Exploring the scope of practice of the Clinical Forensic Nurse Practitioner in Australia.

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Abstract

Specialised areas of nursing have developed in response to the needs of society. This study evolved due to a lack of understanding and knowledge about the role of a Clinical Forensic Nurse/ Nurse Practitioner by members of the health profession, law enforcement agencies and the general public as well as the potential scope of practice for this occupation.

A Grounded Theory approach has been used, utilising contributions from nurses, doctors and others involved in the care of forensic clients across Australia. Clinical Forensic Nurses work in hospitals, clinics and the community but often in isolation from other forensic nurses. Grounded theory was selected because it is useful when little is known or experienced about a situation and is able to identify factors that may define and explain this evolving sub-speciality.

Subjects from various positions within Departments of Emergency Medicine, Medical Forensic Units and the State Police Force gave their consent to participate. They were located in various states and territories of Australia and one was employed as a lecturer at a major tertiary institution. The participants were diverse yet had the common characteristic of being employed in clinical forensic practice.

Data collection involved interviews, observation and document analysis. Using constant comparative analysis, the findings identified a number of barriers and opportunities for the role of the Clinical Forensic Nurse Practitioner in Australia.

Social change and demands have historically informed changes to the roles of nurses in Australia. As society changes and demands on the present health care delivery develop different emphasis, there is potential for increased frequency of providing care for and supporting victims and perpetrators of crime that have legal and forensic implications ‘on the front line’ of care. This care is developed on informed decision making so that the patients’ health, civil, legal and human rights are met.
Declaration

This thesis does not contain material that has been previously published or written by any other person other than the candidate except where due and proper reference has been given in the text.

Signed: ______________________________    Date: ______________________________
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Chapter 1
Introduction

The Problem
Violence impacts all levels of society on social, medical, economic and legal levels. These acts are often non-discriminatory and place a burden on communities and individuals through health effects, life expectancy and the victim/survivor capacity to contribute to society. Violence occurs in a number of forms and is not limited to violence perpetrated by other persons, but also includes violence of natural origins such as weather or geological change. Within societies the impact of a disaster is felt differently and particularly so between men and women (World Health Organisation 2002). The stress, fear and a sense of helplessness that is associated with this situation tend to increase risk factors such as violence (National Sexual Violence Resource Centre 2009). There is a hidden cost to violence that includes physical and emotional sequelae that frequently occur after an incident. This manifests as both physical and mental conditions resulting from the trauma that can have flow-on effects as far as increases to production costs because of absenteeism and increased need for support from the family services sector (Queensland Health 2009).

The reason for the development of “a forensic speciality in the health disciplines, including nursing is the need for a medico legal role to better care for victims (survivors) and offenders” (Kent-Wilkinson 2011: 20). Although clinical forensic nursing has been established in the United States of America (USA), Canada and the United Kingdom (UK) for decades, it is currently developing in Germany, South Africa, Italy, Ireland and Australia. The emergence of the clinical forensic nursing role/speciality of practice is in response to a changing society of increased violence and the subsequent increased need for medico-legal care of the patient. Within the health care system, forensic nursing practice interfaces with other professional systems including “the criminal justice system, child welfare and the mental health care system” (Kent-Wilkinson 2011: 20).

Forensic nursing is not embraced by all nations and the development of expanded roles and scope of practice of the forensic nurse is restricted and even hindered in some countries (Lynch, 2011a; Lambe & Gage-Linder 2007). The rationale for these barriers are varied and
include financial constraints because of the established healthcare model and reluctance from some professionals to delegate more responsibility to nurses because of a perceived loss of power or position. These views place barriers on nurses who are interested in, educated for, but are not fully utilised in clinical forensic practice (Lynch 2011a; Lambe & Gage-Linder 2007).

Forensic nursing does exist in Australia and specific roles have been identified by individual states. New South Wales has adopted the Sexual Assault Nurse Examiner role/model (SANE) while Queensland, South Australia, Western Australia and Victoria have the Forensic Nurse Examiner (FNE) role (Lynch 2011a, Boyd 2008). The role of the nurse is to facilitate more timely access to medical practitioners and thus a more timely response to incidents. SANE/FNE extend this generalised role to include the forensic examination, collection of evidence (identifying, collecting, preserving the evidence and maintaining the chain of custody) and documentation for use in potential court appearances. Legislation within Australia is not universal in recognising nurses as ‘appropriately qualified persons’ and this impacts on who can conduct examinations and collect evidence and constrains the development of contemporary forensic care to both the victim/survivor and offender.

As initially identified in the USA, and indicated to be the same within Australia by forensic nurses interviewed, there can be a long delay for a forensic examination. Victims who present directly to the police in areas where there is no dedicated forensic unit are taken to an emergency department. That department may not be equipped to provide appropriate support for victims because of their inability to provide adequate privacy for the client or counselling services (Qld Health 2009). Access to a Forensic Medical Unit (FMU) and/or Forensic Nurses is usually limited to capital cities or major regional areas. Outside those areas forensic medical examination is only available through community based General Medical Officers (GMO). Within Australia, rural and remote communities do not have access to these services and clients are required to travel vast distances to obtain them. Globally this may also be the situation although it was not the focus of this study.

As forensic nursing has the capacity to address a genuine and identified need within our society, why this has not developed and expanded nationally remains unclear. Of specific relevance to this is the current growth of nurse practitioners in Australia; nurses educated, clinically skilled and licensed to provide advanced care and services independently for the
benefit of the community. In an area where the law and health care work so closely together, it seems logical that forensic nursing, with the breadth and depth of skills across health, the law and the nature of care that nurses provide in collaboration with other health and associated disciplines, is suited to form the basis to practice for a nurse practitioner in an area of need.

**Background and Significance**
Clinical forensic nursing is emerging as a discrete speciality in nursing because violence is no longer viewed as limited to the domain of law enforcement agencies, “rather it is seen as a mutual responsibility between health care and the law” (Lynch 2011b: 1). As an aspect of public health status benchmarking in the USA, the Department of Health and Human Services continues to recognise the inevitable outcome of violence in terms of injuries, disability and death (Lynch 2011b).

Nurses are essential members of the healthcare team and their role has evolved and adapted to meet the changing needs of society. They form the largest sector of health professionals globally and despite the many cultural differences, they provide care in the context of the needs of the people of their country. Cummings (1995 as cited in Kent-Wilkinson 2011: 20) states that “Specialised areas of nursing have developed in response to needs of society”. This adaptability enables nurses to make contributions to service improvements through role development and the flexibility in their scope of practice (National Competency for the Nurse Practitioner ANMC 2006).

A report commissioned by Queensland Health in 2009 to review responses to adult victims of sexual assault identified potential areas of change and improvement as there were considerable variations in responses provided to victims. This was identified more broadly in this study. There are challenges locating and engaging Government Medical Officers (GMO) to undertake forensic examinations in a timely fashion. When there is no GMO in the area, and the victim or survivor may not have a General Practitioner, medical officers at Emergency Departments are limited in what they can achieve. There have been explanations for this situation and they include a shortage of medical officers in Australia, insufficient remuneration for being ‘on call’ every day of the year and the pressures of general practice (Boyd 2008). This is a general issue and not just relevant to forensic cases.
An opportunity does exist for the use of national statistics pertaining to potential involvement of the clinical forensic nurse though the following is offered to explain why this was not attempted in this study.

Data collection is generated through the Australian Bureau of Statistics (ABS) and the Australian Institute of Criminology (AIC). The AIC accesses other programs to obtain detailed statistics than those obtained from the ABS and then publishes a report on that area (AIC 2011). These reports give a broad snapshot of trends, demographics and offers explanations. Recorded crime is categorised into eight areas and the ones that have potential impact for the clinical forensic nurse are homicide (murder and manslaughter), assault and sexual assault (AIC 2011). This does not cover all the potential areas of hospital presentations for clinical forensic nurse involvement.

The information is gained through administrative data sets and surveys. Administrative data is obtained through the criminal justice agencies (police incident reports, court records) and surveys, such as – Crime victimisation and Drug Use monitoring, provide a more accurate picture because they include crime that has not been reported to police (AIC 2011). Data from the survey is used to supplement police statistics, particularly with crimes of low reporting, such as sexual assault (AIC 2011).

There are limitations on this data used in Australian Crime: Facts and Figures 2011 as the following indicates:

Although substantial work has been undertaken to improve the national collections, the collections continue to be hampered by jurisdictional differences in legislation, definitions and data collection methods that are often not uniform. Data recording quality may also be an issue for some of the collection. (AIC 2011: vii)

This study offers a unique opportunity to examine an area of growth in health care need that is currently unmet and under-researched in the role of the clinical forensic nurse practitioner. It is the first study conducted in Australia to explore the potential development of a new role for nurses. In one Australian state (South Australia), a new forensic nursing role is being piloted in conjunction with Flinders University and the police of that state “where the registered nurse collects forensic evidence from arrested suspects within an associated legal...
framework” (Lynch 2011a: 618). Another state (Western Australia) has also supported registered nurses to conduct forensic procedures on victims and collect specimens as a result of a change in legislation that occurred in 2011(Nursing Careers Allied Health 2011). Two further states and one territory of Australia (New South Wales, Victoria and Australian Capital Territory) have dedicated forensic units. These forensic nurses work within legislation that allows them to collect evidence from both victims and offenders, have different working environments such as police stations, emergency departments or specialised rooms, and receive educational support for the different aspects of an expanded role. While there have been a number of studies conducted on forensic correctional nursing in Australia, the role of the clinical forensic nurse in Australia is under-reported (Vecchi 2004). Internationally, it has been shown that the clinical forensic nurse role contributes positively to the health care of vulnerable members of the population (Kent-Wilkinson 2008; Lynch 2006b). Therefore this study has the potential to contribute new knowledge concerning the need for a forensic nurse role in Australia.

**Purpose**
The purpose of this study is to explore the potential role and scope of practice of the clinical forensic nurse practitioner in Australia. This involves the exploration of issues that support or impede the current or future development of this role, the contributions clinical forensic nurse practitioner could make as a member of the multidisciplinary team and how legislation may assist or hinder the development of the role.
Chapter 2

Literature Review

Introduction

In this chapter, the challenge of the nursing profession expanding its range of specialties is reviewed particularly in reference to the emerging role of the nurse practitioner. This role is defined and explored internationally, along with developments and scope of practice contextual to Australian practice. Within this role is the potential emergence of sub-specialties, specifically Clinical Forensic Nursing. Although clinical forensic nursing is established in the USA, Canada and the UK it is still developing in Italy, Ireland, Sweden, South Africa and Australia (Lynch 2011a). The emergence of this role is in response to the changing society of increased violence and the subsequent medico-legal care of the patient (Lynch 2011a; Kent-Wilkinson 2010).

The Nurse Practitioner

A nurse practitioner or advanced practice nurse is defined by the International Council of Nurses (ICN) through its International Nurse Practitioner/Advanced Practice Nursing Network (INPAPNN) (ICN 2002: 1) as:

a registered nurse who has acquired expert knowledge base, complex decision-making skills and clinical competencies for extended practice, the characteristics of which are shaped by the context and/or country in which s/he is credentialed to practice. A masters’ degree is recommended for entry level.

It is suggested that there is increasing support for this definition with other components essential to facilitate and rationalise the implementation of the Nurse Practitioner (NP) role (Browne & Tarlier 2008). Browne and Tarlier (2008) propose these additional components to include legislation protecting the title ‘nurse practitioner’ and a formal system of licensure and credentialing (Buchan & Calman, 2004; ICN 2002). Additionally direct entry to the health care system and a scope of practice that includes diagnosing, prescribing, referrals to other healthcare professionals and in some jurisdictions, admitting rights to hospitals are suggested (Browne & Tarlier 2008; Buchan & Calman 2004; Canadian Nurses Association 2002). Some of these roles have traditionally been performed exclusively by medical practitioners.
The ICNs’ definition was generated to facilitate global understanding of the emerging NP and advanced practice nursing (APN) roles (ICN 2002). There is a variety of titles used throughout the world to denote advanced nursing practice, including but not limited to, family nurse practitioner, adult nurse practitioner, nurse midwife, clinical nurse specialist and emergency room nurse practitioner (ICN 2002). The education, skills and expertise associated with these roles are diverse and context sensitive (ICN 2002).

Some authors suggest there is a “confusing array of titles used to describe the emerging roles and levels of practice” of the NP (Gardner, Carryer, Dunn & Gardner 2004: 17). As noted by Gardner et al. (2004) advanced practice refers to the level of practice, identified by Benner (1984) commencing with ‘novice’ and moving though to ‘expert’. The expert level of practice involves high level of expertise, vision and professional leadership.

The NP displays all the attributes of advanced practice, but in an extended clinical practice role where skills and knowledge extend beyond the normal level in a specific setting (Gardner et al. 2004). This is the case in all countries that have the NP (Gardner et al. 2004). Extended practices have been identified as: advanced clinical assessment, interpretation of diagnostic tests, implementing and monitoring therapeutic regimes, prescribing pharmacological interventions and referrals to and from other health professionals (Gardner et al. 2004).

**Advanced Practice**

In the USA, nurse practitioners fulfill one of three roles identified within advanced practice nursing roles and have an established title protection (Cashin, Buckley, Newman & Dunne 2009). Advanced practice roles include certified nurse-midwives, clinical nurse specialists and certified nurse practitioners (Advanced Practice Registered Nurse (APRN) 2008). The American Nurses Association states that “APRN practice is typically defined by a state-based Nurse Practice Act and is governed by the relevant state Board of Nursing, but other laws and regulations may impact practice and other boards may play a role” (ANA 2009b:1). There are states where the nurse-midwife can be regulated by either the Board of Midwifery or public health (ANA 2009b). Currently there is no uniform model of regulation of APRN across the USA and this has led to a lack of uniformity in that country (Pearson & Peels 2002). The situation is that “each state independently determines the APRN legal scope of practice, roles
that are recognized, criteria for entry into advanced practice and certification examinations” (APRN 2008: 5).

**Development of the Nurse Practitioner**

The NP role was introduced in the USA in the 1960s to improve primary health care to under-serviced communities (Cashin et al. 2009; Browne & Tarlier 2008; Wilson & Shifaza 2008; Currie, Edwards, Colligan & Crouch 2007; Carryer, Gardner, Dunn & Gardner 2007a; Pearson & Peels 2002). Opportunities for university educated nurse practitioners increased and now include the original primary care focus, as well as an array of acute care foci, including inpatient and emergency care (Gardner et al. 2004). It is worth noting that the acute care settings had the established domain and role of the clinical nurse specialist, but this was not separately licensed. The Clinical Nurse Specialist (CNS) in some states of the USA is not identified in the Nurse Practice Act which has resulted in the CNS holding the same scope of practice as the registered nurse within their state (ANA 2009b).

Nurse practitioners in the USA can diagnose and initiate treatment and also have the authority to prescribe in all states and perform authorised services sanctioned by the State’s Nurses Practice Act (Cashin et al. 2009; Phillips 2007; Kaplen, Brown, Andrilla & Hart 2006). The Acts vary from state to state with some allowing the independent authority to prescribe, while for others the authority is linked to a collaborative agreement with a physician (American College of Nurse Practitioners 2003).

During the 1960s Canada also embraced the NP role in an era of physician shortage initially with the support of medical and nursing organisations (Browne & Tarlier 2008; Gardner et al. 2004). The initial support was not long lived and there was a failure to promote the policy and legislation changes required due to the lack of support from professional bodies and a rebounding surplus of physicians (Browne & Tarlier 2008; Gardner et al. 2004; Canadian Nurses Association (CNA) 1993). There was a re-emergence of the NP role in the late 1980s with modest implementation. The rationale for the re-emergence was the perceived shortage of rural and remote primary care physicians, health care reform and a new emphasis on preventive primary care (Gardner et al. 2004; Pearson & Peels 2002; de Leon-Demare, Chalmers & Askin 1999; CNA1993).
The UK followed suit with the introduction of NP in the 1980s with similar factors influencing the initiative as in the USA and Canada. There have been reported issues that have hindered the development of NP in the UK. Similar to the USA, there was a lack of consensus on the definition of the NP role with a perceived overlap of the NP and clinical nurse specialist roles (Gardner et al. 2004; Reveley, Walsh & Crumbie 2001; Roberts-Davis & Read 2001). It has been suggested that the two roles are conceptually and fundamentally different and should be recognised as two entities (Gardner et al. 2004; Reveley et al 2001). In the UK the NP role is unregulated and there is no title protection, resulting in the unrestricted use of the title with no agreed role function or established educational standards (Cashin et al. 2009; Gardner, Gardner, Middleton & Della 2009). Some express concern that individual NPs in the UK are practicing with little or no educational preparation (Wand & White 2007a). It is argued that regulation is required to prevent the growth of NP positions in an ad hoc manner that does not meet national standards (Wand & White 2007a). In 2010 the Commission (for Healthcare Regulatory Excellence) on the future of nursing and midwifery recommended that advanced practice is regulated (AANPE 2012). The Royal College of Nursing (RCN) (2012: 5) in the United Kingdom has reviewed their competencies for the Advanced Nurse Practitioner and indicated:

that their current position is that any nurse who has been educationally prepared, that is Bachelor of Science (BSc) or Master of Science (MSc) level, against the RCN competencies, is entitled to be referred to as an Advanced Nurse Practitioner.

Australia saw the introduction of the NP role in the 1990s, drawing on the experience of other countries, but incorporating its own unique interpretation of the role (Carryer, Gardner, Dunn, & Gardner 2007b).

Nurse Practitioners in Australia

In Australia, the nurse practitioner; is defined by the Australian Nursing and Midwifery Board of Australia (NMBA) (2011: 1) as:

…a Registered Nurse who is educated and authorized to function autonomously and collaboratively in an advanced and extended clinical role.

The role includes assessment and management of clients, referring patients to other health professionals, prescribing medication and ordering diagnostic investigations (NMBA 2011).
This role is grounded in the nursing professions’ values, knowledge, theories and practice and is complementary to other health professionals (NMBA 2011).

The role of the nurse practitioner is formed on the basis of advanced practice nursing. It is an expanded role specifically regulated by legislation and professional regulation and was first implemented in 1998 (Gardner et al. 2004; NMBA 2011). During the last decade, all Australian states and territories adopted legislation enabling the establishment of the NP and formation of branches of the Australian College of Nurse Practitioners to provide education and support (ACNP 2012). Legislation protecting the title and the associated extended practice is present in all Australian states (Middleton, Gardner, Gardner & Della 2011).

The title of Nurse Practitioner is protected by legislation in Australia. This means that nurses using this title are authorised according to nursing regulation as they have met strict preparatory criteria (Driscoll, Worrall-Carter, O’Reilly & Stewart 2005). State and territory nurse registration authorities prior to July 1, 2010 controlled the authorisation process (Gardner et al. 2006). This changed to the National Registration and Accreditation Scheme with the introduction of national registration (Health Practitioner Regulation National Law Act) for nurses in July, 2010 (NMBA 2011). In addition the Trans Tasman Mutual Recognition Act 1997 requires that registration in New Zealand and Australia be mutually recognisable, yet there are inconsistencies in the standards for practice (Gardner et al. 2009). Due to the presence of discrepancies in registration requirements, a study was commissioned to develop shared Australian and New Zealand competency standards for NPs (Gardner et al. 2009). However no articles have been found on the outcomes of this review. The entry requirement for practicing as a nurse practitioner in Australia is a Masters level of education in the specialty as well as evidence of advanced clinical competence and demonstrated clinical experience in the area of specialty (NMBA 2011; Gardner et al. 2004).

Nursing adopted the concept of competence for practice during the early 1990s, yet competence has been used widely in vocational training for many years (Gardner et al. 2004). Australia uses professional benchmarks known as National Competencies for undergraduate education and regulation developed by the Australian Nursing Council (ANC). There is still a reference to competencies in the requirements to be eligible for endorsement as a nurse practitioner and these are published in National Competency Standards for the Nurse Practitioner (NMBA 2011). There was an early sense of opposition to the use of
competencies to determine professional ability as they have been associated with manual occupations, creating tension in applying competency measures to the practice of a nurse who has completed a masters’ degree (Gardner et al. 2004). Without a superior alternative, regulatory authorities must continue to seek a demonstration of safe standards by nurse practitioners through the use of professional competency standards (Gardner et al. 2004). In Australia, NP standards have been benchmarked using competencies developed by the Australian Nursing Federation (ANF) Advanced Practice Competencies (Gardner et al. 2004).

The role of the NP is underpinned by a nursing model of practice and includes activities that have previously been performed only by medical practitioners. Therefore the role crosses boundaries of the two disciplines (Browne & Tarlier 2008; Qld Health 2008). Positioning the role of the NP at this point allows for health and medical services to be offered at a lower cost and attempts to improve access and timeliness of health care for under-serviced and marginalised populations (Qld Health 2008).

The role of the NP was initially developed in response to a medical shortage, the need for cost containment, the need for a more skilled workforce with a focus on health promotion and illness prevention and the need to improve access to the healthcare system (Jennings, Lee, Chao & Keating 2009; Carryer, Gardner, Dunn & Gardner 2007a; Horrocks, Anderson & Salisbury 2002; McMullan, Alexander, Bourgeois & Goodman 2001). NPs bring the nursing perspective to client care and the support they provide; they are not attempting to practice medicine (National Nursing and Nursing Education Taskforce (NNNT) 2006). Similar to reports from other countries, the NP role was introduced to meet the needs of an overstretched health-care system (Jennings et al. 2009).

As noted previously there is a lack of uniformity internationally in the nurse practitioners’ models of care and clinical and statutory protocols and this does not allow for adequate comparison between countries that have implemented this role (Middleton et al. 2011). In Australia the most common clinical field is the Emergency Department Nurse Practitioner unlike that of the USA and Canada where it is the family practice role (Middleton et al. 2011). It is from these contexts that the body of literature is most abundant (Wortans, Happell & Johnstone 2006).
**Political Forces**

Role evolution of the NP has not been without controversy and within Australia it has been voiced primarily by members of the medical profession (Elsom, Happell & Manias 2009; Taylor 2008). This opposition has been based on concerns that NPs do not have the educational preparation or clinical expertise to provide care equivalent to that of the medical profession (Australian Medical Association (AMA) 2005a; Elsom et al. 2009). There have been improvements in the relationship between NPs and the medical practitioners but there remain barriers (Elsom et al. 2009). The five main barriers to a collaborative relationship between the professions include: “a lack of knowledge of the scope of practice of the NP; lack of knowledge and understanding of this role; global resistance based on traditional professional boundaries; and a lack of respect and communication” (Elsom et al. 2009:13). Elsom et al. (2009) suggested this could have originated from the core reason for the development of the NP role, which is medical practitioner shortages. This is a common theme nationally and internationally.

In 2008 the National Health and Hospital Reform Commission (NHHRC) was established by the new federal government to review the delivery of healthcare at that time and there were many recommendations. Two of these were specific to the practice and regulation of nurse practitioners (Middleton et al. 2011). Firstly, national registration was recommended and secondly “that Medicare rebates and Pharmaceutical Benefits Scheme subsidies should apply to nurse practitioners consistent with their scope of practice”(Middleton et al. 2011: 449). To be able to access this, the NHHRC recommended that nurse practitioners must demonstrate that they work collaboratively in a model of care with general practitioners, specialists and obstetricians (NHHRC June 2009).

Concerns were raised about how this was to be achieved operationally and if there would be a positive or negative impact on the practice of the nurse practitioner. The College of Nurse Practitioners questioned if this would lead to a truly collaborative approach by the Australian Medical Association (AMA) or if the recommendation would act as an exclusionary or gatekeeping role (Middleton et al. 2011; Cashin 2009).

Not all medical practitioners oppose the NP role and some of the assertions made of the role have been questioned by Australian doctors with direct experience of working with NPs (Gunn 1998). In addition, NP are prepared to work in areas, both geographical and clinical,
that are inadequately serviced by the medical profession. Therefore, some see no reason to object to their introduction (Gunn 1998).

**Patient Satisfaction**

There have been a number of reviews of patient satisfaction with NP and the results suggest that NPs in primary health care deliver care equivalent to that of a medical practitioner at the first point of contact with patients (Gardner & Gardner 2005; Horrocks et al. 2002). Recent studies from acute care, specifically emergency departments, demonstrate several positive outcomes following the introduction of NP: decreased waiting times, cost effectiveness, and increased patient satisfaction (Jennings et al. 2009). Increases in patient satisfaction are reported to be the result of being offered health education, written instructions and information about obtaining advice following discharge (Jennings et al. 2009). Gunn (1998) suggested that this form of support will improve the working conditions for the medical officers as it frees them to work with the cases that require their level of medical skill.

As noted by Carryer et al. (2007a) there has been very little research to define the essential characteristics of the NP although there has been some research into specialised areas. Currently, many international standards or competencies for NP have not been derived from research (Carryer et al. 2007a). Research conducted to date has focused on cost, quality, patient satisfaction, safety issues and evaluation of the role from the medical perspective and knowledge. Australia and New Zealand are working together on evaluation research that will provide a greater understanding of the NP role and the contribution that can be made to health care, however no evidence of the outcomes of this could be located (Carryer et al. 2007b). It is worth noting that the development of the NP role has created new career options for nurses that will maintain their clinical expertise and further extend nursing knowledge (Currie et al. 2007). The Australian Nurse Practitioners project was developed in three phases, commencing in 2007. It was designed to inform government, health service managers and clinicians on the situation of the nurse practitioner service in Australia because there was minimal information on this service (Middleton et al. 2011). Phase one consisted of two national surveys exploring “demography, scope of practice and barriers to the nurse practitioner service” (Middleton et al. 2011: 449). Work sampling and case studies were the elements of phase two, to investigate “the nurse practitioner role in the health team and their work patterns” (Middleton et al. 2011: 449). The final phase was the patient outcomes after the intervention of the nurse practitioner. The results from the 2007 and 2009 census are
similar, with both stating that the nurse practitioners are under utilised (Middleton et al. 2011). This is specifically related to their being unable to prescribe medication, lack of a Medicare provider number and also lack of support from both the health care organisation and the nursing profession (Middleton et al. 2011).

**Forensic Nursing Defined**

The available literature related to the discipline of forensic nursing is drawn from Canada, USA, UK and Australia and is examined in relation to gaining a better understanding of the breadth of practice. Since the development of forensic nursing, numerous definitions have been formulated to explain this specialty (Kent-Wilkinson 2008). As a developing and recognised specialty of nursing, forensic nursing has a number of sub-specialties that are related to specific aspects of forensics where the legal aspects of caring for patients are inherent in nursing practice. Patients can be victims or offenders, living or deceased (Kent-Wilkinson 2008). Because of the contextual development of this specialty, there is little in the way of information or guidance to affirm what is considered to be foundation knowledge needed by forensic nurses (Kent-Wilkinson 2008).

The International Association of Forensic Nurses (IAFN) has adopted the following definition of forensic nursing, which states:

> Forensic nursing is the practice of nursing globally when health and legal systems intersect (IAFN 2008: 3).

Forensic nursing is an emerging specialty in Australia and other parts of the world, although it is well established in the USA. This specialty has a number of sub-specialties sharing the characteristic of increased attention to the legal implications and dimensions inherent in the care of patients (Kent-Wilkinson 2010). Forensic nurses interact with the systems in healthcare, the community and the legal system (IAFN & ANA 2009). Contexts of practice include “hospitals, pre-hospital care and clinics; legal or investigative arenas; commercial and not for profit enterprises; governments; education, industrial and correctional institutions” (IAFN & ANA 2009: 3). For each system, the role of the forensic nurse shares a similar core of knowledge or skills but the context will influence the scope of practice. Forensic nursing was first recognised as a specialty in 1995 by the American Nurses Association (ANA) and represents a response of nurses to a changing health care environment as well as the global challenges of caring for victims and perpetrators of intentional or unintentional injury (IAFN & ANA 2009). The development of the International Association of Forensic Nurses (IAFN)
came about because of the growth of the largest forensic nursing sub-specialty practitioner in the USA, the sexual assault nurse examiner (SANE), whereas forensic nursing had first been recognised by the American Academy of Forensic Science in 1991 (Kent-Wilkinson 2010; Collins & Halpin 2005). This was a result of inadequate care given to sexual assault victims admitted to the Department of Emergency Medicine, in particular the long waiting times for review and examination (Kent-Wilkinson 2010). With the development of the role of SANE, the physician no longer provided the sexual assault examination and the follow-up mental health counselling. This role was further expanded to include conducting evidentiary exams on domestic violence victims, accident victims and other populations where the collection of evidence may be useful (Kent-Wilkinson 2010).

The IAFN first represented the SANE sub-specialty in 1992 and the formal scope and standards of practice were published in 1997 (Collins & Halpin 2005). The IAFN developed and published the core competencies for Advanced Practice Forensic Nursing seven years later in 2004. The scope and standards of practice for forensic nursing were updated in 2009 by the ANA and IAFN to incorporate changes in technology and contemporary challenges in society (IAFN & ANA 2009).

**Integrated Theory**

Forensic nursing has a practice model that incorporates a combination of shared theory from social sciences, nursing science and legal science (Lynch 2011c). Cross-disciplinary knowledge may include multiple agencies and professions including forensic pathologists, law enforcement, judicial systems and victims of crime organisations. Assessment, planning and outcome effectiveness of the care plan, commonly used by nurses across multiple contexts, are also relevant to forensic nursing (Kent-Wilkinson 2008). The basic philosophical underpinning of practicing nursing, through the application of the nursing process, nursing and caring paradigms, is part of the philosophy of forensic nursing (Kent-Wilkinson 2008). Forensic nursing is multidimensional and is placed between health care and the law, and is best explained as an integrated model (Lynch 2006a). In forensic nursing science the concept of an integrated model has “resulted in an accomplished clinician” who is cross-trained in the principles and philosophies of nursing science, forensic science and criminal justice (Lynch 2006a: 22). There is an integration of multiple theories derived from other disciplines. This process is evolving and when new aspects are integrated into the practice model such as sociology, criminology, clinical and criminal investigation and
education, the cyclic nature of the model suggests continuance, perpetuation and balance (Lynch 2006a). The model engages other agencies in a consultative manner to ensure that the potential for role overlap is minimised and there is no compromise of service standards (Lynch 2006a).

**Roles of the Forensic Nurse**

Where intentional and non-intentional injuries occur with individuals, families and communities, forensic nurses care and treat those involved (IAFN & ANA 2009). This includes “victims and perpetrators of personal violence, victims or perpetrators of man-made catastrophe and victims of natural causes of trauma and population evacuation” (IAFN & ANA 2009: 4). Kent-Wilkinson (2010) claims the development of the forensic nursing role was both proactive and responsive to the needs of victims and offenders in society. Flexible boundaries surround the scope of forensic nursing practice across diverse settings and populations. Legal or forensic issues influence and sometimes guide the care or status of individuals, families or communities with whom the forensic nurses work (IAFN & ANA 2009).

In 1987, a gap was identified between the criminal justice and the health care systems in the management of forensic patients (Lynch 2011b; Saunders 2000). It was identified that without an adequate forensic background, health care workers could adversely affect the processing of evidence and ultimately the scientific investigations for patients with liability related injuries (Smock & Smock 2006; Saunders 2000). Therefore unknowingly, nurses and others whose role it was to provide health care for victims of trauma and crime were inadvertently adding to the long term adverse outcomes for those patients.

Clinical Forensic Nurses and Advanced Practice Forensic Nurses (Nurse Practitioners) assess patients for their acute health needs and provide stabilisation and treatment as part of the acute healthcare team and act as forensic consultants to the team (IAFN & ANA 2009). They may perform specific medical forensic examinations, gather information for the medical forensic history and collect and document forensic evidence from patients. They offer information, treatment, referrals for sexually transmitted infection treatment and other non acute medical concerns, assess for pregnancy risk, and discuss treatment options with patients, including reproductive health options (USA DOJ 2004). They defend the legal right of the patient by the proper collection and documentation of evidence, maintaining the chain
of custody whilst providing an incisive analysis of patients who present with numerous injuries (Dougherty 2011). They typically co-ordinate within the health team to ensure patients are offered crisis intervention in a timely fashion from appropriate providers, offer support and advocacy during and after the examination process and encourage the use of other victim services (USA DOJ 2004). These roles are well established in the USA yet have not fully emerged in Australia.

Forensic nursing has been most prominent in the USA and within this nursing specialty have evolved the following forensic roles: “Death Investigator/Nurse Coroner, Psychiatric Nursing, Clinical Forensic Nurse, Sexual Assault Nurse Examiner (SANE), Nurse Jurisprudence, Forensic Nurse Examiner, Correctional Custody Nurse, Legal Nurse Consultant, Forensic Photographer and Forensic Geriatric nurse specialist” (Lynch 2011c: 16). Forensic nurses provide care across a number of areas of nursing practice, education, research and consultation. They interact with other systems in healthcare, community and the legal environment (IAFN & ANA 2009).

The forensic nurse examiner is not a member of the trauma response team but contributes as the evidence custodian. An ‘extra pair of hands’ in trauma situations ensures that evidence integrity is maintained (Dougherty 2011). The attention to detail ensures that important evidentiary items or findings will withstand the scrutiny of the courts (Dougherty 2011).

There are two levels of forensic nurse practice: basic and advanced (IAFN & ANA 2009). “A registered nurse who has knowledge and skills necessary for a specific role in forensic nursing”, such as sexual assault nurse examiner (SANE) is considered to have basic skills and knowledge (IAFN & ANA 2009: 14). “Advanced forensic practice entails expanded and specialized knowledge and skills. Advanced practice nurses hold a master’s or doctorate degree and are licensed and/or certified and approved to practice in their role of CNS, NP or certified nurse midwife” (IAFN & ANA 2009: 14). They are able to prescribe medication and develop health care interventions (IAFN & ANA 2009). However, these roles (prescribing medication and therapeutics) result in a blurring of activities and actions with those of a nurse practitioner.
The Psychiatric or Mental Health Forensic Nurse

In the UK, Canada, Australia and New Zealand the most prominent forensic nursing role to develop was that of the forensic psychiatric nurse where practice mainly involves offenders as clients (Kent-Wilkinson 2010). In Australia the literature focus is predominantly related to mental health, but there is paucity of historical information surrounding the care of the mentally ill (Warelows & Edwards 2007). Internationally there is a tendency to group psychiatric and mental health together. In Australia, as noted by Roberts (2002) and Wand and Fisher (2006), not all mental health nurses want to be defined by an association with psychiatry. When mental health nurses are consulted about patient behaviour, their approach is towards a long-term focus on assisting the client “to develop ways of living with, overcoming or recovering from mental illness” (Wand & Fisher 2006: 204). However psychiatric nursing is concerned with “addressing the immediate distress and disorder associated with psychiatric crises” (Wand & Fisher 2006: 204).

There is a paucity of literature on the role of the mental health NP, although views have been expressed outlining the potential opportunity to extend mental health services through NPs to populations that are currently underserved as well as enhancing the recruitment and retention of mental health nurses (Wand & White 2007b; Wortans et al. 2006). There have been no studies located to support the NP role in psychiatric or mental health settings (Wortans et al. 2006). Since 2006, there has been an increase in publications that suggest a role for the mental health nurse practitioner in emergency departments (Wand & Fisher 2006; Wand & White 2007a, 2007b). In Australia, access to specialist mental health care for individuals presenting to the emergency department has been improved by the role of the mental health nurse practitioner who is based there. These nurse practitioners also enhance support for the emergency department staff (Wand, White, Patching, Dixon & Green 2012).

North America and the UK are the primary sources of forensic psychiatric nursing literature (Martin 2001). In the USA, the main focus is forensic science, crime investigation and care of the victim whilst less attention has been given to the care of the mentally ill offender in hospital (Martin 2001). The focus from the UK has been upon offenders within hospitals (Martin 2001).

The decade from 1970 through 1980 saw the role of the forensic psychiatric nurse developing when “correctional services began to separate mental health services from custodial services”
This appears to have led to confusion related to the interchangeable terms of forensic and correctional nurse (Lyons 2009). In the USA decentralisation of forensic services began in the early 1970s. Changes were also occurring in Canada, “where forensic psychiatric units were being established and modeled after similar units in the USA” (Cormier 1975 cited in Kent-Wilkinson 2010: 426). Society drove these changes “demanding that 24 hour health and mental health care be provided in correctional facilities by health professionals rather than what had been previously provided by correctional officers and medics” (Kent-Wilkinson 2010: 427). The members of the multidisciplinary team in forensic psychiatric care now included psychiatric nurses who previously worked on the forensic psychiatric units caring for offenders (Kent-Wilkinson 2010). The new team now comprises nurses, psychologists and psychiatrists who refer to themselves as ‘forensic’ health care professionals. The reason for their self-title is that “they provide evidence to the courts on fitness, mental competency, or risk assessments” (Kent-Wilkinson 2010: 427).

The Australian Situation

Studies pertaining to forensic nursing with the victims (survivors) in Australia are limited. In fact only two groups of Australian authors have addressed sexual assault exploring the nurse practitioner role in this area (O’Keefe & Gardner 2003; Hooke, Bennett & Dwyer 2001). There are some studies emerging from the emergency departments and the critical care units based on the importance of evidence collection and handling of items. This leads to the risk of nurses focusing on the technical skills or evidence collection aspects of forensic nursing whereas nursing primarily involves the person/client/patient but with due respect to evidence and forensic issues (Kent-Wilkinson 2008).

Australian forensic nursing awareness appeared in 2004 with a PhD research paper and a tertiary nursing course in Western Australia (Vecchi 2004). There were established tertiary courses in South Australia and Victoria in 2000 (Lynch 2011a). However most Australian authors continue to focus on psychiatric and correctional nursing. The paucity of literature and this narrow focus reflects the ad hoc approach with which Australia has approached this specialty. According to Saunders (2000: 50) over a decade ago, “the Australian justice or criminal system is unlikely to engage the notion of nurses as medical examiner investigators or coroners at this point” whilst this situation remains.
Forensic nursing includes a broad scope of practice and practice information, including roles, titles and links between various disciplines that work together (IAFN & ANA 2009). National and international authors from other countries provide insight to potential future development of this specialty (Lynch 2006b, 2011a; Boyd 2008; Lambe & Gage-Linder 2007; Vecchi 2004). Roles of the CFNP exist in Australia at advanced practice level and internationally as nurse practitioner practice. Existing roles in Australia include the role within Clinical Forensic Nursing Services (CFNS) at the Victorian Institute of Forensic Medicine to facilitate more timely access to medical practitioners and thus a more timely response to incidents; identifying and analysing health and social factors related to violence, murder, suicide, sexual abuse, disease and criminal acts that threaten lives; collection of forensic samples development of forensic protocols, triaging of ‘at risk’ patients, serving as a liaison between health care staff, police officers and coroners, referrals to medical treatment and crisis intervention and education of staff (Lynch 2011c; VIFM 2010; USADOJ 2004; Vecchi 2004).

A report commissioned by Queensland Health (2009) to review responses to adult victims of sexual assault has identified potential areas of change and improvement as there is considerable variation in responses provided to victims. As initially identified in the USA, there is a long delay for a forensic examination and the victims that present directly to the police in areas that do not have a Clinical Forensic Medicine Unit (CFMU) are taken to an emergency department that may not necessarily be equipped to with appropriate support or counselling services (Qld Health 2009). There are only three areas identified in the state of Queensland where a CFMU is located and outside those areas forensic medical examination is only available through community based General Medical Officers (GMOs). There are challenges with locating and engaging a GMO to undertake an examination in a timely fashion. Although there are Forensic Nurse Examiners employed by the CFMU, police representatives indicate that they have been advised not to use them “until their credibility is tested and proven in court” (Qld Health 2009: 62).

It has been proposed that a formal and recognised Clinical Forensic NP role would introduce changes to management, education and practices to clinical forensic nursing. It may overlap with yet strengthen existing roles that presently provide a fragmented organisation of treatment to crime victims (Qld Health 2009; Vecchi 2006).
Conclusion
This chapter has presented an analysis of the literature explaining the evolution of the NP in Australia, USA and the UK and forensic nursing globally as they have developed and continue to advance. Australia has embraced the development of nurse practitioners and is now expanding specialties for that role. It is evident by the paucity of literature that Australia is under-developed in relation to reporting on the role of the clinical forensic nurse, either with basic skills or at an advanced level practice. This review has presented the current published knowledge on these areas and how changes in society can influence change and expansions to the role of nurses.
Chapter 3
Methodology

Introduction
In this chapter, the methodology and methods used for this study are presented. Grounded theory methodology was considered and ultimately selected because of its unique ability to foster the development of concepts and ideas and in some cases theory where no previous evidence exists. An explanation and development of grounded theory opens this chapter. The research process including the methods used for recruitment, sampling, data collection and data analysis are explained and their consistency with those of grounded theory demonstrated. The ethical aspects and strategies for this study complete the chapter.

Grounded Theory Methodology

Qualitative research “is richly descriptive”, including description of context, participants involved and activities of interest (Merriam, Bloom & Brott 2002:5). The approach is formulated by individuals and their interaction with their world or their reality (Merriam et al. 2002). According to Artinean, Giske and Cone (2009:3) “Grounded theory is an inductive qualitative methodology that allows the researcher to identify the predominant concepts of a group of participants and the behaviours they use to resolve their main concerns”. It is anchored in the words, experiences and meanings of the participants (Merriam et al. 2002). Grounded theory is so named because it begins at a basic (ground) area of interest and develops as researchers gather data to build concepts, hypothesis and/or theories (Taylor, Kermode & Roberts 2006). Development of the theory is “generated solely from data and thus the participants’ perspectives are reflected in the findings” (Taylor et al. 2006:330). It is a useful methodology when there is no existing theory to guide the research process, as it allows the identification and blending of factors that can be used to define and explain relatively unknown situations (Artinean et al. 2009; Taylor et al. 2006; Hutchinson 1986; Stern 1985). With no theory to prove, what is salient to an inquiry area emerges through data collection and analysis (Corbin & Strauss 2008).

The methodology was developed by the sociologists Bernie Glaser and Anselm Strauss who first described the methodology in 1967. This was further explicated by Glaser in 1978 (Artinean et al. 2009; Taylor et al. 2006). The theoretical roots of the methodology applied
by Glaser and Strauss were in symbolic interactionism which focuses on the manner in which people make sense of social interactions and the interpretations they attach to the language or symbols used to describe these (Polit & Beck 2010).

As noted by Taylor and colleagues (2006), Glaser and Strauss came to disagree on certain theoretical developments of this methodology mooted by Strauss and Corbin which resulted in an adapted form of grounded theory. In 1990 Strauss with Corbin, a nurse researcher, explained that the purpose of their work was to provide novice grounded theory researchers “with the basic knowledge and procedures in building theory at the substantive level” (Polit & Beck 2010:270). As noted by Polit and Beck (2010: 270) Glaser believed the method that Strauss and Corbin had developed was not that of grounded theory but what he referred to as a ‘full conceptual description’. The original approach of grounded theory was “to generate concepts and theories about their relationships that explain, account for, and interpret variation in the behaviour” while ‘conceptual description’ aims to describe the full range of what is happening in a study area “irrespective of relevance and accounting for variation in behaviour” (Polit & Beck 2010: 271). Grounded theory studies continue to be conducted using the original approach of Glaser and Strauss as well as the later Corbin and Strauss approach (Polit & Beck 2010; Taylor et al. 2006).

There are strategies within other qualitative methods that could be argued to contain a portion of each other. While phenomenology underpins qualitative research because of the school of philosophical thought, it has inquiry techniques that differentiate it from other types of qualitative enquiry. The notion of this approach is of experience and understanding with a focus on the essence or structure of an experience (Merriam et al. 2002). However this method was not considered appropriate to meet the needs of this study where the phenomena of interest is yet to be defined and created. Ethnography focuses on culture and is closely aligned to the field of anthropology (Merriam et al. 2002). As the culture of forensic nursing in Australia does not exist in any formalised form, an ethnographic approach was also considered not appropriate to meet the desired outcomes of this project. Grounded theory has been used by nurses and other health care researchers because practical solutions can be found through the data analysis to the problems and/or identified concerns (Nathaniel 2006; Meadus 2007). Duma, Mekwa and Denny’s 2007 study utilised grounded theory to explore the challenge posed by recovery from sexual assault trauma that confronts the survivors, their significant others and the larger community because there was little research that had been
conducted. Part of the findings highlighted the need to educate health care professionals with theoretical background on how women responded to gender-based violence and this may indirectly influence their decision to work with survivors of gender-based violence. Furber and Thomson’s (2006) study utilised grounded theory to explore midwives’ views in relation to baby feeding because the researchers believed that this approach would enable those being studied to express their concerns or problems and that their views would be respected (cited in Roberts 2008). Of significance to this study was another grounded theory study explaining the development of the nurse practitioner role in accident and emergency practice by Fisher, Steggall and Cox (2006) who noted after searching the literature, only one article on perceptions of the Nurse Practitioner role in the accident and emergency context existed. This reflects the available literature related to the phenomena of interest for this study.

**Procedures of Grounded Theory**

The fundamental feature of grounded theory is that sampling of the participants, data collection and data analysis occur simultaneously (Polit & Beck 2010). This process occurs in the following way: data is collected by the researcher, categorised, a description of an emerging phenomenon is generated and the steps are then recycled until no new information on the phenomena is obtained (Polit & Beck 2010).

Grounded theory applies the procedure of constant comparison of incident with incident or constant comparative analysis (Polit & Beck 2010). Constant comparative analysis is based on theoretical sampling which is the “concurrent collection, coding, and analysis of data used in turn to direct further data collection” (Artinean et al. 2009: 5). Theoretical memos record these comparisons using theoretical codes which allow the researcher to develop categories and hypothesise relationships between the categories (Artinean et al. 2009). Categories emerging from the data are constantly compared with data obtained previously and against new data. This continues until the categories are saturated (no new information is obtained) and a new core category or core strategy emerges (Artinean et al. 2009; Taylor et al. 2006). A core strategy describes the behaviour used by the subjects to resolve their main concerns. There are ‘six Cs’ of social process that grounded theory “examines (causes, contexts, contingencies, consequences, co-variances and conditions) to understand the patterns and relationships among these elements” (Starks & Brown Trinidad 2007: 1374). Knowledge of social realities is achieved through the careful observation of behaviour and speech practices (Starks & Brown Trinidad 2007).
Unstructured interviews, personal observations and informal conversations are the various modes of data collection in grounded theory (Taylor et al. 2006). Other sources of data such as theoretical memos and diagrams are aids in the analysis process and literature is used as a source of data to pose questions about the data, as a means of validating the grounded theory and in the use of theoretical sampling (Taylor et al. 2006).

**Strengths and Weaknesses of Grounded Theory**

The methodology has the ability to move data from the descriptive level to the conceptual level and this occurs without sets of formulae (Artinean et al. 2009). The benefit of this to the researcher is that from the very moment of data collection they can progress from knowing very little about the phenomena under study or of concern to the participants to being well informed on the phenomena or the reasons for participant behaviours (Artinean et al. 2009).

As the researcher immerses themselves in the data, they must be honest and vigilant, not to allow pre-existing thoughts and beliefs to influence the outcomes (Starks & Brown Trinidad 2007). Artinean et al. (2009: 9) believed that “most frequently reported is the researchers’ unwillingness to give up preconceived ideas on how the participants should be responding”. Researchers must engage in a self-reflective process whereby they recognise and set aside their previous knowledge and assumptions and this is normally addressed through keeping a diary/journal (Artinean et al. 2009; Corbin & Strauss 2008; Starks & Brown Trinidad 2007; Taylor et al. 2006).

**Credibility of Grounded Theory**

Credibility is a term that relates to the true and faithful description of the phenomenon (Chiovitti & Piran 2003). This may be achieved by allowing the participants to guide the inquiry and by using their actual words (Chiovitti & Piran 2003). The use of the participants’ own language at all levels of coding adds to the credibility of the findings and this is in accordance with grounded theory methodology (Corbin & Strauss 2008; Chiovitti & Piran 2003).

Triangulation assists with capturing a “more complete and contextualized portrait of the phenomenon in the study” (Polit & Beck 2010: 497). This process involves collecting different data sources of information and examining evidence from these sources, and using it
to build a theme (Creswell 2003). Taylor et al. (2006: 235) posit that “there is a principle that suggests if data is collected based on more than one observation or measurement, it is more likely to be valid because there will be less investigator bias”. Data can be collected from multiple sources and can be collected at different points of time, from different places and people at different levels that all relate to the same phenomenon (Polit & Beck 2010; Taylor et al. 2006).

Reliability refers to “the extent to which research findings can be replicated” (Merriam et al. 2002: 27). However absolute reliability is not achievable because what is seen to be true in one context or study may change because of human behaviour which is influenced by the time, place and situations that people find themselves in (Taylor et al. 2006). Therefore, reliability for this study is approached by ensuring that processes are transparent, and the results are consistent and make sense (Merriam et al. 2002).

**Methods**

**Sites**

Three sites were selected to generate data and due to their potential to provide the desired data. The first application to a premier public hospital in Queensland (Site A) resulted in a decline to be included, as did a forensic unit (Site B) Three alternate public health hospitals were approached: Site C (Department of Emergency Medicine), Site D (Department of Emergency Medicine) and Site E (Department of Emergency Medicine).

Site C (Department of Emergency Medicine) is situated in a northern metropolitan suburb with 676 beds that provided 44,869 emergency services in 2010 (average of 11,217 per quarter). The hospital is a major tertiary level referral hospital and the Emergency Department opened in 2007 (Qld Health 2011).

Site D was approached due to the ease of access to the researcher. This site is situated 100 km north of the metropolitan area with 380 beds servicing about 8,500 emergency department (DEM) attendances a quarter. On average, 55% of DEM patients are admitted within 8 hours of arrival in the emergency department with a median waiting time of 7.55 hours per quarter (Qld Health 2010).
Site E (Department of Emergency Medicine) is situated 700 km north of the metropolitan area with 227 beds and services approximately 10,500 emergency department attendencies per quarter. On average, 70% of patients are admitted within 8 hours of arrival in the emergency department with a median waiting time of 6 hours (Qld Health 2010).

From the above initial sites, potential interviewees were identified from dedicated forensic units.

Site F (Medical Forensic Unit) that provides a broad range of forensic medicine to three major regional locations and supervises and supports Government Medical Officers in the state (Qld Health 2009).

Site G (Medical Forensic Unit) has a mobile service that goes to two key hospitals, they have an examination site at the police investigation unit, and an examination room within the outreach site located in the hospital grounds (interviewees’ description).

Site H (Area Health Forensic Unit) covers two hospitals and is situated between those two hospitals and another hospital that does not see patients, but they have an office there (interviewees’ description).

Site I (Department of Emergency Medicine) is in a metropoliation hospital where sexual assaults are referred to a sexual assault referral centre (interviewees’ description).

Table A on the following page outlines these facilities and the data generated from each site.

Although not initial ‘sites’ of data collection, data was generated from across four states of Australia as telephone interviews. These are presented in Table B.
<table>
<thead>
<tr>
<th>Site</th>
<th>Description – where interviewee worked</th>
<th>Data collected</th>
<th>Comments</th>
</tr>
</thead>
<tbody>
<tr>
<td>A</td>
<td>Premier public hospital, metropolitan (State 1)</td>
<td>Declined to participate due to the number of research projects conducted at the site at that time.</td>
<td></td>
</tr>
<tr>
<td>B</td>
<td>Medical Forensic Unit (State 2)</td>
<td>Declined to participate due to current reviews of the Clinical Nurse position statement 3 months after the access request submitted.</td>
<td></td>
</tr>
<tr>
<td>C</td>
<td>Tertiary Metropolitan public hospital (State 1)</td>
<td>Withdrawn from study because of time constraints. After approximately 12 months, the site specific agreement was still under negotiation.</td>
<td></td>
</tr>
<tr>
<td>D</td>
<td>Regional public hospital (State 1)</td>
<td>Face-to-face interviews</td>
<td>Data reached ‘saturation’ achieved in combination with other external data.</td>
</tr>
<tr>
<td>E</td>
<td>Regional public hospital (State 1)</td>
<td>Face-to-face interviews Observation study</td>
<td>Data reached ‘saturation’ achieved in combination with other external data.</td>
</tr>
</tbody>
</table>

Table A: Sites approached and those used in the study.

<table>
<thead>
<tr>
<th>Site</th>
<th>Description – where interviewee worked</th>
<th>Data collected</th>
<th>Comments</th>
</tr>
</thead>
<tbody>
<tr>
<td>F</td>
<td>Medical Forensic Unit (State 1)</td>
<td>Face-to-face interviews</td>
<td>Data reached ‘saturation’ achieved</td>
</tr>
<tr>
<td>G</td>
<td>Medical Forensic Unit (State 3)</td>
<td>Telephone interviews</td>
<td>Data reached ‘saturation’ achieved</td>
</tr>
<tr>
<td>H</td>
<td>Medical Forensic Unit (State 4)</td>
<td>Telephone interviews</td>
<td>Data reached ‘saturation’ achieved</td>
</tr>
<tr>
<td>I</td>
<td>Metropolitan Hospital and University (State 5)</td>
<td>Telephone interviews</td>
<td>Data reached ‘saturation’ achieved in combination with other external data.</td>
</tr>
</tbody>
</table>

Table B: Forensic Unit sites for telephone interviews.
Population

The population for this study is defined as those persons working intimately with victims and perpetrators of crime, their families and, at times, observers of crime who seek care from the acute care environment. Because of the multidisciplinary and fluid nature of teams in the sites and the nature of the methodology, it was not necessary to accurately quantify the population. The identified population included medical officers, nursing personnel and police officers as well as other members of the healthcare team (administration and support staff).

- Medical Officers: included Acting Medical Directors and Medical Directors of the Emergency Departments.

- Nursing personnel: included registered nurses with experience in the Emergency Department (Nurse Practitioners, Clinical Facilitators, Nurse Educators, Registered Nurses and Forensic Nurses).

- Police Officers: uniformed liaison officer assigned to the hospital.

- Other members of the health care team (for the observations only) included administration staff who record client details, ambulance officers, social workers, patient support personnel (transporting clients to imagery or pathology).

Sample and Sampling Method

The methodology of grounded theory precludes a pre-determined sample size. Rather it is the richness of data provided by the participants that determines whether the sample is sufficient or whether new members need to be recruited (Corbin & Strauss 2008). The phenomenon under study “is the unit of analysis and given that a single participant can generate a significant number of concepts, large samples were not necessary to generate rich data” (Starks & Brown Trinidad 2007: 1374). This sampling approach had the potential for selection bias when participants were not assigned randomly to groups, and there was a possibility that they would not be equivalent (in numbers and job specific personnel) across sites (Polit & Beck 2010). However there was no attempt in this study to compare data across sites, rather, in character with grounded theory, data from all sites and sources contributed to the findings.
Table C illustrates the nature and numbers of participants who contributed to the data.

<table>
<thead>
<tr>
<th>Designation</th>
<th>Number</th>
<th>Employment sites</th>
</tr>
</thead>
<tbody>
<tr>
<td>Medical officers – Medical Directors</td>
<td>2</td>
<td>Department of Emergency Medicine (State 1)</td>
</tr>
<tr>
<td>Medical Officer – Acting Medical Director</td>
<td>1</td>
<td>Forensic Medical Unit (State 1)</td>
</tr>
<tr>
<td>Nurse Practitioners</td>
<td>4</td>
<td>Department of Emergency Medicine and Tertiary Education (3 x State 1, 1 x State 5)</td>
</tr>
<tr>
<td>Nurse Educator</td>
<td>1</td>
<td>Department of Emergency Medicine (State 1)</td>
</tr>
<tr>
<td>Clinical Facilitator</td>
<td>1</td>
<td>Department of Emergency Medicine (State 1)</td>
</tr>
<tr>
<td>Registered nurses</td>
<td>1</td>
<td>Department of Emergency Medicine (State 1)</td>
</tr>
<tr>
<td>Forensic nurses – Clinical Nurse Consultants</td>
<td>2</td>
<td>Forensic Medical Unit (States 3 &amp; 4)</td>
</tr>
<tr>
<td>Police officers</td>
<td>1</td>
<td>Hospital Liaison Officer (State 1)</td>
</tr>
<tr>
<td>Social workers</td>
<td>1</td>
<td>Hospital – Allied Health-assigned to Department of Emergency Medicine (State 1)</td>
</tr>
</tbody>
</table>

Table C: Nature and numbers of participants who contributed to the data.

**Recruitment**

Participant identification was initiated through contacts to the Heads of Departments of the consenting sites by telephone and/or email to gain support to recruitment and collect data. An outline of the purpose of the study and a request for a date and time to discuss the study with existing staff (medical officers and nursing staff) were presented to the Heads of Departments. Similarly, potential participants outside of the initial sites were contacted by email and sent information about the study following initial telephone contact. Four participants were recruited through referrals from some who had been approached to participate in the study. These participants were intimately involved in forensic nursing practice and proved to be rich sources of data.

**Data Collection**

In grounded theory, data can be generated through interviews, observations and document analysis and these three strategies were used in this study (Polit & Beck 2010; Corbin & Strauss 2008; Taylor et al. 2006). The processes of data generation and analysis are indivisible as analysis of the data informs the direction and depth of data generation until
saturation is achieved (Corbin & Strauss 2008). However to prepare for this, the processes for each were analysed prior to data collection and guided data generation and collection.

Interviews
Interviews were selected as the primary data generation approach, consistent with grounded theory methodology. Two approaches were used for interview: face-to-face and telephone. As the study is exploratory and there is paucity of information about the clinical forensic nurse role in Australia it was felt appropriate to use unstructured interviews (Nieswiadomy 2008). When conducting face-to-face interviews it is recommended that the interviewer establish eye contact and be free to observe the respondent, their facial expressions and other non verbal communication such as long pauses as they can influence the interview (Corbin & Strauss 2008; Nieswiadomy 2008). This allows for the participant to reflect about the response without pressure (Taylor et al. 2006).

The timing and setting of the interviews are important and should be suitable for both parties to avoid a potential loss of concentration with respondents preoccupied with other activities to be completed, or tasks left undone. With telephone interviews events such as holidays, important sporting events and a television series may also be a distraction (Nieswiadomy 2008, Taylor et al. 2006). Privacy is essential when conducting interviews to ensure there will be no interruptions and extraneous noise is avoided (Nieswiadomy 2008; Taylor et al. 2006). A researcher should also prepare by undertaking interview training to understand potential barriers to communication, ensure the interviewer and interviewee are comfortable in the roles and that unpreparedness or unfamiliarity in the role of data collection does not detract from the session process (Nieswiadomy 2008).

With face-to-face interviews, there is a potential for the interviewer to influence the data and outcome. When conducting face to face interviews it is suggested that first impressions can be important therefore common courtesy is essential, such as arriving on time, being friendly and relaxed (Nieswiadomy 2008). This also applies to telephone interviews, with a greater focus on verbal mannerisms such as the tone of voice (Nieswiadomy 2008).

When audiotaping an interview Taylor et al. (2006) suggest that the interviewer avoids focusing on the audiorecorder as this interferes with the process and the respondent may
percieve that their opinion is of no importance. Other potential disadvantages associated with audiotaping interviews include a reluctance by the respondent to permit audio taping. Fortunately the respondents in this study readily gave consent for their use.

The researcher had extensive experience with personnel management and interview techniques with patients and staff through their role as a clinician and nurse manager. Interviewing potential staff members has been an integral part of this role for a number of years. Therefore all aspects that support quality data collection through the interview process were readily addressed.

Initially an interview guide was developed with prompts (Appendix 1) and although modification of this was anticipated as data generation and analysis guided the subsequent interviews, this proved unnecessary. The interviews were more conversational than questioning, although the researcher did use the guide whilst anticipating most prompts and responses relevant to the particular participant being interviewed (Artinean et al. 2009). This allowed for broader viewpoints to be captured and to preserve the flexibility required to investigate any inconsistencies that may arise (Taylor et al. 2006). As the interviews were more conversational than questioning, the participants were invited to engage in open discussion at the outset with a view to creating an open ended interview.

When developing the interview timeframe for each site (a week was allocated) it was decided that initial interviews would be no more than 45 minutes in duration and it was planned that if individual participants were to be invited for a follow-up interview, this would be of no more than 20 minutes duration. It was proposed that, if necessary, some of the follow-up interviews may be conducted by telephone. At one site, the researcher was advised that their officers would have to participate in their own time, therefore would not be interested in participating and to not bother them with requesting their inclusion.

The interviews at the sites were conducted in a private location away from the work department and ranged in duration from 10 to 20 minutes. This reduced the potential for interruptions and reduction of work-related noise. There were no follow up interviews as the data generated reached saturation readily. There was one face-to-face, conversational interview conducted away from the formal sites that was of 45 minutes duration.
Interviews were audio recorded, which was useful as the interviews were able to be listened to a number of times to “detect themes and nuances that may have been overlooked during the interview” (Artinean et al. 2009: 10). The audio recordings were transcribed to form written text for analysis and these transcripts were returned to the participants for validation to ensure that they had been recorded accurately and their intent was accurately represented. There were no second interviews or clarification of situations arising from the transcriptions.

There were three telephone interviews. Telephone interviews can be a convenient way to collect data providing it is short, the interviewee is co-operative and the conversation is not too personal (Polit & Beck 2010). When conducting the telephone interview there are influences that may be positive or negative on the respondent and affect gaining co-operation. The researcher is unable to monitor non-verbal communications and facial expressions and can inadvertently inject bias by the tone of their voice (Nieswiadomy 2008; Taylor et al. 2006).

These potential issues were addressed by personal contact before the interview explaining the procedure and during the interview by clarifying any unusual responses. As the researcher was less experienced in this technique, the interview guide was used initially until a greater familiarity of the technique developed. At the completion of the interview the researcher asked if there were any questions and thanked the subject for their participation.

The telephone interviews for this study were conducted with three participants located interstate and were of 30 – 45 minutes duration. These were conducted at the convenience of each participant. The data generated by telephone interview was treated in the same manner as the face-to-face interview data (audio-recording, transcription and content validation).

In the process of interviews and observations, the researcher must be aware of the Hawthorne effect. This is a term used to describe a situation where participants are singled out – through interviews and observations – and perform or behave as anticipated because of the expectancies of the situation (Bailey, Schermerhorn, Hunt & Osborn 1986). This can create a dilemma for the researcher who may resort to covert observation to validate that the behaviours observed are ‘natural’ (Taylor et al. 2006).
Observations

Observation is important because it can clarify a situation when, for example, a person states that they are doing one thing and in reality they are doing another thing (Corbin & Strauss 2008). Using observation, the researcher is able to observe how often behaviour occurs, how long it lasts and how long it takes to achieve a task. Observations for research are categorised according to the relationship between the observer and the subjects. The observer may be a non participant observer (overt) that is when the observer openly identifies that they are conducting research. They become involved with the participants openly and are easily recognised by the use of items such as a clip board. A non participant observer (covert) is one who does not identify that they are observing. They interact with the participants but observe their behaviour without them knowing (Nieswiadomy 2008; Taylor et al. 2006; Creswell 2003). Observations of activities can be structured where the observer uses a predetermined checklist or unstructured involving observing a scene without imposing any structure on the observation (Taylor et al. 2006). Observation may be event or time sampling. Event sampling involves the entire event whilst time sampling is observations of events or behaviour during a designated time (Nieswiadomy 2008).

The observations can focus upon a work environment to gain an understanding of the roles of nurses and other health workers in response to forensic situations. This can involve the researcher observing intermittently for about 30 minutes every two hours to allow for flexibility in relation to the observations of health care workers and events, as well as the time of day (Taylor et al. 2006). Observations are time consuming, and because the researcher is letting the scene unfold it may not occur during a structured timeframe (Corbin & Strauss 2008). Data is limited by the amount that can be seen and recorded. The researcher may seek to clarify observed activities in order to gain the participants’ perspective. Corbin and Strauss (2008) caution that observations should not be used in isolation as the researcher may give meaning to an action or interaction based totally on the observation without checking their meaning with the participant such as the use of non verbal communication.

In this study, the researcher observed the scene as a non participant so that they were available to observe all relevant activities overtly (Corbin & Strauss 2008). The researcher kept ‘a low profile’ and conducted a combination of structured and unstructured observations. The observation guide (Appendix 2) identified some anticipated roles such as ‘Members of acute health care team’, ‘Members of patient support team’ but allowed the
recording of additional behaviours such as the involvement of police officers (Nieswiadomy 2008; Taylor et al. 2006). The focus of attention for observations is that of what was happening, where, when, how, why and with whom, without actual involvement in the activity of the participant. Observing the situation where the telephone interviewees would be interacting was impractical because of time constraints due to the distances to travel for this particular study. The personnel’s focus is forensic and in the other sites they had to focus on many aspects in a busy Department of Emergency Medicine.

Periodic observations were conducted in all the hospital sites, although there was only one event documented. The periodic observation occurred outside of a structured timeframe and situation and commenced during the night and progressed until the following day where the researcher was able to observe an episode of care. This involved the utilisation of medical staff, a social worker, nursing staff and family members. At the conclusion of this intervention it was noted that this case was forensic in nature and this was clarified during a scheduled face-to-face interview. Observation notes were used to describe the actual events.

**Documentary Data**

Information and insights derived from documents can be valuable additions to a knowledge base and can assist the researcher to uncover meaning, develop understanding and discover insights relevant to the research (Bowen 2009; Merriam 1988). Documents provided supplementary data and those selected were in the public domain and included relevant legislation such as *The Crimes (Forensic Procedures) Act* and *Police Powers Acts* from Australian states and territories, generic job descriptions of the forensic nurse examiner from Australia and overseas, the Forensic Nurse, Scope and Standards of Practice (International Association of Forensic Nurses – IAFN) which were reviewed for their contribution to the project. A full list is provided as Appendix 3. Documentary data was combined with the data from interviews and observation to enrich and explain the phenomenon under study (Bowen 2009).

**Field Journals**

As an integral aspect of qualitative studies and observation activities field notes were maintained by the researcher. These are theoretical notes denoting the researcher’s thoughts of the events and personal notes. They also serve as an audit trial, allow the researcher to document their thoughts and reactions as a way of keeping track of emerging impressions of
what the data means, how the data relates to each other and how the data is influencing their understanding of the field of study (Starks & Brown Trinidad 2007). Memos are lengthier and contain more in-depth thoughts about events, are usually written after leaving the field and are part of the analysis. Field notes were developed by the researcher during data collection to maintain an awareness of potential researcher bias and assumptions; a process inherent in grounded theory studies (Corbin & Strauss 2008).

Data collection ceased at each site at the point that the data was saturated, that is when no further data was necessary to substantiate the existence of a process or phenomenon (concept) or there was insufficient data to substantiate the existence or development of further concepts. Data saturation was identified in this study when no new information was obtained by further interviews. This was determined through constant comparative analysis.

**Data Analysis**

A feature of data analysis with grounded theory is the constant comparative method and this occurred throughout data collection (Artinean et al. 2009). The general process used for analysis included open coding, axial coding and selective coding consistent with grounded theory methodology (Polit & Beck 2010; Starks & Brown Trinidad 2007). The researcher works with the data from the commencement of the project in the process of analysis to constantly compare data deemed meaningful to the researcher from the interviews and observations that will be compared for similarities and differences and the emergency of potential concepts (Taylor et al. 2006).

In preparation for data analysis the data was organised. This involved transcribing interviews, entering field notes into a database and organising data from different information sources. When commencing data analysis it was essential to read the transcripts and listen to the audio recordings from the beginning to the end initially, allowing the researcher to enter vicariously into the life of the participant (Corbin & Strauss 2008). Memos of the researcher were included in the analysis during the replay of the audio recordings to compare with the transcripts as suggested by Corbin and Strauss (2008).

Coding commenced as soon as the first interview was completed because this data was the foundation for further data collection and analysis and typifies constant comparison analysis (Corbin & Strauss 2008). Each interview was coded before the next was conducted so that
new information could be incorporated (Starks & Brown Trinidad 2007). The process of coding is a process of data reduction to provide the means of promoting trustworthiness. The three stages that occur in coding and analysis are open coding, axial coding and selective coding (Polit & Beck 2010; Corbin & Strauss 2008; Starks & Brown Trinidad 2007).

Open coding is the breaking apart of raw data and this was performed first as recommended by Corbin & Strauss (2008). The process was taking apart an interview and using a line by line analysis of the sentences and paragraphs spoken by the participant. This allows an opportunity to separate data into parts and apply a code word that allows them to be compared, conceptualised and categorised (Merriam et al. 2002). At this stage, a definition or description of each code was organised allowing for standardisation of the meaning of the code across the data. Categorising is the grouping of code words around a particular concept in the data (Merriam et al. 2002).

Axial coding, also referred to as theoretical coding, occurred when the data was put back together to form links to emerging categories to form a paradigm (Polit & Beck 2010; Corbin & Strauss 2008). Conditions, actions or interactions and consequences are the basic components of the paradigm (Polit & Beck 2010). Axial and open coding occur together.

Selective coding involved “selecting the core category and systematically integrating links between the core and other categories and validating these relationships” (Polit & Beck 2010: 568). To facilitate identifying a central or core category constructing a diagram and reviewing and organising memos assisted with the final analytical stage (Polit & Beck 2010).

To facilitate these processes, the data was coded and stored in qualitative analysis software (N.Vivo QSR) for sorting and final analysis as data accumulated. N.Vivo QSR was selected due to the availability of the software and ready access to training in its use. Reviews of the software indicated that it was well-suited to the needs of this study as this type of software is useful when the researcher wants to quickly locate useful quotations and multiple perspectives on a category or theme (Taylor et al. 2006; Creswell 2003).

Data was entered into the software after manual analysis by the researcher through reading and rereading the transcripts and the allocating of codes. The researcher fed the labelled data into nodes and then gathered the groups into parent nodes for ease of identification.
Comparisons generated questions to substantiate the validity of the emerging concepts and themes and those that could not be grounded in data (saturated) were excluded from the final analysis. When no new ideas emerged from the data, it was considered to be category saturation (Taylor et al. 2006). As the data was reviewed it “resulted in the emergence of a core category, which appeared frequently in the data, had links with all the categories and explained most of the variations in the data” (Strauss 1987 cited in Taylor et al. 2006: 333). The outcomes of the analysis were concepts ‘saturated’ in data that formed into significant themes and thus the outcome of the study. Triangulation of data was achieved through the use of multiple data sources, interviews, observations and documents to confirm emerging findings.

During analysis, credibility, triangulation, reliability and trustworthiness were considered and Table D (on the following page) illustrates when and how this was achieved.
<table>
<thead>
<tr>
<th>Term</th>
<th>Action</th>
<th>Strategy</th>
<th>Rationale</th>
</tr>
</thead>
<tbody>
<tr>
<td>Credibility.</td>
<td>Review audio tapes.</td>
<td>Review data with the participants to validate data and the interpretations.</td>
<td>To give participants the opportunity to review the interview transcription for accuracy.</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
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</tr>
<tr>
<td>Triangulation.</td>
<td>Use of interview, observation and documents data from different areas.</td>
<td>Collect information about events and relationships from different points of view.</td>
<td>To validate content.</td>
</tr>
<tr>
<td>Reliability.</td>
<td>Review raw data.</td>
<td>Review line by line of transcribed interviews and written field notes and memos.</td>
<td>Collect and report detailed and sufficient data.</td>
</tr>
<tr>
<td>Trustworthiness.</td>
<td>Review raw data.</td>
<td>Data reduction and assign a code.</td>
<td>To provide the means of promoting trustworthiness.</td>
</tr>
</tbody>
</table>

Table D: Methods and achievements of rigor.

**Ethics**

Ethical approval was obtained from the University of the Sunshine Coast Human Ethics Research Committee, and the relevant State Government Health Facility for the sites (Appendix 4).

**Informed Consent**

Participants were given the opportunity to participate and were provided with a plain language statement (Information Sheet) outlining the aims, methodology, proposed reporting outcomes of the study and avenues for obtaining further information or raising concerns (Appendix 5). The project was explained verbally in plain language by the researcher. Participants had the opportunity to ask questions and make comments at the outset and throughout the duration of the project. All consenting participants were informed that they were freely consenting to participation in the study and that they were free to withdraw from the project at any time without penalty or coercion of any kind.

As the project involved employees of State Government health facilities, and the state Police Force they were responsible adults able to provide consent (Appendix 6). Participants whose primary language was not English but were employees in an Australian organisation had
proficiency in the English language. These two factors are determined by employment. No participants identified as Indigenous, therefore none required culturally appropriate processes with data collection (interviews) or observation.

After consulting with the Police Liaison Officer, the researcher was informed that permission is not required to interview members of the police force if it concerns the mechanisms of reporting and/or procedures they follow. Face-to-face and telephone interviews were conducted only after consent forms had been signed and all participant questions had been answered to their satisfaction. Consent forms for the telephone interviews were sent via email attachments and were signed and returned before any dates or times for the interview were finalised.

During the interview process there were no expressed or apparent feelings of intrusion as a result of audio taping and each participant agreed to audiotaping of the interviews.

**Privacy**

The interviews and observations did not involve disclosure of private or confidential data of participants or clients, thus reducing the potential for harm. However there was a low risk that such information would be disclosed through data collection. The researcher cleansed any data of private or confidential information/details prior to analysis and the transcripts were sent to the participants for verification. In order to do this, each participant needed to be identifiable. Identity codes were applied to the transcripts and the list of names associated (code translator) to these codes was kept separate from the transcribed data and stored in a locked area.

All data was converted to the electronic form for convenience and stored on a password-protected computer. At the completion of the study, all data was transferred to a memory device, the computer cleansed of the data and any paper copies of transcripts destroyed.

**Confidentiality**

Participants were informed that any information provided would be coded so that no individual is identifiable and it would be treated in the strictest confidence with no effect on their careers. Assurance was given that all identifying details (names and contact details) recorded would be securely stored so that anonymity is maintained (Taylor et al. 2006).
Each participant was asked to maintain confidentiality of the aspects discussed in the interviews to reduce site contamination and breaches in participant confidentiality. No site or individual will be identifiable in any publication that results from this study.

**Security of Data**

Data was transferred to a computer file, which is protected by password and user ID for the period of the study. The computer was in a locked research room on campus at the university. Only the researcher and principal supervisor had access to the data during the study.

**Storage and Final Destruction of Data**

Following the completion of the study, data will be stored for a minimum of five years in a locked cabinet in the faculty. The code translator was destroyed at the completion of the study.

**Safety of Participants, Safety of the Researcher**

Although this study did not involve experiments or interventions, safety relates to the participants’ sense of safety during data collection and the safety of the researcher as a visitor in the environment. Due to the nature of forensic work, aspects of patient safety were also considered.

At commencement of the interviews and/or observation the researcher discussed workplace health and safety requirements, procedures for an emergency involving the participants and that only if they considered the situation stable would data collection commence. Fortunately, no such circumstances arose during the study.

**Limitations of the Study**

The study has a small number of limitations. Firstly, the sample sizes are usually small in qualitative studies, preventing the outcomes from being generalised to wider populations. Therefore all findings are contextual. The study is qualitative, requiring the researcher to interpret the data. This process, although well considered, involves levels of subjectivity. However the use of the field notes and memos during data collection and analysis was designed to reduce this potential.
The researcher is a research student and, as such, had limited experience with qualitative analysis. While research skills strengthened during the study and support and guidance of experienced supervisors was accessed, there remains the potential for flaws in the analysis and the findings.

**Dissemination Strategies**

The findings will be presented in a number of formats and a variety of dissemination strategies will be used. A copy of the final report (thesis) will be lodged in the University of the Sunshine Coast Library following examination and final approval. A short report will be generated and made available to the participants. Following thesis acceptance, manuscripts will be prepared for publication in peer reviewed journals both nationally and internationally. One paper has been presented at a professional meeting (conference) and other opportunities will be sought to present the findings at national and international nursing conferences.

**Conclusion**

This chapter has presented the methods and procedures used in the collection and analysis of the data. Each aspect has been selected to be appropriate to the principles and procedures associated with Grounded Theory.
Chapter 4

Results

Introduction
This chapter presents the analysis of the data collected during this study and the ultimate findings. The study was conducted over a period of two years, a protracted time due to the complexities of attaining ethical support from some sites that were eventually abandoned due to the time constraints of the study. All participants were eager to participate in the study which resulted in rich data to analyse.

Demographic Context
The two sites that were willing to participate in the study were related in that they were branches of the State Public Health Authority within separate Health Districts of one state. These were major regional hospitals whose catchment areas varied considerably from rural to urban. Each site had broad populations to service, characterised by rapid growth in young families, an aging population, a transient workforce, a large Indigenous population and moderate to high unemployment.

The first site (Site C) was geographically accessible to the researcher assisting with refining data collection approaches and negotiating with relevant personnel. There were no Government Medical Officers (GMO) within the site Health District, yet there were forensic nurses who were ‘on call’ for the Criminal Investigation Branch of the State Police Force. The hospital staff were unsure as to how to contact these nurses and who employed them. When forensic clients (particularly sexual assault victims) present to the emergency department and there is no designated forensic staff available, the available medical officers undertake the examination even though they are not trained in forensic procedures and this affects the care of all patients because of the length of time involved for the examination. This can take between 3-5 hours.

Government medical officers were available at the second site (Site D) as were forensic nurses and there was less confusion as to how to contact the nurses but also uncertainty on as to who employed them. When the GMO or forensic nurses were not available, (a medical officer from the emergency department is nominated) a lengthy process was initiated to find the nearest GMO in a nearby health district. This required telephone conversations, faxing
‘how to do’ guidelines and finally completion of examinations. Their role appears to be to give simple, quick training and advice on how to best achieve the requirements.

All remaining participants employed in dedicated forensic units were located in the capital cities of their respective states and territories and were interviewed as individuals within their work environment, but these were not considered formal research sites. This sample participated through telephone and face-to-face interviews.

Fourteen participants willingly gave consent and all worked within various positions of Departments of Emergency Medicine, Medical Forensic Units and the State Police Force. The participants were located in three states and one territory of Australia and one was employed as lecturer at a major tertiary institution. The participants were diverse yet had the common characteristic of being employed in clinical forensic practice or were members of the Emergency Department team as the first contact, who identified that further intervention was required. The medical officers, social worker and a nurse practitioner were all male (n = 6), with the remaining participants being female (n = 7). Forensic nurse examiners located on the eastern coast of Australia held a Graduate Certificate from a primary Victorian University and were mentored by the Victorian Institute of Forensic Medicine (VIFM). Further west, a South Australian University offered a Graduate Certificate, and one private University in Western Australia also offers studies in forensic nursing. None of the participants interviewed had completed their course at the latter university.
Findings

The findings are presented as theoretical concepts with data examples from the respondents and extracts from the documents demonstrating the contribution of the data to concept development. The observation studies provided validating data to some of the concepts and have been included where relevant. The primary theoretical concepts emerging from the data are: ‘It’s just not modern day forensic science’, ‘Practice validated by certification’, ‘You’re pretty much out there and it’s very autonomous’ and ‘The trouble is the legal system’. These concepts explain the processes, identifying factors that influence practice and insight into an alternative approach that could be considered an exemplar model of care.

It’s just not modern day forensic science

The first saturated theoretical concept to emerge from the data illustrated a constant that influenced the clinical environment: traditional professional boundaries and the model of care used were inconsistent with forensic practice. The prevailing constant was the preservation of life as a priority above forensic issues. Data from three respondents illustrates this:

...the clinical has to come before any of the forensic thing. (MD2)

...our priority would be the medical part of it, ensuring that all medical things are taken care of. (MD3)

So your stabbings, your gunshot wounds, your significant road traffic victims, your multiple assaults would tend to be cared for in a resuscitation area of the department. (NP)

This constant is supported in international documents, such as A National Protocol for Sexual Assault Medical Forensic Examinations (2004:77) developed by the United States Department of Justice. They highlight the need to “respond to acute injury, trauma care, and safety needs before collecting evidence”.

This is detailed further, by stating that after the initial medical evaluation, stabilisation and management of the patients’ acute medical situation the medical forensic examination is conducted. Firstly, the consent of the patient is required.
In circumstances in which patients are seriously injured, examiners must be prepared to work alongside other health care providers who are stabilizing and treating them…..examiners may need to perform exams in settings such as health care facility’s emergency department, an operating room, a recovery room, or an intensive care unit (USA DOJ 2004:77).

A further explanation will assist in understanding the complex nature of obtaining consent, the importance of this and why it is very time consuming. This should also be achieved by maintaining the victim’s dignity and respect whilst ensuring the victim has a sense of control. Documentary analysis suggests there is a sequence of events and each event must have consent, such as “talking about the incident, documentation of the event, collection of evidence, taking photographs, writing a report and then the release of the report” (Williams, as cited in Boyd 2008:15). There are states and territories in Australia that have adopted this approach as a respondent working within an established forensic team and environment relayed:

...then the initial components that can be collected really quickly are collected really quickly and then we travel through with that patient in their theatre journey to collect whatever we need to collect from the theatre component.(FN1)

...is a lady that had an injury to her neck that was quite close to major vessels [sic] was basically in the emergency department, quick photos were taken using a syringe just beside the injury as a measure and then once we got up to theatre and they were working on a repair of that then the other things were done while she was there. (FN1)

One respondent highlighted a potential for interference with the inclusion of a forensic nurse into the resuscitation team that is commonly involved with managing major injuries requiring stabilisation:

...I would be concerned that there would be interference, a slowdown, a step in the process that doesn’t need to be there. (MD3)

The constant of life preservation as a priority influences the design of the Departments of Emergency Medicine and the type and use of equipment. Emergency departments are
primarily designed to treat life threatening situations and have few, if any, secluded, secure cubicles that are essential in forensic practice because these do not allow for ease of observation and rapid response to changing clinical situations. Therefore, the emergency department model of care and environmental design was used by default for forensic practices. But this was seen to have limitations, as four respondents highlighted:

*The big thing is maintaining patients’ privacy in this sort of environment. There really isn’t anywhere.* (RN)

*Someone doesn’t want to be talking about their rape with a person next door or the kid next door listening in.* (MD1)

*They need a private area; they need a private cubicle for the extensive test for the examinations and things.* (NP)

*So it needs to be a private place because we have all the appropriate equipment and then staff with the skills and expertise to deal with that, separate to an emergency department, but an emergency department obviously is important because it can be associated to [sic] serious injuries.* (MD1)

Document analysis has identified that few emergency departments have a dedicated room for forensic examination and collection of evidence (USA DOJ 2013; Dougherty 2011). There is a potential risk of cross contamination of forensic evidence with that of non forensic patients and critical evidence coming in contact with debris such as hair, dust and other contaminants. This is because of the close proximity of everyone (Dougherty 2011). DNA analysis today is more sensitive and can potentially detect accidental contamination (USA DOJ 2013).

Staff of the sites’ emergency departments were orientated and trained in the emergency department model of care and had not received any formal forensic training, only opportunistic training when a situation occurred, as three respondents explained:

*Oh that doesn’t ... you know, nobody gets told anything about forensics.* (NP)

*... forensics does not get covered and so it is really on the floor learning that the CF [Clinical Facilitator] would pick up or opportunistically by the clinical nurses.* (NE)

*...we will not do a sexual examination for the reason being is that it needs to be done by an expert to provide the woman with the best possible chance in court.* (MD1)
During a periodic observation session there was a situation that did occur and demonstrated the use of the emergency department model of care, utilising preservation of life as a priority before the forensic aspect. This resulted in the patient being positioned in a curtained cubicle for ease of observation and response to any life threatening changes. Presentation occurred at night for a medical condition (chest pain) and after the initial medical assessment it was established that it was not life threatening, but would require the involvement of the social worker. The patient was to remain in the emergency department until reviewed by the social worker in about seven hours. This meant the client would need to tell their story again to new health care professionals along with a discussion of what was to be organised to assist. During the consultation, the patient was reviewed by a further medical officer and a social worker, and the diagnosis of elder abuse was confirmed. At approximately midday (about 12 hours after presentation), the patient was discharged to their pre-admission environment after the patient refused any type of assistance or to make a formal report of assault to the police. The lack of legislation for mandatory reporting of elder abuse outside of an aged care facility offered the health staff and client no suitable alternative for care or legal intervention (Aged Care Act 1997 Commonwealth). The time frame was extensive and involved numerous health care professionals, each asking similar questions. The researcher, through document analysis, identifies that the influence of forensic science and the specialised skills possessed by the forensic nurse are more likely to identify a victim of abuse or neglect during the initial assessment, be that at triage or within the care environment (Sullivan 2011).

Triaging or sorting of patients according to acuity and need occurs within emergency departments, at police stations and by the forensic patient themselves when deciding if and when to present to any of these environments. It also determines where the person is located for care in emergency departments and the waiting time to be seen by a medical officer or nurse. There is an international/national category system used by staff in emergency departments that guides the triage process (Appendix 7). However there are no specific national or international triaging protocols located for forensic patients, rather it is recognised that some health care facilities use code plans¹ to avoid inappropriate references by staff to sexual assault victims (USA DOJ 2004). But identified recommendations (A National protocol for Sexual Assault Medical Forensic Examination. Adult/Adolescence) (USA DOJ

¹ Such as giving a John or Jane Doe name.
suggest forensic patients be given priority for emergency care because unnecessary waiting time may cause “loss of evidence and undue trauma” and this can be avoided by prompt evaluation, treatment of serious injuries and undergoing medical forensic examination (USA DOJ 2004: 27).

Although there are a number of nurse practitioners working in emergency departments, a ‘fast track’ model of care was used by nurse practitioners, that is the nurse practitioner reviews triaged patients categorised as less acute medical, freeing the medical officers for the more acute situations, as described by two respondents:

*The patients that the nurse practitioner model of care would deal with are the persons or patients that didn’t have life threatening illnesses or injuries.* (NP)

*My role is to work in the Fast Track area of the emergency department seeing the lower acuity patients, categories 4s and 5s and some category 3 with an extended role, I can work out there independently.* (NP)

Two respondents considered that there was no specialised role for the clinical forensic nurse practitioner in the emergency department.

*...I don’t think they would embrace the role because of KPIs and all of the financial pressures in the emergency department.* (NP)

*It doesn’t have to be a nurse practitioner role.* (NP)

If a potential forensic client presented to a police station, triaging would also take place, and the decision would be made to take the person to the nearest emergency department or to organise the services of a forensic nurse or forensic team within the police station or clinic. Some states have facilities available for non-life threatening presentations within the police station as an alternate site of care. This practice is referred to as ‘integrated’ or ‘co-ordinated’ services. As noted by the World Health Organisation (2003), having this facility encourages a fast and effective response to the situation and ensures timely collection of evidence with the simultaneous provision of medical and legal involvement through the interview and the forensic examination. Data from a number of respondents explains:

*...we can accommodate family and all of those other components in a slightly nicer way than we can in a busy emergency department.* (FN1)
...we have a Sexual Assault Referral Centre that most things go to because the EDs here are not very well set up to ... not well set up to any kind of sexual assault proper examination. They don’t have proper scopes or anything like that. (NP)

The mobile service we go to the two key hospitals...(location) [sic] , we have an examination site over at the police investigating unit that we manage and stock and maintain and we also have an examination room here within our outreach site that’s located on the hospital campus so we’re in the back of the hospital grounds. (FN1)

...it wasn’t working well because the doctors were busy, the sexual assault clients weren’t a high priority when they had life-threatening illnesses and staying on in the emergency department or they’d have rush in and do the exam and rush out again and they weren’t trained. So there were gaps where they needed a service. (FN2).

Forensic nurses, government medical officers, forensic physicians or medical officers who have forensic training are not routinely employed as members of the Department of Emergency Medicine. Rather, they are employed by the Health Department and as such must be ‘called in’ for any forensic situation.

... the government medical officer would be the person who they used to call in, but since the forensic nurses have been trained up, there’s now a forensic nurse on call that you can call and they will come in and do the examination and collect evidence. (NP)

… the government medical officers are generally under, they are GPs (General Practitioners) almost,[sic] so they are usually people who have general practice somewhere in an area and they will do this forensic work on a part time or occasional basis as needed, that’s it basically, and they deal with the police with their services. (MD2)

Some will only do sexual assault examinations. They don’t do any other aspect of the role, and that’s just how they are credentialed when they are doing it. (MD2)

If no GMO or forensic nurse is available, there is a lengthy period of negotiating with other emergency department doctors to conduct the examination, using those who have no formal forensic training. Two respondents explain:
... if the forensic nurse is available then they are called in but if they are not available, as I understand then we get the government medical doctor, and if that fails then it is a long debate and a dramatic discussion if we can get one of the ED doctors to complete it. (MD3)

And it’s totally inappropriate. It’s just not modern day forensic science. (MD1)

Because the emergency department staff get involved and have to do it when they’re not trained to do it and it impinges on the care of other patients. (MD1)

It is very difficult because we usually have to phone somebody, usually a Government Medical Officer in another district, then they telephonically tell us what to do and we write it down and we fax it to them and if they are happy with it, then we try to do it and that can take up to 2 – 3 hours to do. That is why we are not very keen to do it and we try to discourage it at all. We only do it under really, really difficult circumstances. (MD3)

In stark contrast to the body of evidence supporting the primacy of the traditional emergency medicine approach to the care of forensic clients, there are states and territories that have memoranda of understanding between the police and the health departments that ensures a more appropriate model of care. The following data excerpts explain:

... we’ve got MOUs (memorandum of understanding) with all of those key stakeholders so we all work fairly tightly together supposedly to provide best care and choice for that victim. (FN1)

The other things I do I suppose is a lot of external stakeholder engagement. (FN1)

The data shows that the present model of care used for forensic clients is strongly influenced by existing structures and practices, none of which have the forensic client at the centre of care. There is a lack of appropriate facilities and education and all mitigate against the forensic nurses or suitable medical staff. However there are some organisations and territories that have recognised and developed a response to needs in society, but clearly this is not universal. The thematic concept of ‘It’s just not modern day forensic science’ is defined as practice that is not mindful of the needs of the forensic client that is characterised by the
primacy of the model of care used in the majority of environments and broad acceptance of ad hoc approaches to forensic examinations.
Practice Validated by Certification

All of the forensic nurses interviewed had completed a 12 month Graduate Certificate in Forensic Nursing. Some had an associated clinical component that was facilitated through the Victorian Institute of Forensic Medicine on the eastern seaboard of Australia. After attaining the qualification, they went on to a ‘call’ roster of forensic nurses. The formal qualification was seen as validation of their skills and knowledge, as reported by one respondent:

I didn’t feel that it was appropriate to be providing a level of forensic medical examination until I had some core qualification that would stand me in good stead for court related purposes. (FN1)

Document analysis identified that internationally there is a growing trend in the use of sexual assault nurse examiners (SANEs) to conduct forensic examinations and forensic nurse examiners (FNEs) are utilised to collect evidence for a variety of alleged crimes (Dougherty 2011). They are registered nurses who have received specialised education and fulfilled recognised clinical requirements (USADOJ 2004). The FNE is an under-recognised sub speciality within the hospital environment and they are required to have a broad range of forensic knowledge and skills that are applicable to patient care within the hospital environment (Sullivan 2011).

International standards show that the forensic nurse is required to obtain specialised education and fulfil clinical requirements and maintain a level of professional development for this expanded role. The researcher is unfamiliar with the international standards for general practitioners as this not the focus of the study. This is not reflected in the data representing the Australian environment, especially in relation to the medical officers within hospital environments and the GPs who work as GMOs. They have the burden of other health care delivery in addition to the broad or selected section of forensic work that they have chosen to deliver. A nurse practitioner respondent explained:

...they use general GPs in that service who work from a work book to go through a SARC (Sexual Assault Referral Centre) exam and of course, gain knowledge and experience but there is no particular training up until then [sic] other than see one, do one, that kind of ethos so none of them have any education other than that. (NP)
Two medical officers also provided data to support this issue:

...we will not do a sexual examination for the reason being is that it needs to be an expert to provide the woman with the best possible chance in court. So you need somebody trained in forensic pathology, whether that be a nurse or doctor. (MD2)

...somebody has to maintain skills somehow so that they are prepared for when that occasion arises so that’s our other responsibility really is to deliver ongoing skills development to people who may not be as exposed as frequently as large populations would be. (MD3)

The nurse respondents in this study came from various clinical backgrounds and a number had experience or preparation in sexual health but not possessing this knowledge and experience did not exclude any from being recruited and trained in forensics.

... there are some, a lot of ED (Emergency Department), a lot of sexual health background, there’s one of them in CCU, Coronary Care nurses who have got [sic] interested in the role and there’s community nursing in the role, so there’s sort of a quite a variety of walks of life that are actually involved [sic].(MD3)

I have a background in women’s health family planning, spent 20 years working in a tertiary maternity unit and also working in family planning. (FN1)

In the forensic clinics, clinical nurse consultants (forensic nurses) fulfil a role that could be considered to be more within the Scope of Practice of a nurse practitioner, yet they do not have the legal or professional qualifications for this role, as the following data excerpts demonstrate:

We see people from the acute presentation, we provide all of their healthcare in relation to that being a victim of that assault which includes sexually transmitted infection screening, blood borne virus screening, we do the follow up for [sic] in relation to the STI (sexually transmitted infections) screening and the three month follow up of blood borne virus screening sometimes up to six or 12 months in a high risk exposure. (FN1)

... so we do have external counselling services that we can refer to or the social workers within the hospital as we can refer anybody we see that might have had a
potential injury to a finger that needs x-raying or any of those sorts of things. So we will provide and manage the immediate sexual assault related components, anything that related to their ongoing medical care. (FN1)

I’ve got standing orders to give the morning after pill for emergency contraception and Hepatitis B and as an immunizer, so I can order that myself. We don’t give routine prophylaxis for sexually transmitted infections; it’s just something we’ve decided. (FN2)

In addition, some reported that they keep in touch with their clients to ensure they attend their referrals, manage their medications and they may also issue medical certificates. The ability to issue medical certificates was the result of a change in legislation in some of the southern Australian states. These nurses appear to be working within the definition of the IAFN & ANA (2009) of ‘advanced practice’ and this covers nurse practitioners. This includes “obtaining both health and forensic histories and conducting health and medical assessment for diagnostic purposes which include evidence collection and treatment of health outcomes (IAFN & ANA 2009:15). As noted, nurses without formal preparation and qualifications of the nurse practitioner are undertaking roles that could be considered to be those of a forensic nurse practitioner. The practice scope of the nurse practitioner is advanced and includes assessment and management of clients, referring to other health professionals, prescribing medications and ordering diagnostic investigations (ANMC 2006).

Document analysis shows that internationally, forensic nurses are required to obtain and maintain specific certification as shown in this example from a position description for a registered nurse in forensic practice (Harris County 2010).

Forensic nursing certifications

- CA/CP SANE (state certification through the Office of the Attorney General) OR
- SANE-A\(^2\) (International Association of Forensic Nurses (IAFN) certification)
- SANE-P\(^3\) (IAFN certification)

Trauma response

- TNCC (Trauma Care Course. This is a basic assessment course of 2 days for nurses who work in trauma.)
- ACLS (Advanced Cardiac Life Support.)

\(^2\) SANE-A refers to Sexual Assault Nurse Examiner – Adult/Adolescent

\(^3\) SANE-P refers to Sexual Assault Nurse Examiner – Paediatric
• PALS (Paediatric Advanced Life Support.)

Annual Continuing Education
• Six hours of education on forensic topics
• Six hours of education on trauma topics (for trauma response)

The minimum entry qualifications for this position (Harris County 2010) are:

| Education/Specialized Training/Licensure: | Bachelor of Science Degree in Nursing. Current State (of Texas) RN Licensure. Preferred certified Sexual Assault Nurse Examiner through either the International Association of Forensic Nurses (IAFN) or Texas Office of the Attorney General or within two years of employment. |
| Work Experience (Years and Area): | Minimum of two years healthcare experience as a Registered Nurse with a background in Emergency/ Trauma, Labour & Delivery, Paediatrics, Intensive Care and/or Forensic Nursing. |

An Australian equivalent, also identified through document analysis shows a Duty Statement for a Forensic Nurse Examiner, (Registered Nurse, Level 1\(^4\)) in the Australian Capital Territory Health that they must be a registered nurse with experience in emergency nursing with sexual health, custodial nursing, drug and alcohol or mental health nursing preferred but not essential. The rationale for this broad experience is to provide general nursing care and triage of priorities with the Australian Federal Police Watch House (FNE 1 Duty Statement, ACT Health 2010). The nurses are required to obtain or show interest in and willingness to gain knowledge and skills in clinical forensic, sexual assault and sexual health nursing by completing post graduate qualifications. For a Registered Nurse (Level 2\(^5\)) the requirement is more specific, specifying that they must have completed a post graduate qualification in clinical forensic and sexual health course.

However, through interviews and journal articles, it became clear two post graduate forensic nursing courses (in Victoria and South Australia) have been discontinued due to falling enrolments. However one South Australian university has recently entered a contract with a premiere US university to offer internationally recognised professional development (40 hours online) in forensic healthcare. This was launched in August 2012, but this program

\(^4\) Registered Nurse Level 1 is the first level of entry
\(^5\) Registered Nurse Level 2 is the next level of advancement
does not provide parity with the scope and depth of knowledge and preparation of the discontinued programs (Belardi 2012).

Because Australian forensic nurses are not employees of hospital Departments of Emergency Medicine (as described in the job description from the Australian Capital Territory), nurses are either employed by the state or territory Department of Health or Department of Justice as a sub section of Forensic and Medical Sexual Assault Care – Nursing, or as part of a Forensic Medicine Unit. The Australian forensic nurse is called in to a forensic situation when a client presents to the Department of Emergency Medicine or a police station. Alternatively they are primarily employed by the hospital or other health facility in another area and make themselves available (on an ‘on call’ or ad hoc basis) in their role as a forensic nurse at completion of their shift. One respondent explained:

\[ Part \text{ of the reason for doing that is that this is not their primary job and so you can’t enforce them to work in an area which may conflict with their primary job, so if they make themselves available, then fantastic. (MD3) } \]

The thematic concept ‘Practice validated by certification’ is characterised through the data as an extended role that requires formal educational preparation, but the ability to attain this in the future is not assured. In comparison with international standards, practice preparation for Australian forensic nurses does not meet parity, there is no professional requirement for ongoing development in the specialty and the prerequisite professional experience is vague. Although there are domestic position descriptions for forensic nurses, the existing forensic nurses are not all primarily employed for this role.
...you’re pretty much out there and it’s very autonomous

The data supporting this concept suggests that many forensic nurses experience professional and collegial isolation. Despite a significant number of nurses completing forensic qualifications, many have left this practice because of a lack of support in the role after completing their qualification, as two participants reported:

... though the training was offered, there wasn't any support after they got their qualifications, so a lot of them haven’t and [sic] continued with this part of their career. (FN2)

...we’re asking for is perhaps a yearly update because once you’ve got your accreditation you’re pretty much out there and it’s very autonomous. (FN4)

Within a discrete clinic forensic unit there was a clear level of peer support with reviews of units and practices in conjunction with the Victorian Institute of Forensic Medicine, but this was not evident in all states. The following data explains:

… we have a weekly education session that occurs where both the doctors and nurses attend if they can actually make it. They’re paid for that session so they come, which makes people engage as a team or allows people to be able to engage more as a team when they’re working in a very autonomous sort of isolated role. (FN1)

...there’s regular video conferences and teleconferences with forensic nurse examiners around the state to sort of keep in touch and talk about any issues and that sort of things. (FN4)

...so people who don’t have that peer support, who don’t have a network around them, they tend to become more aligned into a police way of thinking so that their focus is on the alleged offender, they are an offender, so they are becoming prosecutors in some respect. With peer support then they maintain that distance that they need to be in this. (MD3)
A document review shows that an “estimated 300 forensic nurses were working in isolation” and that the formation of a new professional association for forensic nurses in Australia would strengthen support for these nurses and this is hoped to be achieved within 18 months (Starr, as cited in Belardi, 2012: 5).

The World Health Organisation (2003) guidelines for medico-legal care for victims of sexual assault, specify that follow up care is necessary for both the medical and psychological benefit of the patient. One respondent outlined how they achieve this:

…We’ve got some very good Sexual Health Clinics in our area and so we give referrals to our patients and I do some follow-up with the lot of them, because they do forget that they’ve even been given that referral. (FN2)

The respondents indicated that they considered obtaining additional training was important and relevant, but this was not extended to an ongoing national program. There are organisations that have developed ongoing peer review strategies to share information and foster interaction within teams. This has resulted in an expansion of roles to cover gaps in the service delivery by nurses and loss of appropriately qualified staff. The conceptual theme ‘…you’re pretty much out there and it’s very autonomous’ is supported by the data in that those remaining in practice consider themselves to be autonomous by default yet they crave and appreciate ongoing professional development and interaction from other like-minded practitioners.
The Trouble is the Legal System

Analysis of the available Criminal, Forensic or Police Powers Acts and Codes of each state and territory of Australia offers a profile of those able to be involved in forensic procedures: who is permitted to collect evidence, conduct examinations and the time frame in which this evidence is to be collected. There is no national uniformity in these Acts or Codes and this caused confusion for the researcher.

<table>
<thead>
<tr>
<th>State</th>
<th>Title</th>
<th>Persons permitted to conduct forensic examinations</th>
</tr>
</thead>
<tbody>
<tr>
<td>Australian Capital Territory</td>
<td><em>Forensic Procedures Act 2000</em></td>
<td>Medical Practitioners, Dentist, Nurse, Police</td>
</tr>
<tr>
<td>New South Wales</td>
<td><em>Crimes (Forensic Procedures) Act 2000</em></td>
<td>Doctor, Dentist, Dental Technician, Nurse, Appropriately qualified person</td>
</tr>
<tr>
<td>Western Australia</td>
<td><em>Criminal Investigation Act 2006</em></td>
<td>Doctor, Qualified person, Dentist, Nurse, Qualified person who is a nurse, midwife or other prescribed person</td>
</tr>
<tr>
<td>South Australia</td>
<td><em>Criminal Law (Forensic Procedures) Act 2007</em></td>
<td>Medical Practitioner, a person who is qualified as required regulations to carry out forensic procedure of the relevant type, Dentist</td>
</tr>
<tr>
<td>Northern Territory</td>
<td><em>Police Administration Act 2012</em></td>
<td>Medical Practitioner, Registered Dentist</td>
</tr>
<tr>
<td>Queensland</td>
<td><em>Police Powers and Responsibilities Act 2000</em></td>
<td>Doctor, Dentist</td>
</tr>
<tr>
<td>Victoria</td>
<td><em>Crimes Act 1958</em></td>
<td>Medical Practitioner, Nurses, Midwives, Dentists and with the <em>Crimes Amendment(Forensic Procedure) Bill 2010</em> Police Officers</td>
</tr>
</tbody>
</table>

Table E: Legislation differences.

Some Australian states have discrete legislation that directly affects forensic nursing practice by identifying exactly who they are permitted to examine as a respondent outlined:

*But through Legislation they [forensic nurses] are not able as yet to perform examinations on alleged offenders of crime. (MD3)*

*... but I don't think anybody places any importance on it at all. The trouble is in the legal system, there is really no challenge to change the chain of custody or any of*
the forensic information that is collected. There has to my knowledge, been no challenge in court, so I think until that happens, no one else is going to change. (FN3)

So you know and so far like legally there seems to be no interest in challenging any of the evidence that is collected or anything else, so at one stage, they had ENs (enrolled nurses) collecting evidence and that stopped thankfully, but you know, there is no quality assurance at all. (FN3)

The review of documents has highlighted that the courts have not tested whether forensic nurses are considered ‘experts’. Not only are nurses’ qualifications scrutinised but their area of expertise and level of experience will be examined for them to be deemed an expert (Williams, as cited in Boyd 2008). This is unlike a doctor who has never seen a sexual assault victim, though is deemed an expert in the medical field because of their qualifications alone (Williams 2008). Guidance is given through legislation and court direction on the level of skill required and this is taken into consideration with the training that is available to the nurse (Willis as cited in Boyd 2008).

Nationally, each Act and Code with reference to forensic examinations offers definitions of ‘appropriately qualified police officers, doctors, nurses and dentists’ although some have a more detailed explanation as noted:

A person is an appropriately qualified person to carry out a forensic procedure if the person is a person (for example, a police officer) who is qualified as prescribed by regulation to carry out the forensic procedure. [Crimes (Forensic Procedure) Act, ACT, 2000 Ch2, Part 2.1.13:7]

... qualified person, in relation to a forensic procedure, means a person who is qualified under the regulations to do the procedure. (Criminal Investigation Act, WA, 2006 Part 9, S73:63)

Legislation ensures that the primary non-police personnel permitted to be involved with forensic procedures are medical and dental officers, although some states and territories of Australia have included nurses, (New South Wales, Australian Capital Territory, Western Australia, Tasmania, Victoria and South Australia) whilst other states do not clearly identify
nurses as *appropriately qualified*. The data obtained from the respondents (and presented in a previous section) identifies this limitation and the subsequent impact upon the delivery of forensic services to the general public.

... *if the forensic nurse is available then they are called in but if they are not available, as I understand, then we get the Government Medical Doctor, and if that fails then it is a long debate and a dramatic discussion if we can get one of the ED doctors to complete it.* (MD3)

Legislation in Western Australia authorises nurses and midwives who are qualified, as well as doctors, to conduct forensic procedures on victims and collect evidence, thus reducing the risk of lost evidence (NCAH 2011). The West Australian Police Minister (2011) indicated that victims of sexual assault were disadvantaged if a doctor was unavailable and great distances had to be travelled to obtain a forensic examination to collect evidence.

Having trained nurses available on hand to carry out internal forensic procedures will mean a better outcome for victims in country WA and will, in many instances, eliminate the potential loss of evidence (Johnson in NCAH 2011: 30)

As noted by the Western Australian Police Minister (op cit.), timely examination of the forensic client after presentation is necessary to maximise opportunities for evidence collection. Evidence can be lost through the body (urination for example) and also in clothing through various mechanisms. According to international documentary standards, it is considered that the maximum time for collection of evidence is 72 hours (USA DOJ 2004). This imperative was noted by one respondent:

*Well, preferably within 24 hours if somebody’s been sexually assaulted, we would be wanting to get that evidence.* (PO)

The *Crimes (Forensic Procedures) Act 2000* – NSW (part 2 section 6) outlines time limits for carrying out forensic procedures for suspects as within two hours but no longer. It is the only state or territory that stipulates a definite time parameter and this is used in an exemplar model of care. This is a probable explanation for the identified time period to examine patients so as to “minimise the loss of evidence” (USA DOJ 2013:73)
Our key performance indicator is that we respond within two hours of being requested. (FN1)

Internationally, there is a time period allocated for examiners to arrive at a site after being notified as outlined in the Harris County guidelines (2010).

- Telephone response time to pages should not exceed 10 minutes
- Response time to consulting facility should not exceed 1 ½ hours

Legislation protects the public; it provides a framework upon which to build a system or structure. However it can also become a barrier that obstructs the provision of care within a changing society. Legislation forms the central category of the conceptual model that emerged from the analysis of the data. Upon closer examination the common thread of legislation that should bind the practice and practices of the forensic nurses, in fact contains inconsistencies from each state or territory, therefore the concept ‘The trouble is the legal system’ describes the impact of this upon all aspects of forensic practice.
Conceptual Model

The four concepts that combine into a conceptual model influence the scope of practice of and for the clinical forensic nurse practitioner. *The trouble is the legal system*, that is, legislation is central to the provision of care of the forensic patient and thus the practice of the forensic nurse. Access to forensic medical services can be difficult and confusing in major capital cities even where there are dedicated forensic centres or forensic nurses but these services are limited in some regions and non-existent in rural and remote areas of Australia. In situations where these are not available, the use of GMOs, or emergency department medical officers, usually quite junior or inexperienced who do not have any speciality training and little guidance is accepted and very much appreciated by the forensic patient, hospital, police because of the time requirements. This is because doctors are considered appropriately qualified persons and they have the authority of being within the medical profession. According to one medical officer:

*That is why we are not very keen to do it and we try to discourage it at all. We only do it under really, really difficult circumstances.* (*MD3*)

While nurses in some states and territories are not considered appropriately qualified persons within the legislation they will not have the capacity to overcome traditional professional barriers (gaining specific qualifications, recognition of qualifications and employment within these areas) and the present emergency department model of care that will allow them to develop the essential aspects of care for the forensic patient. This is represented in *It’s not modern day forensic science*. The remaining concepts, *Practice validated by certification* and *You’re pretty much out there and it’s very much autonomous* may exist in a limited capacity, resulting in fragmented training and support.
The trouble is the legal system

It’s not modern day forensic science

Practice validated by certification

You’re pretty much out there and it’s very autonomous

Figure A: Conceptual Model
In the states and territories where nurses are considered appropriately qualified persons there exists formal and professional support to develop and provide contemporary forensic care in an advanced and expanded role that reflects the scope of practice of the nurse practitioner. The traditional barriers have been removed and forensic nurses work as part of a team involving forensic physicians, counsellors, social workers and the police.

‘The trouble is the legal system’ is the concept that anchors the entire model, as it influences and gives guidance, and holds steady all the other concepts. At present there is an ad hoc approach to the access and training of forensic health services and personnel and this is identified with the reduced tertiary courses, the lack of support for the forensic nurses and the use of medical officers without specialty training. Legislation influences policy but it must also be the catalyst for change to greater access to forensic health services and personnel.

The conceptual model leads to the emerging theory that results from the analysis, that is:

*Where legal, professional and ideological barriers can be overcome, there is the capacity and desire to develop a Clinical Forensic Nurse Practitioner model of care that can complement, improve and expand existing health care to the community where there is a genuine and acknowledged gap in services.* (the researcher)
Chapter 5  
Discussion

Introduction
This chapter presents the discussion on the findings from this study, and the emergent theme:

Where legal, professional and ideological barriers can be overcome, there is the capacity and desire to develop a Clinical Forensic Nurse Practitioner model of care that can complement, improve and expand existing health care to the community where there is a genuine and acknowledged gap in service.

The four theoretical concepts that underpin the theory: ‘The trouble is the legal system’, ‘It’s not modern day forensic science’, ‘Practice validated by certification’, and ‘You’re pretty much out there and it’s very autonomous’ will be discussed in light of the available literature. This will be followed by a discussion of the emergent theory. Finally, this chapter will present recommendations from this study to guide future work in this area.

It’s just not modern day forensic science
Internationally and nationally there is one constant and that is the preservation of life above forensic issues (USA DOJ 2004). Emergency departments have been designed with this constant as the focus of practice and care, and have inbuilt support mechanisms that surround this clinical environment that reinforces practice such as a triage system centred on life threatening presentations as a priority. Forensic presentations, unless life threatening, do not have priority and there is no established forensic equivalent triage system (USA DOJ 2004).

The triage process is conducted according to physical parameters, but not all forensic clients present with life threatening injuries. Invasion of personal space (trauma) is profound and lasting (Ferrell & Caruso 2011; USA DOJ 2004). Currently, although developed in 2004, international recommended protocol asks that these patients, particularly those presenting following sexual assault be treated as a priority and some hospitals use a code that ensures anonymity (USA DOJ 2004). Although a recommendation in the protocol, it is almost a decade since this was posited and Australian practice appears not to be cognisant of or acknowledge the need for this priority.
When the present emergency triage system is used in Australia there are maximum waiting times in which the patient must be reviewed and if the presenting issue is not life threatening this could be up to two hours. This delay has the potential for the loss of evidence, especially if the patient needs to void (USA DOJ 2004).

Once admitted for assessment, location of the forensic patient is guided by the traditional Department of Emergency design and triage system which usually does not allow for a secure, private cubicle that would ensure privacy, confidentiality and potential non-contamination of evidence by staff or other non-forensic patients. This was borne out by the respondents in this study and the observation data. Internationally, it is acknowledged that it is not uncommon for this to occur, but there is usually a secure forensic nurse examiner’s office that provides the privacy and confidentiality for the time consuming process of obtaining consent and detailing with the forensic incident (Dougherty 2011).

The present Department of Emergency model of care as described by the respondents and observed adds to the trauma for the forensic patient through delays, lack of privacy, security and the reduction of the gravity of their trauma to physical parameters.

The present model of care in relation to staff knowledge, training, skill and experience, according to the respondents, is largely supported by those untrained in forensics with ad hoc training occurring when a forensic situation presents. It has been identified that without an adequate forensic background, health care workers could adversely affect the processing of evidence and ultimately the scientific investigations for patients with liability related injuries (Saunders 2000). Therefore unknowingly, nurses and others whose role it is to provide health care for victims of trauma and crime are inadvertently adding to the long term adverse outcomes for these patients and potentially compounds the trauma of the forensic patient.

According to the data from the respondents in this study, forensic staff are in large a ‘call in’ team and are not employed in direct care areas where forensic clients present (such as the emergency department) and therefore are not recognised as an integral member of the Department of Emergency team. As such, they can be considered a hindrance by the emergency team with their treatment of a patient. Internationally, the forensic nurse examiner is not a direct member of the trauma response team but contributes to the work of that team as the evidence custodian. Their ‘extra pair of hands’ in trauma situations ensures that evidence
integrity is maintained (Dougherty 2011). The attention to detail ensures that important evidentiary items or findings will withstand the scrutiny of the courts (Dougherty 2011). As noted previously, many emergency departments internationally have a Forensic Nurse Examiner’s office located in their department and this reinforces the notion that they are a member of the broader emergency team (USA DOJ 2004). The situation as described by the respondents in this study suggests that Australian practices lag behind the international community, and although there are dedicated forensic units in some states and territories it was reported by one respondent that only a few units are working to meet these standards (MD1). It could be suggested that professional boundaries that protect an environment familiar to staff, especially when it relates to the treatment of life threatening injuries, may be an excuse to consider the incorporation of an additional non-trauma focussed health professional as an unnecessary interference, especially during an intense period. As was clear in the data from the respondents in this study, there is not a clear understanding of the role of the clinical forensic nurse and, as they are ‘called in’ when emergency staff determine they are needed, they are not integral to the team and are not in a position to demonstrate or educate existing hospital staff on their full role or potential value to the team and ultimately the forensic client.

The nurse practitioner model of care within emergency departments, as evidenced in this study, is characterised by management of less acute clients according to the triage scale, usually Category 4 and Category 5. While this is effective to meet the needs of increasing numbers of clients who present with minor or non life threatening situations, a cynical observer may consider this role to be where the least potential harm can occur with the public. A question worth considering is whether nurse practitioners in the emergency department are extended the opportunity to work to their full potential with the advanced clinical assessment and management of clients that they have been educated for, to refer patients to other health professionals, prescribe medication and order diagnostic investigations according to their scope of practice or has their inclusion proved an effective stop-gap solution to release the medical officers to be part of the treatment of life threatening situations (NMBA 2011)? Another viewpoint is that they are meeting their designated scope of practice contained within their position description for that health establishment.

The traditional professional boundaries that have been identified in the literature in relation to the introduction of nurse practitioners in Australia were evident in this study. The main
barriers to a collaborative relationship between the professions include: a lack of knowledge of the scope of practice of the nurse practitioner; a lack of knowledge and understanding of the role; global resistance based on traditional professional boundaries; and a lack of respect and communication (Elsom et al. 2009). The role of the clinical forensic nurse practitioner would require extensive planning, design, and education of the health care team in general because it is not yet considered a specialised role, yet forensic nurses are called upon for their services because “they have the skills and expertise to deal with this” (MD1). There is a grave risk that the role and scope of practice of a clinical forensic nurse practitioner may be underutilised like that of other nurse practitioners in Australia because of their inability to prescribe medications, the lack of Medicare provider numbers and also a lack of support from both health care organisations and the nursing profession (Middleton et al. 2011). Though there have been changes, as noted previously, to the Pharmaceutical Benefits Scheme and Medicare rebate system involving the nurse practitioner, but it will require continuing research on a national level (Middleton et al. 2011). This is further evidence to support the thematic concept, illustrating that current practices are not in line with international practice.

However, it should not be forgotten that there are situations in some states and territories where forensic nurses are working in expanded roles, that have enabled improved and more timely service for patients in response to society’s needs. This in itself suggests that there is a role for a clinical forensic nurse practitioner in the future.

**Practice Validated by Certification**

The respondents understood the need for formal education beyond their basic preparation, but this was not reflected in the nature of their perceived preparation and experience in clinical practice prior to undertaking education or certification. Rather, if they showed an interest, recruitment appeared to follow. Internationally, there are two levels of forensic nurse practice – basic and advanced (IAFN & ANA 2009). This is not reflected through this study.

There is recognition by employers that a post graduate qualification is necessary, but the appropriate level of this or the nature of clinical experience prior to undertaking certification is not well defined (FNE 2 Duty Statement – ACT 2010). Although employers have universally recognised the need for expanded and specific skills to undertake the role of a forensic nurse, this is not reflected in universal practice as a nurse is not always considered to
be an appropriately qualified person in legislation in relation to forensic examinations (Police Administration Act, Northern Territory, 2012).

Interestingly, similar requirements are not extended to government medical officers who are frequently required to undertake clinical forensic examinations due to the unavailability of a forensic nurse or a forensically trained medical officer. Similarly, when a government medical officer is unavailable the examination is passed on to junior medical officers in the local hospital emergency department. Despite a lack of forensic training, experience and education, they are considered by law to be an appropriately qualified person to perform forensic examinations (Boyd 2008; Crimes (Forensic Procedure) Act, ACT, 2000).

The level of education required of forensic nurses in Australia is at a minimum post graduate which may be as little as a four-course Graduate Certificate (FNE 2 Duty Statement ACT Health 2010). Access to any postgraduate forensic nursing education is about to be even more limited with the reported reduction of courses offered by tertiary institutions because of falling enrolments, even though the level of violence and disaster is on the rise globally (MD2). While ongoing professional development with minimum hours required per year is now required for annual practice certification, this was achieved through legislation with the Health Practitioner Regulation Nation Law Act 2009 (NMBA 2011). As yet, no specific ongoing education or development in the speciality of forensic nursing is required. International practice requires completion of nominated hours specific to forensic nursing for nurses of this specialty, further emphasising the weakness in the current approach to education and training for the role. This does not assist in an argument to prove that forensic nurses in all states and territories should be considered appropriately qualified to conduct forensic examinations.

There has been a long practice record of nurses in Australia assuming expanded roles for which they are educationally unprepared and this underpinned the argument for the introduction of the role of the nurse practitioner (Gardner et al. 2004). Data from respondents in this study suggests that this is continuing in relation to the practice of some forensic nurses. Internationally, the role of a forensic nurse is considered an advanced role and entails expanded and specialised knowledge and skills (IAFN & ANA 2009). Advanced practice nurses hold a masters or doctoral degree and are licensed and/or certified and approved to practice in the role of clinical nurse specialist, nurse practitioner or certified nurse midwife in
the USA (IAFN & ANA 2009). However, this is not the case in the UK where there is a very ad hoc approach to the recognition of Nurse Practitioners (Cashin et al. 2009).

In Australia, forensic nurses have basic postgraduate education and skills level and are employees of health departments and sometimes the justice department. As such, they most often practice ‘outside’ of the employment of hospital-based services and it may be posited that this is how they have been able to fill the gaps in service and meet an otherwise unmet need within society. However this was not clear in this study. What was clear through the data was that a number of forensic nurses are currently at a specialist nurse (post graduate forensic qualifications) level but working in an expanded role up to that of the nurse practitioner (master or doctoral) level of clinical practice. While this was professionally rewarding to the respondents, the enactment of the roles and practice of a nurse practitioner without meeting the professional and legal requirements of this role can send a strong message that the role of nurse practitioner is not necessary or that postgraduate certification, although required, is merely an entry standard to forensic practice.

...you’re pretty much out there and it’s very autonomous

Respondents in this study expressed feelings of professional isolation, dismayed at the loss of a large group who gained forensic qualifications but left the specialty soon after because of lack of support. This situation was not reported elsewhere in the literature and may be unique to the Australian environment.

One cohort of respondents from a dedicated forensic unit maintain peer support and participate in reviews of cases and work within a team environment. This is similar to that in the USA where the inclusion of a forensically skilled nurse is as part of a team that combines to bring a comprehensive service to communities that improves the quality of life and outcomes (Diegel 2011).

Support for Australian forensic nurses is available from the International Association for Forensic Nurses (IAFN & ANA 2009). Though this is of minimal direct benefit for Australian nurses due to international practice standards differences, the association is a reference point to assist with best practice and peer support with accredited hours for professional development and discussion forums (IAFN & ANA 2009).
The respondents in this study expressed concern regarding the lack of a support network for the sole isolated forensic nurse as well as government medical officers. While the respondents in this study were concerned at the loss of peers and professional support, they also acknowledged their autonomous role as practitioners. The respondents identified that they either provide forensic nursing services outside of their primary employment role (usually after hours) or as a member of a multidisciplinary team within a health department or forensic medical service. This removes the forensic nurse from mainstream acute clinical practice and thus the potential peer support available in these environments. Autonomy in the role has also been reported by Balardi (2012) with reference to approximately 300 Australian forensic nurses working in isolation. However, this offers the nurse no alternative than to become autonomous which is one of the characteristics of the role of the nurse practitioner.

The Trouble is the Legal System

The main area of contention that emerged from this study is that there is no uniformity to the Acts or Codes that guide forensic health practices across states and territories, in particular in reference to forensic nurses, who are considered appropriately qualified persons and the non identification of allocated timeframes for collection of forensic evidence according to the respondents.

Between the states and territories of Australia there are variations in legislation and criminal codes. Each state and territory holds different definitions of items under their respective code including who can perform specific types of activities and when and where this is appropriate. Some states have a very concrete approach and everything is explained and listed within the legislation whilst others do not and this opens interpretations to legal argument. Although working within the healthcare profession, each has a responsibility to understand their legislative framework, and this contributes to the ad hoc approach to the present model of care. The titles of the Act, Code or Bill can be misleading and confusing for the lay reader who does not rely on accessing these documents regularly. Most states have forensic related situations included within the Criminal or Crimes Act, Code or Bill, which would appear to be logical as they are linked with potential criminal acts (Crimes (Forensic Procedure) Act, ACT, 2000). There are two states that have them (definition of who, when and where these
can be performed) in the Police Powers or Police Administration Act (Police Powers and Responsibilities Act, Qld, 2000; Police Administration Act, Northern Territory, 2012).

In legislation Australian forensic nurses are either considered appropriately qualified persons or not. If they are considered to be qualified, they are legally able to conduct a forensic examination and collect forensic evidence (Criminal Investigation Act, WA, 2006). In one state this is not entirely correct, and according to one informant (MD3) they are able to conduct a forensic examination and evidence collection but not from an alleged offender. However non-appropriately qualified persons are not legally permitted to conduct forensic examinations or collect evidence on offenders or victims. One area of agreement across states and territories is that doctors, dentists and police officers are appropriately qualified persons, yet their education, training and experience with this is disparate. In the situation where the forensic nurses were permitted to collect evidence and conduct examinations, only one of the respondents indicated that they had a preference to work with perpetrators or victims and the others did not indicate a preference.

A specified time limit for the collection of forensic evidence is only identified in the legislation of one state and this reflects international guidelines and policy as noted in Harris County guidelines (2010). The specified time limits are including with response times for assessment and treatment in the respective hospital’s model of care and their triage system (Harris County 2010). The evidence from this study is clear in that these time limits for assessment and treatment, much less the collection of evidence do not exist in all but one state. While crime and disaster generally are acknowledged to be increasing globally and in the Australian community, legislation has not been proactive or tested in relation to these changes, especially by recognising the potential for the unlimited role of forensic nursing.

Failure of the legislation to be consistent across all states and territories (formally recognising the qualifications and specialised care) will continue to be a major barrier to the development of forensic nursing as a specialty and for the development of a role for a clinical forensic nurse practitioner in Australia. Failure of legislation to support the needs of forensic clients in relation to responsiveness in the assessment, examination and care of these clients is a significant flaw in this changing environment.
Recommendations

A number of recommendations arise from this study.

1. Nurses have recognised that there is a gap in unmet services to forensic patients and they have gained formal qualifications and expanded the role to that of nurse practitioner level. In order to be recognised, formal education to master’s level is required to legitimise the scope of practice.

2. Amendments to legislation are required to accept and acknowledge the qualifications of forensic nurses to authorise them as an appropriately qualified person.

3. Using existing developments as an example, memoranda of understanding, development of pilot programs with the police, health department and dedicated forensic units should be encouraged nationally.

4. Support is needed to fully develop the Australian Association of Forensic Nurses as this will assist to raise the profile of the forensic nurses, lobby for legislation change, provide professional support to isolated nurses and offer professional development.

5. Development of a program of education to raise awareness of forensic issues with staff in the Department of Emergency Medicine, operating theatres and other specialised areas and to inform them of the role and scope of practice of forensic nurses with whom they work.

6. Further study needs to be conducted into the various models of care, such as forensic nurse examiner or sexual assault nurse examiner to best serve the health care system of Australia and in particular the rural and remote area.

Conclusion

This study aimed to explore the scope of practice of the clinical forensic nurse practitioner in Australia. What the evidence and analysis indicates is that:

*Where legal, professional and ideological barriers can be overcome, there is the capacity and desire to develop a clinical forensic nurse practitioner model of care that can complement, improve and expand existing health care to the community where there is a genuine and acknowledged gap in services.*

However the barriers to enable the role and thus scope of practice for a clinical forensic nurse practitioner are significant, and these emerge from within and without the nursing profession as well as legislation that underpins practice and forensic services. It is apparent from this study that the roles of some current forensic nurses already overlap with those of a nurse
practitioner, yet this is not recognised by those in the role. Formal education may be considered to be key to this, but the loss of most formal education for forensic nurses in Australia would appear to be the second major barrier to the development of the role of the clinical forensic nurse practitioner.
References

A National Protocol for Sexual Assault Medical Forensic Examinations Adults/Adolescents
2004 United States of America Department of Justice Office on Violence Against Women.

Advanced Practice Registered Nurse (APRN) 2008 ‘Consensus Model for APRN Regulation:
Licensure, Accreditation, Certification & Education’.


American Nurses Association. 2009a. ‘Scope and Standards of Practice’

American Nurses Association. 2009b.'State Law and Regulation’

Artinean B., Giske T. & Cone P. 2009 ‘Glasian Grounded Theory in Nursing Research:

Association of Advanced Nursing Practice Educators – UK (AANPE). 2012 ‘Timeline:
Regulating/Governing Advanced Practice’ www.aanpe.org/Regulation/Governance -
along story. Accessed 29/10/12.


Australian Medical Association (2005a) AMA rejects independent nurse practitioners as


Browne A. & Tarlier D. 2008 ‘Examining the potential of nurse practitioners from a critical social justice perspective.’ Nursing Inquiry. 15:2 83-93.


Elsom S., Happell B. & Manias E. 2009 ‘Nurse Practitioners and Medical Practice: Opposing Forces or Complementary Contributions?’ Perspectives in Psychiatric Care. 45:1 9-16.


Harris County Hospital District, 2010 ‘Forensic Nursing Services Program Guidelines’ Texas.


International Association of Forensic Nurses (IAFN) and American Nurses Association (ANA) 2009 Forensic Nursing: Scope and Standards of Practice. Nursesbook.org The publishing program of the ANA.


Merriam S., Bloom L. & Brott P. 2002 ‘*Qualitative Research in Practice: examples for discussion and analysis*.’ *John Wiley & Sons.* San Francisco.


Saunders L. 2000,’Forensic Nursing formalizing a new role or recognizing existing practice?’ *Australian Nursing Journal.* 8: 3 49-50.

Starks H. & Brown Trinidad S., 2007 ‘Choose Your Method: A Comparison of
Phenomenology, Discourse Analysis, and Grounded Theory’. Qualitative Health
Research. 17:137 DOI 10.1177/109732307307031

Stern P.M. 1985 ‘Using grounded theory method in nursing research’ M. M. Leininger (ed)

Sullivan K. 2011 “Forensic Investigation in the Hospital” in: Lynch V.A. with Duval B.

for Practice’. Thomson Nelson. Australia.

Nursing Journal. 15:4 20-23.

United States of America Department of Justice Office on Violence Against Women. 2004 A
National Protocol for Sexual Assault Medical Forensic Examinations
Adults/Adolescents

United States of America Department of Justice Office on Violence Against Women. 2013 A
National Protocol for Sexual Assault Medical Forensic Examinations
Adults/Adolescents. 2nd edition

Vecchi C. 2004 ‘Western Australia: Landmark initiatives are fuelling the expansion of
forensic nursing Down Under.’ On the Edge. 10: 4 8-10.

Vecchi C. 2006 “Australia” in Lynch V. “Global Perspectives on Forensic Nursing” in:

Victorian Institute of Forensic Medicine 2010.’ About VIFM’.

Wand T. & Fisher J. 2006. ‘ The mental health nurse practitioner in the emergency
department: An Australian experience.’ International Journal of Mental Health. 15.
201-208 doi 10.1111/j.1447-0349.2006.00415.x

Wand. T. & White K. 2007a ‘Progression of mental health nurse practitioner role in

Wand T. & White K. 2007b ‘Exploring the scope of the Emergency mental health nurse
practitioner role.’ International Journal of Mental Health Nursing 16, 403-412. Doi
10.1111/j.1447-0349.2007.00495.x

Wand T., White K., Patching J., Dixon J & Green T. 2012 ‘Outcomes from the evaluation of
an emergency department-based mental health nurse practitioner outpatient service in

history and our future.” International Journal of Mental Health Nursing. 16. 57-61 doi
10.1111/j.1447-0349.2006.00445.x

Williams A. 2008 ‘Forensic medical care for sexual assault victim/survivors in Australia’.
ACSSA Newsletter No 17. 12-17.

practitioners in an adult emergency department.’ International Journal of Nursing
Practice. 14. 149-156. doi 10.1111/j.1440-172x.2008.00678.x

World Health Organisation (WHO) 2002 Gender and health in disaster.

World Health Organisation 2003, Guidelines for medico-legal care for victims of sexual

Wortans J., Happell B. & Johstone H. 2006 ‘The role of the nurse practitioner in
psychiatric/mental health nursing: exploring consumer satisfaction.’ 13, 78-84.
Appendix 1

Interview Prompts
Appendix 1 – Interview Prompts.

These initial questions will provide a greater understanding of the roles involved within this team and how they relate to each other.

- Could you outline your role within the Emergency Department?
- Could you outline who is part of the team?
- Can you tell me what their roles are?
- As part of your role, do you provide education or information materials to other professionals or members of the public?
- What steps are involved for the medical and nursing staff when a patient is suspected to be a victim of crime/trauma?
- Do these steps change when the police bring in the patient?
- As part of the team responsible for the care of the patient do you supply the court with a testimony?
Appendix 2

Observation Guide
Appendix 3

Full List of Document Evidence
Appendix 3 - Full List of Document Evidence.

*Crimes Act (1958) Victoria*

*Crimes (Forensic Procedure) Act (2000) Australian Capital Territory*

*Crimes (Forensic Procedures) Act (2000) New South Wales*

*Criminal Investigation Act (2006) Western Australia*

*Criminal Law (Forensic Procedures) Act (2007) South Australia*

Forensic Nurse Examiner (FNE) 1 Duty Statement, 2010 Australian Capital Territory Health

Forensic Nurse Examiner (FNE) 2 Duty Statement, 2010 Australian Capital Territory Health

Harris County Hospital District, 2010 ‘Forensic Nursing Services Program Guidelines’ Texas

*Health Practitioner Regulation Nation Law Act (2009)*

*Police Administration Act (2012) Northern Territory*

*Police Powers and Responsibilities Act (2000) Queensland*

United States of America Department of Justice Office on Violence Against Women. 2004 A

*National Protocol for Sexual Assault Medical Forensic Examinations*

Adults/Adolescents

United States of America Department of Justice Office on Violence Against Women. 2013 A

*National Protocol for Sexual Assault Medical Forensic Examinations*

Adults/Adolescents

2nd edition
Appendix 4

Ethics
Ms Mary Middleton
36-40 Kerrs Lane
NAMBOUR QLD 4560

Dear Ms Middleton,

HREC Reference number: HREC/11/QCO 12

Project Title: Exploring the scope of practice of the Clinical Forensic Nurse Practitioner

I refer to our letter to you dated 23 March 2011.

It has come to our attention that an amendment is required to our Human Research Ethics Committee Register in relation to the HREC Reference number issued to your SAA.

Can you please adjust your records to reflect the new HREC Reference number of 11/QCO/12 (rather than the previously advised number 10/QCO/33).

I apologise for any inconvenience caused.

Thank you for submitting the above project for ethical and scientific review. This project was considered by the Central Queensland Health Service District Human Research Ethics Committee (HREC) meeting held on 31 March 2011.

This HREC is constituted and operates in accordance with the National Health and Medical Research Council’s (NHMRC) National Statement on Ethical Conduct in Human Research (2007), NHMRC and Universities Australia Australian code for the Responsible Conduct of Research (2007) and the CPMP/ICh Note for Guidance on Good Clinical Practice.

I am pleased to advise that the Human Research Ethics Committee has granted approval of this research project. The documents reviewed and approved include:

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<tr>
<td>Application – Cover Letter and NEAF</td>
<td>Version 2</td>
<td>March 2011</td>
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<td>Research Project – Information Sheet</td>
<td>Version 2</td>
<td>October 2010</td>
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<td>Research Protocol</td>
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<td>Observation Guide</td>
<td>Version 1</td>
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<td>Budget</td>
<td>Version 1</td>
<td>July 2010</td>
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<td>CV for Mary Middleton</td>
<td>Version 1</td>
<td>May 2010</td>
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<tr>
<td>Approval letter – University of Sunshine Coast</td>
<td>Version 1</td>
<td>13 December 2010</td>
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<tr>
<td>Approval letter – HREC Metro North HSD</td>
<td>Version 1</td>
<td>25 November 2010</td>
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Please note the following conditions of approval.

1. None applicable.

2. The Principal Investigator will immediately report anything which might warrant review of ethical approval of the project in the specified format, including:
   a. Unforeseen events that might affect continued ethical acceptability of the project. Serious Adverse Events must be notified to the Committee as soon as possible. In addition the Investigator must provide a summary of the adverse events, in the specified format, including a comment as to suspected causality and whether changes are required to the Patient Information and Consent Form. In the case of Serious Adverse Events occurring at the local site, a full report is required from the Principal Investigator, including duration of treatment and outcome of event.

3. Amendments to the research project which may affect the ongoing ethical acceptability of a project must be submitted to the HREC for review. Major amendments should be reflected in a revised online NEAF (accompanied by all relevant updated documentation and a cover letter from the principal investigator, providing a brief description of the changes, the rationale for the changes, and their implications for the ongoing conduct of the study). Hard copies of the revised NEAF, the cover letter and all relevant updated documents with tracked changes must also be submitted to the HREC coordinator as per standard HREC SOP. Further advice on submitting amendments is available from http://www.health.qld.gov.au/ohmr/html/req/requ_home.asp

4. Amendments to the research project which only affect the ongoing site acceptability of the project are not required to be submitted to the HREC for review. These amendment requests should be submitted directly to the Research Governance Officer (by-passing the HREC).

5. Proposed amendments to the research project which may affect both the ethical acceptability and site suitability of the project must be submitted firstly to the HREC for review and, once HREC approval has been granted, then submitted to the RGO.

6. Amendments which do not affect either the ethical acceptability or site acceptability of the project (e.g. typographical errors) should be submitted in hard copy to the HREC coordinator. These should include a cover letter from the principal investigator providing a brief description of the changes and the rationale for the changes, accompanied by all relevant updated documents with tracked changes.

7. The HREC will be notified, giving reasons, if the project is discontinued at a site before the expected date of completion.

8. The Principal Investigator will provide an annual report to the HREC and at completion of the study in the specified format.

9. The District administration and the Human Research Ethics Committee may inquire into the conduct of any research or purported research, whether approved or not and regardless of the source of funding, being conducted on hospital premises or claiming any association with the Hospital or which the Committee has approved if conducted outside Central Queensland Health Service District.

HREC approval is valid for twelve (12) months from the date of this letter.

Should you have any queries about the HREC's consideration of your project please contact Rod Boddie, HREC Chairperson on (07) 4920 5765. The HREC Terms of Reference, Standard Operating Procedures, membership and standard forms are available from http://www.health.qld.gov.au/ohmr/html/req/requ_home.asp

You are reminded that this letter constitutes ethical approval only. You must not commence this research project at a site until separate authorization from the District Chief Executive Officer or nominated delegate has been obtained.
A copy of this approval must be submitted to the District Research Governance Officer/Delegated Personnel with a completed Site Specific Assessment (SSA) Form for authorization from the CEO or Delegate to conduct this research at Central Queensland Health Service District.

Once authorization to conduct the research has been granted, please complete the Commencement Form (Attachment II) and return to the office of the Human Research Ethics Committee.

The HREC wishes you every success in your research.

Yours sincerely

[Signature]

Rod Boddice
Chairperson, Human Research Ethics Committee
Central Queensland Health Service District

20 April 2011
Appendix 4 (2)

Ethics
Miss Mary Middleton
36 – 40 Kerrs Lane
NAMBOUR QLD 4560

Human Research Ethics Committee
The Prince Charles Hospital
Metro North Health Service District
Rode Road,
Chermside QLD 4032

Enquiries to: Jacqui_Hayward@health.qld.gov.au
Philip_Lee@health.qld.gov.au
Office Ph: (07) 3139 4691
(07) 3139 4500
Fax: (07) 3139 6907
Our Ref: FL/JL/Final Approval

25 November 2010

Dear Miss Middleton,

RE: HREC/10/QPCH/129: Exploring the scope of practice of the Clinical Forensic Nurse Practitioner. M. Middleton

Thank you for submitting the above project for further ethical and scientific review. This project was considered by Metro North - The Prince Charles Hospital Human Research Ethics Committee (HREC).

This HREC is constituted and operates in accordance with the National Health and Medical Research Council’s (NHMRC) National Statement on Ethical Conduct in Human Research (2007), NHMRC and Universities Australia Australian Code for the Responsible Conduct of Research (2007) and the CPMP/ICH Note for Guidance on Good Clinical Practice.

I am pleased to advise that the Human Research Ethics Committee has granted final approval of this research project. The documents reviewed and approved on 22 November 2010 include:

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<td>Observation guide</td>
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<td>14 October 2010</td>
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<td>October 2010</td>
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This information will be tabled at the next meeting on 9 December 2010, for noting.

Please note the following conditions of approval:

1. The Principal Investigator will immediately report anything which might warrant review of ethical approval of the project in the specified format, including:
   a. Unforeseen events that might affect continued ethical acceptability of the project.
Serious Adverse Events must be notified to the Committee as soon as possible. In addition, the Investigator must provide a summary of the adverse events, in the specified format, including a comment as to suspected causality and whether changes are required to the Patient Information and Consent Form. In the case of Serious Adverse Events occurring at the local site, a full report is required from the Principal Investigator, including duration of treatment and outcome of event.

2. Amendments to the research project which may affect the ongoing ethical acceptability of a project must be submitted to the HREC for review. Major amendments should be reflected in a revised online NEAF (accompanied by all relevant updated documentation and a cover letter from the principal investigator, providing a brief description of the changes, the rationale for the changes, and their implications for the ongoing conduct of the study). Hard copies of the revised NEAF, the cover letter and all relevant updated documents with tracked changes must also be submitted to the HREC coordinator as per standard HREC SOP. Further advice on submitting amendments is available from http://www.health.qld.gov.au/ohmr/html/regu/regu_home.asp

3. Amendments to the research project which only affect the ongoing site acceptability of the project are not required to be submitted to the HREC for review. These amendment requests should be submitted directly to the Research Governance Office/\textit{r} (by-passing the HREC).

4. Proposed amendments to the research project which may affect both the ethical acceptability and site suitability of the project must be submitted firstly the HREC for review and, once HREC approval has been granted, then submitted to the RGO.

5. Amendments which do not affect either the ethical acceptability or site acceptability of the project (e.g. typographical errors) should be submitted in hard copy to the HREC coordinator. These should include a cover letter from the principal investigator providing a brief description of the changes and the rationale for the changes, and accompanied by all relevant updated documents with tracked changes.

6. The HREC will be notified, giving reasons, if the project is discontinued at a site before the expected date of completion.

7. The Principal Investigator will provide an annual report to the HREC and at completion of the study in the specified format.

8. The District administration and the Human Research Ethics Committee may inquire into the conduct of any research or purported research, whether approved or not and regardless of the source of funding, being conducted on hospital premises or claiming any association with the Hospital; or which the Committee has approved if conducted outside The Prince Charles Hospital Health Service District.

HREC approval is valid for 2 years from the date of this letter.

Should you have any queries about the HREC's consideration of your project please contact Jacqui Hayward or myself on the above phone numbers or email addresses. The HREC terms of Reference, Standard Operating Procedures, membership and standard forms are available from http://www.health.qld.gov.au/ohmr/html/regu/regu_home.asp
You are reminded that this letter constitutes ethical approval only. You must not commence this research project at a site until separate authorisation from the District CEO or Delegate of that site has been obtained.

A copy of this approval must be submitted to the District Research Governance Officer/Delegated Personnel with a completed Site Specific Assessment (SSA) Form for authorisation from the CEO or Delegate to conduct this research at The Prince Charles Hospital Health Service District.

Once authorisation to conduct the research has been granted, please complete the Commencement Form http://www.health.qld.gov.au/northside/documents/form_notification and return to the office of the Human Research Ethics Committee.

The HREC wishes you every success in your research.

Yours faithfully

Dr Russell Demman
CHAIR
HUMAN RESEARCH ETHICS COMMITTEE
METRO NORTH HEALTH SERVICE DISTRICT
Appendix 4(3)

Ethics
13 December 2010

Ms Mary Middleton
Dr Leonie Mosel Williams
Professor Margaret McAllister
Faculty of Science, Health and Education

Dear Mary, Leonie and Margaret

**Expedited ethics approval for research project: The Nurse Practitioner Role in Clinical Forensic Nursing (S/10/268)**

This letter is to confirm that on 7 December, following review of the application for ethics approval of the research project, *The Nurse Practitioner Role in Clinical Forensic Nursing (S/10/268)*, the Chairperson of the Human Research Ethics Committee of the University of the Sunshine Coast granted expedited ethics approval for the project.

The Human Research Ethics Committee will review the Chairperson's grant of approval and the conditions of approval at its next meeting and, should there be any variation of the conditions of approval, you will be informed as soon as practicable.

The period of ethics approval is from 7 December 2010 to 25 November 2012.

Could you please note that the ethics approval number for the project is HREC: S/10/268. This number should be quoted in your Research Project Information Sheet and in any written communication when you are recruiting applicants.

As stated in the 25 November 2010 letter of ethics approval from the Prince Charles Human Research Ethics Committee, approval to commence research at your particular sites is given when the relevant Queensland Health "District CEO or Delegate" gives authorisation.

The conditions of approval for this project are that you:

1. conduct the research project strictly in accordance with the research proposal submitted and granted ethics approval, including any amendments required to be made to the proposal by the Human Research Ethics Committee (except as subsequently amended and approved by the Committee or approved by delegated authority exercised by the Chairperson or a Sub-committee)
2. Inform the Human Research Ethics Committee immediately of anything which may warrant review of ethics approval of the research project, including: serious or unexpected adverse effects on participants; proposed changes in the protocol; unforeseen events that might affect continued ethical acceptability of the project; and a written report of any adverse occurrence or unforeseen event that might affect the continued ethical acceptability of the research project must be submitted to the Chairperson of the Human Research Ethics Committee by no later than the next working day after recognition of an adverse occurrence/event.

3. Provide the Committee with a written Annual Report on the research project by 7 December 2011 and on completion of the project on 25 November 2012 using the proforma "Annual Report on Approved Research Project Involving Humans”

4. If the research project is discontinued, advise the Committee in writing within 24 hours of the discontinuation.

5. Make no change to the project as approved in its entirety by the Committee, including any wording in any document approved as part of the project, without prior written approval of the Committee for any change.

6. Comply with each and all of the above conditions of approval and any additional conditions or any modification of conditions which may be made subsequently by the Human Research Ethics Committee.

You are advised that failure to comply with the conditions of approval and the National Statement on Ethical Conduct in Research Involving Humans may result in withdrawal of approval for the project.

You are required to advise the Committee in writing within 24 hours if this project does not proceed for any reason.

Should you require an extension of ethics approval, please submit a written request for this purpose using the proforma 'Annual Report on Approved Research Project Involving Humans' (see Section 9).

An Annual Report on this activity will be due by no later than 7 December 2011.

An electronic version of 'Annual Report on Approved Research Project Involving Humans' may be accessed on the University of the Sunshine Coast portal at: Research and Research Training > Research Ethics > Human Research Ethics > Forms > Annual Report Form.

If you have any queries in relation to this ethics approval or if you require further information please contact the Research Ethics Officer by email at humanethics@usc.edu.au or by telephone on +61 7 5459 4574.
I wish you well with the success of your project.

Yours sincerely

[Signature]

Barbara Palmer
Manager, Office of Research
Appendix 5

Consent Form
Consent to Participate in Research.
Exploring the scope of practice of the Clinical Forensic Nurse Practitioner.
Ethics Approval Number (S/10/268), HREC/10/QPCH/129.

I have read and understood the contents of the Research Project Information Sheet for the above research project.

I realise that this research project will be carried out as described in the Research Project Information Sheet, a copy of which I have kept.

Any questions I have about this research project and my participation in it have been answered to my satisfaction.

I agree to participate in the research project, Exploring the scope of practice of the Clinical Forensic Nurse Practitioner.

I give consent for data about my participation to be used in a confidential manner for the purposes of this project, and in future research projects.

-----------------------------------------------
*Participant's Contact details *
Required only for the purpose of validation of the transcripts and/or receive a copy of the final report.

Participant name: ______________________ Email address: ______________________
Address (if preferred to email): ____________________________________
Appendix 6

Information Sheet
Research Project – Information Sheet

A Study exploring the scope of practice of the Clinical Forensic Nurse Practitioner
Ethics Approval Number (S/10/268).

My name is Mary Middleton and I will be conducting this study as a research student at the University of the Sunshine Coast. I am a Registered Nurse with extensive experience in the Operating Room.

You are invited to participate in this study. Participation is voluntary and you should feel comfortable with all aspects of the study and data collection. If not, you can withdraw at any time from any aspect of the study without penalty or explanation by informing myself or Dr. Mosel Williams.

The potential scope of practice for the Clinical Forensic Nurse Practitioner is gaining interest and attention as clinical forensic nursing in Australia is emerging as a new nursing specialty. This specialty includes the well established sub-specialty of forensic psychiatric and correctional nursing. Clinical forensic nursing is complementary to clinical forensic medicine which developed in response to the changing needs and demands of society. Clinical forensic nursing involves practice with victims of trauma, and/or victims of crime including the primary victim, their family or close contacts and, at times observers of trauma/crime. Emergency department staff is normally the contact of forensic clients where they are triaged for subsequent care. This point of contact is where the Clinical Forensic Nurse Practitioner will be of greatest benefit to the client.

The crime of violence against a person’s body and will is present in our society. Offenders use physical and/or psychological aggression to victimize a person or group, and in the process often threatening a victim’s sense of privacy, safety and well being. Victims may be reluctant to report the crime or trauma to law enforcement officers yet seek medical attention for a variety of reasons. Clinical Forensic Nurses and Practitioners assess patients for acute needs and provide stabilization and treatment as part of the acute healthcare team and act as forensic consultants to the team. They may perform specific medical forensic exams, gather information for the medical forensic history and collect and document forensic evidence from patients. They offer information, treatment, referrals for sexually transmitted infection treatment and other non acute medical concerns, assess for pregnancy risk, discuss treatment options with the patient, including reproductive health services. They typically co-ordinate within the health team to ensure patients are offered crisis intervention in a timely fashion from appropriate providers, offer support and advocacy during and after the examination process and encourage use of other victim services (U.S. Depart. of Justice 2004). The overall aim of this study is to explore the
potential scope of practice of the Clinical Forensic Nurse Practitioner in the Australian health environment.

Participation in this study will involve face-to-face interviews and potentially, observation of your practice with forensic client/s. Data collection for the whole project will occur over a 3 month period but your involvement would be limited to activities that would occur primarily within a 7 day period. An interview with you would be audio recorded and later transcribed. An initial interview will be no more than 45 minutes in duration with a possible follow-up interview of no more than 20 minutes that may occur within the 7 day period or following a review of the initial transcript. Interviews will be conducted at your convenience (and that of the organization) away from the Emergency Department. The transcript/s of your interview/s will be sent to you to review for accuracy and to ensure that your intent is clear. The initial interview will start with questions that will lead to wider discussion of the role of a Clinical Forensic Nurse.

The reason you have been asked to participate is because of your current involvement with or potential involvement in forensic practices and care. We would like to gain a greater understanding of your role in the treatment of patients who are also victims of violence or trauma and your professional relationship to other members of the health and forensic team.

Observations will involve observing the work environment to gain a better understanding of the roles of the multiple members of the health team in response to potential forensic situations. The observations will be conducted by me and will not involve participation in professional activities or client care (client interviews, examinations or access to health records). At no time will identifiable information be requested or is to be given to the researcher. If the participant inadvertently commences to do so, the researcher will give a nonverbal signal to stop, and if required walk away. Rather, the focus will be the specific roles and responses of members of the health and forensic team. The focus of attention will be where, when, how and why things occur without actual involvement in your care. I want to observe how often, how long interactions take and focus on the processes which go into the delivery of care however I do not wish to be privy to any discussions with the client/s to respect client confidentiality. However I may ask for clarification of processes at the conclusion of the care episode. There should be no discomfort or harm to yourself or other members of the health care team, or clients as there will be no psychological testing or intimate care, although recounting episodes of care may cause some emotional discomfort.

This study goes towards meeting the requirements of a higher degree by research. My supervisor (nominated as the Principal Researcher) is Dr. Leonie Mosel Williams RN PhD, Faculty of Science, Health & Education. (Telephone (07)54594549, Facsimile (07) 54565004, email lwillia2@usc.edu.au). The project will be co-ordinated through the Research Services Unit at the University of the Sunshine Coast. This will be the co-ordinating site and home for data management and storage.

Although you may not directly benefit from this research, it will inform the direction for the future development of the Clinical Forensic Nurse Practitioner in Australia, especially in relation to their scope of practice.
Any information that is obtained through this study that has the potential to identify you will remain confidential and will be not disclosed without your explicit permission. This information will be kept for 8 years as per guidelines of the University of the Sunshine Coast and left to the faculty. At the conclusion of the study a summary report will be available to those participants who request this.

If you have any concerns or complaints about the way this research project is being conducted please raise them with the Principal Researcher or, if you prefer an independent person, contact the Chairperson of the Human Research Ethics Committee at the University of the Sunshine Coast c/-the Research Ethics Officer, Teaching and Research Services, University of the Sunshine Coast, Maroochydore DC 1558; telephone (07) 54594574; facsimile (07) 54301177; email humanethics@usc.edu.au.

You may have time to consider whether you wish to participate in this study. If you agree to participate, please contact Mary Middleton at the telephone number/email address provided below. Your early response would be appreciated as it is planned to commence the data collection shortly. If you would like any more information about any aspect of this study please contact Mary Middleton.

On behalf of the University of the Sunshine Coast and myself, your assistance is greatly appreciated.

Mary Middleton, (Telephone 0416031339, Facsimile (07) 54760553, email middy36@westnet.com.au)
Appendix 7

Triage Categories
Appendix 7. - ATS categories for treatment acuity and performance thresholds

<table>
<thead>
<tr>
<th>Category</th>
<th>Maximum Waiting Time</th>
<th>Performance Indicators</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Immediate</td>
<td>100%</td>
</tr>
<tr>
<td>2</td>
<td>10 minutes</td>
<td>80%</td>
</tr>
<tr>
<td>3</td>
<td>30 minutes</td>
<td>75%</td>
</tr>
<tr>
<td>4</td>
<td>60 minutes</td>
<td>70%</td>
</tr>
<tr>
<td>5</td>
<td>120 minutes</td>
<td>70%</td>
</tr>
</tbody>
</table>