Point School was opened at Shingle Point by the Anglican church in 1929 (Truth & Reconciliation Commission of Canada [TRC], 2015). The missionary schools became obsolete during the 1950s, when the discovery of resources in the NT drove the Government of Canada to expand into the Beaufort Delta region (TRC, 2015). Inuvik was created as a government administrative centre to replace the flood-prone Aklavik in 1957, and children across the arctic were taken from their families and placed into student residences in Inuvik jointly operated by the federal government and the Roman Catholic (Grollier Hall) and Anglican (Stringer Hall) churches (TRC, 2015). During the day, students attended Sir Alexander Mackenzie School. Notably, the legacy of the residential school system in the Beaufort Delta had long-lasting impacts, as Grollier Hall was not closed until 1997, and Sir Alexander Mackenzie School was not demolished until 2014 (TRC, 2015; Canadian Broadcasting Corporation, 2014). More recently, the discoveries of mass unmarked gravesites of children in the colonial school system have contributed to re-traumatization of many colonial school survivors and the global acknowledgement of Canada's cultural genocide of its Indigenous populations (Austen, 2021).

In addition to the colonial legacies of the residential school system, many Inuvialuit and Inuit were affected by the Tuberculosis (TB) Epidemic of the 1950s and 1960s (Inuvialuit Regional Corporation [IRC], n.d.). During this epidemic, many Inuvialuit of the western arctic were sent to "Indian Hospitals" in southern Canada for treatment. Residents of the Beaufort Delta were sent to Charles Camsell Hospital in Edmonton, which treated Indigenous patients (IRC, n.d.). The average stay for residents often lasted as long as two and a half years, and many

Inuvialuit were sent “south” and never returned. Information on these patients was never provided to the families (IRC, n.d.). The history of the colonial school system and segregated hospitals demonstrates incongruence between Indigenous epistemologies and ways of living and colonial practices, leading to a fundamental distrust of the healthcare system. As a way of mitigating this distrust, developing the current project proposal by employing Indigenous frameworks will increase the relatability of the proposed project for the population of interest.

Indigenous peoples have unique worldviews, partially due to long periods of habitation in specific regions (Healey & Tagak Sr., 2014). Indigenous knowledge is accumulative and dynamic, and it is important to acknowledge that all community members have knowledge, though the quantity and quality of said knowledge may vary among community members (Healey & Tagak Sr., 2014). Indigenous knowledge is stored in memories and activities and expressed orally via stories and songs, and via cultural practices (such as dance), and value and belief systems (Healey & Tagak Sr., 2014). Fundamentally, Indigenous epistemology is influenced by relationships with people, relationships with the environment, and relationships with spirits (Healey & Tagak Sr., 2014). It is important to note that the Gwich’in, Dene, and Inuvialuit peoples do not have epistemologies unique to their specific cultures, as was discovered in the environmental survey. As such, the author researched and employed two Indigenous epistemologies, one with a uniquely First Nations approach to honour the Gwich’in and Dene peoples, and one with a Canadian Inuit approach to honour the Inuvialuit people. Each framework will be explained in the following sections, with a focus on how these frameworks have been employed in previous projects, and will be utilized in this project.

Etuaptmumk

Etuaptmumk, or "seeing with two eyes", has been proposed by Mi'kmaq elders Albert and Murdena Marshall as a framework for respecting both Indigenous ways of knowing and Western ways of knowing (Hatala et al., 2020). When employing *etuaptmumk*, researchers use one eye to examine data from a Western perspective, and one eye to examine data from an Indigenous perspective (Hatala et al., 2020; Chatwood et al., 2015). By using both eyes, as is intended, the researcher honours both Indigenous and Western ideologies.

Etuaptmumk respects the value of Indigenous perspectives in healthcare and informs relational practice by encouraging trust (Sylliboy & Hovey, 2020). Nurses are uniquely situated to honour relational practice in general, and *etuaptmumk* in particular, by employing the fundamental values of honestly, humility, and respect (Hatala et al., 2020). It is through approaching individuals with the aforementioned values that the nurse fosters trust—trust that the nurse will do the right thing, take the right actions, present themselves as who they purport to be, and ultimately, be aware of how they act through cultural norms and practices (Sylliboy & Hovey, 2020). Practically, a nurse can utilize the acronym FIRST when working with Indigenous patients: recognizing the importance of the Indigenous patient's immediate and extended **F**amily, communicating respectfully when imparting **I**nformation, building **R**elationships with Indigenous patients, understanding the cultural safety **S**pace, and providing options for traditional and standard clinical **T**reatments (Sylliboy & Hovey, 2020).

In a study by Hatala et al. (2020), researchers examined the relationships between health, resilience, and well-being in 28 Indigenous youth by way of connection to the land in an urban environment. The study utilized qualitative methodology informed by *etuaptmumk* and social constructivist epistemology in designing the methodology for the research. In this study, the researchers examined "photovoice" to determine how connections to the land enlighten public

health interventions for urban Indigenous youth (Hatala et al., 2020). Importantly, *etuaptmumk* informed the choice of methodology, how the methods were employed, and how data were analyzed and interpreted (Hatala et al., 2020). Hatala et al. (2020) note that *etuaptmumk* emphasized the relational nature of knowledge, instead of merely emphasizing the commodification of knowledge. That is to say, instead of merely obtaining and possessing knowledge with the goal of dissemination, because the study was informed by *etuaptmumk*, researchers were connected to the subjects. In fact, through the choice of photovoice methodology, researchers were able to enter the youth's world and relate to them (Hatala et al., 2020). In this project, then, the fundamental goal was not to create, obtain, and possess knowledge for knowledge's sake. Rather, it was to employ knowledge gathering in a relational sense to ultimately forge a connection to the patient population, thereby providing better care.

Piliriqatigiinniq

Piliriqatigiinniq translates to "working together for the common good", and is a framework to guide health research with the Canadian Inuit population (Healey & Tagak Sr., 2014). *Piliriqatigiinniq* is guided by four principles: *innuqatigiittiarniq* (respect for others), *pittiarniq* (being good), *unikkaaqatigiiniq* (story-telling), and *iqqaumaqatigiiniq* (all thoughts into one) (Healey & Tagak Sr., 2014). *Innuqatigiittiarniq* focuses on building relationships between people, and in doing so, strengthening the greater community (Healey & Tagak Sr., 2014). To employ *innuqatigiittiarniq* in research, one must clearly articulate the motivations and intentions of both the researcher and research. In this way, the researcher builds strong relationships with the community, and fosters the community's trust in the researcher's intentions (Healey & Tagak Sr., 2014). Similarly, *pittiarniq* emphasizes good and moral behaviour; the researcher must be humble and approach the research with humility (Healey & Tagak Sr., 2014). By utilizing

superior moral behaviour, the researcher demonstrates trustworthiness, which translates well to a nurse's relational practice.

Unikkaaqatigiiniq prompts the researcher to honour the strong oral culture of the Canadian Inuit (Healey & Tagak Sr., 2014). As previously mentioned, story-telling is an avenue to share knowledge, values, and histories. *Unikkaaqatigiiniq*, then, reminds the researcher that story-telling is informed knowledge (Healey & Tagak Sr., 2014). Finally, the principle of *iqqaumaqatigiiniq*, or "all thoughts into one", prompts the researcher to honour the holistic worldview of the Canadian Inuit, and that knowledge and respect for holism is important (Healey & Tagak Sr., 2014). Registered nurses are well positioned to understand this principle, as one of the fundamental tenets of nursing is practicing from a holistic worldview.

In a study examining Inuit family perspectives on sexual health and relationships in Nunavut, Healey (2014) interviewed 20 parents across three Nunavut communities with the goal of informing public health interventions relating to high sexually transmitted infection (STI) and pregnancy rates among Nunavut teenagers. In this study, Healey (2014) employed all four principles of *piliriqatigiinniq* to emphasize relational methodology. Most importantly, the data were analyzed through the process of immersion and crystallization, which is a process explained by the holistic nature of *iqqaumaqatigiiniq* (Healey, 2014). Utilizing a holistic worldview in this study illustrates the similarities between the *etuaptmumk* and *piliriqatigiinniq* epistemologies. Both frameworks emphasize relational practice that is achieved through superior moral behaviour, thereby creating trust between the Indigenous patient and/or research subject and the healthcare provider and/or researcher. Thus, as was previously mentioned with respect to the *etuaptmumk* framework, the fundamental goal of Indigenous research, and by extension, this project, is not to generate knowledge for knowledge's sake. Rather, the fundamental goal of this

project is to generate knowledge, and utilize it in a manner that advances the relationship between nurse and patient, with the overarching goal of improving care for the patient population of the Beaufort Delta and northern Sahtu.

Literature Review

To effectively guide practice change and program implementation for the current proposal, a literature review was conducted to examine the effectiveness of SANE programs, post-SA program design, evaluation methods, nursing practice development, and use of Rogers' Diffusion of Innovation Change Theory. The findings of the review and their relevance and alignment with this proposal for a northern and indigenous-focused SANE program will be highlighted in the following sections.

Effectiveness of SANE Programs

Generally, the effectiveness of SANE programming was evaluated by clinical outcomes such as patient satisfaction with SANE-led care, and the effect of SANE-led care on ED flow. Other outcomes of note identified in the literature included cost-effectiveness of SANE-led care. In an initial article investigating SANE-led care, Du Mont et al. (2014) examined patient demographics and satisfaction in 1,484 participants (1,425 women, 54 men, 5 transgender) across 30 of 35 sexual assault/domestic violence centres in Ontario between 2009 and 2011. Nine hundred and twenty participants completed the researcher-developed Client/Guardian Satisfaction Survey, and of those participants, 907 patients rated their care as good or excellent on a 4-point Likert scale (Du Mont et al., 2014). In a follow-up study, Du Mont et al. (2017) examined the same data for demographics and satisfaction with post-assault care in the Indigenous population. Notably, Indigenous women are more likely to be assaulted between the ages of 12 and 18, present to the centre with a police presence, and most importantly, less likely

to rate their care as good or excellent (95.7% of Indigenous women versus 99.1% of non-Indigenous women) (Du Mont et al., 2017). The latter study is particularly important as it specifically acknowledges Canadian Indigenous women, which is the population of interest in the current project. Furthermore, the study by Du Mont et al. (2017) acknowledges the disparity in satisfaction of care between Indigenous women and non-Indigenous women; understanding the factors for this disparity is imperative for creating a culturally-informed program.

In a study by Sampsel et al. (2009), researchers gathered information about patient demographics, assault characteristics, forensic examination results, and treatment protocols in two Ontario EDs before and after SANE program implementation. Importantly, the study demonstrated that the time from a post-SA patient's presentation to exam decreased, STI prophylaxis increased, physicians performed more pelvic exams, and the overall number of patients presenting to the ED after SA increased. Similarly, Stermac and Stipe (2009) examined 466 SA cases in a Toronto-area hospital and found that there was generally no difference in patients directed to SANE-led care (n=210 patients) or to physician-led care (n=256 patients). Physicians were more likely to see patients where the SA was accompanied by trauma or physical coercion, but physician-led exams were also more likely to be interrupted mid-exam (25.1% of physician exams versus 20% of SANE exams) (Stermac & Stipe, 2009). Furthermore, SANE-led exams were shorter, and the time to SANE-led exams was shorter (3.25 hours versus 4 hours for physician-led exam) (Stermac & Stipe, 2009). Both studies showed an overall improvement in ED flow as patients were examined quicker, SANE-led exams were shorter, and there were fewer interruptions to the patient when they were examined by a SANE. Furthermore, consideration for post-exam follow-up was enhanced, as more patients received STI prophylaxis, and in general, more patients presented following SA.

Finally, a literature review by Nathanson et al. (2016) used rapid evidence methodology to search major online peer-reviewed databases and grey literature to examine the effectiveness of SANEs on several variables. Of note, one study demonstrated the cost-effectiveness of SANE-led programs when compared to physician-led post-assault care (Nathanson et al., 2016). The literature review, however, was focused on the Australian healthcare system, which is not comparable to the Canadian healthcare system.

Ultimately, the literature review demonstrated that SANE programs are considered effective in relation to the highlighted clinical outcomes (patient satisfaction and effect of SANE programming on ED flow). There was, however, a glaring difference in patient satisfaction with SANE-led care between Indigenous and non-Indigenous women. This difference may be due to a lack of Indigenous-informed care and the overall racialization of healthcare as previously mentioned. This difference in satisfaction, therefore, emphasizes the importance of the guiding framework and the implementation of an Indigenous-informed project in the IRH ED.

Program Design and Evaluation

Descriptions of SANE programming design were varied across the literature. Programs were often healthcare-based programs or forensics-based programs (not both), and were led exclusively by SANEs or designed so that SANEs were part of a SART. Logan et al. (2006) described a United States program where SANEs were part of a greater SART; their duties included evidence collection and documentation, STI prophylaxis, and counselling. The SART included the police, state attorneys, a rape crisis centre, the state university, and county government (Logan et al., 2006). On evaluation of the program design, Logan et al. (2006) noted the importance of collecting patient demographics to direct program resources. For example, examining the program design gave rise to the notion that SANEs should provide prevention

and/or informational education to high school and college students, as well as marginalized citizens, as these demographic groups constituted the majority patient population (Logan et al., 2006). In essence, the SANE would have both a clinical and educator role. Clinically, the SANE would examine and treat patients. From an educator perspective, the SANE would engage in public health initiatives by educating high-risk patient populations about preventing SA. Furthermore, program evaluation noted the high instance of re-victimization in the patient population; greater follow-up by SANEs and counselling services beyond the initial presentation were recommended to mitigate re-victimization (Logan et al., 2006).

Martin et al. (2007) completed a literature review describing several SANE program designs in the United States. The authors categorized the studies into five groups: SA training for clinicians, surveys of clinicians caring for SA victims, studies comparing two modes of service delivery (SANE examiners versus physician examiners), studies focused on post-exposure prophylaxis, and follow-up reviews of patients treated and services provided in SANE programs (Martin et al., 2007). Of note, the authors discovered that SANE programs with a healthcare focus attracted more patients, and that patients preferred a combination of medical examination and counselling post-SA (Martin et al., 2007). Importantly, Logan et al. (2006) and Martin et al. (2007) both noted patient preference for healthcare-based post-SA program design. This observation is particularly important to the current project, as it provides a guiding focus for program design.

With respect to SANE program evaluation, the literature review revealed three important parameters of evaluation: patient satisfaction, patient psychological well-being, and patient understanding of the medico-forensic process. Campbell et al. (2008) described the creation and implementation of a survey to evaluate a SANE-led program and patient well-being. The survey

examined program activities, nurse consistency, and short-term patient psychological outcomes and determined that patients felt empowered after participating in SANE-led post-SA care (Campbell et al., 2008). The participants noted that the nurses listened, exhibited care and compassion, and gave clear instructions for medications (Campbell et al., 2008). Importantly, the participants felt informed and that they could re-connect with the program as needed (Campbell et al., 2008). This particular study highlighted patient satisfaction with SANE-led programming, as well as an improvement in psychological well-being as important program evaluation parameters. Furthermore, one may deduce that because patients were satisfied with SANE-led care and reported improved psychological well-being, Campbell et al. (2008) contribute additional evidence for the effectiveness of SANE-led post-SA care.

In a 2009 study, Du Mont et al. interviewed 19 women about their understanding of the medico-forensic process in SANE programs across Ontario. The interview consisted of closed- and open-ended questions concerning time of presentation to the SA program, staff-victim relations, reasons for undergoing a medico-forensic examination, prior knowledge of the forensic collection process, and feelings about having undergone a medico-forensic exam (Du Mont et al., 2009). Of note, Du Mont et al. (2009) found that women believed that the healthcare component of the exam was more important than the forensic exam and the forensic collection process. Importantly, 26.3% of women interviewed believed that a medico-forensic exam was necessary to ensure their health was not jeopardized, and 31.6% of women believed they had no choice but to undergo the exam once they had presented for care. Du Mont et al. (2009) highlighted the need for greater education surrounding a woman's right to refuse any and all components of an exam without jeopardizing their health.

Finally, Du Mont et al. (2018) developed a training program educating general ED staff

nurses about patients presenting after SA, and subsequently evaluated this training program. The training consisted of both in-person in-services, as well as an online module; the authors then employed a 5-point Likert scale to measure ED staff opinions on 16 statements relating to the training (Du Mont et al., 2018). While not specifically assessing SANE program administration, the evaluation framework can be translated to SANE program evaluation. Ultimately, it was evident from the literature review that patients presenting for post-SA care value a healthcare-focused program design, and that this preference points to the value of specially trained medical professionals conducting post-SA care. This preference also highlights the value of SANE-led programs in locations where post-SA victims will present, such as the IRH ED.

Implementing Program and Practice Change

Rogers' Diffusion of Innovation theory is a tangible tool for implementing practice change and is a reasonable guiding framework for implementing a practice change for the IRH ED RNs. As such, the literature review included an examination of studies which implemented Rogers' theory; three studies were identified from the literature as relatable to the current project.

In a study by Bowen et al. (2012), the authors utilized Rogers' theory to implement a delirium screening tool in a US-based intensive care unit. The authors employed the five stages of Rogers' theory: knowledge, persuasion, decision, implementation, and confirmation. In the knowledge phase of the study, Bowen et al. (2012) planned educational in-services for the nurses, held meetings for the physicians and residents, and created poster boards about the tool to be displayed on the unit. During the persuasion phase, Bowen et al. (2012) identified "champions" among the staff to facilitate the implementation of the tool; the authors then placed new poster boards with relevant information about the implementation of the tool on the unit during the decision phase. In an effort to create ease of use, Bowen et al. (2012) placed the new

tool directly into patients charts during the implementation phase, and then posted the results of the study on the unit during the confirmation phase of the study. Overall, the authors found that 85% of assessments were completed on eligible patients (159 assessments completed out 187 potential assessments), and a successful practice change at weeks 2 and 18 following the study (85% and 88% adherence rate, respectively) (Bowen et al., 2012). As such, the authors declared the implementation of the new tool, using Rogers' theory, as successful.

In another study, Watson-Wolfe et al. (2014) identified the need for practice change by decreasing the use of antipsychotic medications in patients with dementia. The authors completed a pre-test assessment of antipsychotic use in the patient population, followed by an education in-service for staff about antipsychotic use in patients with dementia guided by the principles of Rogers' theory (Watson-Wolfe et al., 2014). Watson-Wolfe et al. (2014) noted an overall decrease in antipsychotic use in this particular population: the pre-test prescription rate was 20.3% and RN documentation for use was 16.7%. After the education in-service, the prescription rate was 15.4% and RN documentation for use was 75% (Watson-Wolfe et al., 2014).

Finally, Guilbert et al. (2014) designed a cross-sectional study to examine factors associated with practice change, delays in practice change, and the strength of adoption of change in an initiative for RNs to prescribe contraception in Quebec using Rogers' theory as a guiding framework. The authors surveyed 745 RNs and noted that 57.3% of those surveyed had implemented the new practice of prescribing contraceptives (Guilbert et al., 2014). Guilbert et al. (2014) determined that nurses implemented practice change quicker when they perceived the organization they were employed by as favourable, the RNs practiced continuous re-invention of practice, and the RNs worked for a small organization. Two additional factors affecting practice

change included the degree of perceived difficulty and the degree of mentorship available (Guilbert et al., 2014). That is, nurses were more likely to implement changes that were simple, and if good mentorship was available from the employer. Guilbert et al. (2014) note that Rogers' Diffusion of Innovation theory explains the strength of implementation well, but not necessarily the ease of implementation. Rogers' theory is a reasonable framework to employ when proposing practice change as it highlights the importance of consulting and involving nurses in the proposed change. Yet, Rogers' theory, while important in the initial stages of planning the proposed project, does not fully consider the essential nature of practice development required for this project. Thus, literature relating to nursing practice development was reviewed in an effort to enhance the successful implementation of this important practice change for ED RNs.

Practice Development

Practice development focuses on developing staff, and is also concerned with transformational culture (Manley & McCormack, 2003). That is, practice development is less focused on the idiosyncrasies of a nurse's practice, and more concerned with the development of the nurse, which will then translate into developing said nurse's practice. Individual transformation then becomes collective transformation; a transformational practice development by one nurse has the potential to influence many. The following section outlines three examples of practice development obtained from a literature review.

Chambers et al. (2012) describe a program designed to translate an understanding of the lived experience of a patient detained under the Mental Health Act into nursing practice in an Irish hospital. The authors employed an action research paradigm, where research becomes part of the change process by engaging people in the study to examine their own practice (Chambers et al., 2012). The study was conducted in three phases: firstly, 19 detained patients were

interviewed about their lived experience as detainees under the Mental Health Act. From this phase, an education program was implemented with 14 staff from two inpatient wards during phase two, and then an evaluation of pre- and post-program knowledge was conducted during phase three (Chambers et al., 2012). The authors note that the participants in phase two learned new personal and professional skills, which was documented and corroborated by the participants' managers (Chambers et al., 2012). In fact, there was a noticeable difference in staff and patient engagement, which then increased the staff's confidence when engaging with patients.

In a study by Burley et al. (2019), the authors designed an intervention to increase uptake of an enhanced recovery program (ERP) following total knee arthroplasty (TKA) and total hip arthroplasty (THA) in a US hospital. The authors note ERPs enhance patient well-being post-operatively, and indeed, can lead to shorter length of stay (LOS) in the hospital. Thus, the primary aim of the study was to decrease LOS by increasing staff uptake of ERPs in the post-operative period (Burley et al., 2019). Notably, after successful uptake of the ERPs, the authors noted a decrease in mean LOS after THA from 2.18 to 1.81 days (Burley et al., 2019). There was also a decrease in mean LOS after TKA from 2.25 to 2.21 days (Burley et al., 2019). The decreased LOS was noted to improve patient outcome, which was a direct result of increased uptake in ERPs, representing practice development of the post-op team (Burley et al., 2019). The transformational nature of the project was noted in continued improved outcomes (Burley et al., 2019).

Finally, Hardiman and Dewing (2019) designed a participatory action study to test two facilitation models (Critical Allies and Critical Friends) with the intent of achieving transformation towards a person-centred culture in the workplace of an Irish hospital. The aim of

the study was three-fold: firstly, the researchers wanted to examine facilitation in workplace learning. Secondly, the researchers wanted to provide a framework for facilitation. Finally, the researchers wanted to create an atmosphere where practitioners can increase their understanding of the culture and context of their own workplace (Hardiman & Dewing, 2019). To prepare, the researchers underwent their own contextual preparation, both of the research site, and of themselves, which is an integral part of participatory action research and person-centredness (Hardiman & Dewing, 2019). Ultimately, the participants showed growth in person-centred ways of working and a transformation from intrapersonal to interpersonal skills (Hardiman & Dewing, 2019). Furthermore, the participants also showed enlightenment and empowerment after their training, which has influenced others in the workplace, thereby demonstrating overall practice development (Hardiman & Dewing, 2019).

Practice development is conspicuously interwoven with person-centred practice in the literature (Hardiman & Dewing, 2019; Hardiman et al. 2020; O'Donnell et al. 2020). The relationship between these two concepts is applicable to the proposed project, as a greater focus on Indigenous-informed care is, indeed, a focus on person-centred care for the majority Indigenous population of the Beaufort Delta and northern Sahtu. The preceding literature review aimed at deconstructing the current model of care, where physicians perform post-SA exams, with the intent of identifying the issues in the current context. The primary issue identified by the writer, and through the literature review, is that women prefer a healthcare-focused post-SA program with specially trained individuals to guide them through the post-assault period; this model is not currently offered at the IRH. Furthermore, the current practice, designed around the medical model, is not meeting the person-centred needs of the patients presenting to the IRH ED. In order to practice from a person-centred paradigm, a cultural shift in programming is required

to honour and respect the majority Indigenous population. From a nursing perspective, this cultural shift must be completed via practice development. A detailed guide for implementing said practice development is presented in the forthcoming sections.

Proposed Implementation of RN-led Post-SA Care in the IRH ED

At the outset of the forthcoming description of the implementation of SANE-led care in the IRH ED, it is important to note that the description is a proposal for future implementation. At the time of writing this proposal, the information is the most up-to-date information available; however, with passing time, the information in this proposal is subject to change and should be updated accordingly. Furthermore, as is common across the North, a high turnover rate for staff in all spheres (frontline, medical, and management) has the potential to influence the implementation of the following proposal. Yet, with a greater focus on person-centred care via a greater focus on Indigenous-informed care, it is this author's expectation that all parties will be interested in implementing the following proposal.

The implementation of person-centred, Indigenous-informed post-SA care is multi-faceted, and for the purposes of this proposal, has been separated into two stages. The first stage, and the focus of this proposal, is the practice development of IRH ER RNs into SANE practitioners. The second stage, to be considered after successful implementation of the first stage, is the formation of a SA response team, which would include counsellors, the justice committee, victim advocates, RCMP representatives, and other members to assist in post-assault care and the justice system. At this time, however, a SART is outside the realm of this proposal, and thus, the first stage of implementation will be prioritized in the forthcoming sections.

Development Team

To initiate practice development for ER RNs at IRH by way of implementing RN-led post-SA care in the IRH ED, a comprehensive team comprising members from many disciplines will be necessary. A schematic illustration of team members is depicted in Figure 2.

Figure 2

Development Team Members

GNWT Management	Team Lead, Acute Care (Charge RN) Manager, Acute Care Services Senior Manager, Health Services Territorial Manager, Acute Care Services
Nurse Educators	Clinical Nurse Educator, North Territorial/Clinical Education Manager
Indigenous Representatives	Regional Indigenous Wellness Coordinator, GNWT Health Representative, Gwich'in Tribal Council Health Representative, Inuvialuit Regional Corporation
Allied Healthcare	Medical Director, IRH Medical Social Worker, IRH Director of Social Programs
Practice & Professional Issues	Executive Director, RNANT/NU Member of Legislative Assembly, Inuvik

Frontline Service Providers	ED Medical Director ED RNs IRH RNs
Author	Meghan Sweetnam (also ED RN)

Note. A schematic illustration listing potential development team members.

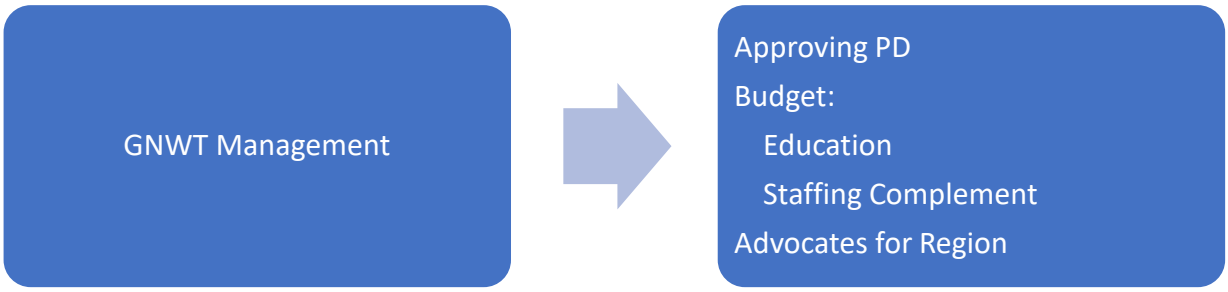
As previously mentioned, IRH operates within a centralized health authority located in Yellowknife; as such, not all team members will be located in Inuvik. Nevertheless, teamwork through telecommunications and travel is a well-practiced entity across much of Canada's North, and thus, the varied locations of team members should not pose a problem for team communications.

From NTHSSA management, four team members have been identified. The **Team Lead for Acute Care and Emergency**, who acts as the charge nurse between both departments from Monday to Friday, 0730-1530, should be involved as a liaison between frontline healthcare providers and middle and upper management. The Team Lead reports to the **Manager of Acute Care Services**, who acts as the nursing manager for the nursing staff at IRH. This manager reports to the **Senior Manager of Health Services,** and ultimately, the **Territorial Manager of Acute Care Services**. In order to effectively create practice change through practice development, all levels of management must be involved for several reasons. Firstly, the Senior Manager and Territorial Manager are responsible for approving any practice development requiring a change in service provision. These managers also collaborate on the budget for nursing staff, and would be required to approve funding for education leave and the appropriate staffing to meet the proposed needs. Furthermore, the Senior Manager acts as liaison between IRH and the territorial authority, and is the best advocate for change at the territorial level. The

Manager of Acute Care Services at IRH is responsible for direct staff management, and would be responsible for recruiting and educating staff for the proposed program. Finally, the Team Lead would be the liaison between the Nursing Educators, managers, and the frontline nursing staff, and would assist in recruiting and educating staff. Furthermore, because the Team Lead is in frontline care and in a position of continuity (Monday to Friday), it would be advantageous to have this position as part of the development team. A schematic representing the responsibilities of the GNWT management is illustrated in Figure 3.

Figure 3

GNWT Management Team Roles & Responsibilities



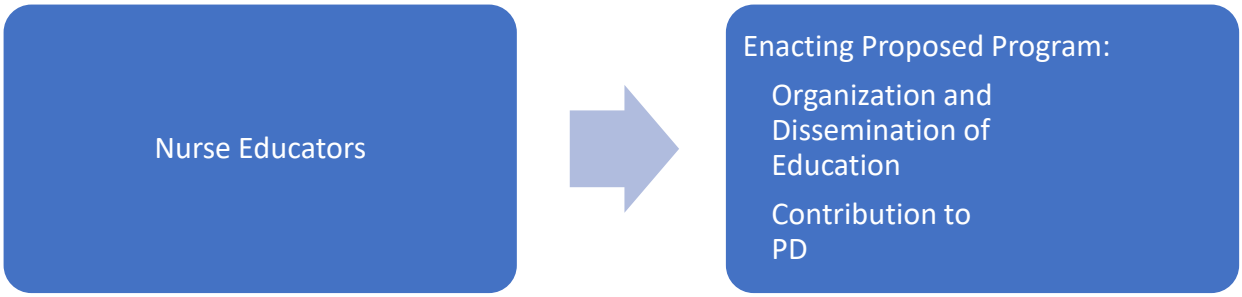
Note. A schematic illustration listing GNWT Management's contribution to team development.

There are two nurse educators who will be recruited for the development team: the **Clinical Nurse Educator North** (based in Inuvik, but responsible for the territorial areas of the Beaufort Delta and Sahtu), and the **Territorial and Clinical Education Manager** (based in Yellowknife). The nurse educators are crucial team members, as their primary roles would be the organization and dissemination of education relating to SANE training, and contribution to practice and professional development. In short, the clinical nurse educators would be primarily responsible for enacting the proposed program, and indeed, ensuring that the frontline nurses engage in practice development. The Clinical Nurse Educator North would be responsible for

direct program implementation at IRH, but approval for the proposed program must come from the Territorial and Clinical Education Manager in Yellowknife. Thus, both educators must be included in the development. A schematic representing the responsibilities of the Nurse Educators is illustrated in Figure 4.

Figure 4

Nurse Educator Team Roles & Responsibilities



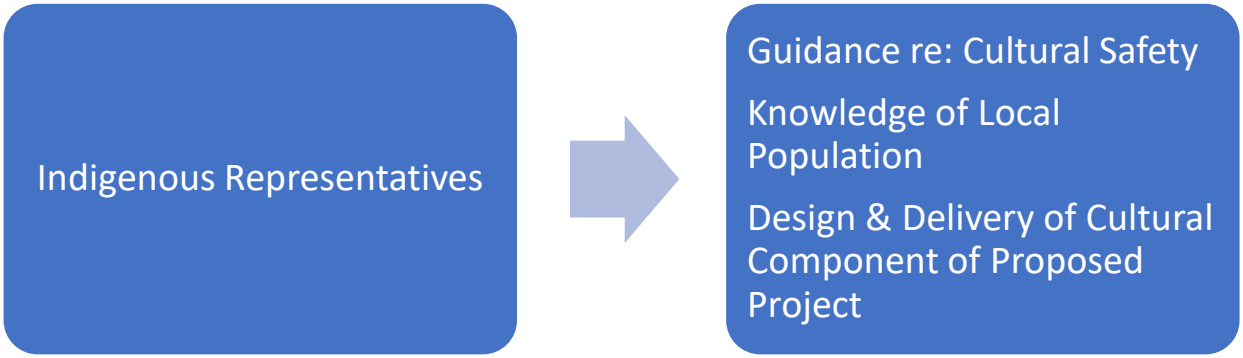
Note. A schematic illustration listing the Nurse Educators' contribution to team development.

In an effort to ensure appropriate Indigenous representation for the proposed program, the **health representative from each Indigenous government** (Inuvialuit and Gwich'in), as well as the **Regional Indigenous Wellness Coordinator** (from the NTHSSA) will be recruited for the development team. The Indigenous representatives have several roles in the proposed program development: firstly, the Indigenous representatives would provide guidance relating to cultural safety in healthcare. Furthermore, the Indigenous representatives have an intimate knowledge of the local population, and in fact, may also be able to provide insight into the underreporting of SA noted in the consultation component of this project. The representatives from the Indigenous governments may also have knowledge of available out-patient services that are culturally specific, and knowledge of potential funding or revenue resources for project implementation. Most importantly, however, the Indigenous representatives will be integral in the delivery of the

cultural component of proposed training. In order to ensure that the program is culturally safe for the patient population, part of the proposed training for the ER RNs will include a cultural component that must be delivered in conjunction with the Indigenous representatives in keeping with the cultural framework of the project. This component will be developed and disseminated in conjunction with the Indigenous representatives to ensure cultural safety and authenticity. A schematic representing the responsibilities of the Indigenous representatives is illustrated in Figure 5.

Figure 5

Indigenous Representatives' Team Roles & Responsibilities



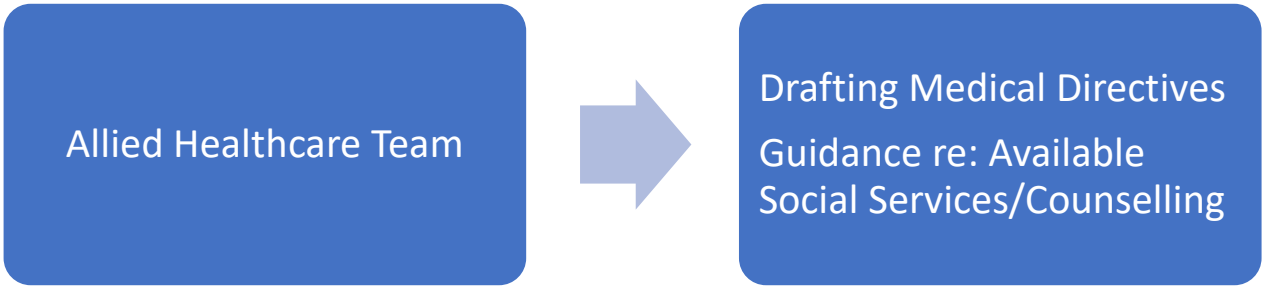
Note. A schematic illustration listing the Indigenous representatives' contribution to team development.

Allied health providers, including the medical team and social services, will be approached to act as members of the development team. The **Medical Director of IRH** is a key member of the team, as his approval is required for the proposed delegated practices. Furthermore, the medical director must approve of any medical directive development. One medical directive for the entire procedure of post-assault care would be ideal, but may not be feasible as the post-SA care is very involved. Thus, medical directives relating to pharmacology

(STI prophylaxis, emergency contraception, and pain management), vaginal examinations, and required laboratory testing (notably, bloodwork and swabs for culture and sensitivity relating to STIs) could be developed. Social services would be consulted for guidance relating to counselling services available during the post-assault period (i.e. in-house versus on-call services), and what counselling services are provided during the follow-up period. Key members of social services include the in-patient **Medical Social Worker (MSW**), and the **Director of Social Programs**. As there is no specific counselling service for the emergency department, close work with the social services department may lead to better coverage for post-assault patients. A schematic representing the responsibilities of the allied healthcare team is illustrated in Figure 6.

Figure 6

Allied Healthcare Team's Roles & Responsibilities



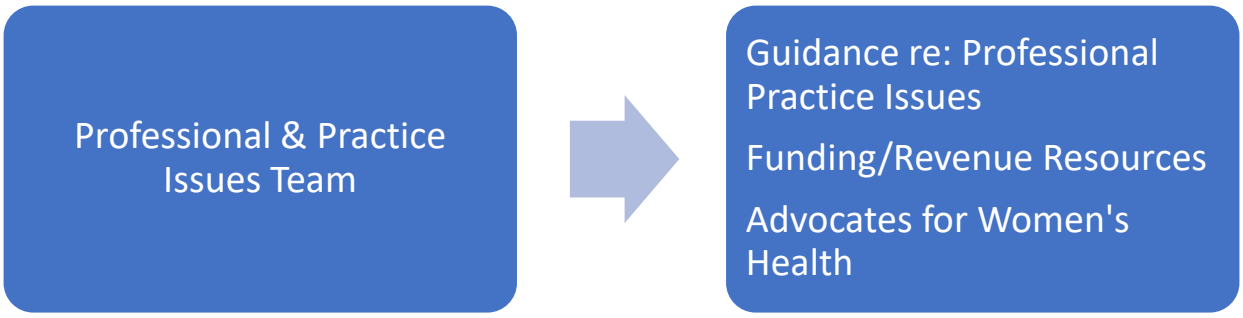
Note. A schematic illustration listing the allied healthcare team's contribution to team development.

The Registered Nurses Association of the Northwest Territories and Nunavut (RNANT/NU) will be approached for guidance on professional and practice issues. For example, the **Executive Director of RNANT/NU** will be able to provide guidance on practice development. Furthermore, one of the **Members of the Legislative Assembly (MLA) for**

Inuvik is a former nurse manager, and also an Inuvialuit beneficiary. She would be able to provide valuable insight for possible funding and revenue resources, as well as act as an advocate for nursing practice development. As professional women, these potential team members also advocate for women's issues, which is essential when developing a program where women are the key population of interest. A schematic representing the responsibilities of the professional and practice issues team is illustrated in Figure 7.

Figure 7

Professional & Practice Issues Team's Roles & Responsibilities



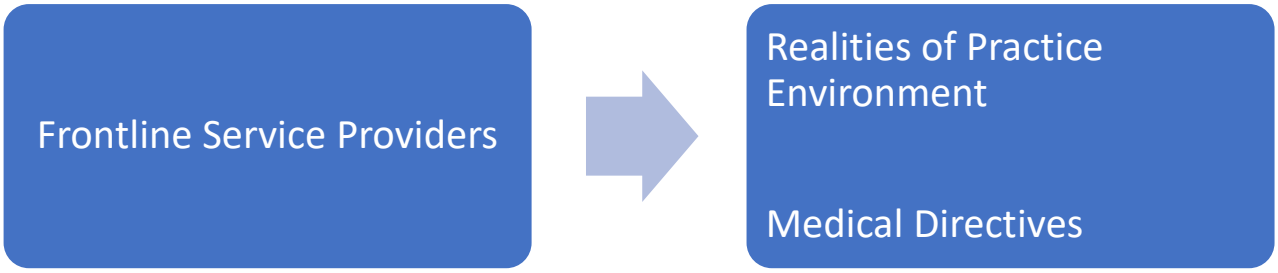
Note. A schematic illustration listing the professional and practice issues team's contribution to team development.

Finally, the frontline service providers will be consulted as members of the development team. These service providers include the **ER Medical Director**, the **ER RNs**, and any other interested **RN team members** from public health, obstetrics, or community health. As members of the development team, the frontline staff will contribute information about the realities of practice and the proposed development. The service providers will also contribute to the medical directives and are the targeted population for practice development. As both a frontline care provider, and the developer of the proposed program, the **writer** will join the team and give guidance for the implementation of the frameworks (i.e. emancipatory practice

development/*etuaptmumk*/ *Piliriqatigiinniq*). Furthermore, the writer will also provide guidance relating to the resources required for the successful implementation of the proposed program, and serve as a liaison between all team members. Schematic diagrams representing the responsibilities of the frontline service providers' and the author's responsibilities are illustrated in Figures 8 and 9, respectively.

Figure 8

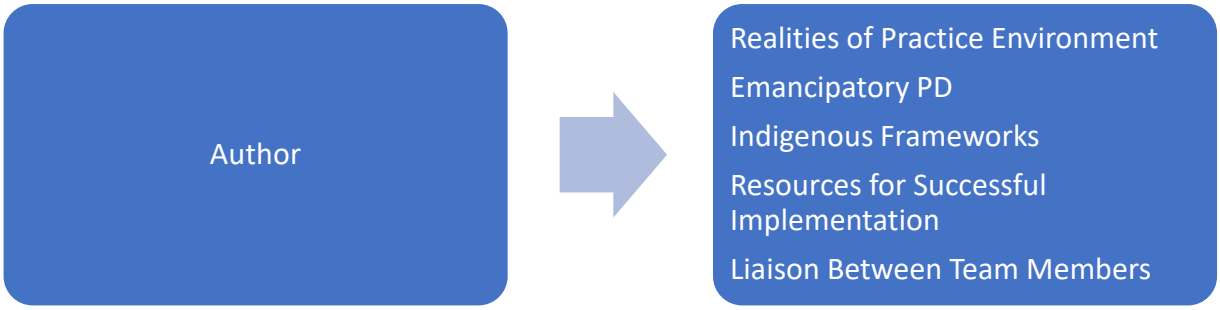
Frontline Service Providers' Roles & Responsibilities



Note. A schematic illustration listing the frontline service providers' contribution to team development.

Figure 9

Author's Roles & Responsibilities



Note. A schematic illustration listing the author's contribution to team development.

Program Development

Requisite Nursing Education

The goal of the proposed program is to educate frontline RNs to provide post-SA care for SA patients presenting to the IRH ER. At the outset of the project, it was conceived that the frontline providers should be ED RNs as they have first contact with the presenting patients, but with greater research into team modelling and cost-effectiveness in Canada's North, any RN with an interest in post-assault care or women's health could be provided with the requisite education and join the group of RNs providing post-SA care. In fact, research has revealed different avenues for post-assault care education, and thus, different designations in practice.

During the first stage of the proposed program, RNs will participate in a practice development approach designed to prepare them to deliver person-centered post-assault care in the IRH ER. Education for post-assault care comes in many forms; firstly, the British Columbia Institute of Technology (BCIT) offers certification in Forensic Nurse Examination (BCIT, n.d.a). The education consists of two online courses: Introduction to Forensic Health Sciences and Forensic Nurse Examiner Core Education: Theoretical Aspects (BCIT, n.d.a). Each course consists of 45 contact hours, and the certification is accredited by the International Association of Forensic Nurses (IAFN) (BCIT, n.d.a). At the conclusion of the online modules, the RN is required to complete 16 clinical hours in post-assault care through one of IAFN's partner hospitals. At the conclusion of this certification program, the RN may use the SANE designation. For the program at IRH, it is proposed that at least one, and preferably two, frontline service providers complete the education required for this designation.

The IAFN also offers a 41-hour online didactic training program with partnerships for the clinical simulation component (IAFN, 2021b). This course consists of eleven modules covering information about specimen collection, collaborating with community resources, STI testing, and

the legal process among other topics (IAFN, 2021a). Similar to the certification offered by BCIT, the clinical practice component must be completed in addition to the didactic portion of the training. This overview of post-assault care is sufficient for the majority of RNs who wish to become post-assault care providers in the IRH ER. To mitigate the difficulty coordinating the clinical simulation training from remote northern Canada, the ultimate goal for this program would be to form a partnership with Aurora College (the NT's education institution) to provide the clinical simulation components in the NT; however, this partnership is out of the current range of the project and may only be made available once the program is successfully implemented.

Notably, the cost for either training option can be covered by two professional development programs offered by the GNWT for its employees. The first program, the Professional Development Initiative (PDI), is intended to provide enhanced skills relevant to the employee's position and covers distance learning and required resources (such as textbooks) (GNWT, 2020). The maximum amount of funding per individual per year is $3550 in Inuvik, which would fully fund the $500 cost of the online course delivered by the IAFN (GNWT, 2020; IAFN, 2021b). The second program offered by the GNWT is called the Targeted Academic Support Program (TASP), and offers more substantial funds for tuition, resources, and practicum costs (GNWT, n.d.). The TASP program would cover the tuition costs for the BCIT certification program (approximately $1,596), as well as the travel and working time for the clinical simulation components required by both the IAFN and BCIT programs (BCIT, n.d.b; BCIT, n.d.c). As each permanent employee is eligible for either or both GNWT professional development programs, the costs for SANE education are not the responsibility of the staffing

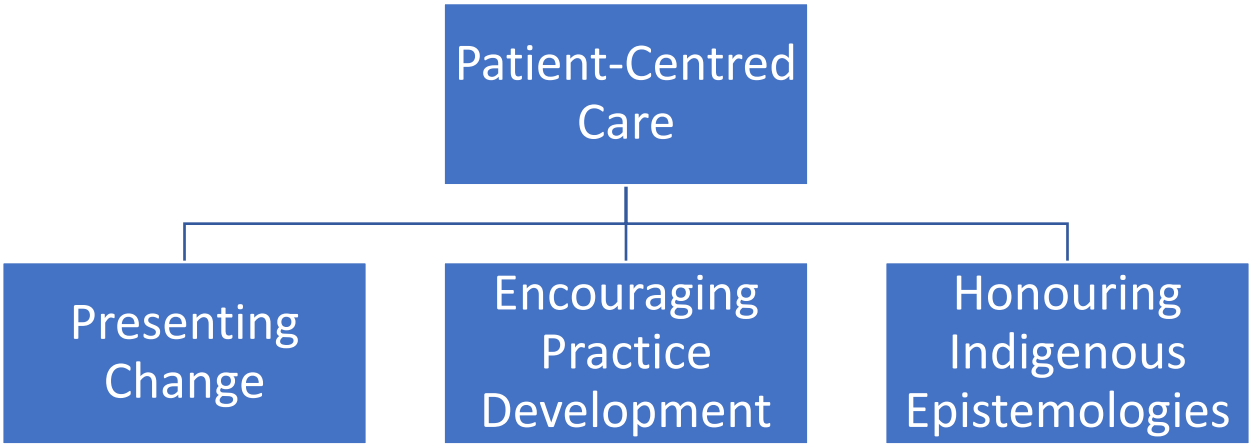
budget, and indeed, can be fully funded by revenue outside any provided by nursing management.

Fostering Patient-Centred Care: Presenting Change, Encouraging Practice Development, and Honouring Indigenous Epistemologies

To move to patient-centred care for post-SA victims in the IRH ER, a three-pronged approach must be taken, and indeed, acts as the core foundation of the proposed program. Firstly, a procedural change must be offered. This offering can be structured via Rogers' Diffusion of Innovation Theory. Rogers' theory is a five-stage theory which may assist in generating interest in RN-led post-assault care in the IRH ER. The idea of change must first be presented to all frontline providers (including physicians and RNs), as well as NTHSSA management, in an organized manner to encourage interest in undertaking the monumental task of changing the status quo. After change is proposed and agreed upon, the RNs participating in the program must engage in practice development, which may be guided by implementing emancipatory practice development. Finally, both components must be presented through an Indigenous epistemological lens, which honours the patient population in question, and also shifts the program from one solely based in developing nurses to one which encourages patient-centre care. A diagram representing this approach is depicted in Figure 10.

Figure 10

Fostering Patient-Centred Care: A Multifaceted Approach



Note. A schematic illustrating the importance of a multifaceted approach to patient-centred care.

To present a change to the status quo, Rogers' Diffusion of Innovation Theory will be utilized. As discussed in the study by Bowen et al. (2012), the five steps of Rogers' Diffusion of Innovation Theory are knowledge, persuasion, decision, implementation, and confirmation. For the current project, the knowledge stage of Rogers' theory would encompass in-services with RNs, physicians, the MSW, the Regional Indigenous Wellness Coordinator, and the team lead and Manager of Acute Care Services (Bowen et al., 2012). These in-services would detail the proposed program in oral and written forms of communication and would be led by the writer. The goal during this stage of the project would be to generate interest in the program, and to encourage a shifting worldview to one of patient-centred care. During the knowledge stage, it will be clearly noted that in order to deconstruct the current medical model of care for post-SA examinations, an entirely new paradigm of emancipatory practice development must be introduced. The nursing staff must embrace this paradigm to change the current model of care.

The focus of this paradigm, and thus, the program at large, is to develop the nursing staff, with the ultimate goal of creating a transformational culture of practice for the participating RNs (Manley & McCormack, 2003). The RNs must be encouraged to develop their individual practice through self-reflection and self-understanding (Manley & McCormack, 2003). For the purposes of this program, activities that encourage self-reflection and self-understanding include self-reflective journaling, and structured entrance and exit interviews. Furthermore, as was described by Hardiman and Dewing (2019), the participants must engage in contextual preparation. Contextual preparation orients the practitioner to their immediate surroundings, and highlights their individual practice at the outset of practice development so that the journey towards developing one's practice is more tangible. As the practitioners develop their individual practice, a transformational culture is encouraged, which leads to lasting change, and eventually, practice development for staff not directly engaged in the program.

During the persuasion phase of Rogers' theory, a "change champion" would be identified by the writer, physicians, and RNs (Bowen et al., 2012). This change champion would be the first of the staff trained for post-SA care. Ideally, the change champion would be certified as a SANE by completing the educational program through BCIT. The champion would then begin implementing RN-led post-SA care in the ER. Importantly, the change champion must be someone the potential team members believe they can approach for guidance. Preferably, this RN would be a full-time staff member of the IRH ER, knowledgeable in several different areas of care provision (women's health, post-traumatic counselling, etc.), and an effective teacher. The champion would also be the first RN to engage in practice development, and must be amenable to this process.

During the decision phase of Rogers' theory, additional RNs would be recruited, and

information about the required education for completing post-SA care would be disseminated to the team (Bowen et al., 2012). An entrance interview regarding the staff member's current contribution to post-assault care, their knowledge of culturally-informed care, and their thoughts on, and knowledge of, the importance of practice development would be completed. Furthermore, the process of engaging in practice development would be detailed, and instructions would be provided regarding self-reflective activities such as journaling, and engaging in guided group discussion. The implementation stage of Rogers' theory would encompass staff enrollment in the required education, and an undertaking of the aforementioned reflective activities. In the initial stages of the program implementation, the staff would be encouraged to keep a weekly journal about their practice development, and attendance to weekly meetings would be encouraged for staff discussion. It should be noted that the implementation phase of the program could reasonably last a year or more, and staff must be made aware of this time commitment at the outset of the program.

The final stage of Rogers' theory is the confirmation stage (Bowen et al., 2012). During this stage, the staff will have come to an understanding of practice development, and will engage in an exit interview to determine growth over the program. This stage will also encompass an evaluation of the entire program: firstly, the participants will compare the before and after of specific parameters (such as patient assessment). Furthermore, the participants will examine their personal and collective development by reviewing their journals and the group discussion over the course of the program's implementation. The eventual goal of developing staff includes transforming the context where patient care takes place (i.e. from one of an exam room to one of a holistic view of a person's physical, mental, emotional, and spiritual well-being). Developing staff should also encourage further practice development that is normalized in an individual's

practice (McCormack, 2013). For example, the patient-centred care encouraged in post-assault care can, and should, be transformed into routine care of patients presenting with all complaints. Finally, the goal of practice development is improving patient care by implementing a patient-centred care paradigm that honours Indigenous culture and traditions.

The unique nature of this program lies in the fact that it is a program that will be delivered by a healthcare team at the beginning of transitioning from a colonial approach to healthcare for a majority Indigenous population. The fundamental goal of practice development is to develop nurses such that better outcomes are experienced by the patient. As the majority population of the Beaufort Delta and Sahtu is Indigenous, person-centred care for this population would require the nurse to have knowledge of the Indigenous ways of knowing, as well as the application of these unique paradigms to practice. Employing emancipatory practice development requires nurses in this program to reflect on post-assault care for patients, but more specifically, post-assault care for Indigenous patients. Practice development requires nurses to examine their current approach to practice and critically examine how to move from their current practice to one that supports Indigenous post-assault victims. A key component of this development will be discussion surrounding Indigenous epistemology and the aforementioned Indigenous frameworks. In the forthcoming sections, recommendations for the delivery of this information will be examined.

Encouraging Change: Examining the Status Quo and Organizational Policies

Organizational Support

In order to change the current model of post-assault care, the organization must be willing to endorse a new practice model. The summary of consultations, including participation from management and medical personnel at IRH, demonstrates overwhelming support for the

proposed program. The consultees identified that nurses are a trusted entry-point to care and as having the time and holistic practice necessary for completing post-SA exams. Furthermore, the consultees noted that nurses are a more consistent presence in the department, and forge a better relationship with presenting patients. RNs, if properly trained, have the knowledge, skills, and judgement to complete the post-SA physical examination, and indeed, add an element of compassion and integrity to the process that is currently lacking in the present model. These principles are well-stated in the literature, which has been previously examined.

The challenge presented by achieving, and maintaining, organizational support for the program includes an especially high staff turnover rate. Transience is common in Canada's North; in the writer's six years at the IRH, there have been four Managers of Acute Care Services. Furthermore, for one year, the position lay vacant and the nursing staff were directly managed by the Senior Manager. Additionally, the team lead position has been vacant for more than a year, as the current team lead is on maternity leave and a candidate has not been hired into the position. The physician transience rate is also high. The complement of physicians at IRH is 9.5 positions; at the current time, five of these positions are filled while five lie vacant. Finally, of the 6.5 full-time positions in the IRH ER, 3.5 positions are vacant at the writing of this proposal. All of the aforementioned vacant positions are covered by locum staff, who travel to Inuvik for periods between two weeks and four months. Most locum physicians contract for one month of work at IRH, and also locum in many other centres across Canada. As is evident, achieving and maintaining support for any programming is difficult when the majority of the staff is transient; however, this challenge can be alleviated by ensuring that the development team primarily consists of permanent staff members who are invested in community wellness.

Education

To change the current model of care, the clinical nurse educators must be supportive of the program. Ideally, the clinical nurse educator will work in consultation with the writer to deliver the appropriate education for post-assault physical examinations, as well as the proposed Indigenous wellness component. Challenges posed by this support include the high turnover rate of clinical nurse educators at IRH. At the time of the consultations, as well as at the time of the writing of this proposal, the clinical nurse educator position is vacant. Furthermore, the Clinical Nurse Educator North position at the IRH is managed out of Yellowknife; in truth, the Clinical Nurse Educator North takes direction on education from the territorial agenda. Proposing a regional program in a territorial authority may prove difficult as it may not meet the territorial agenda. Furthermore, the Clinical Nurse Educator North position is demanding, as the position is responsible for ensuring the education and certification of nurses from multiple sites (IRH, as well as the community health centres in the Beaufort Delta and Sahtu). Nevertheless, this challenge could be mitigated by delegating the majority of the staff education to the writer and the Indigenous Wellness Coordinator. Furthermore, at the team development stage of this proposed program, a working committee should be developed to help meet the objectives of the program; in this way, much of the workload could be moved from the Clinical Nurse Educator North position, and shared amongst the working committee.

Funding

Funding for the program will require a re-allocation of healthcare dollars when compared to the current model. As previously examined, funding for education can be secured through the GNWT PDI and TASP programs, but funding for increased nursing hours may pose an immediate challenge for the program. In the current model, the on-call emergency physician

provides post-SA care; this model serves as the status quo because the physician is already on-call and, theoretically, the physician has all of the skills required to complete post-assault care. As a result, it appears that no extra healthcare dollars are dedicated to the care of post-SA patients. In fact, physician-led exams take longer, thereby delaying the care of other patients (Stermac & Stirpe, 2009). Furthermore, service interruptions are more common in physician-led exams, which contributes to a longer stay in the emergency department for the patient and more interventions (Stermac & Stirpe, 2009). In the writer's experience, most male physicians at IRH will defer post-SA care of female patients to female physicians; this leads to another on-call doctor being consulted for the exam at increased cost.

Green et al. (2021) identify four business models aiming to provide SANE care in a network of EDs in Missouri, United States. Ultimately, the model chosen involved hiring six full-time SANE ED RN providers; the providers worked a combination of 1-2 SANE shifts per week, and 1-2 ED shifts per week (Green et al., 2021). This model was chosen because it allowed the providers to keep their SANE and ED skills, and also decreased vicarious trauma for nurses when engaged in sole SANE practice (Green et al., 2021). This model is similar to the ideal plan for the IRH ED; recruiting RNs who retain their full-time employment as frontline providers (i.e. ED RNs, public health RNs, labour and delivery RNs) is the key to cost effectiveness in the program. Furthermore, this model allows the RNs to retain their primary practice skills, which is essential in a small, rural facility. In time, as more RNs are trained, at least one RN with post-SA care education should be scheduled for every shift, and can be re-assigned to complete post-SA care as needed.

An issue identified in the literature for rural SANE providers is the ability to maintain skills that are only be utilized on an infrequent basis (Miyamoto, Thiede, Born, Perkins, Bittner,

& Scanlon, 2021; Walsh, Meunier-Sham, & Re, 2019). Part of this issue is mitigated in the implementation plan by designating one or two frontline providers to complete SANE certification, and to maintain the education necessary for same. It is likely, however, that these nurses will not always be physically available to provide guidance. Miyamoto et al. (2021) discuss options for alleviating this challenge, the most applicable being the development of a telehealth response team where experts in SANE care provide assistance on an on-call basis for rural and remote post-SA care providers. Ideally, a group of SANE certified experts are recruited and hired by the health authority to act on-call to assist the providers at IRH from a secure location on a secure network. This principle is almost entirely the same as ED physicians consulting specialists at other facilities for disciplines such as orthopedics, pediatrics, and neurology. It would certainly assist the IRH RNs in retaining a post-SA care program, but at this time, is beyond the scope of the current proposal. Nevertheless, it is a consideration that will be pertinent once the program has been established.

Policy and Practice Development

In order to effectively change the current model of care, several disciplines must undertake the task of changing and developing new policy. All program and practice development initiatives are considered territorial initiatives, and are directed by the territorial agenda in Yellowknife. Thus, there are currently no policy development committees at IRH. It is important, therefore, that staff in positions of authority (such as the Senior Manager and the IRH Medical Director) are able to advocate for the program's importance at the territorial level. Should the program be considered for IRH, management, the medical team, RNANT/NU, and the writer would be involved in considering which practices could be delegated from physicians to RNs, and drafting medical directives to that effect. While a seemingly monumental task at the

current time, and with the current staffing shortages, transferring post-SA care to RNs is in the best interest of the patient, which is the goal of healthcare practitioners. There is support for the proposal, and with the working committee, it is possible that this task can be completed.

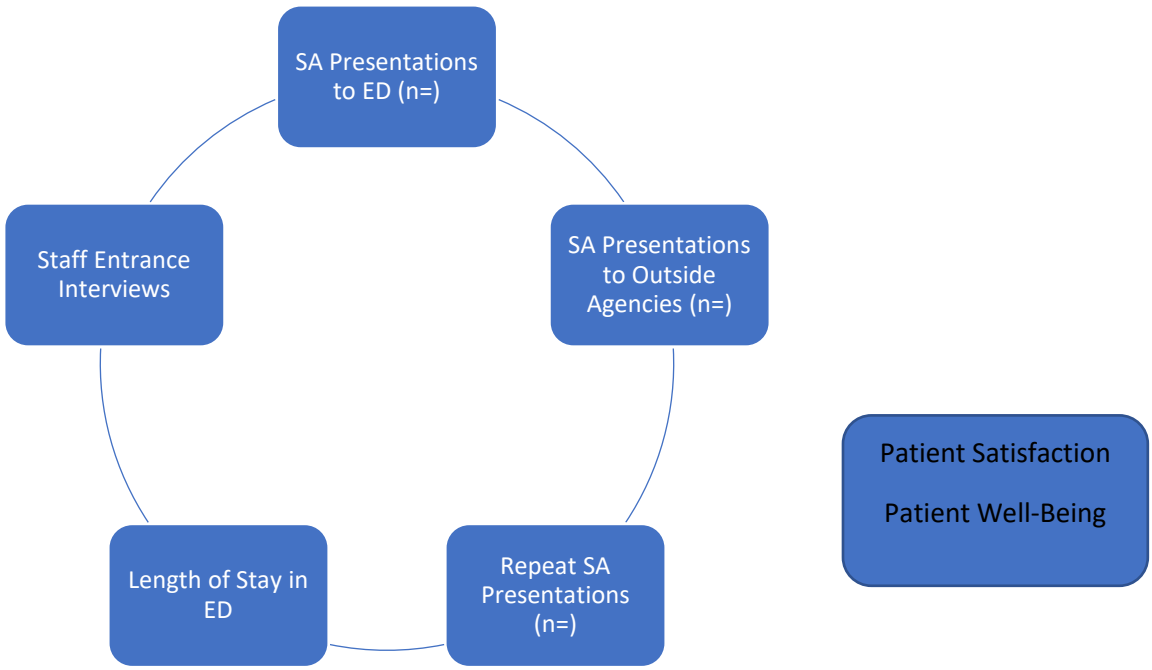
Evaluating RN-led Post-Sexual Assault Care in the IRH ED

Initial Evaluation Parameters

At the outset of the proposed program, clinical data should be examined to develop the baseline evaluation indicators that will be used to determine if program implementation is successful. Firstly, the committee should examine the number of SA presentations to the IRH ED during one calendar year; this case review should also include other, related presentations such as cases of domestic violence, to determine whether there were instances when patients were sexually assaulted but chose not to complete post-SA care. During this case review, repeat presentations should also be surveyed for demographics purposes. Furthermore, patient length of stay should be reviewed, as it is linked to the cost-effectiveness of initiating and maintaining RN-led post-SA care. In partnership with the RCMP, social services, the justice committee, and victim services, cases where patients presented to other agencies with complaints of SA, but then chose not to pursue a post-SA exam, should also be examined. Presentations to other agencies, but not to the IRH ED, could indicate hesitancy to participate in the current model of post-SA care, which would lend support to changing the status quo. A diagram illustrating the initial evaluation parameters is illustrated in Figure 11.

Figure 11

Initial Evaluation Parameters



Note. A schematic illustration depicting the initial evaluation parameters prior to implementing the proposed program.

Ultimately, the best method of evaluation would be patient satisfaction with the current care model, as was collected in Du Mont et al. (2014), Du Mont et al. (2017), and Campbell et al. (2008). Unfortunately, collecting data on this parameter would also prove very difficult in the current model of care due to the sensitive nature of the patient's presentation to the ED. During the initial presentation to the ED, where the patient must recount their experience and undergo an invasive physical exam, it would not be prudent to collect data while the subject has recently undergone a traumatic experience, and is potentially re-traumatized by the post-assault care. To introduce another instance where the patient may be re-traumatized (i.e. evaluating their recent experience) would not be ethically responsible. For this reason, Figure 10 notes that collecting data about patient satisfaction and patient well-being would be ideal, but not within the circle of responsible data collection.

To examine the success of practice development, entrance interviews with staff relating

to current practice must be conducted. The interviews should examine how the staff contribute to the current model of physician-led care, their knowledge of culturally-informed care, and their thoughts on, and knowledge of, the importance of practice development. Ideally, a peer-reviewed system of evaluation should also be considered, where the nurses involved in the program, management, and the writer anonymously evaluate another nurse's practice to ensure objectivity using a Likert scale evaluation form.

Follow-up Evaluation Parameters

The proposed program should be evaluated after six months and one year of implementation. During these review periods, the number of SA presentations to the ED, the number of repeat presentations, and the length of stay of each patient presentation should be re-evaluated. The program would be deemed successful if the number of presentations to the ED increased. During the consultation period, it was stated that many SA victims do not seek care in the Beaufort Delta and Sahtu regions, likely due to shame and a lack of guidance or desire to seek criminal charges against the perpetrator. If the number of presentations increase after an RN-led post-SA care model is introduced, it can be inferred that patients are more likely to seek care if they are comfortable with the post-assault care process. Similarly, re-examining the number of cases where a patient presents to an alternate agency without ED follow-up may indicate the success of the program. Examining patient length of stay will assist in determining the cost-effectiveness of the program, a parameter that is pertinent in the responsible spending of healthcare dollars.

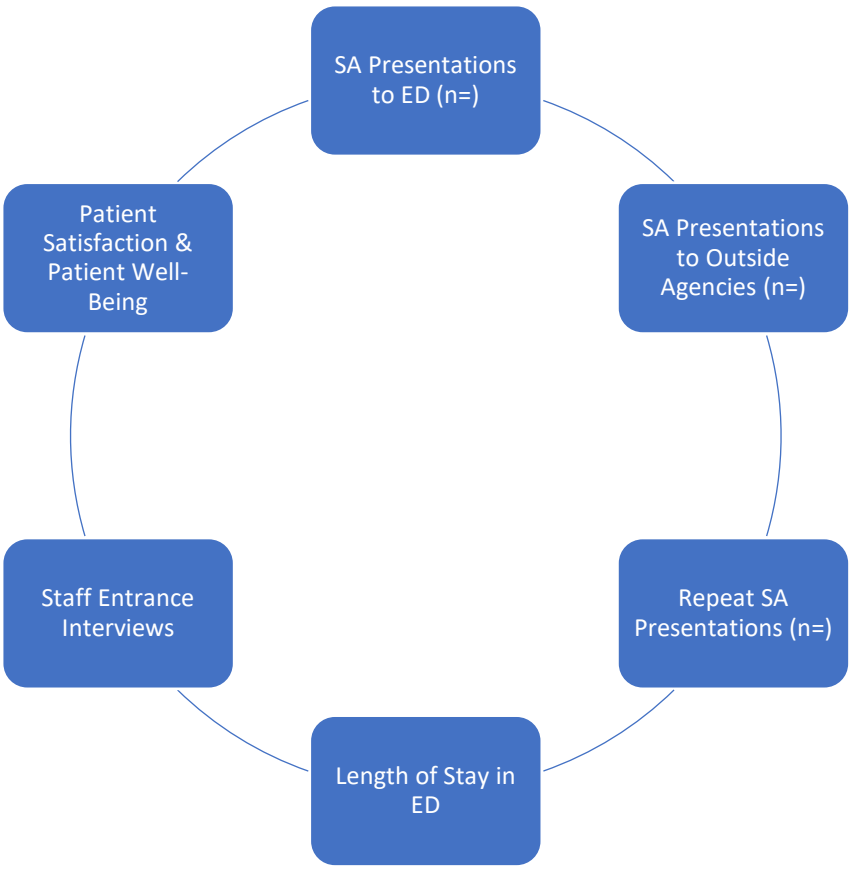
Part of the RN-led model of post-assault care ensures proper follow-up with the patient. The patient should be put in contact with the appropriate counselling services, and should also be examined in an office setting approximately 2-4 weeks after the assault to review lab work and

coping. At this follow-up appointment, it would be reasonable to disseminate a survey determining a patient's satisfaction with RN-led post-assault care. The initial trauma period will have passed, and the patient has had the choice to begin appropriate post-traumatic counselling care. The likelihood of re-traumatization still exists, but is not as great as in the initial exam. Thus, it would be reasonable to examine a patient's satisfaction with care using a Likert scale questionnaire similar to that employed by Du Mont et al. (2014). While it would not be possible to compare the pre- and post-program data, this survey would still prove beneficial in determining the success of the proposed program.

Finally, to examine the nursing team's practice development, exit interviews with staff relating to their practice must be conducted. The exit interviews would again examine the nurse's contribution to post-assault care, their knowledge of culturally informed care, and their thoughts on, and knowledge of, the importance of practice development. The peer-reviewed system of evaluation should also be re-examined, with an emphasis on transformational practice development. During the exit surveys, management, nursing peers, and the writer should comment on whether the nurse has taken practice development and applied it to other areas of practice. If the nurse has undergone practice development in relation to this program, and additionally, in other areas of practice, the emancipatory practice development paradigm utilized in this program's implementation should be considered a successful means of encouraging practice development for all IRH nursing staff in all areas of practice. A diagram illustrating the follow-up evaluation parameters is illustrated in Figure 12.

Figure 12

Follow-up Evaluation Parameters



Note. A schematic illustration depicting the follow-up evaluation parameters required after six months and one year of program implementation.

Recommendations for RN-led Post-Sexual Assault Care in the IRH ED

To successfully implement the proposed program, several recommendations, primarily concerning education and funding, must be determined. With respect to implementing the proposed program, the frontline RNs must complete education and certification in post-SA care. As previously noted, one designated "champion" and the writer should be the first nurses to complete the SANE course to achieve SANE certification via BCIT. In this way, the program has designated "super-users" the other staff can approach for questions, or consult during exams as needed. The other staff could complete the SA certification through the IAFN, thereby

undergoing extensive training without committing to SANE certification. As more staff join the program, the more senior team members can work to achieve their SANE certification as needed.

Also regarding education, the writer and Clinical Nurse Educator must begin work in determining the necessary skills for facilitating emancipatory practice development amongst staff. These enhanced skills can be achieved through further academic research into emancipatory practice development, and through contact with experts in practice development research. Several practice development researchers have been identified through this proposal, including Brendan McCormack, David Coughlan, and Mary Brydon-Miller. Contact with these researchers, and their educational institutions, should provide direction regarding facilitating practice development education.

A key part of this program is the development of an educational component relating to post-SA care for the Indigenous patient. As the overarching goal of the proposed program is to improve patient outcomes by delivering patient-centred care, it is imperative that the participating nurses develop their practice in a way that is respectful of Indigenous epistemology. The frameworks discussed in the background of this proposed program provide an entry point to understanding Indigenous approaches to healthcare. In conjunction with the Regional Indigenous Wellness Coordinator, the writer plans to develop an educational module focusing on the cultural practices of the Gwich'in, Dene, and Inuvialuit peoples, as well as discussing the principles of patient-centred care in these populations.

To facilitate the development of this cultural module, the writer and Regional Indigenous Wellness Coordinator must consult with Indigenous leaders and elders in the Beaufort Delta and Sahtu to determine what specific health principles are important to the people of this region. While the frameworks identified in the Background section of this proposal are representative of

Indigenous approaches to care, they are not specific to the peoples of this region. Thus, the frameworks should be presented to the leaders and elders, and built upon accordingly. To bridge the divide between colonial healthcare practices and Indigenous patients, it would be prudent to begin with less sensitive topics, such as practices important during routine care, and work towards discussing post-SA care once trust has been built. Consequently, this educational module will be able to be utilized across the spectrum of care, thereby contributing to transformational practice development.

Conclusion

The impetus for this proposal came as the author noted a lack of patient-centred care in a specific incidence: post-SA care for women in the IRH ED. Initially, a practice change for IRH ED RNs was envisioned to allow nurses to obtain post-SA care education, and eventually, the practice of post-SA care would be delegated to RNs. As the project proposal progressed, however, it became evident that much more planning was required to effect real change. After looking at patient demographics and realizing the lack of patient-centred care for all women, but especially Indigenous women, it was clear that this proposal must be framed from an Indigenous perspective which honours Indigenous ways of knowing. Furthermore, instead of merely introducing a practice change for the IRH RNs, it became clear through research that practice development was an avenue that presented lasting change, or in truth, transformational change.

The evidence for the effectiveness of SANE-led post-SA care illustrates that patients rate RN-led post-SA care highly (Du Mont et al., 2014; Du Mont et al., 2017; Sampsel et al., 2009; Stermac & Stirpe, 2009). The evidence also reveals that patients prefer a healthcare-focused program, prioritizing patient care over the forensics process (Campbell et al., 2008). Local consultations revealed support for RN-led post-SA care, echoing the evidence in noting that RNs

prioritize holistic patient care, which is especially required in the post-SA period. To that end, this project proposal recommends a three-pronged approach to patient-centred care in the post-SA period: proposing change, RN practice development, and honouring Indigenous epistemologies.

Implementing the proposed project requires several actions, including assembling a development team, proposing practice change to the territorial health authority, securing funding for education and alternate staffing models, and developing new policies and procedures. In fact, the work required to implement this project seems daunting. Yet, the most work must be done by the participating RNs, as they are required to engage in self-reflection and contextual preparation, in addition to completing new clinical education. Nonetheless, a shift in perspective is what is required in this instance; patient-centred care through practice development reduces the colonial influences and distrust of the healthcare system held by many Indigenous patients. Truthfully, as non-Indigenous healthcare providers educated in colonial institutions, we are reinforcing colonial practices by utilizing the medical model of care, especially in a traumatic period such as the period following SA. To truly work with Indigenous patients, we must honour Indigenous ways of knowing, and nursing is well-positioned to practice in the holistic manner outlined in the *etuaptmumk* and *Piliriqatigiinniq* ideological frameworks. Thus, despite the work that must be done to change the status quo, there has never been a more timely period in history. Patient-centred care leads to better health outcomes. Practice development leads to transformational change in the nursing profession. Initiating practice development for IRH RNs, therefore, will lead to better health outcomes for patients presenting in the post-SA period with the added benefit of decolonizing one aspect of healthcare. History has indicated that it is time

we decolonize healthcare; nursing, then, can be on the precipice of making history, and in the process, contributing to patient well-being, and advancing the profession.

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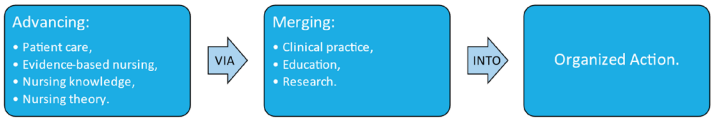
Appendix

Recommending Practice Development for Registered Nurses in Remote Northwest Territories, Canada Through Participation in Sexual Assault Nurse Examiner Education

MEGHAN A. SWEETNAM
FACULTY OF NURSING, MEMORIAL UNIVERSITY OF NEWFOUNDLAND

NURS 6661: PRACTICUM 2
DR. W.J. MADDIGAN

Practice Development



McCormack, 2014

Purpose

Primary Goal:

- To recommend a practice development project for IRH ED RNs to obtain SANE education.

Ultimate Goal:

- Achieve better outcomes for Indigenous women experiencing SA.
  - Patient-centred care.

Indigenous Frameworks

ETUAPTMUMK → FIRST NATIONS

- Elders Albert & Murdena Marshall (Mi'kmaq).
- "Two-eyed seeing."
- Informs relational practice by encouraging trust.

(Hatala et al., 2020; Chatwood et al., 2015)

Indigenous Frameworks

PILIRIQATIGIINNIQ → INUIT

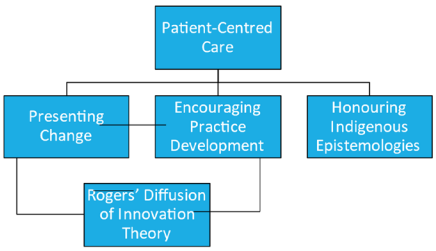
- *Innuqatigiittiarniq*
  - Respect for others.
- *Pittiarniq*
  - Being good.
- *Unikkaaqatigiiniq*
  - Story-telling.
- *Iqquamaqatigiiniq*
  - All thoughts into one.

(Healey & Tagak Sr., 2014)

Implementing the Proposal: SANE Nursing Education

- British Columbia Institute of Technology (BCIT):
  - Introduction to Forensic Health Sciences (45hrs).
  - Forensic Nurse Examiner Core Education: Theoretical Aspects (45hrs).
  - Clinical Practice Component (16hrs).
- International Association of Forensic Nursing (IAFN):
  - 11 modules (41hrs).
  - Clinical Practice Component (16hrs).

Implementing the Proposal: Fostering Patient-Centred Care



Patient-Centred Care: Presenting Change & Practice Development

- Structured using Rogers' Diffusion of Innovation Theory:

1. Knowledge: in-services with select team members to detail proposed program.
   - Goal: to generate interest in the program and encourage shifting worldview to patientcentred care.
2. Persuasion: identify a "change champion" as first RN to complete SANE education and begin practice development.
3. Decision: additional RNs recruited and provided with SANE education and knowledge of practice development.
   - Entrance interviews.

Patient-Centred Care: Presenting Change & Practice Development

4. Implementation: team enrollment in required education and undertaking practice development.
5. Confirmation: staff engage in exit interviews to determine growth.
   - Evaluation of program.

Patient-Centred Care: Honouring Indigenous Epistemologies

- Person-centred care for Indigenous population:
  - Knowledge of Indigenous epistemologies.
  - Application of Indigenous epistemologies to practice.
- Self-reflection.
- Participation.

Implementing the Proposal: Organizational Support

- Consultation process revealed strong support for SANEd post-SA care.

Challenges	Solutions
▪ High staff turnover rate in all spheres (nursing, physicians, management).	▪ Generating interest from permanent staff invested in the community. ▪ Generating interest from local Indigenous governments.

Implementing the Proposal: Education

- Clinical Nurse Educator:
  - Delivers post-SA examination education.
  - Facilitates Indigenous epistemological education.

Challenges	Solutions
▪ Educating the educator.	▪ Working committee.
▪ Workload.	

Implementingthe Proposal: Funding

- Education programs.
- Staffing re-allocation.

Challenges	Solutions
▪ Funding for staff education.	▪ Professional Development Initiative (PDI). ▪ Targeted Academic Support Program (TASP).
▪ Re-allocating healthcare dollars.	▪ ↑ nurses educated = ↓ staffing dollars required. (Green et al., 2021)

Implementingthe Proposal: Policy & Practice Development

- To allow SANE-led post-SA care in the ED, new policy and practice documents must be developed.

Challenges	Solutions
▪ Time-consuming.	▪ Best practice. ▪ Patient-centred care.

Evaluation

Initial	Follow-up
Number of presentations to IRH ED & outside agencies	Number of presentations to ED & outside agencies
Length of stay in ED	Length of stay in ED
Repeat presentations	Repeat presentations
Staff interviews	Staff interviews
	Patient satisfaction
	Patient well-being

(Campbell et al., 2008)

Recommendations

- SANEs vs. post-sexual assault care providers.
- Facilitating emancipatory practice development.
- Indigenous frameworks.

Next Steps

- Presenting proposal to management, physicians, and frontline RNs.
- Securing one or two "change champions."
- Consultations/academic research relating to emancipatory practice development.
- Consultations with local Indigenous elders/health experts relating to framing Indigenous care.