Factors That Influence Pediatric Sexual Assault Nurse Examiner Competence

Hannah M. Pressler

School of Nursing and Health Sciences

Simmons College

Boston, MA

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Simmons College
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Name: Hannah Pressler

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Sexual assault nurse examiners play a significant role evaluating sexually abused children. Delayed disclosures, language and comprehension, and the mechanisms of child sexual abuse all make the assessment of children differ from that of sexually assaulted adults. Few researchers have explored pediatric SANE competence. For this project, I explored pediatric SANEs’ self-perceived competence and influencing factors. I developed a 28 item web-based survey available distributed to the 3001 members of the International Association of Forensic Nurses via their members-only social network by a link to the SurveyMonkey URL for a four week period. There were 1504 sexual assault nurse examiners who met the inclusion criterion. The response rate was 13% ($N = 198$) with 143 pediatric examiners.

More than 50% of pediatric examiners rated six facilitating factors to a great extent. Five of these six factors were available in pediatric SANE practices. In linear multiple regression analyses, the relationship of the composite score of the availability of facilitating factors ($p = < .001$) and IAFN SANE certification ($p <= .001$) accounted for 36% of total variance of pediatric SANEs’ self-perceived competence. When individual available factors were included with predictor variables, SANE_P certification and video or photodocumentation of pediatric examinations ($p = < .001$) accounted for 45% of the total variance of SANEs self perceived competence. SANEs identified practice barriers including inadequate numbers of children to examine, lack of fiscal support and available continuing education, and geographic and professional isolation as barriers to competence. SANEs reported examining twice as many children as recommended for competence.

Limitations included the small response rate and use of a convenience sample that limited the generalizability of results.

*Key words:* sexual assault, pediatrics, SANEs, evaluation, examination
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Dedication

“Most people in emergency rooms don't want to touch cases like this, because, they don't want to become part of that darkness. They don't want to lift that rock.” (Astrid Heger, MD in Guttman, 1997, n.p.) Metaphorically, SANEs were willing to lift that rock and bring to light the children hiding beneath and, in the process, crossed into territory previously occupied only by physicians.

This capstone inquiry project is dedicated to the SANEs, advanced practice nurses and child abuse pediatricians who provide care to children who experience sexual abuse, inflicted injury, psychological abuse, and neglect, and who drive prevention and question child deaths. You help heal today’s children who are our leaders of tomorrow.
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Factors that Influence Sexual Assault Nurse Examiner Competence

Introduction

In the early to mid 1970s, emergency department nurses started to notice that rape victims were receiving a lower standard of care. Ledray and colleagues (1999; O’Brien, 1996) noted inadequate services and long waits, untrained examiners who could not qualify as expert witnesses, and who often expressed a desire not to examine these patients. The sexual assault victims thus experienced a second victimization from the examination when their injuries were overlooked and emotional needs ignored. As a result, nurses found themselves performing the assessments and doing their best to collect medical-legal evidence without formal training. In 1976, the first Sexual Assault Nurse Examiner (SANE) (see Appendix A) program was started in Memphis, Tennessee. Since 1976, the presence of SANEs and Sexual Assault Response Team (SART) (see Appendix B) advocates in emergency departments with their commitment to sensitive patient care, education of law enforcement personnel and emergency department staff has resulted in more humane care for persons who have been sexually assaulted (Huft, Speck, & Patton, 2009).

In 1992, 72 forensic nurses who were predominantly SANEs met in Minneapolis, Minnesota and established the International Association of Forensic Nurses (IAFN), the professional organization that represents forensic nurses world wide (Ledray, 1999).

Background of the Clinical Problem

The child victim of sexual abuse.

In 1977 as adult SANE programs were developing in the United States, Kempe (1977) described child sexual abuse as a hidden epidemic. Kempe’s seminal article on child maltreatment in 1962, and his American Academy of Pediatrics’ lecture on child sexual abuse in 1977, expanded awareness and knowledge about this unspoken aspect of pediatric health care among attendees and later to all health care providers who care for children.
However, only a limited number of pediatric physician providers developed expertise in the recognition of the often absent, subtle, or nonspecific diagnostic findings of child sexual abuse.

**Incidence of child sexual abuse.**

While we may never know the number of children who have been sexually abused, Crawford-Jakubiak speculated that the occurrence is more “common than childhood cancer, congenital heart disease and juvenile diabetes combined” (2011, p. ix). What we do know is child protection agencies reported 676,569 victims of child maltreatment in 2011 with 9.1 percent (61,568) of these child victims experiencing sexual abuse (U. S. Department of Health & Human Services, 2011, p. ix). There are experts who hypothesize that these figures are analogous to the “tip of the ice burg” (Sedlak et al., 2010).

**Evolution of pediatric sexual assault nurse examiners.**

Initially SANEs evaluated and collected forensic evidence only from adult sexual assault victims. SANEs did not initially provide care to children, as the nature of child sexual abuse (CSA) differs from that of sexual assault in adults with delayed disclosures, sexual acts that may not leave physical findings or forensic evidence, sexual behaviors not resulting from sexual abuse, and dysfunctional family relationships (Drach, Wientzen, & Ricci, 2001). Prior inaccurate medical interpretation of physical findings (Adams et al., 2007) limited the need for forensic evidence collection. SANEs recognized the special needs of sexually abused children including the delivery of the same sensitive comprehensive care that SANEs provided for adult victims of sexual assault. With today’s current understanding and knowledge of physical findings, the availability of photo-documentation with online peer and expert review of findings and the development of pediatric SANE training, SANEs can and do examine sexually abused children. They provide age appropriate, sensitive nursing
care and developmentally appropriate evidence collection to these youngest victims (Ledray, 1999).

One could ask why examine these children who do not present acutely? Does it not retraumatize the child? These examinations, when developmentally appropriate and sensitively completed, can reassure children and their parents of the integrity of children’s bodies, find subtle healed injuries or normal congenital variants interpreted as abusive injuries, collect evidence if it presents itself, and assess the emotional status of the child. Thus pediatric SANEs provide objective evaluations and emotional support for families during a time of trauma. They encourage follow-up with children’s primary care providers and discuss the importance of mental health treatment to decrease children’s risk for ongoing emotional sequellae.

**Geographic and population influences on competence.**

Most children who are sexually abused continue to be evaluated in pediatric emergency departments (U. S. Dept. of Justice, 2004, n.p.). Most board certified child abuse pediatricians practice in metropolitan pediatric emergency departments and Child Advocacy Centers (CACs). Child abuse physicians are often involved in resident and post graduate fellow physician education, research, prevention programs, and medical directorships of child abuse evaluation and treatment programs. Bechtel and colleagues (2008) documented that SANEs who practice in pediatric emergency departments provide more comprehensive care than pediatric emergency department providers who are not SANEs. CACs now provide a child friendly environment where children can be examined further decreasing trauma. SANEs are currently found on the staff of many of these CACs (Ann Lynn, personal communication, June 10, 2011).

In some remote rural areas, the responsibility to examine these children falls to providers in clinics, tribal, or federally funded health centers. Pediatric emergency
departments and CACs are usually located in more densely populated metropolitan centers, not in small rural hospitals or sparsely populated regions. SANEs may provide care to the patients in these rural hospitals and health centers. However, the lower population density means there are fewer sexually assaulted patients who present for examinations. Fiscal restraints and concerns for patient census can prevent nurse managers in these rural settings from sending nurses for pediatric SANE training. As a result, adult and adolescent SANEs often accept the role of assisting poorly trained emergency department providers in the medical forensic assessment of prepubertal children.

Geographic location and population density are issues that affect SANEs’ experiential learning. In 2010, the Census Bureau defined urban geographic divisions as those including metropolitan or densely populated areas and rural, those consisting of all areas outside urban centers (U. S. Census Bureau, 2010). As would be expected, SANEs who practice in urban population centers examine more sexually assaulted adults and children than their counterparts who reside in sparsely populated rural areas.

**Summary of clinical problem.**

As a pediatrician, C. Henry Kempe’s legacy, the awareness of sexual abuse in children and young teens by health care providers, is far greater than it was 35 years ago. However, these children are still cared for by limited numbers of expert child abuse physician providers. SANEs as specially trained nurses spearheaded the efforts to provide competent care to adult victims of sexual assault and have accepted responsibility for evaluating these child victims of sexual abuse. Due to the distribution of the population of North America, SANEs in rural areas might examine fewer pediatric patients than do their counterparts in urban areas. The examination of fewer patients decreases experiential learning and might indeed impact the competence of these dedicated nurses. Thus, this is an area appropriate for nursing care improvement.
Capstone Inquiry Project Purpose

The purpose of this capstone inquiry project was the exploration of competence and factors perceived by SANEs who examine children and young adolescents as supporting or hindering competence in their SANE practice.

Capstone Practice Inquiry Project Questions

This capstone project addressed the following five questions:

1. What do sexual assault nurse examiners who examine pediatric patients identify as facilitators of competence?
2. What is the availability of facilitators of competence to sexual assault nurse examiners who examine pediatric patients?
3. What do sexual assault nurse examiners who examine pediatric patients identify as barriers to competence?
4. How do sexual assault nurse examiners who examine pediatric patients perceive their competence?
5. What is the relationship between Forensic Nursing Certification Board (FNCB) SANE certification and how sexual assault nurse examiners who examine pediatric patients perceive their competence?

Specific Aims of this Capstone Practice Inquiry Project

The specific aims of this capstone practice inquiry project were twofold: First, to identify factors that participating SANEs experienced as facilitating or hindering their competent practice when they examine prepubescent children and young adolescents; second, to explore SANES’ perception of their own competence. As FNCB SANE certification (adult and adolescent SANE or SANE-A and pediatric SANE or SANE-P) is one method of assessing SANEs’ competence, I explored the relationship of certification to perceived competence. As I contemplated the relatedness of other environmental, personal,
and professional factors I expanded this exploration to include highest degree attained, practice site by geographic density, practice sites as Child Advocacy Centers (CAC).

As it is difficult to identify SANEs from state licensure, as a proxy, for this project I queried SANE members of IAFN who examine prepubertal children and young adolescents. Demographic questions provided information on geographic and practice location of SANEs’ practice and background questions provided information about IAFN certification and SANE education commonalities and differences.

**Significance of the Problem**

**Child sexual abuse.**

In 1994 President William Clinton designated sexual assault as a national problem in need of a governmental response (Bachar, Campbell, Fisher, & Rumburg, 2010). As a result of the potential for immediate and chronic medical and mental health consequences including the increased risk for further sexual violence during a survivor’s life, decreased optimal health and functioning, and its economic toll, sexual assault has also been identified as a public health problem (Anderson, Mangels, & Langsam, 2004; Becker-Blease, Cheit & Freyd, 2009; Fang, Brown, Florence, & Mercy, n.d.; Molnar, Buka, & Kessler 2001, p.753).

Sexual abuse and its sequellae complicate the lives and health care of vulnerable children, teens, and adult survivors. Kaplan (2011, p.1) described the early medical response to child sexual abuse as being “sputtering and sporadic” but as reports of child sexual abuse have increased, medical providers have been called upon to provide compassionate and knowledgeable care to these children. Who are these providers and are they adequately trained to provide care to these vulnerable and often traumatized children? For this capstone inquiry project, I focused on SANEs, nurse examiners who with additional training and skills have embraced the challenge of evaluating children and young adolescents who have been sexually abused.
The complex nursing care required by sexually assaulted children and teens affects both urban and rural nurses who have had to become more knowledgeable skilled professionals, an evolution that this project does address. Rural nurses have developed increasing independence and maintain broad sets of intricate clinical skills necessary to meet the nursing needs of patients across the life span. They may care for fewer patients than their urban counterparts, but these patients often have conditions that require specialized care (Bushy & Hurme, 2009; Stanton, 2009). In rural areas, nurses may be experts in emergency care, but upon completion of adult or pediatric SANE training, they become novices needing support and guidance in the care of sexually assaulted adults and children.

Adams and colleagues (2007) identified a role for SANEs as part of a team who cares for sexually abused children (Adams, et al., 2007)and a role for child abuse nurse practitioners to review examinations and provide direction and supervision. Starling (2011) identified a role for SANEs in the care of these children; however, she also addressed the issue of lack of quality monitoring of SANE practice by a national governing body.

**Competence in SANE practice.**

IAFN as the international professional organization of forensic nurses developed *Forensic Nurse Scope and Standards*, as well as *Education Guidelines for the Sexual Assault Nurse Examiner* (adult and pediatric). In 2002, IAFN offered the first certification examination for SANEs who evaluate adults and adolescents. Candidates who successfully pass this examination identify themselves as SANE-A. In 2006, IAFN offered the first pediatric certification examination. IAFN certified pediatric SANEs identify themselves as SANE-P. However, IAFN does not regulate SANE practice. Regulation of nursing practice is by individual state statute. Hornor (2011) identified 17 states that regulated pediatric SANE practice with no consistency of state models of regulation. It was beyond the scope of
Hornor’s project to explore issues of SANE competence in states where there was no regulation of SANE practice, leaving the question of competence and quality unanswered.

In informal discussions at the IAFN Annual International Conference on Forensic Nursing Science and Practice, members addressed concerns of quality monitoring. These concerns parallel those of IAFN leadership as expressed by the Chief Executive Office of IAFN to me in an informal discussion (Carey Goryl, personal communication, October 4, 2011).

Starling’s (2011) concern for quality echoed Hornor’s question of SANE regulation and paralleled the concerns for competent care expressed by IAFN leadership and JCAHO’s focus on the attainment of quality measures. While the question of the quality of SANE practice is germane, the relevance of this project lay in the exploration of SANEs own perceptions of their competence. Exploring SANEs’ perceptions of their competence and their identification of the factors that facilitate and hinder their competence will help guide IAFN leadership in continuous quality change practice recommendations.

**Policy implications.**

This Capstone Practice Inquiry Project was designed to identify facilitators and barriers of SANE competence while acknowledging SANEs’ concerns that can parallel those expressed by IAFN leadership (Carey Goryl, personal communication, October 4, 2011) and child abuse pediatricians. As a result, SANE program directors and IAFN will have the opportunity to develop and implement evidence-based interventions that foster and support SANEs’ transition from novice to competent forensic nurse.

Pediatric SANE practice extends beyond the forensic examination to include provision and explanation of physical findings to distraught parents, law enforcement and child protection workers and judges and juries during court testimony. Care provided by SANEs contributes to increased patient satisfaction and the attainment of quality measures.
through improved patient care and compliance with the 2009 Joint Commission on Accreditation of Health Care Organizations’ (JCAHO) standards for the care of patients who experience any interpersonal violence including sexual violence. The above issues become shared policy concerns among stakeholders including practitioners, professional and certification agencies, regulators, state boards of nursing, healthcare planners, and health care facilities.

**Literature Synthesis**

**Introduction.**

The focus of this project, competent pediatric SANE practice, necessitated an understanding of child sexual abuse – definitional issues, epidemiology, prevalence, and methods of tracking national child abuse data. Included in this review is the evolution of child abuse evaluations by physician providers, the recognition of child abuse pediatrics as a specialty practice and of child sexual abuse as a public health problem, and the concern that health care providers do not recognize sexual abuse. This integrative literature review also focuses on competence literature, competence measurement including specialty certification as a competence measurement, rural/frontier health care, and the challenges confronted by of rural/frontier SANEs they pass through Benner’s stages from novice pediatric SANE to competent pediatric SANE.

Authors of forensic nursing literature support the role of SANEs in the evaluation of the sexually assaulted person in the emergency department by addressing the care that SANEs provide, the quality of evidence collection, satisfaction of prosecutors, concerns of bias resulting from the model utilized, and expert testimony (Adams, et al., 2007; Bechtel, Ryan & Gallagher, 2008; Huft, Speck & Patton, 2009; Ledray, 1999; Littel, 2001; Patterson, Campbell & Townsend, 2006). However, few authors have addressed the development of competence, proficiency, or expertise that SANEs gain through clinical
experience and continued knowledge acquisition, or what factors facilitate or hinder the development of competence when opportunities for clinical experience are limited.

In *From Novice to Expert*, Benner (1984) explored exemplars of the development of nurse clinical knowledge through the passage from novice to expert from the completion of a series of clinical tasks to the holistic integration of the nursing care of the person. SANEs who provide care in busy urban medical centers have opportunities for expansive clinical experiences that SANEs in rural/frontier areas do not have, making this journey to competence and expertise less difficult.

**Evolution of Recognition of Child Sexual Abuse as a Health Care Issue**

**Child sexual abuse: A significant health problem.**

Child sexual abuse (CSA) is a significant health problem as a result of immediate and long term sequellae. CSA is a significant public health problem because of its financial impact and the decrease in optimal health and functioning in persons who had experienced sexual abuse as children. Immediate findings include inflicted injury, anogenital trauma, sexually transmitted infections, acute psychological morbidity such as acute Post Traumatic Stress Disorder (PTSD), acute depression, and suicidality (Hornor, 2010). Chronic problems include the physical and psychological morbidity that child and adult survivors of child sexual abuse may experience, as well as long term effects on the family and community (Hornor, 2010). Indirect costs or the effects of CSA on adult survivors’ functioning, health, and risk factors for death, have been documented in the adverse childhood experience studies and subsequent analyses (Dong et al, 2004; Felitti, et al, 1998).

**Child sexual abuse: Hallmarks of recognition and acknowledgement.**

In 1962, Kempe and colleagues described the spectrum of physical abuse of children (Kempe et al, 1962). In 1972, Kempe founded the Kempe Center at the University Of Colorado School of Medicine. Its mission was to have the nation’s experts provide treatment
for abused children, train professionals, and conduct research to ensure a healthy and hopeful future for abused children. In 1977, Kempe described child sexual abuse as a hidden epidemic in his seminal lecture, *Sexual Abuse: Another Hidden Pediatric Problem*. This lecture was later published and disseminated to the pediatric community (Kempe, 1978). Although the conceptual entity of child maltreatment entered the consciousness of pediatric health care providers and later the consciousness of all health care providers who cared for children, only a very limited number of physician providers developed expertise in the recognition of the physical findings of child maltreatment.

**Child sexual abuse: A public health problem – federal analysis and response.**

In 1985, the Surgeon General of the United States convened the workshop *Violence and Public Health* (U. S. Public Health Service, 1986), a hallmark event for the inclusion both of child sexual abuse as a public health issue and early forensic nurse leaders in the planning committee. Koop and others emphasized the need for more comprehensive education of all health care providers concerning child sexual abuse and for the necessity for multidisciplinary child abuse evaluation teams (Koop, 1986).

As health care providers publically acknowledged their recognition of child abuse and the need for reporting, Congress passed the Child Abuse Prevention and Treatment Act (CAPTA) in 1974. CAPTA provided the minimum federal definition of different types of child maltreatment upon which all states now base their definitions. In 1988, Congress amended CAPTA directing the Secretary of the Department of Health and Human Services (HHS) to establish a national data collection and analysis program (U. S. Department of Health & Human Services, 2009, p.1). The result of this data collection was the establishment of the National Child Abuse and Neglect Data System and Health and Human Services (HHS) publication, *Child Maltreatment, 1990*. Although HHS initially notified the states that data collection was voluntary, it has since become an important method of tracking
child maltreatment trends horizontally across the states as well as vertically by year. Its limitation is the provision of data only for child abuse including sexual abuse that occurs within the home or by a guardian.

CAPTA was reauthorized and amended in 2003 by the Keeping Children and Families Safe Act of 2003 (Public Law 108-36). In this version, Congress acknowledged the scope of the problem of child abuse and the toll that continued failure to present a coordinated approach to prevention and treatment would have on the nation. Congress identified that toll as “a cost to the Nation (sic) of billions of dollars in tangible expenditures, as well as significant intangible costs” (U. S. Department of Health & Human Services, n.d., n.p. 42 USC 5101 et seq; 42 USC 5116 et seq. Section 2). CAPTA was most recently reauthorized on December 20, 2010, by P.L. 111-320, CAPTA Reauthorization Act of 2010 (U. S. Department of Health & Human Services, 2011).

CAPTA 2003 directed the Secretary of DHHS to collect data for the Fourth National Incidence Project of Child Abuse and Neglect (NIS–4): Report to Congress (Sedlak, 2001, p.1), a periodic second compendium of child maltreatment data initially mandated by Congress in 1974. The authors, in an attempt to more accurately identify the number of children in the United States who have been maltreated, used data from the Department of Health and Human Services (DHHS) and also from sentinel reporters who were representatives from various professions in identified communities. Their data represented an iceberg theory of child maltreatment - statistics where only the tip of the iceberg is known to CPS (Sedlak et al, 2010) (see Appendix C).

In 1995 to 1996, the National Institute of Justice and the Centers for Disease Control and Prevention jointly sponsored a national telephone survey, National Violence against Women Survey (NVAWS) (Laney & Siskin, 2003). Although the professionals conducting the survey did not specifically analyze child sexual abuse, Tjaden and Thoennes in their
summary of this survey reported that 17.6% of women and 3.0% of men surveyed had been raped at some time in their lives (2006, p.7). The United States Department of Justice’s Bureau of Statistics (JBS) estimated that in 2006 for every 1,000 persons 12 years or older, there occurred one rape or sexual assault” (Tjaden & Thoennes, 2006, p.9).

Child sexual abuse remains an ongoing problem in the United States, where it affects many child victims and their families. In 2011, approximately 9.1% or 61,568 of the 676,569 maltreated children in the United States were sexually abused (U. S. Department of Health and Human Services, 2012, p.21). Of these 61,568 sexually abused children, 16,192 (26.3%) were 12-14 years old and 13,422 (21.8%) were 15-17 years old (U. S. Department of Health and Human Services, 2012, p.21). These cumulative national data, the National Child Abuse and Neglect Data Set (NCANDS), extracted exclusively from the states’ Child Protective Services (CPS) case reports (U. S. Department of Health and Human Services, 2011, p.19) are limited to family perpetrated sexual abuse. When reviewing statistics in Child Maltreatment, it is important to remember the minimum definition of child abuse and neglect in CAPTA that is used for data collection in Child Maltreatment:

Any recent act or failure to act on the part of a parent or caretaker which results in death, serious physical or emotional harm, sexual abuse or exploitation; or an act or failure to act, which presents an imminent risk of serious harm (U. S. Department of Health & Human Services, 2012, p.vii).

Because of concerns that previous research and national data sets of sexual victimization are limited in estimating the number of children aged 0-12 years who had been sexually victimized, Finkelhor and colleagues analyzed data from the Second National Incidence Studies of Missing, Abducted, Runaway, and Throwaway Children (NISMART–2) in 2008. Interviews with 16,111 adult primary caretakers and 5,015 youth aged 10-18 years (Finkelhor, Hammer, & Sedlak, 2008, p.3) provided the data for the estimated 285,400
children aged 17 and younger who were sexually assaulted in 1999 (Finkelhor, Hammer, & Sedlak, 2008, p.5).

Finkelhor and colleagues surveyed a nationally representative sample of 4549 children, aged 0-17 years and/or their primary caretakers in 2008 (Finkelhor, Turner, Ormrod, & Hamby, 2009, p.1412). Of these children, 6.1% had experienced sexual abuse during the previous year and 9.8% during their lifetime. Girls, age 14 to 17 years, had the highest rates of sexual assault with 7.9% in the previous year and 18.7% in their lifetime (Finkelhor, Turner, Ormrod, & Hamby, 2009, p.1413).

Child abuse today is recognized as a public health problem that requires a proactive approach of prevention rather than a reactive approach. A public health approach prevents disease, focuses on prevention and safety, and promotes health. This approach evaluates systems and organizations as well as family.

Child Maltreatment as a public health issue is approached from multiple perspectives. Authors have reviewed many of the emotional and physical sequellae of child abuse including teen pregnancy, intimate partner violence, substance abuse, depression and anxiety, criminality, sexually transmitted infections including HIV, risk factors for many other physical sequellae, changes within the anatomy of the brain, and the immediate cost as well as the aggregate lifetime cost of child maltreatment per victim (Becker-Blease, Cheit & Freyd, 2012; Fang, Brown, Florence, & Mercy, 2012; Zimmerman & Mercy, 2010).

**Physician recognition of child sexual abuse.**

Who examines these sexually abused children, files reports with child protective services and law enforcement and makes referrals to decrease psychological morbidity? Who examines children if there is no child abuse pediatrician available?

The American Academy of Pediatrics (AAP) in their early guidelines for the evaluation of sexual abuse of children identified primary care pediatricians as examiners of
choice. This decision was based on the relationships between pediatricians and children and the trust between caretakers and pediatricians (American Academy of Pediatrics, 1991; American Academy of Pediatrics, 1999). In the update of these guidelines in 2005, the AAP conceded that many pediatricians even with the mandatory child abuse component of their residency did not feel adequately prepared or competent to conduct a sexual abuse evaluation (Kellogg, 2005). The requirements for this rotation were identified as “needs of children at risk (e.g. those in poverty, from fragmented or substance abusing families, or victims of child abuse/neglect)” (Accreditation Committee for Graduate Medical Education, 2007, n.p.).

This concession by the AAP and the revised curriculum by the Accreditation Committee for Graduate Medical Education (ACMGE) followed two decades of research that documented pediatricians and other child health care providers are not comfortable diagnosing sexual abuse, are not competent in the recognition of normal prepubertal female anatomy, do not examine prepubertal girls’ genitalia regularly with well care visits, and do not report suspected sexual abuse as frequently as they should (Brayden, Altemeier, Yaeger & Muram, 1991; Dubow, Giardino, Christian, & Johnson, 2005; Ladson & Doty, 1987; Lentsch & Johnson, 2000; Makoroff, Brauley, Brandner, Myers, & Shapiro, 2002; Starling, Heisler, Paulson, & Youmans, 2009).

When Dubow and colleagues (2005) surveyed pediatric chief residents, they learned these chief residents believed they were not adequately prepared to evaluate sexual abuse. Despite recent academic training, they performed no better when attempting to label normal genital anatomy than did the practicing pediatric providers surveyed by Lentsch and Johnson in 2000. However, chief residents did examine prepubescent girls’ genitals during health care visits more frequently than the practicing pediatricians and pediatric nurse practitioners surveyed by Lentsch and Johnson (2000).
From the above mentioned studies it is possible to conclude that pediatricians are not adequately learning to evaluate prepubertal female genitalia. As recently as 2005, 59% of residency programs offered no child abuse clinical rotations and only 16% of responding programs offered more than ten hours of didactic education (Narayan, Socolar, & St. Claire, 2006). Novice pediatricians enter practice without the skills that will allow them to become competent in their evaluation of sexually abused children.

**Child abuse pediatrics: Subspecialist post-residency training.**

The American Academy of Pediatrics reported in 2011 that there were 264 pediatricians with specialty board certification as Child Abuse Pediatricians (American Board of Pediatrics, 2011, n.p.). There are 25 child abuse pediatric fellowships with a limited number of total fellows in the United States. Currently, approximately 50% of current board-certified child abuse pediatricians are greater than 50 years of age. While these Child Abuse Pediatricians serve a vital leadership role, it is clear that the current number of child abuse pediatricians cannot examine the increasing number of children who have been identified as being sexually abused.

**Nurse practitioners and the recognition of child sexual abuse.**

There is a paucity of documentation in nursing literature about nurse practitioners’ abilities to recognize normal anogenital anatomy and abnormal findings. Hornor and McCreeley surveyed pediatric nurse practitioners (PNPs) and learned that 67% of those responding examined prepubertal females’ genitalia during well child examinations. Only 50% of responding PNPs were able to correctly identify a common pediatric variant (Hornor & McCreeley, 2000).

The American Association of Colleges of Nursing (AACN) issued the position statement, *Violence as a Public Health Problem*, recommending that all baccalaureate and post baccalaureate nursing education programs incorporate a lifespan approach to
interpersonal violence (IPV) including sexual assault, child maltreatment, and its cultural aspects into their curricula (American Association of Colleges of Nursing, 1999). In 2002, the National Organization of Nurse Practitioner Faculties (NONPF) and the AACN delineated competencies for all nurse practitioners upon graduation or entry into practice. Included among these competencies for PNPs and family nurse practitioners (FNPs) was the assessment for child abuse and neglect and the effects of violence on the child (American Association of Colleges of Nursing & National Organization of Nurse Practitioner Faculties, 2002, p.30). The child abuse content was not standardized, so there is no documentation to show whether this education is incorporated into didactic content, clinical content, or both. A review of the nursing literature revealed no evidence that additional research exploring nurse practitioners’ knowledge of child sexual abuse or of the standard of care for evaluating these children exists.

**Sexual Assault Nurse Examiners**

**The uneasy beginnings of a physician-SANE partnership.**

If one believes that every child who is physically or sexually abused should have a medical evaluation with appropriate plan of care to decrease the risk of revictimization and the development of psychological morbidities, who will evaluate these children? SANEs who complete a pediatric SANE training program with a supervised clinical component have an essential role in providing care to the children who are victims of sexual abuse and sexual assault. The question that remains is the question of ongoing competence of these SANEs.

In 2007, Adams and her child abuse pediatrician colleagues authored *Guidelines for Medical Care of Children Who May Have Been Sexually Abused* (Adams, et al, 2007). These experts acknowledged that not all physician providers had the skills required to provide comprehensive developmentally appropriate pediatric sexual abuse evaluations. Many communities do not have access to child abuse pediatricians and in fact 14 states have zero to
one child abuse pediatricians (American Board of Pediatrics, 2011, n.p.). Many communities have limited access to other physician providers, nurse practitioners, or physician assistants who are skilled in performing these evaluations. In a demonstration of inclusivity, this group of child abuse experts expressed agreement that SANES should examine children who have been sexually abused, should be included on multidisciplinary sexual abuse evaluation teams, and that they, as experts, should provide SANEs with opportunities for peer review. This arrangement supports SANEs as they assume responsibility for continually updating their knowledge, skills and their acquisition and maintenance of competence (Adams et al., 2007).

These child abuse physician experts were also cognizant of the fact that the education and scope of practice of SANEs differ with their level of education and training. Therefore, they expressed the need for the SANE role to be clearly defined “along the continuum of care for pediatric patients, to assure quality and to utilize available resources” (Adams et al, 2007, p.170). These physicians recognized the importance of physician-SANE teams and the need for collaboration and oversight, and peer review. Not all child abuse pediatricians and not all forensic nurse leaders agree with this spirit of inclusivity nor do they agree that it was borne out of necessity.

Heger, an early pioneer physician in the field of child maltreatment, described a common reaction of emergency department medical staff to child sexual abuse: “Most people in emergency rooms don't want to touch cases like this, because, they don't want to become part of that darkness. They don't want to lift that rock” (Guttman, 1997, n.p.). Metaphorically, SANEs were willing to lift that rock and bring to light the children hiding beneath and, in the process, crossed into territory previously occupied only by physicians. SANEs became valued partners in emergency departments, developing the skills needed to examine adult and child sexual assault victims in the absence of available, willing, and/or qualified physician examiners.
The increasing role of the SANE.

In 1991, an early leader in forensic nursing and Director of the Memphis Sexual Assault Evaluation Center reported that many SANEs had already incorporated child sexual abuse examinations into their practice (Patricia Speck, personal communication, May, 1991). By that time, earliest forensic nursing leaders had laid the cornerstone for the establishment of the International Association of Forensic Nurses (IAFN), which was founded in 1992. In 1997, the procedure for child sexual abuse evaluations was delineated in *The SANE Development and Operation Guide* (Ledray, 1998). The focus on child sexual abuse evaluations continued, as the value of SANEs was acknowledged by governmental agencies and IAFN initiated the process of certification for both adult and pediatric SANEs. In 2001, the Department of Justice opined “All adults and children who are sexually assaulted deserve to receive the prompt and compassionate emergency medical-forensic care that SANEs offer” (Littel, 2001, p.14).

In 2002, The Forensic Nursing Certification Board (now The Commission on Forensic Nursing Certification or CFNC) developed a specialty certification examination for SANEs who evaluate adults and adolescents. Nurses who have successfully passed this examination identify themselves as SANE-A (adult and adolescent SANE). In 2007, the Forensic Nursing Certification Board offered the first SANE-P (pediatric SANE) certification examination, a national specialty certification for pediatric SANEs (International Association of Forensic Nurses, 2011). ANCC working with the CFNC established a portfolio appraisal process for APNs and other forensic nurses with graduate nursing education who met application criteria and who wanted certification reflecting their advanced forensic nursing status rather than entry level SANE practice. The application process opened in late 2012.

SANEs greatly altered the dynamic of how health care professionals work together. Together they determine how Sexual Assault Response Teams (SART) with advocates and
SANEs will provide the comprehensive care that these vulnerable patients and their families require. Within emergency departments, there are teams who provide care for the most emergent trauma or cardiac patients. The incidence of patients experiencing abuse and assault might be low in comparison to cardiac or trauma patients in some Emergency Departments but nurse managers who incorporate SANE/SART multidisciplinary teams (MDTs) into emergency department practice recognize the importance of a care team with members who are skilled in the care and treatment of sexual violence.

SANE/SART teams allow other emergency department providers to focus on trauma and critically ill patients as they humanely expedite the evaluation of all persons who have experienced sexual violence. SANE evaluations, especially those evaluations requiring forensic evidence collection are time consuming when they are done correctly. SANEs provide support for these children and their families during the evaluation, communicate with other team members, initiate appropriate post-evaluation care including mental health referrals, laboratory studies, and appropriate treatment and communication with the primary care provider.

Pediatric SANEs are committed to belonging to the team that provides care to sexually abused children and to parents who have some fear that their child has been sexually abused. They recognize that the SANE/SART team approach improves patient care and patient satisfaction, preserves resources needed for critically ill patients and help the hospital control costs that providers would incur for the facility if they worked alone or if a social worker was called in to the hospital to provide support to a family. SANEs with their knowledge can assume a leadership role in the team’s acceptance of the presence of child sexual abuse and assault in their community.
Nursing Specialty Certification

**IAFN SANE certification.**

CFNC certification for SANEs is one way that SANEs can demonstrate to their SANE/SART team, patients and patient families that they are knowledgeable professionals. CFNC certification like other national certification for registered nurses is voluntary, although some employers and states do require certification. Nursing organizations that provide the mechanism for nursing specialty certification agree that voluntary certification for registered nurses validates knowledge and competence in an area of specialty nursing practice, ensures continuing competence through continuing education and practice requirements for certification maintenance and provides nurses with an increased sense of intrinsic and extrinsic rewards (American Board of Nursing Specialties, 2006; American Nurses Credentialing Center, 2009; International Association of Forensic Nurses & Commission for Forensic Nursing Certification, 2013; Pediatric Nursing Certification Board, 2006).

The IAFN has approximately 3000 active members (IAFN, 2012c) in the United States with 1504 members who “self identify their discipline as SANE” but who not necessarily certified by CFNC (K. Day, personal communication, March 13, 2013); however, approximately 44-50% members of IAFN are CFNC certified and these 44-50% of members represent the 1504 SANE members of IAFN. The Commission for Forensic Nursing Certification (CFNC) has certified 1,307 nurses (44%) as SANE-A, SANEs who evaluate adults and adolescent patients (International Association of Forensic Nurses, 2013a) and 372 nurses (12%) as SANE-P, SANEs who examine prepubertal children and young adolescents (International Association of Forensic Nurses, 2013b). Some SANEs hold both certifications.
As one explores IAFN membership and SANE certification, it is apparent SANEs who are certified embrace certification as a symbol of their competence and of the practice of the highest standard of forensic nursing care. If national certification is indeed a measure of competence, how does one measure the ongoing competence of SANEs who are not members of IAFN and lack access to certification or who choose to forego certification?

While Hornor (2011) identified 17 states that regulate SANE practice, there was no consistency of regulatory agencies among these states. There are states that require IAFN certification. There are states that require state certification. There are states whose SANE practice is regulated by the Board of Nursing. The number of states with statutory authority to require certification to practice as a SANE is not known.

How do SANEs who are not certified through IAFN validate their knowledge of the theoretical and clinical foundations of the nursing care of persons who experiences sexual violence? How do they demonstrate their commitment to evidence based forensic nursing practice to colleagues, to other professionals and to their community? How does one measure the ongoing competence of SANEs who are not certified? Does this become a regulatory issue for individual states or for the facilities that hire SANEs? Do individual facilities who hire SANEs develop written or oral examinations, clinical simulations or assessment by an expert SANE who will provide feedback on theoretical and experiential knowledge? Alternatively do they require certification as they often do for critical care or transport nurses? Do individual SANE program have requirements for competent practice? These questions should be asked but they are beyond the scope of this project. However, this capstone inquiry will identify factors identified by pediatric SANEs as necessary for competence development and maintenance.
Rural/frontier Health Care

Barriers to care in rural/frontier areas may differ from those experienced by sexual assault/abuse victims and their families in urban or suburban areas. Barriers can include stigma, overlapping personal and professional relationships, lack of financial resources, lack of anonymity for victims as well as for perpetrators, lack of services including medical and mental health services, fear for self and family, isolation, and jury bias should adjudication occur (Averill, 2007; Logan, 2005; Moore, 2009; Rennison, 2002; Robby & Anderson, 2011).

One factor that plays an important role in competence of any provider who evaluates children for sexual abuse is the number of examinations that providers perform. Data from a recently published study by Adams and colleagues suggests that a minimum of five evaluations per month may be required for “ongoing competency in interpreting medical and laboratory findings in children evaluated for suspected sexual abuse (Adams, et al., 2012, p. 392).

Many health care issues with the potential to affect the number of examinations SANEs perform can exist in rural/frontier areas. Sparse population limits confidential and anonymous access to care and increases driving distance to hospitals while fiscal viability of hospitals impacts hospital closure, access to care and programs such as sexual assault response programs in these areas. There is a greater incidence of health care disparities and risk factors for interpersonal violence including child sexual abuse as a result of life circumstances including poverty and isolation. This same recognition that interpersonal violence including child abuse is an unspoken issue in these communities can be the impetus for health care providers to leave because of fear of retaliation when they intervene (Averill, Padilla, & Clements, 2007, p.42). There are fewer health care professionals to provide preventive care including child maltreatment screening and expert support and peer review
for SANEs in rural areas (Bushy, 2011; Graves, 2008; Hurme, 2009; Lee, 2004; Littel, 2001; Montour, 2009) which often necessitate travel of significant distances to health care facilities, to receive emergency care and specialized confidential services for adults and children who have experienced sexual violence (Frasier, 2011).

Access to safe havens for women experiencing gender-based violence is limited (Thurston, 2006). When women cannot escape violent homes, their children are doubly at risk for maltreatment including sexual abuse (Hamby, et al. 2010) and in turn are at increased risk for perpetuating a cycle of violence (Crooks, 2011).

Figure 1. Cycle of Violence

(adapted from Crooks, 2011)

This childhood exposure to multiple adverse childhood experiences (Dong, et al 2004; Felitti, et al, 1998) contributes to higher rates of chronic illnesses such as hypertension, diabetes, obesity, alcohol, and cigarette abuse, higher rates of suicide, and death from accidents (Bushy, 2011; Graves, 2008; Lee, 2004) seen in rural/frontier populations.

Not unlike adult sexual assault victim, children do not always disclose sexual abuse or assault. Finkelhor and colleagues in their analysis of data from the Second National Incidence Studies of Missing, Abducted, Runaway, and Throwaway Children (NISMART-2) learned that only 30% of interviewed youth had notified law enforcement about their sexual assault and younger children had difficulty disclosing abuse by family members (Finkelhor, Hammer & Sedlak, 2008). A reason for failure to immediately disclose by adolescents and
teens is probable disapproval of their activities at the time of the assault. Children are dependent and loyal to their family and are easily intimidated by family members and acquaintances who abuse them (Finkelhor, Hammer & Sedlak, 2008). From data obtained from the National Survey of Children’s Exposure to Violence (NatSCEV), Finkelhor and colleagues reported girls ages 14 to 17 years recounted an 18.7% lifetime incidence of sexual assault (Finkelhor, Turner, Ormrod, & Hamby, 2009, p.1413).

While Finkelhor and colleagues did not provide results by population density, Sedlak and colleagues in their analysis of data from NIS-2, found incidence rates for child maltreatment were consistently higher in rural areas. These researchers learned that children in rural counties were “1.5 times more likely to be sexually abused” (statistically marginal) than their counterparts who live in large metropolitan urban areas or other urban areas (Sedlak, et al, 2010, p. 190).

Silverman and colleagues reported that teens in rural/frontier areas experience a greater risk for dating violence, risky sexual behavior, and pregnancy than teens in suburban areas (Silverman, Raj, & Clements, 2005) but the actual levels of dating violence in rural/frontier areas closely approximated those found among teens in urban areas. The authors were not able to parse out from available data whether the violence was solely physical or also sexual or if the increased rates of pregnancy were the result of sexual violence. Risky sexual behavior is well documented as one sequellae of prior sexual abuse (Giardino & Giardino, 2008; Putnam, 2003; Saewyc; 2006; Senn, Carey, & Vanable, 2008) and adds to the vulnerability of these teens who need understanding and compassionate, age-appropriate care if they experience sexual revictimization.

As a result of these concerns, Congress established the Rural Domestic Violence, Dating Violence, Sexual Assault, and Stalking Assistance Program (Rural/Frontier Program) in 1994 housed in United States Department of Justice, Office of Violence against Women.
The primary purpose of this program was the enhancement of the safety of children, youth, and adults who are victims of domestic violence, dating violence, sexual abuse, sexual assault, and stalking by supporting projects uniquely designed to address and prevent these crimes in rural/frontier jurisdictions (U. S. Department of Justice, n.d.).

Logan and colleagues reported that data analysis from their study revealed barriers to services for sexual assault victims were subsumed into four domains: availability, acceptability, cost or affordability, and accessibility. Within accessibility, “incompetence of medical providers” who dealt with sexual assault was a major barrier in the reporting of sexual assault (Logan, Evans, Stevenson, & Jordan, 2005).

Nurse scientists who have researched rural/frontier nursing described nurses who work in critical access hospitals as “generalists” (Hurme, 2009, p.67). By necessity, rural/frontier nurses must be competent in more than one clinical area of the hospital and must be willing to accept new roles and learn the skills needed to competently perform in these roles. Recommendations from Logan and colleagues included the need for skilled sexual assault examiners and mental health providers (Logan, Evans, Stevenson, & Jordan, 2005) for rural/frontier inhabitants who are sexually assaulted. While physician providers might not have the opportunity or desire to fulfill this role, it is a role well suited for adoption by these expert generalist nurses. Although SANEs provide quality nursing care to people who have been sexually assaulted, Littel (2001, n.p.) opined that these programs might not be available in many rural/frontier areas. Barriers include lack of funding for a community wide program, difficulties for small hospitals justifying the expense of sustaining a SANE program, SANE recruitment difficulties, maintenance of competence because of the limited number of evaluations that they perform, and burnout because of inadequate coverage. These concerns were echoed by the director of the Maine State SAFE Program (P. Campbell, personal communication, June 4, 2012).
In order to overcome these problems, some state SANE programs have chosen to organize on a regional basis. Regionalization allows SANEs to evaluate children in multiple hospitals within a region. SANEs’ call schedules become more reasonable and hospitals share the cost of SANEs who take call. SANEs are less isolated professionally and opportunities for case reviews increase (P. Campbell, personal communication, March 14, 2011). The downside to regionalization in large primarily rural/frontier states with vast differences in county size and population density is that it can be erratic. It can involve two hospitals in two counties and multiple SANEs or four hospitals in a large county and few SANEs.

West Virginia, a smaller state, piloted the first regional SANE program the Regional Mobile SANE Project. Multiple counties are included in each region providing SANEs with a greater opportunity to evaluate adults and children than they would have if they worked in only one facility (Littel, 2001).

Maine, a large primarily rural state, houses its Sexual Assault Forensic Examiner (SAFE) program in the Office of the Attorney General (see Appendix D). Several hospitals have developed regional hospital-based programs. One program is located within Maine’s largest and least populated counties with SAFEs sharing call among three hospitals. Another program is shared among two hospitals located in two counties (P. Campbell, personal communication, March 14, 2011). However, because the Maine SAFE program is not housed within a state licensing board, recommendations for continued competence can be made and opportunities offered but not enforced.

Other facilities have adopted the use of telemedicine to provide supervision, consultation, and peer review to SANEs who examine victims of sexual assault. The use of telemedicine can help limit the number of examinations a child receives, thereby reducing the trauma of repeated examinations. The contact with experts also provides support, education
and continuous quality improvement for telemedicine participants in rural areas (MacLeod, et al, 2009; Thraen, Frasier, Cochella, Yaffe, & Goede, 2008). These are examples of solutions that can hopefully ensure the commitment of SANEs and foster competence within rural/frontier areas.

**Competence**

Dreyfus and Dreyfus elaborated on the concept of competence when they first described the five stages of skill acquisition as starting with the initial stage of novice and progressing in the following order through competence, proficiency, expert, and mastery (Dreyfus, S. E. & Dreyfus H.L., 1980). These stages were later modified to beginner, novice, competence, proficient, and expert (H. L. Dreyfus, 1998). The authors described *competence* as the stage in which the learner begins to prioritize activities and realizes that it is necessary to make decisions without the rules that they learned when they were *beginners* (Dreyfus, S. E. & Dreyfus H. L., 1980, p.8). Through lessons previously learned and prior experiences, the learner develops internal guidelines and must choose which is appropriate for a given situation (H. L. Dreyfus, 1998). Benner later incorporated these concepts into her theoretical framework.

**Nursing competence: Definition and measurement issues.**

The issues of competence and the maintenance of competence in professional nursing are not new. The American Academy of Nursing and Coalition for Nursing Futures addressed the need to assess competence and develop criteria that will identify triggers for competence reassessment (American Nurses Association, 1997). In 1999, the American Nurses Association (ANA), posited: “The profession of nursing is obligated to provide adequate and competent nursing care,” although its authors acknowledged that there was no definition of professional competence or continued competence (Whittaker, Carson, & Smolenski, 2000, n.p.). A panel of nurse experts reviewed the dilemma of whether to assess
all nurses for continued competence or “identifying certain triggers that would highlight
nurses who needed to be evaluated” including working with few peer registered nurse co-
workers, and the changing nature of nursing practice (Whittaker, Carson, & Smolenski, 2000,
n.p.). The importance of peer interaction is essential for SANEs, as well as all professional
nurses, and is the foundation of peer review, one component of ethical practice explicated in
the American Nurses’ Association (ANA) Code of Ethics for Nurses with Interpretative
Statements (ANA, 2001), IAFN Scope and Standards of Practice (Huft, Speck & Patton,
2009), and IAFN Vision of Ethical Practice (IAFN, 2008).

As a result of discussions concerning competence and continuing competence, the
American Nurses Association appointed a panel of nurse experts in 2000 and charged them
with the responsibility of developing a definition of professional nursing competence. This
group of nurse experts defined professional nursing competence as:

behavior based on beliefs, attitudes, and knowledge matched to and in the context of a
set of expected outcomes as defined by nursing scope of practice, Code for Nurses,
standards, guidelines, and benchmarks that assure safe performance of professional
activities. (Whittaker, Carson & Smolenski, 2000, n.p.)

In 1996, while examining the issue of professional nurse competence, The National
Council of State Boards of Nursing (NCSBN) developed the definition of competence as “the
application of knowledge and the interpersonal, decision-making, and psychomotor skills
expected for the practice role, within the context of public health” (National Council of State
Boards of Nursing, 1999, p.1). In 2005 heeding the Institute of Medicine’s report, Crossing
the Quality Chasm (2001), the NCSBN revisited the question of competence and continuing
competence. They acknowledged that competence is multifaceted and difficult to measure as
competence is a developmental process, and nursing is a voluminous profession with a
multiplicity of specialties and subspecialties, and with different levels of supervision and regulation (National Council of State Boards of Nursing, 2005, p.1).

The question that appears repeatedly in the literature addressing competence measurement and definition asks if assessing competencies the same as competence? When Clinton and colleagues assessed competencies in graduates of diploma and degree programs, they adopted a definition of competence as a person’s overall capacity and competencies as specific capabilities. They posited that it is the assessment of both capacity and competencies that is necessary for a holistic assessment of competence (Clinton, Murrels, & Robinson, 2005).

The NCSBN’s Post-Entry Competence Study followed a volunteer group of 549 registered nurses and licensed practical/vocational nurses over a five year period to assess early nursing practice and explore the developmental trajectory of competence in these nurses. These nurses provided their perceptions of competent nurse practice. During early practice, the nurses focused on individual tasks that comprised patient care. The investigators learned that some but not all of the participants showed growth in insight, self-reflection, and traits attributed to competence (Kearney, 2009).

Anderson and colleagues proposed e-portfolios for assessment of competence for advanced practice nurses. They identified two main uses: formative as a tool to document the process of becoming – the developmental journey through education and career as the portfolio owner becomes more confident and competent, and as a record of continuing education, presentations, published papers of other documentation of professional competence (D. Anderson, Gardner, Ramsbotham, & Tones, 2009). The IAFN with ANCC have initiated portfolio appraisal standards for the board certification for advanced practice and other forensic nurses with graduate level education who meet all criteria established by ANCC and but e-portfolio availability will not be available to entry level forensic nurses.
**Nursing core clinical competencies.**

Lenburg (1999) comprehensively explored education and performance assessments of competence which formed the groundwork for the development of the COPA model (Competency Outcome and Performance Assessments). This model integrates practice-based outcomes with interactive learning methods and performance assessment of competencies. Lenburg (1999, p.2) identified four questions that must be answered for the implementation of the model. These include:

- What are the essential competencies and outcomes for contemporary practice?
- What are the indicators that define that practice?
- What are the most effective ways to learn those competencies?
- What are the most effective ways to document that nurses have achieved required competencies?

Lenburg (1999, p.3) citing her prior research identified eight essential core competencies:

- Assessment and intervention
- Communication
- Critical thinking
- Teaching
- Human caring relationships
- Management
- Leadership
- Knowledge integration skills (Lenburg, 1999, p.3).

It was her belief that nurses must *know*, they must be able to *do*, and the language must exist for competence based assessments. It is only by assessing outcomes using “critical elements” that she defined as “observable behaviors that are mandatory for a
designated skill at a targeted level of practice” that the acceptable baseline level of practice that is competence can be identified (Lenburg, 1999 p.7).

**Development of pediatric SANE competence.**

For novice pediatric SANEs who are competent as adult or adolescent SANEs, the progression to competence as pediatric SANEs may be supported by prior experience in the organization of forensic evidence collection of adults or by prior experience as a pediatric nurse. To gain competence as pediatric examiners, SANEs require additional knowledge of normal child development, adaptation of their adult and adolescent clinical skills of physical examination and evidence collection to techniques appropriate for young children. They need to develop interpersonal skills with children who are frightened, and to develop comfort with the modification of the normal evaluation routine to examine frightened or behaviorally or developmentally challenged children. Theoretical concepts, evidence collection, and pediatric physical and developmental assessment are clearly identified as pediatric SANE competencies (International Association of Forensic Nurses, 2011); however, the skills needed to modify the examination are the result of experience. This is not only the science but the art of being an expert pediatric health care provider. These are the skills that competent pediatric SANEs can begin to develop as they develop the ability to apply critical thinking to problem solving while providing care to child sexual abuse victims. As pediatric SANEs become competent, they are able to incorporate different techniques of evaluation including pediatric medical interview skills, assessment of a child’s developmental abilities, and the recognition that both the anatomy of children and the mechanism of sexual abuse of children differs from sexual assault in adolescents and adults (Christian, Lavelle, De Jong, Loiselle, Brenner & Joffe, 2000).

Competent pediatric SANEs learn to recognize the unique nature of every child and that child’s response to abuse. They learn to incorporate their cognitive knowledge of child
FACTORS THAT INFLUENCE PEDIATRIC SANE COMPETENCE

development into every encounter with a child. Pediatric SANEs will then start to individualize engagement with a child, and parents or caretakers, and complete the evaluations as caring nurses whose focus on both the interpersonal and technical processes maintains the objectivity essential for pediatric forensic practice.

All SANEs are taught to be objective fact finders. Pediatric SANEs need to be aware of confirmation bias, the desire to do right for a sexually abused child, and subtle pressure exerted by law enforcement and prosecutor colleagues that can result in an uninformed inaccurate diagnosis of abuse.

Ongoing pediatric education and peer review of pediatric examinations can support the knowledge and competence of pediatric SANEs. Both education and peer review support competence through the review of normal and abnormal anogenital findings, of current recommendations for assessment and diagnostic categories of findings, current treatment recommendations of sexually transmitted infections, and the review and discussion of current literature that deals with all aspects of child maltreatment.

One practical consideration differs in the training of adult/adolescent and pediatric SANEs is standardized patients for simulated pediatric sexual abuse examinations is not appropriate. Children are a vulnerable population unable to provide informed consent to function as a standardized patient. However, vignettes of sexual abuse can be used to ascertain knowledge of assessment procedure, roles of MDT members, and state mandated reporting laws (Misener, 1986). Still, one must ask how do SANEs gain competence in the evaluation of children? If they do become competent, how do they maintain competence practicing in small rural/frontier hospitals with a limited number of pediatric patients, and the limited opportunity to work with peers and participate in peer review or simulation training?

The 19 contributing authors of IAFN’s Pediatric Education Guidelines (2008, p.15.) opined: “Required clinical skills shall be performed until competency is demonstrated” and
“Competency is determined by the professional assessing the required clinical skills” (International Association of Forensic Nurses, 2008, p.15). To accomplish this, the assessor must demonstrate proficiency or expertise in child sexual abuse evaluations and both the assessor and SANE have working knowledge of the competencies outlined in *Forensic Nursing: Scope & Standards of Practice* (Huft, Speck & Patton, 2009).

To summarize, it appears that the criteria for SANE competence include maintenance of national certification and assessment by proficient or expert clinicians who have working knowledge of SANE competencies. These are broad criteria that might not be met by SANEs who practice in rural/frontier areas. Marcia J. Tomaselli, Education and Certification Coordinator, IAFN, reported that most SANE programs have “some type” of peer review or if the role of the sexual assault nurse is included in a job description, evaluation would be part of annual performance review (M. Tomaselli, personal communication, July 27, 2010). This statement raises the question of who does do the annual performance review and do those assessors have adequate knowledge of SANE practice to optimally assess SANE competence?

Experienced educators and experts in pediatric SANE practice and psychometric tool development developed the content for the Pediatric SANE certification examination and for the requirements for certification maintenance. SANE program nurse managers using Lenburg’s COPA model with recommended minimal criteria necessary for competent SANE practice and the *Scope and Standards of Forensic Nursing Practice*, can develop competence based outcomes for all stages of SANE practice.

**Summary of Literature Synthesis**

The authors of the literature consistently identify sexual violence as an ongoing public health problem. Children who are sexually abused or assaulted are at significant risk for lifelong behavioral and psychological sequellae, chronic health problems, as well
repeated victimization throughout their life. It is essential that all children who experience sexual abuse or assault should be evaluated in a developmentally appropriate and humane manner by a skilled and knowledgeable examiner. There is no question that child abuse pediatricians with their advanced practice nurse and physician colleagues can provide this care and they do so; however, they practice primarily in urban medical centers and CACs. It is well documented in the literature that neither generalist pediatricians nor generalist pediatric nurse practitioners competently recognize findings related to sexual abuse. Pediatric SANEs have the basic training needed to become competent examiners. Novice pediatric SANEs need expert preceptors, peer review, equipment for photo or video documentation, support of child abuse experts to review documentation, pediatric patients of all ages for ongoing skill development, and ongoing competence assessment by a provider who is knowledgeable about child sexual abuse as well as the scope and standards of care for pediatric SANEs.

SANE practice is not static it is a developmental process. Ongoing competence assessment must include education and practice recommendations for IAFN certification renewal. Additionally, competence must be assessed for SANEs both in states that regulate practice and for SANEs and who do not practice in a state where there is regulation and who are not nationally certified. Ensuring competence can be a complicated issue. Regulation while addressing competence can also interfere with the freedom of choice that is inherent in the culture of rural/frontier inhabitants including many SANEs. SANEs perform a service that many providers do not want to perform. The question of ensuring ongoing competence for all SANEs is indeed complex but is a question that must be answered.

Conceptual Framework

Scholars and practitioners in nursing synthesize knowledge gleaned from the basic sciences, theory, and experience and apply that knowledge to the practice and art of nursing.
Benner and colleagues (Benner, 1984; Benner, Tanner, & Chesla, 2009) built upon the Dreyfus model (Dreyfus & Dreyfus, 1980) of competence development and its relationship to their philosophy of nursing as an applied science. Benner explored nursing competence, not through a written measure of knowledge but through the use of exemplars. She recognized that as nurses’ competence developed, they were able to adapt their theoretical experiential knowledge to ongoing challenges in their clinical practice. Competent nurses were able to document their educated adaptation in their clinical practice, as well as in the reflective interviews that Benner conducted (Benner, 1984, p.3; Benner, 2004). Benner and colleagues described competence as a meshing of the didactic knowledge learned in the classroom – concrete or virtual – with the experiential learning of the nurse (Benner, 1984; Benner, Tanner, & Chesla, 2009). Benner realized as nurses become increasingly competent, they progress from more “elemental” problem solving (Benner, 1984, p.3) to the recognition of problems and potential problems. Competent nurses develop the ability to formulate, organize, and prioritize plans of care and long term goals that are “based on considerable conscious, abstract, analytic contemplation of a problem” (Benner, 1984, p.26). Competent nurses confront the challenge of transitioning their interpersonal involvement from social exchange, over-involvement, or detachment through a process of reflective inquiry. Competent nurses establish a level of connection and involvement that is essential for the continued evolution of their skills and knowledge as caregivers.

As nurses enter a new specialty practice arena, they must become familiar with the theoretical knowledge and practice skills in that specialty. Some of the experiential knowledge such as communication skills, some technical skills, and knowledge of community resources may carry over. Before these competent but novice nurses can apply their abilities to critically analyze new clinical problems to novel situations, they must first
learn the theory, the shared vocabulary, and master the skill set associated with the new specialty.

Benner (1984) recognized difficulties in the measurement of competence. Competencies or skills include the transition from focusing on the present status to developing educated intuition and anticipating future problems before they actually occur; measuring how nurses relate to patients as the nurses develop self-reflection and transition to therapeutic interactions; and how nurses learn to cope with a stressful environment. Benner identified seven domains of nursing practice that subsumed the exemplars or those descriptions in the nurses’ personal stories:

- The helping role
- The teaching coaching function
- The diagnostic and patient-monitoring function
- Effective management of rapidly changing situations
- Administering and monitoring therapeutic interventions and regimens
- Monitoring and ensuring the quality of health care practices
- Organizational and work role competencies

(Benner, 1984, p.46).

Benner’s theory of the transition from novice to expert is the overarching theoretical basis for this capstone practice inquiry project. Pediatric SANEs’ patient assessment, nursing intervention, knowledge integration skills, and critical thinking can be subsumed under Benner’s domain of the helping role. Pediatric SANEs provide age-appropriate explanations of procedures, process, systems and findings to children and their parents and communicate forensic findings to physician colleagues, law enforcement and child protective workers. When competent, pediatric SANEs effectively use the nursing process to manage rapidly changing situations. Their ability to communicate with team members within the hospital
and community, to teach, to establish therapeutic human caring relationships, and to integrate their didactic education with experiential learning are subsumed under the domains of helping, of teaching and coaching, and of effectively managing unstable situations.

Competent SANEs develop and maintain quality measures including forensic documentation skills and peer review. They become leaders in the education of colleagues and the community concerning the recognition and prevention of all forms of interpersonal violence including child maltreatment. These competencies are subsumed under Benner’s domains of monitoring and ensuring the quality of health care practices, organizational and work role competencies, the teaching-coaching function for staff and community, and the helping role.

Pediatric SANEs integrate their knowledge of current recommendations from the Centers for Disease Control (CDC), American Academy of Pediatrics (AAP) and of IAFN education guidelines for the evaluation of pediatric patients with current literature based interpretation of physical findings. This knowledge is subsumed by the domain of administering and monitoring therapeutic interventions and regimens. Competent pediatric SANEs have the ability to maintain caring, professional, therapeutic patient relationships in concert with their ability to critically process information from a variety of sources. These critical skills can help them interact without bias with parents and guardians in highly charged situations and to embody Benner’s competent nurse.

**Conceptual and Operational Definitions**

For the purposes of this capstone practice inquiry project the following definitions operationalize the conceptual definitions found in the capstone project’s research questions.

**Conceptual definition of sexual assault nurse examiners.**

*SANEs* are registered nurses who have additional didactic education and clinical preparation in the forensic evaluation of persons who have experienced sexual assault (Littel,
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SANEs’ practice is the basic level of forensic nursing practice that occurs at the “intersection of the health care system, the legal system, and the child protection system” (Ferrell & Caruso, 2011; Huft, Speck, & Patton, 2009).

Operational definition of SANEs.

SANEs are those IAFN members who met the inclusion criteria of registered nurses, or advanced practice nurses in Section I of the survey. Inclusion criterion for the project limited the sample to practicing SANEs and advanced practice sexual assault nurse examiners who do not primarily identify themselves as SANEs and who will be further defined by the demographic data collected from responses to question 28 found in Section VIII of the survey. These demographic data were collected and analyzed from all respondents. Only pediatric SANEs’ responses to questions 3-12 found in Sections II - Section VI concerning facilitating factors of competence, availability of facilitating factors, presence of barriers to competence and self-perceived competence were analyzed for this project.

Conceptual definitions of pediatrics/pediatric.

Pediatrics (noun) is the branch of health care practice whose practitioners are concerned with health of children including physical, intellectual, and psychological growth and development, disease and risk prevention, the recognition of acute and chronic health care health care problems that require intervention and treatment (Merriam-Webster, 2011; Microsoft, 2009). Pediatric (adjective) SANEs evaluate children for sexual abuse.

Operational definitions of pediatric.

For the purpose of this project, pediatric was defined in two ways:

Pediatric patients are children who were examined for sexual abuse or assault by SANEs. They were examined by pediatric SANEs because these children were too young to be included within adult/adolescent sexual assault patient age parameters established by
individual SANE programs or health care facilities. “Pediatric patient” was further defined by responses to question 2 of Section I of this survey.

_Pediatric SANEs_ have completed pediatric SANE training and have met the requirements of their individual SANE programs to examine pediatric patients. They are defined by the ages of the children whom they examine. A pediatric SANE can have state pediatric certification, IAFN SANE-P certification or both, or have no certification as a pediatric SANE. Pediatric SANE was further defined by responses to multiple questions in Sections VI-VIII of this survey.

**Conceptual definition of competence.**

*Competence* is defined as behavior based on beliefs, attitudes, and knowledge matched to and in the context of a set of expected outcomes as delineated by relevant nursing documents that include scope of practice statements, the American Nurses Association _Code for Nurses_, standards, guidelines, and benchmarks that assure safe performance of professional activities (Whittaker, Carson, & Smolenski, 2000).

**Operational definition of competence.**

*Competence* was defined as beliefs, attitudes, and knowledge, as expressed by individual pediatric SANEs that are matched to and in the context of expected outcomes of SANE practice as delineated in _Forensic Nursing: Scope and Standards of Practice_ (Huft, Speck & Patton, 2009; IAFN, 2008, pp. 12-16). Perceived competence of SANES in this sample was measured by responses to questions 9-10 found in Section V of the survey and questions 11-12 in Section VI as well as question 18 in Section VII.

**Conceptual definition of facilitating factors.**

_Facilitating factors_ are defined as “any factors which stimulate, provide, or promote” the development of competence” (World Health Organization, 1994).
Operational definition of facilitating factors.

Facilitating factors were those factors that facilitate or support the practice of pediatric SANES. They were measured by responses to questions 3-4 found in Section II of the survey and question 5-6 in Section III.

Conceptual definition of barrier.

A barrier is a material or immaterial factor that impedes (Merriam-Webster, 2011, n.p.) competence.

Operational definition of barrier.

Barriers were those factors that impede the practice of pediatric SANES. They were measured by responses to questions 7-8 found in Section IV of the survey.

Conceptual definition of IAFN certification.

SANEs with CFNC certification must initially meet all eligibility requirements set by IAFN and pass the Commission for Forensic Nursing Certification (CFNC) developed examination(s) in their area(s) of practice (SANE-A certification is granted to those SANEs who pass the adult/adolescent certifying examination; SANE-P certification is granted to those SANEs who pass the pediatric certifying examination). Certification is valid for three years with renewal attainable through completion of required continuing education credits and practice requirements or by re-taking the examination (International Association of Forensic Nurses & Commission for Forensic Nursing Certification, 2013). Advanced Forensic Nursing Certification is granted by ANCC after application submission with portfolio and assessment and acceptance of that portfolio.

Operational definition of certification.

IAFN SANE certification was defined as current CFNC SANE-A and/or current CFNC SANE-P certification and ANCC advanced forensic nurse certification as current
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AFN-BC recognition. Both were measured by the responses to questions 13-18 found in Section VI of the survey.

Research Methodology

Aim

This capstone inquiry project was designed to explore facilitating factors and barriers to clinical competence, certification, population density of practice site, practice in a CAC, highest nursing degree attained and their relationship to self-perceived competence of pediatric SANEs. I would like this project to be the beginning of SANE competence research projects. I want to ensure prepubertal children and young teens are receiving optimal developmentally appropriate care by competent examiners. I should like to see this capstone inquiry as an introductory step in forging a more collegial relationship between forensic nursing and child abuse pediatrics.

Research questions

For this capstone inquiry project I addressed the following research questions:

1. What did sexual assault nurse examiners who examine pediatric patients identify as facilitators of competence?
2. What was the availability of facilitators of competence to sexual assault nurse examiners who examine pediatric patients?
3. What did sexual assault nurse examiners who examine pediatric patients identify as barriers to competence?
4. How did sexual assault nurse examiners who examine pediatric patients perceive their competence?
5. What is the relationship between International Association of Forensic Nurses national certification and how sexual assault nurse examiners who examine pediatric patients perceive their competence?
Project Design

For this capstone inquiry project I employed a prospective, descriptive, cross-sectional, exploratory design utilizing an anonymous self-administered survey. I developed the survey consisting primarily of closed quantitative Likert scale rating questions and several dichotomous yes-no questions. Participants were provided with the opportunity to offer additional comments and to elaborate on responses through open ended questions at the close of each section of the survey.

An on-line tool: SurveyMonkey.

Once I decided to conduct an on-line survey, I investigated several on-line tools. One, SurveyMonkey™, had several desirable attributes: it had been frequently used in several domains including nursing so the interface was well-known; it is reasonably priced, has basic analytics tools, and in its paid "Gold" version has the ability to directly export data into SPSS .sav format (W. L. Salomon, personal communication, October 19, 2012). It also has the ability to use skip-logic, the ability to use the results of one survey item to direct subsequent actions to avoid respondent confusion and ease subsequent data analysis (figure 2). Such skip-logic is facilitated by visual logic flow-sheeting in the Guideline Interchange Format 3 (Boxwala et al., 2004).

Population and Sample

On January 2, 2013 the link to the survey was sent to IAFN members. At that time IAFN had 3001 members who were registered with IAFN’s Open Member Community. The CEO after a discussion with the IAFN Board of Directors granted permission to post the hyperlink to the survey on their members’ only web page. These posts were distributed by e-mail and were also available on the IAFN Member Community home page. The population sampled for this Capstone project consisted of the 3001 members of IAFN Members-Only Community. However, at that time, I had no access to the number of sexual assault nurse
examiner members of IAFN nor did I know how many IAFN members disable the e-mail function of the members’ only web page.

The inclusion criterion for the project limited the sample to practicing SANEs, advanced practice nurses and other advanced forensic examiners who are IAFN members. The initial screening question excluded IAFN members who were not SANEs. An additional screening question divided the sample into two groups. Adult/adolescent SANEs who examined adults and adolescents over 14 years of age were directed to Section VII where certification and demographic data were collected. Only pediatric SANEs were directed to Section II of the survey. Screening and demographic data including certification data were collected from all SANEs. Only pediatric SANEs were directed to questions addressing factors that facilitated competence, barriers to competence and self-perceived competence in Section II through Section VI. There was no target number of participants for the sample. During survey development and data collection, I was unable to obtain the number of practicing SANE members of IAFN or the number of members who disabled the e-mail function of the application.

Upon the close of the survey at 11:59 P.M. on January 31, 2013, 199 SANEs had viewed the survey. One participant exited after completing the first screening question and is not included in the summary statistics. Of the remaining 198 SANEs who viewed the surveys, 143 SANEs (77.2% of viewers) provided care to prepubertal children and young teens with some of these SANEs also providing care to older adolescent and adults. Fifty five SANEs (27.8% of viewers) provided care only to older adolescents and adults. This latter group was directed by skip-logic to Section VII of the survey.

**Sampling method and recruitment plan.**

Upon approval of this capstone practice inquiry project by the executive director of IAFN (see Appendix G) and the Human Subjects Approval by the Simmons College
Institutional Review Board (see Appendix H), four posts delivered as e-mails were sent to all IAFN members through the *IAFN Member Open Community* site (see Appendix I1). This members-only site is the primary mode of communication between IAFN leadership and its membership. A preliminary post on December 28, 2012 announced the survey and invited all SANEs who examined pediatric patients including young adolescents to participate. A second post sent to IAFN members on January 2, 2013 invited them to participate in the project. This e-mail also contained the unique Uniform Resource Locator (URL) for the electronic version of the survey. Two additional requests to participate were sent to IAFN members through the same platform targeting SANEs who had not responded requesting them to participate and thanking SANEs who had participated. Upon closure of the survey, I sent a final e-mail thanking all SANEs who participated in the project.

Skip-logic screening (Figure 2) directed participating SANEs to appropriate areas of the survey. If a participant responded “no” to the question “Are you a SANE?” they were directed to the page where they were thanked for participation with only the opportunity to exit the survey; however, no IAFN members other than SANEs responded to the survey.

**Data Collection**

Data were collected with an electronic World Wide Web-based (WWW; web) investigator developed survey (see Appendix I3). Data collection opened on January 2, 2013 at approximately 12:05 am and closed on January 31, 2013 at 11:59 pm. There were 199 IAFN member SANEs who responded to the survey.

Upon closure of data collection on the web-based survey, SurveyMonkey, data was exported in native SPSS .sav format and into an Excel .xls data sheet on the investigator’s secure computer. The data was stored and then coded and transformed in SPSS 21 for analysis. Data in Excel .xls format was examined using Crystal Reports 2008 to verify data consistency and possible alternative transformations (W. L. Salomon, personal...
communication, February 9, 2013). Data cannot be traced back to specific participants in this project.

Multiple nurse authors agree that use of web-based research may present methodological issues (Ahern, 2005; Cantrell & Lupinacci, 2007; Lagan, 2010). Web-based research is, however, a valuable adjunct to more traditional hard copy methods of data collection. Web-based research has the potential to reach a broader sample in a more expedient and cost effective way than mail or e-mail surveys. The use of IAFN’s social media to announce the survey is a blended approach of a social network post/e-mail for notification and information gathering by a web-based survey. Web-based surveys also provide the medium for a large group of participants from geographically diverse areas to respond to a lengthy survey with sensitive questions and to do so in an anonymous manner that cannot link their names or e-mail addresses to their responses.

**Organizational and systems issues using social media for research.**

Kaplan and Haenlein (2010) argued that social media can benefit all business entities by providing cost-effective and timely communication. IAFN recognized these benefits and introduced the use of social media in August, 2011.

As the professional organization that provides leadership and standards for forensic nursing practice, IAFN has an organizational goal, “To establish and improve standards of evidence-based forensic nursing practice” (IAFN, 2006, n.p.). This capstone inquiry project aligns not only with this goal, but also with IAFN’s four additional organizational goals:

- To incorporate primary prevention strategies into our work at every level in an attempt to create a world without violence.
- To promote and encourage the exchange of ideas and transmission of developing knowledge among its members and related disciplines.
- To establish standards of ethical conduct for forensic nurses.
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➢ To create and facilitate educational opportunities for forensic nurses and related disciplines.

This project also addresses quality questions expressed by IAFN leadership and the role of regulation and competence that member SANEs informally expressed in discussions at the 19th Annual IAFN International Conference on Forensic Nursing Science and Practice.

This capstone inquiry project supports the ethical practices described in IAFN’s Vision of Ethical Practice (IAFN, 2008), as well as core ethical principles of nursing, the respect for individuals including protection of the anonymity and the privacy of persons. Therefore, this survey included an informed consent. Completion and return of the survey was considered consent to participate. While there is debate whether social networking sites are private or public space (Ahern, 2005), I chose to address the members’ only site as private space that limits use of the site to IAFN members. The web-based SurveyMonkey survey development tool further guaranteed anonymity. There are personal privacy issues associated with use of computers that are beyond the scope of privacy provided by the design of this project.

Instrument Development

A thorough search of the literature revealed no published surveys that measured SANE competence or factors that support or hinder competence for adult, adolescent, or pediatric SANEs. The Pediatric SANEs’ Self-Perceived Competence Scale: Facilitating Factors and Barriers survey resulted from a comprehensive review of the nursing literature including SANE education, practice, and certification, clinical competence, forensic nurse clinical competencies, scope of practice, facilitators of clinical competence, and IAFN standards of practice (Huft, Speck, & Patton, 2009; IAFN, 2008; IAFN, 2008a; IAFN, 2011; IAFN & Commission for Forensic Nursing Certification, 2013; Smolenski, 2005). I developed the survey after consulting with a statistician who is an expert in survey design.
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(see Appendix I3). Validity and reliability testing was conducted and is discussed in a subsequent section of this report (see Appendix E2; Appendices F1-F4; Appendix J).

This eight section investigator developed survey was primarily a quantitative survey. However, each section included one or two dichotomous response (yes-no) questions providing the option for additional comments that could add to the richness of the data.

- **Section I: Screening questions:** Question 1, using skip-logic, screened all viewers and directed those viewers who were not SANEs to an exit page where they were thanked for their interest in participating. Question 2 used skip-logic to direct SANEs who did not examine children to the demographic section of the survey. SANEs who did examine children were directed to Section II.

- **Section II:** This section identified 11 facilitating factors supporting pediatric SANE competence (Question 3). This four choice Likert scale measured SANEs’ responses to Research Question 1: What do sexual assault nurse examiners who examine pediatric patients identify as facilitators of competence. Choices included *to no extent, to a minimal extent, to a moderate extent,* and *to a great extent.* The section closed with the *yes-no* question, “Are there other factors that support the development and maintenance of competence as a pediatric SANE?” Respondents were asked to please elaborate if they answered in the affirmative. The facilitating factors subscale was found to be reliable (11 items; \( \alpha = .77 \)).

- **Section III:** The availability of factors that facilitate pediatric SANE competence in SANEs’ primary practice sites (Question 5) addressed Research Question 1. Question 5 contained 10 items (\( \alpha = .78 \)) requiring qualitative dichotomous responses - *available* or *not available.* These responses were recoded as categorical data (*not available* = 0 and *available* = 1). This section closed with the *yes-no* question, “Are there other factors you can identify that support the development and maintenance of
competence as a pediatric SANE that are available to you in your primary practice? Respondents were asked to please elaborate if they answered in the affirmative.

- Section IV: Barriers to competent SANE practice (Question 7) was a four choice Likert scale that measured SANEs’ responses to Research Question 3: “What do sexual assault nurse examiners who examine pediatric patients identify as barriers to competence.” There are 11 items. The four ordered responses to six items (α = .79) included not a barrier, slight barrier, moderate barrier, and major barrier. Section IV closes with the yes-no question: “Are there other barriers that you can identify to the development and maintenance of pediatric SANE competence?” Respondents who checked a “yes” response were asked to please elaborate.

- Section V: Rating self-perceived competence as a pediatric SANE (Questions 9-12). Question 9 was a four choice Likert-type scale that measured SANEs’ responses to Research Question 4: How do pediatric sexual assault nurse examiners perceive their own competence. The four ordered responses included not at all competent, slightly competent, somewhat competent, and very competent. This question contained 11 items and was highly reliable (α = .83). Additional analysis of these data explored the relationship between competence and the availability of facilitating factors of competence, certification, population density of practice site, practice location in a CAC, and highest nursing degree attained.

- Section VI: The relationship between number of children examined and competence. This section provided data for additional analysis; specifically the relationship between the annual number of child sexual abuse evaluations SANEs opined necessary for competence and the actual number performed. These discrete numeric data obtained from Questions 25 and 26 in Section VI provided the latter data and were analyzed for descriptive statistics. The samples were not independent;
therefore, the dependent samples paired T-test was used to determine differences in
the test means on measures collected from the same SANEs.

➢ Section VII: The relationship between certification and competence. This section
contained questions about IAFN certification with ordinal and nominal responses
that explore the research question: What is the relationship between IAFN national
certification and how pediatric SANEs perceive their competence. Data were
recoded to dichotomous yes and no categories. However, because of the relationship
and possible interrelationships (interactions) of other facilitating factors, certification
was explored in concert with highest nursing degree, length of practice, population
density of practice site and practice in a CAC.

➢ Section VIII: Demographic and background questions.

Validity and reliability.

Instrument validity was measured prior to entering the final edited survey into
SurveyMonkey™. Face validity is an assessment of the “clarity and comprehensibility” of a
survey (Thibodeau & Hawkins, 1988, p.56). Five registered nurse colleagues with differing
educational backgrounds who were not SANEs reviewed the survey and completed the face
validity questionnaire developed by Thibodeau and Hawkins (J.W. Hawkins, personal
communication, April 28, 2012) (see Appendix E1 and Appendix E2). After reviewing
responses and suggestions from the panel of registered nurses, I sent the survey to a panel of
experts to establish content validity. Content validity concerns the “degree to which an
instrument has an appropriate sample of items for the construct that is being measured and
adequately covers the construct domain” (Polit & Beck, 2008 p.458).

A review of the draft survey by a doctorally prepared forensic nurse and child abuse
expert provided the initial content review and editing (see Appendix F1). The survey and the
research questions were sent to ten pediatric forensic nurse experts for review. The experts
completed a content validity questionnaire (see Appendix F2) designed to evaluate the relevance of each individual question or item to the constructs being measured, the relevance of each section and the survey in its entirety to the construct of competence (see Appendix F3). The data obtained from this questionnaire were analyzed providing content validity with an I-CVI (item content validity index) of .83 indicating that there was agreement among the proportion of experts who rated the item as quite relevant or highly relevant. Analysis of I-CVI data provided the scale content validity index (S-CVI), the averaging the I-CVIs for a recommended S-CVI that is 0.90 or above (Polit and Beck, 2008, p.459) (see Appendix F4). Additional changes to the survey were made upon review of content validity. After I established validity I entered the survey items into the SurveyMonkey web-based application. The survey was not sent to the experts a second time as the changes made were the result of almost unanimous suggestions from the panel of experts. Questions with I-CVIs less than .70 were eliminated with the exception of certification questions because of their relationship to Research Question 5: What is the relationship between International Association of Forensic Nurses national certification and how sexual assault nurse examiners who examine pediatric patients perceive their competence?

Reliability measures the reproducibility of a survey instrument (Litwin, 1995, Polit, & Beck, 2008, Tavakol & Dennick, 2011). Cronbach’s alpha coefficient was used to measure the homogeneity of each individual scale in the survey. An alpha coefficient of 0.7 or higher within a range of 0-1 is acceptable (Litwin, 1995). The Cronbach’s alphas for the four Likert Scales were analyzed with no significant change with removal of any items (see Table 1).

Data Analysis

The dependent variable in this capstone inquiry project was self-perceived competence. Independent variables included in the five research questions were facilitating factors, availability of facilitating factors, barriers and certification. The latter data was
coded into dichotomous yes (pediatric certification and/or pediatric and adult adolescent certification). All other certifications were coded as no for no pediatric certification. Adult/adolescent certification and ANCC AFN certification contributed to frequency analyses but not to analyses involving pediatric certification data.

I recognized individuals with facilitating factors available in their practice can differ in their competence for reasons other than those facilitating factors. Thus, I later made the attempt to include other variables that could otherwise explain the relationship between facilitating factors and competence. To that end, I computed a multiple regression analyses with availability of facilitating factors as a whole and individual factors, certification, highest level of nursing education and population density (rural area) of practice site and practice in a CAC as predictor or independent variables and the group mean of items included in question nine, “How do you rate your competence as a SANE?” as the outcome or dependent variable.

Data management.

SurveyMonkey structured responses and transformed data into SPSS computable .sav format as well as Excel .xls spreadsheets. Data were coded after input into SPSS by appropriate labeling to clarify data review.

Examination of the data revealed that Likert scale values were recorded as binary indicator variables (this was a limitation as SurveyMonkey did not allow for a matrix of single choice (radio button) questions using ordinal or categorical values. As a result, the indicator variables were recoded into ordinal values (1, 2, 3, and 4) prior to formal statistical analysis (W. L. Salomon, personal communication, February 9, 2013). I reviewed frequency tables and reviewed both original SurveyMonkey data and SPSS data to locate and recode errors and missing data.

SurveyMonkey codes missing data in SPSS .sav format as system missing data (SYSMIS). This is appropriate when questions are omitted intentionally by skip-logic; such
values do not contribute to the denominator of a statistic. This is in contrast to items that should have been answered but were not—user missing data; these included indicator variables that were not “1” (should have been “0”), and scale (numerical) variables that were missing any value. Missing indicator variables were recoded as "0" and missing scale values as "-1" (W. L. Salomon, personal communication, February 9, 2013). In the multiple regression analysis, “-1” coding was changed to “0.”

Several items containing irreparable errors (“available” and “not available” indicators were both checked) were entered as "0" (user missing data). When several Likert scale items were coded twice in one question (slightly competent and somewhat competent), the investigator developed the rule concerning coding of this data: the first dual response was randomly coded as either the first choice (slightly competent) or second choice (somewhat competent). All subsequent items in a scale with two dual responses were coded with alternating responses.

Methods for data analysis: Quantitative data.

SPSS 21 Premium Version was used for statistical analysis including univariate descriptive statistics (measures of central tendency, frequency distribution and range with upper and lower limits, percentages and standard deviations for demographic and descriptive data (Polit, 2008; Fowler, 2009; Rudstam, 2007) with supportive tables.

Descriptive analysis of demographic data provided the number of respondents as well as the number of IAFN members who were excluded from the survey and the number of remaining SANE respondents. This data concerning SANEs provided the number and percentage of pediatric SANE respondents, adult SANE respondents, and respondents who are both adult/adolescent and pediatric SANE respondents. Analyses of SANE’s years in practice and hours worked as SANE monthly provided means, medians, modes, standard deviations, minimum, maximum and ranges (Table 1). The highest level of nursing education provided
the numbers and percentage of respondents with each degree (Table 3) while the question on advanced practice status provide the number of advanced practice nurses (APNs), the percentage of SANEs who are APNs, and the breakdown by practice specialty (Table 4). The area of population density (Table 2.1) and the type of facility (Table 2.2) where the SANE practices provided data concerning urban, suburban, rural and frontier areas, (Table 2.3) number of patients evaluated and the type of facility where the SANE practice is located. This data provide the number of respondents who practice in rural or frontier regions.

Descriptive analysis of state certification data provided the percentages of respondents with state certification as pediatric SANEs, state certification as adult/adolescent SANEs and respondents who are both state adult/adolescent and pediatric SANE (Table 5). Descriptive analysis of IAFN certification data focused on SANE-P certifications and SANEs who are dually certified as both SANE-P and SANE-A. These data were included in the multiple regression analysis for Research Question 5. A summary of state certification data and Certification by CFNC will be found in Table 5-Table 6; Table 7-Table 9).

Research Question 1 includes items that pediatric SANEs identify as facilitating factors of competence and Research Question 2 focuses on the availability of these factors. Descriptive data will explore some of the differences between factors that facilitate competence and the availability of these factors.

Research Question 3 examines barriers to competent pediatric SANE practice. Descriptive analysis of data will provide the response to this question. One question that was explored is whether SANEs identified the examination of a limited number of pediatric patients as a barrier to competence. Another was whether geographic and professional isolation were identified as barriers.

Research Question 4 explored SANEs’ self-perceived competence. Descriptive analysis of data from Questions 9 and 10 provided this response as did descriptive analysis of
data concerning the numbers of children they examine annually. Results from the paired
dependent sample T-test will explore the results of measures obtained from the same group
of SANEs. Because of extreme outliers in questions 25 and 26, (Table 15.1 & Table 15.2)
numbers of prepubescent children and young teens examined annually, associated
demographic factors were examined with these patient statistics (Table 15.3). Research
Question 5 explored the relationship between self-perceived competence and certification.
This variable was included in the multiple regression analysis.

**Methods for data analysis: qualitative analysis.**

Questions asking for participant comments provided the opportunity for narrative
responses decreasing the potential for investigator bias (Polit & Beck, 2008). The responses
to these open ended questions will be presented as comments and frequencies of comments.

**Human subjects’ protection.**

The project survey was an anonymous web-based survey designed to collect no
personal information from respondents and nor could the survey be linked to respondents’
names or e-mail addresses. The survey was reviewed by the primary stakeholder IAFN,
represented by their CEO, who reviewed and approved the survey for distribution (Appendix
G). Upon approval of this capstone practice inquiry project by the IAFN, it was submitted to
the Simmons Institutional Review Board where it was approved (Appendix H).

An informational letter about the project survey accompanied all e-mails and
informed consent was included with the survey (I1). The initial part of the survey was the
informed consent (I2). Participants were provided with contact information for the
investigator, her committee chair and the Simmons IRB. The completed or partially
completed survey was considered to be consent. Requests to participate were sent via the
IAFN Member Community social network to all IAFN members. Members can filter
messages so members who find notices of posts including invitations to participate in research can filter these messages.

SANEs received no remuneration or incentives for participating in or completing the survey. While this potentially reduced the sample size, it also eliminated any potential for interpreting an incentive as a coercive measure.

**Adverse effects of this capstone project.**

The investigator expects no major adverse reactions to taking this survey. The only potential adverse reaction would occur if the survey caused participants to experience discomfort by questioning their level of competence. Respondents, who might have experienced an adverse reaction, were invited to discuss the survey with the investigator and/or her committee chair. Perceived risk to respondents who complete this survey is minimal. Risk was reduced by the thorough informed consent including explanations that SANEs could skip questions and exit the survey at any time.

There were no benefits from participation although some individual participants might have felt satisfaction from supporting a colleague’s educational endeavors and for contributing to forensic science research.

**Web-based technology: Security, HIPAA and Section 508 Compliance.**

Participants responded to the survey on-line. Electronic surveys were stored in a secure SurveyMonkey™ data warehouse located in the United States where they will be saved for five years. No personal health information will be obtained from participants; therefore, HIPAA (Health Insurance Portability and Accountability Act) compliance is not applicable to this survey. SurveyMonkey is Section 508 of the Rehabilitation Act of 1973 compliant and accessible (SurveyMonkey, n.d.).
Results

Recruitment of Participants

The survey was included as an internet link to an “Invitation to Participate” on the IAFN Membership Open Community social network on January 2, 2013. Data collection closed January 31, 2013 at 11:59 P.M. Please see methods section for complete recruitment information.

Sample

The invitation to participate was sent to the 3001 members of IAFN with a self-identified SANE” membership of 1504 SANEs (K. Day, personal communication, March 13, 2013) meeting the eligibility criteria. The response rate was 13% (N = 198) of IAFN SANE members. Three SANEs provided care exclusively to children, 55 SANEs provided care exclusively to adults and adolescents ages 14 years, and older and 143 SANEs provided care to both pediatric and adult. Completed responses from 115 SANEs who provided care to children were included in the multiple regression analysis.

Sample demographics.

The range of years of SANE practice with both pediatric patients and adult-adolescent patients was 27 years with a minimum of zero years and a maximum of 27 years. When pediatric SANE data were corrected for screened-out adult SANEs, the mean number of years of practice as a pediatric SANE was 4.9 years with a median of three years. The mean number of years SANEs practiced as adult-adolescent SANEs was 8.4 with a median of seven years. SANEs worked an average of 76 hours per month (Table 1).

Three questions explored the SANE practice sites. The first explored location by population density (Table 2.1), the second by the setting of SANE practice (Table 2.2) and the third explored the variety of emergency departments where SANEs practiced (Table 2.3). The majority of responding SANEs practiced in a hospital setting with the largest subgroup
practicing within the emergency department. Of SANES who practiced in emergency departments the majority practiced in large urban medical centers or teaching hospitals or urban or suburban community hospitals. Approximately 17% of SANEs practiced in rural hospitals or rural medical centers (Table 2.1). SANEs also practiced in CACs and in a variety of free standing community clinics including a university and a prosecutor’s office (Table 2.2).

The responses for the highest nursing degree earned ranged from diploma to doctoral degree. These data presented in a normal distribution by academic ranking with 41% of respondents with bachelors of science in nursing, 28% with a diploma or nursing associate degree and 28% with a masters of science in nursing or nursing doctoral degree and three percent with Juris Doctorates (Table 3). Advanced practice nurses who included pediatric sexual assault examination in their practice identified themselves as nurse practitioners, certified nurse midwives, and clinical nurse specialists (Table 4).

Approximately 43% of responding SANEs who provided care to pediatric patients had SANE-P certification by the Commission for Forensic Nursing Certification. This is 16% of IAFN’s SANE-P members. Seventy four (57%) responding SANEs who provide care to children are not certified as pediatric SANEs. Two nurses with ANCC AFN-BC certification examined pediatric patients in their forensic practice (Table 7).

Data from demographic questions including numbers of pediatric examinations performed annually, highest degree, practice location by population density, practice in a child advocacy center, and certification were analyzed.

Research Findings

Research question #1.

What did sexual assault nurse examiners who examine pediatric patients identify as facilitators of competence? Survey Question 3 uses a Likert scale to explore the question,
“How do you rate the extent to which each of the following can help with the development and maintenance of competence for SANEs who examine prepubescent children and young adolescents?” There were 11 items with a four point rating scale from 1 (to no extent) to 4 (to a great extent). Only pediatric SANEs responded to this question (Table 10). The 55 SANEs who identified themselves as adult/adolescent SANEs were directed away from Survey Question 3 by skip-logic programming leaving 143 SANEs respondents. SANEs rated peer review and expert review by a child abuse pediatrician or nurse practitioner more favorably than expert review of all acute pediatric cases within 24 hours which they rated least favorable of all facilitating factors involved with collaboration or review.

One quarter of SANEs provided comments about facilitating factors. After reviewing this free text I collapsed comments into four themes: education, self-efficacy in pediatric SANE practice and external support. The majority of comments (77%) were subsumed under collaboration and ongoing learning. Over half of the comments subsumed under collaboration with peers and experts also demonstrated SANEs self-efficacy in pediatric SANE practice. One cogent example was, “Review of cases seen by providers outside the institution in which one typically practices. State-wide web-based case reviews (sic) is one way to provide this. If review is done only internally there is a closed loop in which mistaken notions became entrenched truths.” The belief that certification is a standard of pediatric SANE competence is also a marker of SANEs self-efficacy in practice.

When addressing the need for ongoing education, some responding SANEs included education and demonstrated their self-efficacy in their responses: “Self study and review of latest research,” “Maintaining knowledge through access and regular review of the current literature,” “I do my own education personally through research.” While these SANEs express their belief that ongoing or life long education is essential for their competent practice as pediatric SANEs, many SANEs expressed their belief in education as a
facilitating actor of competence. Comments included: “Education…Education…Education,” “access to current journals” and “SANE training for other nurses.” Other SANEs opined the need for both financial support and institutional/systems support of their practice: “Have Joint Commission (sic) mandate to hospitals that they have at least one certified sane (sic) on staff to oversee program,” “financial support for being on call or on duty.” These comments support the quantitative data found in responses for Research Question 1.

Research Question #2.

The second research question focused on exploring the practice site availability of facilitating factors of competence for sexual assault nurse examiners who examine pediatric patients. Survey Question 5 consisted of ten items with dichotomous responses of available or not available. The 55 SANEs who identified themselves as adult/adolescent SANEs were directed away from Survey Question 5 by skip-logic programming leaving 143 responding pediatric SANEs. Responses for available facilitating factors ranged from a low \( n = 57; 43\% \) for state SANE certification to a high \( n = 114; 82\% \) for the opportunity to examine young adolescents. Over half of SANE respondents had no availability of SANE mentorship, review of all acute pediatric examinations within 24 hours, or state certification. Over half of SANE respondents had expert review of all pediatric evaluation available either digitally or on site although 42\% SANEs had no onsite expert review and 47\% of SANEs had no expert review of photo or video documentation. While 19\% of SANEs lacked the technology for photo or video documentation 19\% of SANEs did not use available photo documentation of all examinations (Table 10, Figure 2).

Nineteen SANES offered twenty responses to the request for additional comments concerning the availability of facilitating factors. The nineteen responses were collapsed into two themes, mentorship/collaboration and education. Mentorship/collaboration contains responses reflecting the expressed desire of SANEs for consultation with experts or peers or
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the presence of a mentorship program. Comments included: “immediate digital image
consultation during exam,” “peer mentorship,” “collaboration with the SANE at the CAC,”
and “cooperation and willingness of neighboring SANE Programs to assist in Case Review
(sic) and mentoring.” Others addressed the need for statewide quarterly meetings, monthly
case reviews, and Cooperation (sic) and the expertise of SANEs to conduct peer review.”

Additional comments supporting the second theme of education included: “Access to
current journals; peer review program,” “regular review of literature, involvement in research
and providing education,” “Continuing education.” These comments support the quantitative
data from responses to Research Question 2.

Research Question # 3.

Research Question 3 explored barriers to competence and was addressed by Survey
Questions 7 and 8. There were six Likert scale questions in this section. Each had a four
point rating scale from 1 (not a barrier) to 4 (major barrier). The mean response rate was
94%. The response rate was based on the number of pediatric SANEs who progressed to this
question by skip-logic. An additional 55 SANEs were directed by skip-logic to questions in
a different section of the survey. Seventy seven percent of responding SANEs identified an
inadequate number of pediatric patients that a SANE examines as a moderate or major
barrier to competence. This barrier was followed closely by inadequate funding for
continuing education (response rate 76%). The availability of continuing education (72%)
and limitation of hours worked (70%) fell in the midrange of SANEs who rated them as
moderate or major barriers. Geographic (54%) and professional isolation (66%) were the
lower two barriers rated by respondent SANEs although both were considered moderate or
major barriers by greater than 50% of SANEs. Frequency data supported these individual
responses (see Table 11, Items 7.a-f.).
Respondents had the opportunity to provide free text to identify additional barriers to their SANE practice. Twenty seven SANEs provided 43 comments collapsed into seven themes the largest being financial and professional isolation often found as co-themes. Most frequent comments included “lack of support by hospital administration,” lack of support by “community agencies (law enforcement)” and hospital refusal to pay for continuing education, certification or training SANEs.

**Research Question #4.**

Survey Questions 9 and 10 together address SANEs’ self-perception of their competence by exploring Research Question 4, “How do sexual assault nurse examiners who examine pediatric patients perceive their competence?” There were 134 responses to both questions. Nine pediatric SANEs did not respond. Only pediatric SANEs responded to these questions. Skip-logic directed SANEs who examined only adults and older adolescents to a different section of the survey.

Survey Question 9 consisted of 11 items in a four point Likert rating scale from 1 (not at all competent) to 4 (extremely competent). These items rated SANEs nursing knowledge of topics such as ethics, child protection laws, CDC recommendation for the evaluation and treatment of sexually transmitted infections and Adams’ and colleagues’ current "Guidelines for Medical Care for Children Who May Have Been Sexually Abused" (2010). Competencies integrating this knowledge with the practice and art of pediatric forensic nursing included the ability to perform developmentally appropriate examinations, caring for a pediatric patient who refuses to be examined, modification of adult sexual assault evidence collection to meet the developmental needs of a pediatric patient and the use of technology for video or photo documentation (Table 12).

Survey Question 10 explored how responding SANEs rated their professional functioning in caring for children using Benner's novice to expert hierarchy. Eighty five
percent of responding SANEs rated themselves as competent, proficient or as expert sexual
assault examiners when caring for children (Table 13).

I recoded the mean score from Survey Question 9 into a dichotomous variable, competent (yes or no) which I used as the dependent variable in the multiple regressions. The results are presented after completion of the research questions.

Additional analyses within this section explored pediatric SANEs’ opinions concerning the number of prepubertal and young adolescent examinations they need to complete annually to attain and maintain competent. These questions were answered only by pediatric SANEs. Adult and older adolescent SANEs were directed to another area of the survey. Almost half of responding SANES (n = 46) proffered the need for pediatric SANEs to complete 10 to 19 prepubertal examinations annually for competence while another 36 SANEs opined the need for 20 to 25 exams annually.

**Research Question #5.**

This research question explored the relationship between SANES’ perception of their competence in their pediatric SANE nursing practice and IAFN certification. Fifty eight responding SANEs (45%) who provide care to pediatric patients have SANE-P certification. This is 16% of IAFN’s SANE-P members. Seventy four (55%) responding SANEs who provide care to children are not certified (Table 7). Two nurses with ANCC AFN-BC certification examined pediatric patients in their forensic practice.

Approximately 59% of SANE respondents rated the extent to which IAFN certification could help with the development and maintenance of competence to a moderate extent or to a great extent. The remaining responding SANEs rated the extent to which IAFN certification could help with the development and maintenance of competence as to no extent or to a minimal extent) (Table 10, Figure 2).
Additional analyses.

Although Research Question 5 specifically explored the relationship between certification and competence, I realized the unasked question was, “What is the relationship of the availability of facilitating factors to self-perceived competence and how do they fit with other factors in SANE practice?” At a minimum the analysis of this question should consider years of experience, highest nursing degree attained, practice in a pediatric rich environment such as a CAC, population density of SANE practice setting and most important the availability of facilitating factors. Toward this end, I conducted multiple regression analyses to determine how perceived competence was related to these independent variables. I examined the relationship between self-perceived competence and the availability of facilitating factors in two ways: First, I explored the availability of facilitating factors as an aggregate predictor variable and then I examined them as individual predictor variables in the second model with the additional predictor variables listed in the first model.

In a first multiple regression model using the combined availability of facilitating factors variable, 36% of the total variance in self-perceived competence was explained by the predictor variables. Of those predictor variables in the model only two were significant ($p < .05$): IAFN SANE-P certification ($p < .001$) and the availability of the aggregate facilitating factors ($p < .001$) were positively related to perceived competence. While this analysis demonstrated that the availability of facilitating factors was related positively to perceived competence, it did not elucidate which individual facilitating factors fuel that relationship.

To better understand the role facilitating factors had in the development and maintenance of self-perceived competence, I also conducted a second multiple regression analysis that included each facilitating factor in the availability list as a predictor variable with location of practice in a CAC, certification, rural location used in model 1. In this multiple regression model, predictor variables explained 45% of the total variance in self-
perceived competence. Of those predictor variables in the model two were significant \( p < .05 \). First, IAFN SANE-P certification was again positively related to perceived competence \( p = .001 \). The individual available facilitating factor with a significant positive relationship to perceived competence was “photo or video documentation of all pediatric examinations” \( p < .001 \).

Results of paired t-test.

Data from Questions 11 and 12 were also included in the additional analyses from this section of the survey. This data allowed for the exploration of the number of young adolescents pediatric SANEs opined should be examined annually to develop and maintain competence. For the purpose of this capstone inquiry, young adolescent was defined as having a sexual maturity rating of two or greater and not having attained their fourteenth birthday.

In the demographic section of this instrument SANEs were queried in Survey Questions 25 and 26 about the number of prepubertal and young adult patients they examined annually. Adult/adolescent SANEs were not directed away from this question asking how many prepubertal children they examined annually resulting in a larger baseline response \( n = 183 \). Fifty three SANEs reported zero children examined; a number approximating the number of SANEs who were previously screened out as adult /adolescent SANEs. Although the actual number of prepubertal children examined is unknown, I have decided to treat the 53 SANEs who responded with a zero as system missing data.

With the resulting cleaned data I conducted a paired t-test to compare the difference between the number of prepubertal and young teen examinations SANEs opined as needed annually for competence and the number of prepubertal and young adolescent examinations SANEs performed annually. These analyses revealed a significant difference between the mean number of examinations SANEs opined as needed (examination opined, \( M = 23.77 \), \( SD = \))
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= 27.76) and the number of examination they conducted \(M = 46.42, SD = 71.04\), Conditions; \(t(123) = -4.616, p < .001\). These results must be cautiously interpreted because of the extreme outliers in the number of examinations performed annually and will be further discussed later in this paper.

Young adolescent data also revealed a significant difference between the annual number of young adolescent examinations opined as needed for competence \(M = 21.32, SD = 26.67\) and the number of examination conducted annually \(M = 52.00, SD = 84.83\), conditions; \(t(123) = -4.729, p < .001\). Again, there are extreme outliers in these data necessitating caution in the interpretation of these results (Range = 699, Min = 1, Max = 700) (Table 14; Table 15.2). In summary, by SANEs’ report, the sample responding to this survey examine approximately twice as many prepubescent children as they opine are necessary to maintain competence and over twice as many young adolescents as they opine are needed for the attainment and maintenance of competence.

**Summary of Results**

A multiple regression analysis demonstrated the relationship of the aggregate score of the availability of facilitating factors \(p = <.001\) and IAFN SANE certification \(p = <.001\) accounting for 36% of total variance of pediatric SANE self-perceived competence. Additional multiple regression analyses demonstrated the positive relationship between IAFN SANE-P certification \(p = .001\) and video or photo documentation of all pediatric examinations \(p < .001\) accounting for 45% of the total variance of pediatric SANEs’ self-perceived competence. Results from a paired t test revealed a significant difference between the number of examinations of prepubertal and young adolescent examinations SANEs recommended as needed for competent practice and the number of examination SANEs reported doing annually. SANEs reported examining twice as many children as they reported were necessary for competent pediatric SANE practice. However, caution needs to be taken
in interpreting this data because of the presence of extreme outliers in the latter data.

SANES who responded to this survey were primarily registered nurses who were not advanced practice nurses. The majority of responding SANEs practiced in metropolitan (population density) areas and in emergency departments. Approximately 20% of responding SANEs practiced in CACs and 17% practiced in rural or frontier areas.

**Discussion**

The idea for this capstone inquiry project was conceived during discussions of competence with SANEs in Maine, a rural state, where the number of examinations SANEs perform in a year can be limited. Informal discussion with colleagues at an IAFN International Conference on Forensic Nursing Science and Practice nurtured this interest as did several papers concerning SANE practice I submitted during my studies as a DNP student. As my reading and discussions increased, I became more interested in SANE competence, how SANE competence was assessed, who assessed SANE competence, and what guaranteed SANEs who examined children were competent and applied their knowledge to examine children in a developmentally appropriate manner.

Child sexual abuse/assault affects not only the lives of its young victims but also the lives of their families and the providers who examine these children. As described previously, child sexual abuse is a public health problem with significant implications for this nation’s economy and the future health of its people. The authors of child sexual abuse literature address the reality that many health care providers including pediatricians, lack adequate knowledge about sexual abuse. I found very little in the literature about SANE competence. I saw this capstone project as an opportunity for an initial exploration of SANE competence with its facilitating factors and barriers and as an opportunity to contribute to forensic nursing science. Ideally some of these findings will be translated into forensic nursing science to support the practice of SANEs who provide the care others do not provide.
As a clarification, I use “children who might have experienced sexual abuse” in the discussion. I do so to draw attention to the reality that not all children who are examined for concerns of sexual abuse have actually been sexually abused.

**Research Questions 1 and 2: Facilitating Factors and Their Presence in Practice**

1. What do sexual assault nurse examiners who examine pediatric patients identify as facilitators of competence?

2. What is the availability of facilitators of competence to sexual assault nurse examiners who examine pediatric patients?

The first and second research questions of this project explore factors that facilitate pediatric SANE competence and the availability of these factors. SANEs rated the extent to which they found facilitating factors supportive of competent practice.

In the first of these questions two items focused on competency of examinations of pediatric patients through SANEs performance of an adequate number of pediatric examinations. Two items then focused on external factors – availability of pediatric and forensic education and financial support for education and certification, and two items focused on certification by states in which SANEs practiced, by national IAFN SANE-P certification. Seven items in these questions focused on professional collaboration including peer review; review of all pediatric examinations by expert child abuse physicians or nurse practitioners; mentorship, and photo or video documentation of examinations, allowing web-based review by experts in the field as needed and/or on a scheduled basis.

Frasier (2011), a child abuse pediatrician, distinguished peer review from expert review or oversight in her comments: “Oversight/supervision suggests critical cases are seen, reviewed, and secondarily documented by a clinician with more advanced diagnostic skills and experience. Peer review suggests some cases are reviewed by peers of equal training and expertise.” Peer and expert review provide collegial critiques of findings and documentation,
direction, feedback on photography/video techniques, and ongoing education through
discussion. Destructive criticism should not be part of this process.

While it is true that only approximately 5% of children who have been acutely
sexually abused have injuries and 95% have normal examinations, injuries heal rapidly often
leaving no evidence of trauma (Berenson, et al., 2000). Without proper magnification and
technique of examination, injuries can be missed. Conversely, normal anatomic variants and
dermatologic manifestations of disease can be mistaken for injury. Although a plausible
theoretical hypothesis, SANEs identified expert review of all acute child sexual abuse within
24 hours to be the least helpful facilitating factor integrating case review with their SANE
practice. However, greater than 50% of SANEs found within 24 hour turnaround review as a
moderate or major facilitating factor of competence so its importance cannot be discounted.
Possible explanations can include turf disputes and communication issues between
physicians and nurses and lack of availability of expert review. Fifty-five percent of SANEs
reported expert case review of all acute pediatric sexual abuse examinations was not
available to them; 45% of SANEs reported 24 hour review of all acute pediatric cases was
available (Table 10, Item 5.d; Figure 2). Therefore, the risk of not having timely expert
review of examination findings either directly or through video or photographs, is
problematic because an examiner can miss physical findings but more often, a normal
examination is called abnormal. Timely review might suggest reexamination before subtle
findings resolve or to confirm a normal variant. Reporting physical evidence of abuse when
there is none, is disruptive to family life, unjustifiably involving child protective services and
law enforcement and potentially causing unwarranted emotional trauma to child and parents.

While expert review is important, so is peer review with other SANEs. Peer and
multidisciplinary team (MDT) review enrich and further develop the depth and potentially
breadth of the SANE role within the MDT. Peer and MDT reviews can improve
communication and trust, foster critical thinking and provide mechanisms for problem solving within the team and among the associated institutions, community and agencies. Peer review is an opportunity to share and validate knowledge; and is an essential component of ethical nursing care.

It is not just SANEs who benefit from these reviews. In New England and other parts of the country, child abuse physicians have virtual monthly peer review for review of difficult and/or ambiguous cases (personal communication, Christine Barron, January 10, 2013). Many if not most child abuse physicians use a closed electronic mailing list (LISTSERV™, Mailman, Yahoo Groups, etc.) requiring subscription and approval to join for immediate collaboration, discussion of practice issues, and sharing of the professional literature. Nurse practitioners, SANEs, and other professionals in the child abuse arena are also able to subscribe to this electronic mailing list. Given the sensitivity of some information, de-identification for HIPAA compliance is strongly self-enforced (these lists are not “moderated”).

Many authors of the child abuse literature address the importance for expert child abuse physician, expert nurse practitioners, and SANEs to work as colleagues (Adams, et al., 2007; Kaplan, 2011; Makaroff, et al., 2002; & Starling, et al., 2011) to provide care for these children. Certainly other opinions exist: some child abuse physicians believe that the care of these children belongs only in the hands of a physician and not with SANEs or nurse practitioners; some SANEs believe that collaboration with physicians or child abuse nurse practitioners is not necessary; and not all SANEs support ongoing peer review. Such issues also surface in the legal system as to who or what constitutes an expert witness as opposed to a witness of fact.

In this capstone inquiry project, several SANEs offered comments about peer and expert review when asked about other facilitating factors for competence in the survey. One
respondent in this project opined: “I don't think that ALL (sic) exams need to be peer reviewed and/or evaluated by pediatrician. I feel a quarterly peer review with case study of compelling and dynamic issues regarding history and/or findings is a better use of time.” Another shared perspective was that “an expert SANE could review cases rather than a child abuse physician or nurse practitioner.”

Gaining expertise in the physical findings of pediatric sexual abuse is an ongoing endeavor. While I do not disagree with the statement, “An expert SANE could review cases …” concerning SANEs’ expert review, expert review is an opportunity to learn and build trust. All disciplines involved must accept the expertise of other team members and learn the art of effective constructive critique rather than damning criticism; this critique should be “calibrated” to the appropriate level of expertise for maximal efficacy. When we as forensic nurses examine children, we are taking the first steps in making a potentially damaged child whole and that is an inviolable responsibility. A vital part of that responsibility is review and confirmation of our assessments.

Nursing has been struggling to define competence in nursing practice for years. How does one define expertise as a pediatric SANE, given that SANEs are early in the professional development process (ANCC Certification for Forensic Nursing was to have launched in November 2012)? Consider the following:

1) SANEs complete a 72-96 hour pediatric training.

2) Child abuse physicians complete a three year post doctoral child abuse fellowship.

3) Nurse practitioners who function as advanced forensic nurses are advanced practice nurses with additional graduate education preparing them to practice independently with a different level of responsibility and a different process of critical thinking. Forensic Nursing’s primary goal is analytical – the unbiased collection of history and physical evidence; therapeutic nursing is precisely that –
interactions with the fostering of wellness, treatment of illness, and patient
advocacy focused on the patient.

4) Nurse practitioners and other advanced practice nurses develop expertise in the
area of child maltreatment/child sexual abuse through formal and informal
ongoing training, supervision, oversight and peer review with other child abuse
experts with whom they maintain mutually collaborative relationships, a process
addressed by Frasier (2011).

We as health care providers must learn to communicate, respect, and appreciate what
we can learn from our peers and from experts. We can quote past errors in early child abuse
literature by physician experts. We might also argue that we are different disciplines and so
the diagnoses of physical findings of sexual abuse should be couched in the language of
nursing diagnoses. Unfortunately, the language of nursing diagnosis for physical findings of
child sexual abuse would lack the specificity needed for adjudication and for detailed
description. Consider that for SANEs in this study, 72.5% identify themselves as non-APNs
(Table 4); therefore, the use of Nursing Diagnoses vs. Descriptive Diagnoses is potentially
more likely, resulting in miscommunication on a semantic and/or conceptual level with
APNs and other child abuse specialists. The language of nursing diagnosis for physical
findings of sexual abuse would lack the specificity needed not only for adjudication but also
to effectively communicate with members of the multidisciplinary team providing care for
these child/adult victims.

The physical assessment of children involves diagnostic language for sexual abuse in
both pediatric nursing and medicine and for social workers who conduct forensic interviews.
In the future these diagnostic terms will form the basis of the taxonomies found in electronic
documentation systems. As such it involves life-long learning and research within the all
involved subspecialties to prevent errors in assessment and decrease errors in judgment and
to develop evidence based standards of care.

Adams’ guidelines are a case in point; they have been revised several times by a team
of 30 experts who reach consensus on changes since the guidelines first appeared in the
literature in 2007 (Adams & Kaplan, 2011). To quote one responding SANE: “If review is
done only internally there is a closed loop in which mistaken notions became entrenched
truths.”

Other responding SANEs expressed concerns that state nursing practice requirements
were the result of attempts to limit their involvement and “steer” children to referral centers
and child abuse physicians. An example of this concern is the statement: “Many states are
making it very difficult for nurses to see these pts. (sic) with all the certifications required.”
Only 17 states regulate SANE practice and among those 17 states there is no standardized
regulation of practice (Hornor, 2011): these are confirmed by respondents in Tables 5 for
certification and Tables 6.1 and 6.2 for certification renewal. State licensing boards delineate
registered nurses’ scope of practice in their nurse practice acts. If an individual state or
institution requires specialty certification, additional training or continuing education for
SANEs, it is to standardize practice for the safety of the patient within the scope of practice;
not to limit nursing practice.

The requirement for pediatric SANE certification is one way to standardize
requirements for pediatric SANE practice and to assess competence in pediatric SANE
practice; however, to make SANE certification mandatory through a state licensing agency
requires state legislation to change the nurse practice act. Massachusetts requires state SANE
certification for pediatric SANEs. The program is a state budget item funded by the state and
housed within the Department of Public Health (DPH). SANEs are employees and standards
for practice are overseen by the DPH.
The availability of facilitating factors in a practice can foster their use and acceptance by SANEs in that practice. In this capstone project ten facilitating factors were explored as available or not available in SANEs’ practice sites (Table 10, Items 5.a – f; Figure 2). Three items lacked availability to 50% or greater of responding SANEs. These items included state SANE certification, SANE mentorship, and expert review of acute cases within 24 hours. One potential explanation for the lack of availability of expert review of acute cases within 24 hours is the clustering of child abuse pediatricians in academic medical centers and more urban areas, whereas SANEs practice in all areas of population density including rural and frontier areas. SANEs who are separated by geographic barriers are often many miles from medical centers with practicing child abuse pediatricians and may not have the technology for immediate review or consult with child abuse specialists.

Adams and colleagues (2012) conducted a web-based study consisting of 20 case studies of children with suspected child sexual abuse with photographs and 41 follow-up questions. SANES, nurse practitioners, and pediatricians who responded and who examined fewer than five children monthly had mean scores well below 30 ($N = 41$). In the follow-up questions ($n = 41$) mean scores of child abuse pediatricians (34.8) was significantly higher ($p < .05$) than pediatricians and SANEs (29.3). The authors recommended ongoing case review with an expert in child sexual abuse medical evaluation and reading current child sexual abuse literature for non-specialist clinicians who examine fewer than five children monthly for suspected sexual abuse.

One surprising result from this capstone project survey was that 81% of pediatric SANEs reported using photo- or video-documentation for all pediatric examinations, and 62% reported having photo or video equipment to review documentation with a child abuse pediatrician or child abuse nurse practitioner (Table 10, Items 5.a and 5.e; Figure 2). I included the survey question about technology to clarify not available responses for photo
documentation of examinations. SANEs are documenting pediatric anogenital examinations with digital or video cameras. Almost 91% of pediatric SANE respondents rated photo documentation of all pediatric evaluation as *moderately* or *greatly helpful* as facilitating factors of competence (Table 10, Item 3.b; Figure 2).

Photography or videography of anogenital and other physical findings of child maltreatment is well documented as the standard of care for pediatric abuse examinations (Adams & Kaplan, 2013; Heger, 2011; National Children’s Alliance, 2011). Its use often renders additional examinations to verify SANEs’ findings unnecessary, thereby preventing potential emotional or iatrogenic physical trauma to a child by repeated examinations or by an examination by a poorly skilled examiner. Furthermore, still or video documentation produces objective documentation of clinical evidence that can be used in adjudication quality measures.

Forensic and pediatric continuing education was included as a facilitating factor of competence and its absence was identified as a barrier. This dichotomy segues into:

**Research Question 3: Barriers to Competence**

3. What did sexual assault nurse examiners who examined pediatric patients identify as barriers to competence?

Not surprisingly, respondents (95%) rated the degree to which the availability of continuing education with fiscal support by their employers (89%) as a moderate or major facilitating factor of their competence (Table 10, Items 3.j and 3.k; Figure 2). Fiscal support was not available to 48% of pediatric SANE respondents (Table 10, Item 5.f; Figure 2). Lack of fiscal support for continuing education was rated as a moderate or major barrier by 76% of pediatric SANE respondents and lack of availability of continuing education was rated as a moderate or major barrier by 71% of responding pediatric SANEs (Table 11, Items 7.e and 7.f).
Also not surprisingly, 95% of responding SANEs rated the examination of an adequate number of all pediatric patients as a moderate or major facilitator of their competence (Table 10, Items 3.e and 3.f; Figure 2), while 81% of SANEs responded that that they lacked the opportunity to perform adequate examinations for competence (Table 10, Item 5.g and 5.h; Figure 2). Seventy eight percent of responding SANEs identified the lack of opportunity to examine an adequate number of prepubertal children and young teens as a barrier to competence (Table 11, Item 7.a). These results demonstrated that some SANEs lack the opportunity for adequate examinations to be competent and recognize limited clinical experience as a barrier to their competence as pediatric SANEs.

Pediatric child abuse and forensic nursing researchers acknowledge these issues. Campbell and colleagues (2008) addressed the “relationship between pediatric exam (sic) experience and anogenital injury detection” as the “most important finding” (p.194) in their study. Markoroff, et al., (2002) found pediatric emergency department physicians with less experience diagnosed more children with positive findings of sexual abuse than did their child abuse specialist colleagues. As a result of her research, Adams has suggested a minimum of five sexual abuse examinations per month, as well as regular review of current child abuse research, as necessary to maintain competence in the medical evaluation of sexually abused children (Adams, et al., 2012, p. 392). This number of pediatric examinations is difficult to achieve in a hospital or practice in which five children might have been examined in a year for sexual abuse.

If the limited number of SANEs who participated in this capstone inquiry project are not examining adequate numbers of children for them to feel competent and have limited access to pediatric and forensic pediatric continuing education, what percentage of the SANEs who did not participate have adequate clinical experience and access to continuing
FACTORS THAT INFLUENCE PEDIATRIC SANE COMPETENCE

education? How do we as colleagues and how does IAFN as forensic nursing’s professional organization support these SANEs?

In addition to the lack of availability of continuing education and financial support for continuing education, professional (65%) and geographic (53%) isolation were reported as moderate or major barriers (Table 11, Items 7.c - f). This is further supported by the correlation in the multiple regression analyses that revealed a rural location was negatively correlated to the mean availability score for facilitating factors of competence. Implications of geographic isolation include: decreased local continuing education and technology in smaller hospitals; professional isolation due to limited SANE peers; and limited opportunity to examine children who have been sexually abused. Potential conflicts of interest in small rural communities include: marital/professional role conflict; limited number of families; confidentiality issues; role conflict resulting from the limited number of nurses in small rural hospitals (Averill, 2007; Bushy, 2011; Graves, 2008; Hurme, 2009; Lee, 2004; Littel, 2001; Logan, 2005; Montour, 2009; Moore, 2009).

Professional isolation also leads to burnout (Nelson, Pomerantz, Howard & Bushy, 2007), as well as decreased peer and expert review (Frasier, 2011), crucial components for the maintenance of competence and ethical nursing practice. Peer interaction is an essential part of the ethical foundation of forensic nursing practice described previously in the literature review. It is essential for feedback and positive reinforcement. When SANEs practice in forensic nursing isolation, there are no knowledgeable peers or leaders to observe the critical elements inherent in competent practice (Lenburg, 1999).

Research Question 4: Self-Perceived Competence

This research question “How did sexual assault nurse examiners who examine pediatric patients perceive their competence?” addresses pediatric SANEs self-perceived competence. IAFN identifies theoretical concepts, evidence collection, and pediatric
physical and developmental assessment as broad pediatric SANE competencies (International Association of Forensic Nurses, 2011). Adams and colleagues published “It’s Normal to be Normal” in 1994. This original article became the basis for the guidelines for the evaluation of sexually abused children that Adams and her colleagues have published and continue to update (2007). While 59% of SANE respondents rated their professional practice as proficient or expert and 25% rated their practice as competent (Table 13), 50% rated their competence in applying Adams’ guidelines as very competent, with another 30% rating their application of Adams guidelines as somewhat competent (Table 12, Item 9.g). These guidelines contain evidence based findings that are integral to examiners’ knowledge base when they examine children for concerns of sexual abuse. It is not necessary to memorize these guidelines but to have them available and consistently apply them to practice and to seek expert review to confirm findings.

Fifty seven percent of responding SANEs rated themselves as very competent and 39% rated themselves as somewhat competent in the application of current Centers for Disease Control (CDC) guidelines for testing, prophylaxis, and treatment of sexually transmitted infections (STI) in children. Applying CDC guidelines for pediatric STI testing and treatment is also an integral component of caring for these children. Unlike Adams’ guidelines with application in the adjudication and child protection processes of sexual abuse investigations, the appropriate application of STI prophylaxis has significant implications for health.

Unfortunately, written and electronic guidelines have never been effectively incorporated into and applied in clinical practice. In recent years, adoption of clinical guidelines with resulting behavior change has been facilitated by incorporating guidelines into clinical workflow through electronic medical record clinical decision support (Cabana, et al., 1999; Stolte, Hill, & Chin, 1999). Cabana and colleagues also identified several barriers
to implementation of guidelines including lack of awareness, lack of familiarity, lack of self-efficacy, and lack of agreement with guidelines (1999).

Sixty eight percent of responding SANEs rated themselves as very competent in the care of a child who refused an examination as well as the developmentally appropriate physical examination on a prepubertal child. Providing care for a child who refuses an examination is part art and part science. Knowledge of child development informs examiners how they should interact with children of different ages. Skilled examiners modify their interactions with children based on their educated intuition from initial contact with each pediatric patient. Performing a developmentally appropriate examination of a child rests on SANEs’ knowledge of anogenital anatomy and specifically hymenal developmental morphology, as well as developmental theory.

While comparing frequency data and the means of all summed items in Survey Question 9 with Benner’s stages in Survey Question 10, I decided Question 9 was a more robust measure of competence. Question 9 measured knowledge and application of knowledge albeit limited, whereas Question 10 measured SANEs’ self-perceived competence whether accurate, over-inflated, or under-estimated. In the multiple regression analyses, the mean competence score was used as a proxy for competence. Rural location and diploma or nurses with associate degrees were negatively related to the mean competence score.

SANEs provided their opinions concerning the number of prepubertal and young adolescent examinations needed for competent SANE practice and the number of examinations they performed on prepubescent children and young adolescents annually. Each of these data sets had extreme outliers that may well skew the results and make these responses less valid. These data were rechecked not only in the original downloaded SPSS dataset but also in the SurveyMonkey database to confirm outliers (see Table 14, Table 15.1, and Table 15.2).
As presented earlier in the paired t-test results, SANEs examined a significantly higher number of children than they felt were necessary to maintain competence (Table 14). Seventy nine percent of SANEs \((n = 99)\) opined 25 prepubertal examinations or fewer were needed annually, but only 17% \((n = 21)\) of the SANEs recommended 60 examinations annually, the number of examinations cited by Adams, et al. (2012) as needed annually for competence. However, in practice, 60% of SANEs reported examining 25 or fewer children annually, with an additional 20% of SANEs reporting they examined between 51 and 60 children annually.

The number of young adolescent examinations SANEs felt were necessary for competence was comparable to the number of prepubertal examinations needed for competence (Table 14). In the opinion of 83% of SANEs, 25 young adolescent examinations or fewer were needed annually for competence with an additional 14% of SANEs reporting their opinion of 60 examinations should be completed annually. However, 58% of SANEs \((n = 75)\) reported they examined 25 young adolescents annually and an additional 23% of SANEs \((n = 30)\) reported they examined 60 young adolescents annually. While Adams and colleagues did not specify the number of young adolescent examinations needed for competence, hymenal changes during puberty can make the identification of subtle trauma difficult. In my opinion, it is sound practice to apply Adams’ criterion of 60 examinations as indicated for pediatric patients also for young adolescent patients. One can only speculate whether SANEs who opined more examinations were indicated for competence than they themselves performed annually, included themselves in the recommendation.

**Research Question 5: The Relationship Between Certification and Competence**

The final research question explores the relationship of certification and competence. Approximately 86% of pediatric SANEs’ responses concerning their reasons for certification included *symbol of my competence*, 47% of responses included *pride as a SANE or IAFN*
member, and another 78% responses included personal goal (Table 8). Fifty nine percent of SANEs rated the Commission on Forensic Nursing Certification (CFNC) SANE certification helpful in the attainment and maintenance of competence to a moderate or great extent (Table 10, Item 3.h; Figure 2). Certification has been well documented by the authors of nursing literature as a hallmark of competence (American Nurses Credentialing Center, 2009; International Association of Forensic Nurses & Commission for Forensic Nursing Certification, 2013). While one could argue the bias of these organizations because certification is also a source of significant revenue, the positive responses of SANEs echo statements found in the literature. Certification and certification renewal are indeed expensive, especially in the current troublesome economic climate. The cost to apply for testing for SANE-A and SANE-P certification requires an initial investment of $275-$400 (late registration) for each application. These fees could well affect the ability of some SANEs to invest in certification and might further decrease the desire of employers to fiscally support certification.

Only 27% (n = 35) of responding SANEs reported the state SANE certification as a requirement for practice, while one and one half percent (1.5%) of states required SANE certification from the Commission on Forensic Nursing Certification (Table 5). Lastly, the problem of oversight of SANEs who are not employed by hospitals once again presents itself. Who has the skills to neutrally appraise SANEs’ competence? State regulation through licensure requirements is not well received by some SANEs, but rather seen as an interference with SANE practice. However, if a SANE program is located in a prosecutor’s office, competence might be viewed through a different lens resulting in an interpretation of increased prosecutions as competent SANE practice.
Project Limitations

The data obtained with this survey have limited generalizability due to the small sample size. The invitation to participate was sent to the 3001 members of IAFN with a self-identified SANE™ membership of 1504 SANEs (K. Day, personal communication, March 13, 2013) meeting the eligibility criteria. The response rate was 13% \( n = 198 \) of IAFN SANE members and 16% \( n = 58 \) of the 372 certified SANE-P examiners (IAFN International Association of Forensic Nurses, 2013b). This was a potential limitation noted at the onset of survey development. However, the multiple regression analysis \( n = 115 \) provided adequate power to generalize to the sample of SANEs who responded but not to IAFN SANE membership or SANEs who are not IAFN members.

I chose to not use an incentive to encourage SANEs to complete the survey. While I am certain that an incentive only for those participants who completed the survey would have increased the response rate, I felt as though I would be implementing a subtle coercive tactic with a questionable ethical basis, although Institutional Review Boards do routinely approve incentives to encourage participation in projects. I was also concerned that the use of a desirable incentive would increase sampling bias.

Sampling bias was another limitation of convenience sampling. SANEs who are IAFN members and who use the IAFN Community social networking site may not be representative of SANEs who are not members of IAFN, while IAFN member SANEs who responded to the survey may not be representative of IAFN member SANEs who did not. The results of this project have significant implications for ongoing competence, pediatric SANE practice, and future research.

Responses to both Survey Questions 11 and 12 contained outliers of 250 examinations recommended annually for competence. Because of the presence of these outliers, I reviewed all original data from SPSS and for questions 11 and 12 and included
review of original SPSS and SurveyMonkey data when I found outliers in data from questions 25 and 26. Question 11 had one extreme outlier response of 250 prepubertal examinations, but there were also three responses of 100 prepubertal examinations needed annually for competence. Question 12 also had an outlier of 250 young adolescent examinations were needed annually, with two responses of 100 young adolescent examinations (Table 14 & Table 15). However, it is not unreasonable for a sexual abuse examiner in a metropolitan area CAC or state-wide child abuse program to examine 250 children annually. After review of the data and box plots, and consultation with several child abuse experts, I chose to include these outliers ($n = 250$) for Survey Questions 11 and 12 in the data analyses.

Another potential reason for the outlier for young adolescent data in Survey Question 12 is the imprecise definition of young adolescent in different programs. Individual SANE programs decide if young adolescent is defined by sexual maturity rating or age. As a result, young adolescent can vary from first sign of breast development to an age such as the upper limit of 14 years, as defined in this project, or younger or older, or to first menses. I chose an upper age limit of 14 years for this project in order to provide a more precise definition. There are programs that include 12 year olds in their adult/adolescent programs. This inclusion presents its own problems because of the potential developmentally inappropriate examination of these children.

These outliers became more extreme when reviewing the actual number of pediatric examination conducted annually. The range of prepubertal children examined annually is 500 and the range for young adolescent examinations performed annually is 698. In order to better understand if these six extreme outlier examinations were indeed outliers, I examined the hours worked as SANEs, certification, highest nursing education, other certification and degrees and self identification as an APN or not for each of these six examiners (Table 16).
consulted with child abuse nurse practitioners and advanced forensic nurse experts who reside in varying areas of the United States about the results of these questions. These interactive consultations helped shaped this discussion of outliers as all agree it was either impossible to forensically examine this number of children annually or if they were examined, the stress of examining this number of children was guaranteed to produce examiner burnout.

After these discussions with forensic nurse experts, I concluded that these data might not be correct and might reflect the number of patients seen annually by all SANEs in a program or might be all pediatric patients seen by advanced practice nurses rather than only sexually abused patients. I could find no available literature to support the maximum number of forensic examinations that should be performed annually by SANEs. However, the National Association of Medical Examiners does place an upper limit on the number of autopsies a forensic medical examiner can perform before errors are made and quality impaired (National Association of Medical Examiners, 2011).

I erred in the use of skip-logic. This error directed members away from the certification section of the survey, eliminating the capture of adult and adolescent SANE data for certification details. I also should have used skip-logic to direct adult/adolescent SANEs from responding to questions about the number of prepubertal children or young adolescents they examined annually. As a result, I did not have a correct assessment of certified adult/adolescent SANEs.

I would reword some of the questions differently if I decide to use this survey again and I would review other web-based applications because of difficulties with the database download. SurveyMonkey was in the process of integrating a Beta version and there were some difficulties with slow downloads and the inability to review all of the free text (this is better done in Excel after Null data is excluded). The amount of data cleaning required was
extensive. SurveyMonkey states that it interfaces with SPSS; however, SurveyMonkey does not differentiate between *system missing* and *user missing* data. This requires recoding of all data resulting from skip-logic questions to distinguish between the two missing data types.

In summary, limitations of this capstone inquiry project included small sample size and sampling bias resulting from use of a convenience sample. There are extreme outliers in data from the two questions exploring the number of pediatric patients examined annually. Extreme outliers can skew data used in analyses. This capstone inquiry project is not without its strengths. Forensic nursing is a young nursing specialty and IAFN is a young professional organization. This project is a beginning.

**Conclusions and Implications for Future Practice**

SANEs who responded to this survey were primarily registered nurses who were not advanced practice nurses. These SANEs practiced an average of 76 hours each month. While some SANEs practiced for 27 years, the average length of practice for adult SANEs was 8.4 years and for pediatric SANEs was 4.9 years.

In this capstone inquiry project sample, pediatric SANEs practiced an average of 58% of the mean number of years adult-adolescent SANEs practiced. SANEs averaged 76 hours of practice monthly. Over sixty percent of SANEs had bachelor, diploma, or associate degrees as their highest nursing degree and 28 percent were master or doctorally prepared. SANEs sampled primarily practiced in metropolitan areas and in emergency departments. Seventeen percent of the sample practiced in rural or frontier areas and approximately 20% practiced in child advocacy centers.

The aggregate score of availability of the facilitating factors with SANE certification had a significant (p = <.001) positive relationship to self-perceived competence. When exploring the relationship of the availability of individual facilitating factors with other predictor variables, there was a significant positive relationship (p = <.001) between IAFN
SANE-P certification and video or photo documentation of all pediatric examinations and 45% of the total variance of pediatric SANEs’ self-perceived competence. There were negative correlations between rural practice and a diploma or associate degree in nursing and the availability for of facilitating factors that support competence.

SANEs who practiced in rural areas identified inadequate number of all pediatric patients, lack of funding for continuing education and lack of continuing education as well as professional and geographic isolation as barriers to competence.

While overall, SANEs rated themselves as competent, proficient or expert, there were some apparent knowledge deficits and deficits in competency application. These were in the area of providing care to a child who refuses care, developmentally appropriate examinations, knowledge and application of CDC Guidelines for STI evaluation and treatment of sexually abused children and most notably, knowledge of Adams, et al, (2010) guidelines for care of a sexually abused child.

There was a significant difference between the number of examinations of prepubertal and young adolescent examinations SANEs recommended as needed for competent practice and the number of examination SANEs reported doing annually. SANEs reported examining twice as many children as they reported were necessary for competence although these figures have to be interpreted carefully because of the number of extreme outliers.

It is without question that SANEs do the work that other health care providers dread doing when they care for the victims of sexual assault and child sexual abuse. Of the 198 responding SANEs, 143 SANES (16% of SANE-Ps) provided care to pediatric patients.
Implications for future clinical research.

Opportunities for further clinical research include the forensic and pediatric education needs of rural SANEs alternative methods of providing education to larger numbers of rural nurses such as webinars and on-line education. Another potential project is the exploration of the technology available to rural SANEs to increase case review, immediate consultation with child abuse experts, as well as SANEs comfort with technology. *Meaningful Use* is now a reality. There will be opportunities for increased quality improvement in patient care through mining of forensic nursing data and from research into the usability of existing forensic documentation and its improvement to provide the combination of free and standardized text for optimal and time effective documentation.

Implications for forensic nursing practice.

Forensic nurses provide care other health care personnel are often reticent to provide. This project identifies a few factors that can support forensic nursing competence. While it can be argued the results do not have the statistical power to generalize to the whole of forensic nursing, the results have clinical and professional significance and do argue for the support of these facilitating factors and the exploration of other facilitating factors that support forensic nurses within their practice institutions.

Barriers such as geographic isolation cannot be removed, but practices can be developed that ameliorate SANEs’ feelings of professional isolation and decrease potential burnout. Regionalization of forensic nursing care involving multiple facilities in one area or more than one area can decrease professional isolation through shared call schedules and workload, increase the potential for mentorship and for peer review or a peer review network. Telemedicine used for specialties like neurology and psychiatry can increase immediate consultation with distant experts and foster regular case review. Skype™, an inexpensive
method of teleconferencing, can also support deidentified peer review, support clinical research discussions among practicing SANEs stimulate and journal club.

Electronic medical records (EMR) now mandated by The Affordable Care Act will continued to be developed for forensic nursing. The use of EMRs will support quality review and quality improvement research projects. Forensic nursing electronic documentation will continue to evolve to contain free text for history and current concerns and standardized text for review of systems and in part for the physical examination while free text and video will complete the physical examination documentation.

As forensic nursing grows as a specialty, more colleges and universities are developing both degree and certificate forensic nursing programs. Unfortunately, university based forensic education is not a remedy for one of the major concerns of respondents, the lack of affordable education. However, with the ubiquitous nature of computers, smart phones and I-pads and their myriad apps (small domain-specific programs and applications), forensic nurses have the potential to increase their access to on-line education. IAFN is currently developing more webinars for its members. Members have the opportunity to initiate on-line journal clubs, article swaps and evidence based discussions through the Members ‘Only’ social network.

SANEs are entry level forensic nurses. Historically, diploma graduates, associate degree nurses, and nurses with BSNs form the core SANE membership. These are the nurses who have been willing to do this difficult work. As SANEs want to incorporate more into their evaluations, should IAFN explore the possibility of requiring the minimum of a BSN degree for certification? This would surely be an unpopular decision, but would it not also reflect the expanded roles some SANEs desire?

ANCC is accepting applications for portfolio assessment for advanced forensic nursing certification (AFN-BC). This certification will provide one more standard for
professional competence. Hopefully, forensic nurses will not perceive this as a two class system, but as a team effort to provide optimal care to victims of violence. Child abuse nurse practitioners who have not sought SANE certification because of their scope of practice can now attain board certification reflecting their scope of practice. ANCC, through their portfolio appraiser application process, also sets standards for those who assess portfolios for applicants for AFN-BC credentials.

Perhaps the SANE regionalization of the future will consist of undergraduate degree SANEs who have an MSN/APN SANE clinical director responsible for daily oversight and patient care. Supervising these teams of SANE programs would be a doctorally prepared board certified advanced forensic nurse who is also an expert clinician. This AFN-BC would conduct immediate case review for acute child sexual abuse cases and when the examining SANE supervisor requests such review. They would also coordinate case review for non-acute sexual abuse within 72 hours of the abuse examination and monthly peer review to critique documentation and photodocumentation. If programs were located in rural areas, the SANE program directors and the AFN-BC would examine children with inflicted injury and, with the child’s primary care provider, arrange for transport to a children’s hospital with child abuse physician if needed.

Hospital administrators and board members need education about interpersonal violence and the effects of adverse childhood experiences on the future health of the members of their community. This is another opportunity for advanced practice forensic nurses. All forensic nurses and child abuse pediatricians need to co-exist and develop trust and provide the best care possible for our children who are our future.

One unspoken goal of this project was to find “common ground” for team work and to support evidence based practice through its results. The largest area for this cooperation would be in expert review of evaluations and monthly or quarterly computer assisted case
reviews. Only through the sharing of cases will physicians become comfortable with SANEs’ knowledge and will SANEs become accepting of the shared responsibility with their physician colleagues. Child abuse physicians can become champions of the role of SANEs with hospital executives and boards who are reluctant to support programs that do not increase hospital income.
Tables and Figures

Table 1

Demographic Data: Years of Practice and Hours per Month (Questions 19, 20, 21)

<table>
<thead>
<tr>
<th></th>
<th>Years as adult SANE</th>
<th>Years as Pediatric SANE</th>
<th>Hours Worked/Month</th>
</tr>
</thead>
<tbody>
<tr>
<td>N Valid</td>
<td>188</td>
<td>184</td>
<td>184</td>
</tr>
<tr>
<td>Mean</td>
<td>8.39</td>
<td>4.88</td>
<td>75.83</td>
</tr>
<tr>
<td>Median</td>
<td>7.00</td>
<td>3</td>
<td>40</td>
</tr>
<tr>
<td>Mode</td>
<td>7</td>
<td>0</td>
<td>160</td>
</tr>
<tr>
<td>SD</td>
<td>5.736</td>
<td>5.601</td>
<td>76.049</td>
</tr>
<tr>
<td>Range</td>
<td>27</td>
<td>27</td>
<td>480</td>
</tr>
<tr>
<td>Minimum</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Maximum</td>
<td>27</td>
<td>27</td>
<td>480</td>
</tr>
</tbody>
</table>

Note. Maximum N = 198 if all responded

Table 2.1

Practice Site by Population Density (Question 22)

<table>
<thead>
<tr>
<th></th>
<th>Inner City</th>
<th>Urban -Not -Inner City</th>
<th>Suburban</th>
<th>Rural</th>
<th>Frontier</th>
<th>Other</th>
</tr>
</thead>
<tbody>
<tr>
<td>Frequency</td>
<td>43</td>
<td>54</td>
<td>44</td>
<td>32</td>
<td>1</td>
<td>15</td>
</tr>
<tr>
<td>Percentage of N</td>
<td>22.8%</td>
<td>28.6%</td>
<td>23.3%</td>
<td>16.9%</td>
<td>0.5%</td>
<td>7.9%</td>
</tr>
</tbody>
</table>

Note: N = 189 of 198 possible respondents.

Table 2.2

Practice Site by Type of Facility (Question 23)

<table>
<thead>
<tr>
<th></th>
<th>Emergency Department</th>
<th>Child Advocacy Center</th>
<th>Federally-funded Health Center</th>
<th>Other</th>
</tr>
</thead>
<tbody>
<tr>
<td>Frequency</td>
<td>152</td>
<td>39</td>
<td>3</td>
<td>39</td>
</tr>
<tr>
<td>Percentage of N</td>
<td>80.42%</td>
<td>20.63%</td>
<td>1.59%</td>
<td>20.63%</td>
</tr>
</tbody>
</table>

Note: N = 189 of 198 possible respondents. Multiple responses were possible, hence Frequency (233) is greater than N and Percentage = 123.3%.
Table 2.3

*Practice Site by Emergency Department Geographic Location (Question 24)*

<table>
<thead>
<tr>
<th></th>
<th>Urban Academic Medical Center</th>
<th>Urban Community Hospital</th>
<th>Suburban Community Hospital</th>
<th>Rural Community Hospital</th>
<th>Critical Access Hospital</th>
<th>Other</th>
</tr>
</thead>
<tbody>
<tr>
<td>Frequency</td>
<td>48</td>
<td>33</td>
<td>44</td>
<td>27</td>
<td>12?</td>
<td>16</td>
</tr>
<tr>
<td>Percentage of N</td>
<td>24.2%</td>
<td>16.7%</td>
<td>22.2%</td>
<td>13.6%</td>
<td>6.3%</td>
<td>8.1%</td>
</tr>
</tbody>
</table>

*Note.* Maximum N = 198 if all responded; n work at multiple sites.

Table 3

*Highest Degree Completed (Question 27)*

<table>
<thead>
<tr>
<th>Degrees or Advanced Degrees</th>
<th>Diploma</th>
<th>ADN</th>
<th>BSN</th>
<th>MSN</th>
<th>DNP</th>
<th>PhD</th>
<th>Other BA/BS Degrees or Advanced Degrees</th>
</tr>
</thead>
<tbody>
<tr>
<td>Frequency</td>
<td>17</td>
<td>35</td>
<td>78</td>
<td>44</td>
<td>4</td>
<td>5</td>
<td>27</td>
</tr>
<tr>
<td>Percentage of N</td>
<td>8.99%</td>
<td>18.52%</td>
<td>41.27%</td>
<td>23.28%</td>
<td>2.12%</td>
<td>2.65%</td>
<td>14.29%</td>
</tr>
</tbody>
</table>

*Note:* N = 189 of 198 possible respondents. Multiple responses were possible, hence Frequency (210) is greater than N and Percentage = 111.1%. Some advanced degrees are not necessarily in Nursing.

Table 4

*Self-Identification as an APN (Question 28)*

<table>
<thead>
<tr>
<th></th>
<th>Nurse Practitioner</th>
<th>CNM</th>
<th>CNS</th>
<th>Other</th>
<th>Not an APN</th>
</tr>
</thead>
<tbody>
<tr>
<td>Frequency Overall</td>
<td>29</td>
<td>4</td>
<td>6</td>
<td>2</td>
<td>108</td>
</tr>
<tr>
<td>Percentage of N</td>
<td>19.5%</td>
<td>2.7%</td>
<td>4.0%</td>
<td>1.3%</td>
<td>72.5%</td>
</tr>
<tr>
<td>APN Percentage</td>
<td>67.4%</td>
<td>9.3%</td>
<td>14.0%</td>
<td>4.7%</td>
<td></td>
</tr>
</tbody>
</table>

*Note:* N = 149 of 198 possible respondents. Of these, 41 (27.5%) self-identified as APNs. The percentage breakdown of these is shown on the third line.
Table 5

*SANE Certification by State and by Practice Site (Questions 13 & 14)*

<table>
<thead>
<tr>
<th>Item</th>
<th>State Required</th>
<th>Practice Site Required</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Frequency</td>
<td>Percentage of N</td>
</tr>
<tr>
<td>Adult/adolescent SANE certification only (State specific)</td>
<td>4</td>
<td>3.1%</td>
</tr>
<tr>
<td>Both adult/adolescent and pediatric SANE (state specific) certification dependent on age parameters of SANE practice</td>
<td>31</td>
<td>23.7%</td>
</tr>
<tr>
<td>Generic forensic nurse certification</td>
<td>3</td>
<td>2.3%</td>
</tr>
<tr>
<td>My state/practice site does not require state certification</td>
<td>91</td>
<td>69.5%</td>
</tr>
<tr>
<td>My state/practice site requires IAFN certification dependent on age parameters of SANE practice</td>
<td>2</td>
<td>1.5%</td>
</tr>
<tr>
<td>Certification in age-related specialty is recommended not required</td>
<td>N/A</td>
<td>N/A</td>
</tr>
</tbody>
</table>

*Note. N = 131 of 143 possible respondents.*
Table 6

Certification Renewal: Requirements for State Certification Renewal (Question 15)

<table>
<thead>
<tr>
<th>Continuing Education</th>
<th>Clinical Requirements (Hours)</th>
<th>Clinical Requirements (Examinations)</th>
<th>Attendance at Mock Trial</th>
<th>No Requirements for Renewal</th>
<th>Certification Not Required</th>
</tr>
</thead>
<tbody>
<tr>
<td>Frequency</td>
<td>36</td>
<td>15</td>
<td>26</td>
<td>2</td>
<td>44</td>
</tr>
<tr>
<td>Percentage of N</td>
<td>18.2%</td>
<td>17.6%</td>
<td>13.1%</td>
<td>1%</td>
<td>22.2%</td>
</tr>
</tbody>
</table>

*Note. N = 131 of 143 possible respondents.*

Table 6.1

Certification Renewal: Requirements for State Certification Renewal (Question 15 removing Question 13 "My state/practice site does not require state certification")

<table>
<thead>
<tr>
<th>Continuing Education</th>
<th>Clinical Requirements (Hours)</th>
<th>Clinical Requirements (Examinations)</th>
<th>Attendance at Mock Trial</th>
<th>No Requirements for Renewal</th>
<th>Certification Not Required</th>
</tr>
</thead>
<tbody>
<tr>
<td>Frequency</td>
<td>28</td>
<td>12</td>
<td>24</td>
<td>2</td>
<td>10</td>
</tr>
<tr>
<td>Percentage of N</td>
<td>70.0%</td>
<td>30.0%</td>
<td>60.0%</td>
<td>5.0%</td>
<td>25.0%</td>
</tr>
</tbody>
</table>

*Note. N = 40 of 40 possible respondents.*

Table 7

Type of CFNC Certification (Question 16)

<table>
<thead>
<tr>
<th>SANE-P</th>
<th>SANE-A</th>
<th>SANE-A &amp; SANE-P</th>
<th>ANCC AFN-BC</th>
<th>Not Certified</th>
<th>Not Yet Eligible Plan to Become Certified</th>
</tr>
</thead>
<tbody>
<tr>
<td>Frequency</td>
<td>8</td>
<td>36</td>
<td>50</td>
<td>2</td>
<td>32</td>
</tr>
<tr>
<td>Percentage of N</td>
<td>5.97%</td>
<td>26.87%</td>
<td>37.31%</td>
<td>1.49%</td>
<td>23.88%</td>
</tr>
</tbody>
</table>

*Note. N = 134 of 198 possible respondents.*
Table 8

Reasons SANEs Choose CFNC Certification (Question 18)

<table>
<thead>
<tr>
<th>Reason</th>
<th>Frequency</th>
<th>Percentage of N</th>
</tr>
</thead>
<tbody>
<tr>
<td>Displays My Pride as an IAFN Member</td>
<td>47</td>
<td>47.0%</td>
</tr>
<tr>
<td>Symbol of My Competence as a SANE</td>
<td>86</td>
<td>86.0%</td>
</tr>
<tr>
<td>Demonstration of My Self-Respect &amp; Personal Fulfillment</td>
<td>70</td>
<td>70.6%</td>
</tr>
<tr>
<td>It is a Professional Goal</td>
<td>78</td>
<td>78.0%</td>
</tr>
<tr>
<td>Other</td>
<td>9</td>
<td>9.0%</td>
</tr>
</tbody>
</table>

Note: N = 100 of 102 possible respondents. Multiple responses were possible, hence Frequency (209) is greater than N and Percentage = 146.4%

Table 9

Reasons SANEs Choose Not to be Certified by CFNC (Question 17)

<table>
<thead>
<tr>
<th>Reason</th>
<th>Frequency</th>
<th>Percentage of N</th>
</tr>
</thead>
<tbody>
<tr>
<td>Practice Site Requires Certificate in Primary Specialty</td>
<td>5</td>
<td>15.6%</td>
</tr>
<tr>
<td>Practice Site Does Not Require SANE Certificate</td>
<td>10</td>
<td>31.3%</td>
</tr>
<tr>
<td>Cost of Certificate</td>
<td>15</td>
<td>46.9%</td>
</tr>
<tr>
<td>I am not Interested in Certificate</td>
<td>2</td>
<td>6.3%</td>
</tr>
<tr>
<td>I have State Certificate</td>
<td>2</td>
<td>6.3%</td>
</tr>
<tr>
<td>I am an APN with APN Board Certificate</td>
<td>4</td>
<td>12.5%</td>
</tr>
</tbody>
</table>

Table 9 (con’t)

<table>
<thead>
<tr>
<th>Reason</th>
<th>Frequency</th>
<th>Percentage of N</th>
</tr>
</thead>
<tbody>
<tr>
<td>I am Board Certified as an Advanced Forensic Nurse by ANCC</td>
<td>0</td>
<td>0.0%</td>
</tr>
<tr>
<td>I am Not Yet Eligible for CFNC Certification</td>
<td>0</td>
<td>0.0%</td>
</tr>
<tr>
<td>I cannot meet the Clinical Requirements</td>
<td>0</td>
<td>0.0%</td>
</tr>
<tr>
<td>I cannot Meet the Continuing Education Requirements</td>
<td>1</td>
<td>3.1%</td>
</tr>
<tr>
<td>Other</td>
<td>12</td>
<td>37.5%</td>
</tr>
</tbody>
</table>

Note: N = 32. Multiple responses were possible, hence Frequency (51) is greater than N and Percentage = 159.9%
## Table 10

**Facilitating Factors & Availability (Questions 3 & 5)**

<table>
<thead>
<tr>
<th>Item</th>
<th>Q 3 &amp; 5 text</th>
<th>Facilitators (Q3)</th>
<th>Availability (Q5)</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td>To no extent (1)</td>
<td>To a minimal extent (2)</td>
</tr>
<tr>
<td>3.a</td>
<td>Scheduled peer review of all pediatric evaluations</td>
<td>2 (1.5%)</td>
<td>6 (4.4%)</td>
</tr>
<tr>
<td>3.b</td>
<td>Photo documents all pediatric examinations</td>
<td>0 (0.0%)</td>
<td>12 (8.8%)</td>
</tr>
<tr>
<td>5.a</td>
<td>Expert review of all photos by a child abuse pediatrician or NP</td>
<td>N/A</td>
<td>N/A</td>
</tr>
<tr>
<td>3.c</td>
<td>Expert review of all pediatric evaluations by child abuse pediatrician or NP</td>
<td>4 (2.9%)</td>
<td>26 (19.0%)</td>
</tr>
<tr>
<td>3.d</td>
<td>Expert review of all acute pediatric exams in 24 hours</td>
<td>6 (4.4%)</td>
<td>43 (31.6%)</td>
</tr>
<tr>
<td>5.d</td>
<td>Technology for expert &amp; peer review of photo document.</td>
<td>N/A</td>
<td>N/A</td>
</tr>
<tr>
<td>3.e</td>
<td>Adequate prepubertal pediatric patient exams</td>
<td>1 (0.7%)</td>
<td>5 (3.7%)</td>
</tr>
<tr>
<td>5.g</td>
<td>Adequate young adolescent patient exams</td>
<td>2 (1.5%)</td>
<td>6 (4.4%)</td>
</tr>
</tbody>
</table>
### Factors that Influence Pediatric SANE Competence

<table>
<thead>
<tr>
<th>Question</th>
<th>Category</th>
<th>Yes (%)</th>
<th>Yes (%)</th>
<th>Yes (%)</th>
<th>Yes (%)</th>
<th>Yes (%)</th>
</tr>
</thead>
<tbody>
<tr>
<td>3.g</td>
<td>Mandatory State SANE certification</td>
<td>23 (17.0%)</td>
<td>37 (27.4%)</td>
<td>44 (32.6%)</td>
<td>31 (23.0%)</td>
<td>57 (43.2%)</td>
</tr>
<tr>
<td>3.h</td>
<td>IAFN certification</td>
<td>18 (13.2%)</td>
<td>39 (28.7%)</td>
<td>47 (34.6%)</td>
<td>32 (23.5%)</td>
<td>N/A</td>
</tr>
<tr>
<td>3.i</td>
<td>Participation in SANE mentorship program</td>
<td>6 (4.5%)</td>
<td>13 (9.8%)</td>
<td>67 (50.4%)</td>
<td>47 (35.3%)</td>
<td>62 (46.3%)</td>
</tr>
<tr>
<td>3.j</td>
<td>Availability of pediatric &amp; forensic SANE CE</td>
<td>3 (2.2%)</td>
<td>4 (2.9%)</td>
<td>29 (20.9%)</td>
<td>103 (74.1%)</td>
<td>N/A</td>
</tr>
<tr>
<td>3.k</td>
<td>Employer fiscally supports SANE CE</td>
<td>6 (4.4%)</td>
<td>9 (6.5%)</td>
<td>36 (26.1%)</td>
<td>87 (63.0%)</td>
<td>70 (51.9%)</td>
</tr>
</tbody>
</table>

*Note. N range for Question 3 was 139-138, for Question 5 was 132-135 of 143 possible respondents.*

**Figure 2**

*Facilitating Factors & Availability (Questions 3 & 5) – Graphical Representation*
Table 11

**Barriers to SANE Competence (Question 7)**

<table>
<thead>
<tr>
<th>Item</th>
<th>n (%)</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Not a barrier</td>
</tr>
<tr>
<td>a. Inadequate number of pediatric patients for SANEs to examine</td>
<td>16 (11.9%)</td>
</tr>
<tr>
<td>b. Limitation of number of hours available to work as a pediatric SANE</td>
<td>23 (17.0%)</td>
</tr>
<tr>
<td>c. Geographic isolation</td>
<td>31 (23.1%)</td>
</tr>
<tr>
<td>d. Professional isolation</td>
<td>25 (18.5%)</td>
</tr>
<tr>
<td>e. Inadequate funding for continuing education</td>
<td>11 (8.3%)</td>
</tr>
<tr>
<td>f. Inadequate availability of continuing forensic education</td>
<td>12 (8.9%)</td>
</tr>
</tbody>
</table>

*Note. N range was 133-135 of 143 possible respondents.*
Table 12  
*Self Perceived Competence: Knowledge and Competencies (Question 9)*

<table>
<thead>
<tr>
<th>Item</th>
<th>Not Comp (1)</th>
<th>Slight Comp (2)</th>
<th>Somewhat Comp (3)</th>
<th>Very Comp (4)</th>
</tr>
</thead>
<tbody>
<tr>
<td>a. Ability to Balance Ethical Decisions With Legal Responsibility in all Pediatric Sexual Abuse/Assault Evaluations</td>
<td>0 (0.0%)</td>
<td>2 (1.5%)</td>
<td>30 (22.4%)</td>
<td>102 (76.1%)</td>
</tr>
<tr>
<td>b. Ability to Conduct Age Appropriate Physical Exams on all Prepubertal Children</td>
<td>1 (0.7%)</td>
<td>2 (1.5%)</td>
<td>40 (29.9%)</td>
<td>91 (67.9%)</td>
</tr>
<tr>
<td>c. Ability to Conduct Age Appropriate Physical Exams on Young Adolescent Patients</td>
<td>0 (0.0%)</td>
<td>2 (1.5%)</td>
<td>18 (13.5%)</td>
<td>113 (85.0%)</td>
</tr>
<tr>
<td>d. Ability to Apply my State’s Mandatory Child Abuse Reporting Laws Reporting Laws</td>
<td>0 (0.0%)</td>
<td>0 (0.0%)</td>
<td>15 (11.2%)</td>
<td>119 (88.8%)</td>
</tr>
<tr>
<td>e. Ability to Provide Care for Child or Young Adolescent who Refuses Exam</td>
<td>0 (0.0%)</td>
<td>3 (2.3%)</td>
<td>39 (29.5%)</td>
<td>90 (68.2%)</td>
</tr>
<tr>
<td>f. Use of Digital Video or SLR Camera for Exam Documentation</td>
<td>3 (2.2%)</td>
<td>9 (6.7%)</td>
<td>45 (33.6%)</td>
<td>77 (57.5%)</td>
</tr>
<tr>
<td>g. Modification of Adult Sexual Assault Evidence Kit for Use in Prepubertal Pediatric Exams</td>
<td>2 (1.6%)</td>
<td>2 (1.6%)</td>
<td>21 (16.3%)</td>
<td>104 (80.6%)</td>
</tr>
<tr>
<td>h. Applying Adams’ &quot;Guidelines for Medical Care for Children Who May Have Been Sexually Abused&quot; (2010 revision)</td>
<td>21 (18.3%)</td>
<td>2 (1.7%)</td>
<td>34 (29.6%)</td>
<td>58 (50.4%)</td>
</tr>
<tr>
<td>i. Adhering to HIPAA Regulations in Care for Suspected Pediatric Sexual Abuse/Assault Patients</td>
<td>1 (0.8%)</td>
<td>2 (1.5%)</td>
<td>13 (9.8%)</td>
<td>117 (88.0%)</td>
</tr>
<tr>
<td>j. Knowing Current CDC Pediatric Guidelines for STI Testing, Prophylaxis &amp; Treatment</td>
<td>2 (1.6%)</td>
<td>0 (0.0%)</td>
<td>46 (37.7%)</td>
<td>74 (55.2%)</td>
</tr>
<tr>
<td>k. Applying Current CDC Pediatric Guidelines for STI Testing, Prophylaxis &amp; Treatment</td>
<td>2 (1.6%)</td>
<td>3 (2.5%)</td>
<td>47 (38.5%)</td>
<td>70 (57.4%)</td>
</tr>
</tbody>
</table>

*Note. N ranged between 115 - 234 of 143 possible responders.*
Table 13

\textit{Self-Perceived Competence: Benner’s Rating (Question 10)}

<table>
<thead>
<tr>
<th>Level</th>
<th>Novice</th>
<th>Advanced Beginner</th>
<th>Competent</th>
<th>Proficient</th>
<th>Expert</th>
</tr>
</thead>
<tbody>
<tr>
<td>Frequency</td>
<td>4</td>
<td>16</td>
<td>34</td>
<td>42</td>
<td>38</td>
</tr>
<tr>
<td>Percentage of N</td>
<td>3.0%</td>
<td>11.9%</td>
<td>25.4%</td>
<td>31.3%</td>
<td>28.4%</td>
</tr>
</tbody>
</table>

\textit{Note.} $N = 134$ of 143 possible respondents.

Table 14

\textit{Demographic Data: Annual Examinations of Pediatric Patients (Questions 11, 12, 25, 26)}

<table>
<thead>
<tr>
<th></th>
<th>Needed Annually for Competence$^a$</th>
<th>Examined Annually$^b$</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Prepubescent Children</td>
<td>Young Adolescent</td>
</tr>
<tr>
<td>$N$</td>
<td>143</td>
<td>143</td>
</tr>
<tr>
<td>Mean</td>
<td>20.83</td>
<td>18.50</td>
</tr>
<tr>
<td>Range</td>
<td>251</td>
<td>251</td>
</tr>
<tr>
<td>Minimum</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Maximum</td>
<td>250</td>
<td>250</td>
</tr>
</tbody>
</table>

\textit{Note.} $^a n = 143$ for Needed Annually for Competence was taken from SANE-Ps only or dual SANE-P/SANE-As.

$^b n = 183$ for Needed Annually for Competence was taken from SANE-Ps only, SANE-As only, or dual SANE-P/SANE-As.

Table 15

\textit{Box Chart: Outliers Questions 11-12 & 25-26}
Table 15.1

*Outliers with Related Demographics*

<table>
<thead>
<tr>
<th>Number Prepube. Exams</th>
<th>Number Young Adoles. Exams</th>
<th>FNCB SANE Cert.</th>
<th>Highest Nursing Degree</th>
<th>Other Degrees or Certs.</th>
<th>Identifies Self as:</th>
<th>Hours/Month as SANE</th>
<th>Practice Location Comments</th>
</tr>
</thead>
<tbody>
<tr>
<td>250</td>
<td>250</td>
<td>Not eligible &amp; not interested</td>
<td>DNP</td>
<td>NP</td>
<td>173</td>
<td>CAC covers 18 counties</td>
<td></td>
</tr>
<tr>
<td>300</td>
<td>450</td>
<td>SANE-P ADN</td>
<td>PNP Certificate</td>
<td>NP</td>
<td>120</td>
<td>CAC inner city</td>
<td></td>
</tr>
<tr>
<td>275</td>
<td>300</td>
<td>SANE-P MSN</td>
<td>No Response</td>
<td>No Response</td>
<td>130</td>
<td>Urban stand-alone advocacy center</td>
<td></td>
</tr>
<tr>
<td>50</td>
<td>700</td>
<td>No Response</td>
<td>BSN MEd, post Master Forensic Nursing Certificate</td>
<td>No response</td>
<td>160</td>
<td>Full time NP in P.H. setting covering 12 counties</td>
<td></td>
</tr>
<tr>
<td>48</td>
<td>500</td>
<td>Not Certified</td>
<td>BSN WHNP Certificate</td>
<td>NP</td>
<td>15</td>
<td>Primary Care Practice pts. From all areas</td>
<td></td>
</tr>
<tr>
<td>500</td>
<td>500</td>
<td>Not Certified</td>
<td>MSN</td>
<td>NP</td>
<td>60</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
Table 16

*Multiple Linear Regression: Predictor variable Mean Availability of Facilitating Factors*

<table>
<thead>
<tr>
<th>Model</th>
<th>$R$</th>
<th>$R^2$</th>
<th>Adjusted $R^2$</th>
<th>$SEE$</th>
<th>$R^2$ Change</th>
<th>Change Statistics</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>.491$^a$</td>
<td>.241</td>
<td>.235</td>
<td>.34214</td>
<td>.241</td>
<td>40.912</td>
</tr>
<tr>
<td>2</td>
<td>.576$^b$</td>
<td>.332</td>
<td>.321</td>
<td>.32224</td>
<td>.091</td>
<td>17.423</td>
</tr>
<tr>
<td>3</td>
<td>.603$^c$</td>
<td>.364</td>
<td>.333</td>
<td>.31937</td>
<td>.032</td>
<td>1.577</td>
</tr>
</tbody>
</table>

a. Predictors: (Constant), Q5.a-j Availability Mean of Scores
b. Predictors: (Constant), Q5.a-j Availability Mean of Score Q16 - Peds or Peds/Adult IAFN Cert
c. Predictors: (Constant), Q5.a-j Availability Mean of Scores, Q16 - Peds or Peds/Adult IAFN Cert, Q22 - Practice Site - Rural, Q23 - CAC practice site, Q27 - Degree - Master & above, Q27 - Degree - Diploma & Associate
Table 17

_Multiple Regression: Predictor variables Individual Available Facilitating Factors_

<table>
<thead>
<tr>
<th>Model</th>
<th>$R$</th>
<th>$R^2$</th>
<th>Adjusted $R^2$</th>
<th>$SEE$</th>
<th>$R^2$ Change</th>
<th>$F$ Change</th>
<th>df1</th>
<th>df2</th>
<th>Sig. $F$ Change</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>.358$^a$</td>
<td>.128</td>
<td>.121</td>
<td>.36483</td>
<td>.128</td>
<td>16.640</td>
<td>1</td>
<td>113</td>
<td>.000</td>
</tr>
<tr>
<td>2</td>
<td>.668$^b$</td>
<td>.447</td>
<td>.363</td>
<td>.31050</td>
<td>.318</td>
<td>4.072</td>
<td>14</td>
<td>99</td>
<td>.000</td>
</tr>
</tbody>
</table>

a. Predictors: (Constant),
Q16 - Peds or Peds/Adult IAFN Cert

b. Predictors: (Constant),
Q5.a - Video/photo Doc,
Q5.b - Review of all Video/photos,
Q5.c - Review of all Peds Evals,
Q5.d - Review of all Acute Peds Evals = <24 hrs,
Q5.e - Technology for Review of Video/photo Doc,
Q5.f - Employer Finances Peds & Forensic CEU Re:SANE Care of Peds,
Q5.g - Examine Adequate Number of Prepubertal Peds Annually,
Q5.h - Examine Adequate Number of Young Adolescents (Post-menarche),
Q5.i - Mandatory Ongoing State SANE Certification,
Q5.j - Participation in SANE Mentorship,
Q16 - Peds or Peds/Adult IAFN Cert,
Q22 - Practice Site - Rural,
Q23 - CAC practice site,
Q27 - Degree - Diploma & Associate,
Q27 - Highest Degree
Figure 3

Relevance Scale for Content Validity: Skip Logic Schema/Flow Chart

Survey Skip Logic Data Schema (revised 3-4-2013)
Appendices

Appendix A

Acronyms

AANC  American Nurses Credentialing Center
ABNS  American Board of Nursing Specialties
ABP  American Board of Pediatrics
ABSNC  Accreditation Board for Specialty Nursing Certification
AFN-BC  Board Certified Advanced Forensic Nurse
ANA  American Nurses Association
ANCC  American Nurses’ Credentialing Center
CAH  Critical Access Hospital
CAPTA  Child Abuse Prevention and Treatment Act
CEN  Certified Emergency Nurse
CMS  Centers for Medicare and Medicaid Services
CFNC  Commission for Forensic nursing Certification
DHHS  U. S. Department of Health and Human Services
FNCB  Forensic Nursing Certification Board
IAFN  International Association of Forensic Nurses
IRB  Institutional Review Board
NCANDS  National Child Abuse and Neglect Data System
NIS-4  Fourth National Incidence Project of Child Abuse and Neglect
PHS  U. S. Public Health Service
PNCB  Pediatric Nursing Certification Board
RAC  Rural Assistance Center
SANE  Sexual Assault Nurse Examiner
SANE-A  Certified Sexual Assault Nurse Examiner – Adult
SANE-P  Certified Sexual Assault Nurse Examiner – Pediatric
Appendix B

Glossary of Terms

- APSAC is the American Professional Society on the Abuse of Children. On APSAC’s website is a description of APSAC as is the leading national organization supporting professionals who serve children and families affected by child maltreatment and violence. As a multidisciplinary group of professions, APSAC achieves its mission in a number of ways, most notably through expert training and educational activities, policy leadership and collaboration, and consultation that emphasizes theoretically sound, evidence-based principles.

- CAPTA is the Child Abuse Prevention and Treatment Act. It is the federal law from which all states derive the individual definitions of different types of child maltreatment found in their civil and criminal statutes.

- Certification (nursing) is the “formal recognition of the specialized knowledge, skills, and experience demonstrated by the achievement of standards identified by a nursing specialty to promote optimal health outcomes” (American Board of Nursing Specialties, 2005, n.p).

- Child abuse physician is a physician who has passed child maltreatment specialty boards offered by the American Academy of Pediatrics (AAP) or who has been grandparented by the AAP because they have a long standing history of clinical expertise as well as research in the field and part pated in the development of the specialty boards.

- Child maltreatment includes physical abuse or inflicted injury, sexual abuse, emotional or psychological abuse and neglect of any child under the age of 18 years by a parent, guardian or other caretaker (Center for Disease Control and Prevention, 2010, n.p.).
Child sexual abuse as defined in the Child Abuse Prevention and Treatment Act of 2003 includes the employment, use, persuasion, inducement, enticement, or coercion of any child to engage in, or assist any other person to engage in, any sexually explicit conduct or simulation of such conduct for the purpose of producing a visual depiction of such conduct. It also includes the rape, and in cases of caretaker or inter-familial relationships, statutory rape, molestation, prostitution, or other form of sexual exploitation of children, or incest with children (Title 1, Definitions, section 111, #4).

Child sexual abuse involves any sexual activity with a child where consent is not or cannot be given. This includes sexual contact that is accomplished by force or threat of force, regardless of the age of the participants, and all sexual contact between an adult and a child, regardless of whether there is deception or the child understands the sexual nature of the activity. Sexual contact between an older and a younger child also can be abusive if there is a significant disparity in age, development, or size, rendering the younger child incapable of giving informed consent. The sexually abusive acts may include non-contact sexual acts such as voyeurism or exposure to other sexual activities (Saul & Audage, 2007, p.1).

Commission for Forensic Nursing Certification is an autonomous arm of the International Association of Forensic Nurses. It was formerly The Commission for Forensic Nursing Certification. It is responsible for the development and administration of certification examinations for forensic nurses (IAFN and FNCB Website, 2013, n.p.).

International Association of Forensic Nurses is the professional organization of all forensic nurses. The IAFN provides leadership in forensic nursing practice by developing, promoting, and disseminating information internationally (IAFN Website).

National Council of State Boards of Nursing (NCSBN) is a not-for-profit organization whose purpose is to provide an organization through which boards of nursing act and
counsel together on matters of common interest and concern affecting the public health, safety and welfare, including the development of licensing examinations in nursing (National Council of State Boards of Nursing, 2011, n.p.).

- SANEs are registered nurses who have additional didactic education and clinical preparation in the forensic evaluation of persons who have experienced sexual assault (Littel, 2001).
- SANE-A identifies SANEs providing care to adults and adolescents who have earned certification through the FNCB as meeting “the highest standards of forensic nursing practice for sexual assault nurse examiners and have obtained objective validation of their expertise through certification” (IAFN and FNBC, 2011, n.p.).
- SANE-P identifies SANEs who earn certification as meeting “the highest standards of forensic nursing practice for sexual assault nurse examiners and have obtained objective validation of their expertise through certification” (IAFN and FNBC, 2011, n.p.).
- SANEs (pediatric) are registered nurses who have completed an IAFN approved pediatric SANE training that includes a minimum of 40 hours of didactic training and additional pediatric clinical training.
- Sexual Assault Response Team (SART) is a community-based team that coordinates the response to victims of sexual assault. The team may be comprised of SANEs, hospital personnel, sexual assault victim advocates, law enforcement, prosecutors, judges, and any other professionals with a specific interest in assisting victims of sexual assault (Rape, Abuse and Incest National Network, n.d., n.p.).
### Appendix C

**National Incidence of Harm Standard Maltreatment NIS–4 (2005–2006), and Comparison with the NIS–3 (1993) and the NIS–2 (1986) Harm Standard Estimates - Total number of children and Rate per 1,000 children**

<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>ALL MALTREATMENT</strong></td>
<td>1,256,600 17.1</td>
<td>1,553,800 23.1 †</td>
</tr>
<tr>
<td><strong>ABUSE</strong></td>
<td></td>
<td>931,000 14.8</td>
</tr>
<tr>
<td>ALL ABUSE</td>
<td>553,300 7.5</td>
<td>743,200 11.1 *</td>
</tr>
<tr>
<td>Physical Abuse</td>
<td>323,000 4.4</td>
<td>381,700 5.7 †</td>
</tr>
<tr>
<td>Sexual Abuse</td>
<td>135,300 1.8</td>
<td>217,700 3.2 *</td>
</tr>
<tr>
<td>Emotional Abuse</td>
<td>148,500 2.0</td>
<td>204,500 3.0 †</td>
</tr>
<tr>
<td><strong>NEGLECT</strong></td>
<td></td>
<td>155,200 2.5</td>
</tr>
<tr>
<td>ALL NEGLECT</td>
<td>771,700 10.5</td>
<td>879,000 13.1 †</td>
</tr>
<tr>
<td>Physical Neglect</td>
<td>295,300 4.0</td>
<td>338,900 5.0</td>
</tr>
<tr>
<td>Emotional Neglect</td>
<td>193,400 2.6</td>
<td>212,800 3.2</td>
</tr>
<tr>
<td>Educational Neglect‡</td>
<td>360,500 4.9</td>
<td>397,300 5.9</td>
</tr>
</tbody>
</table>

*Note. Estimated totals are rounded to the nearest 100. Rates per 1,000 children are in Italics unless noted, the difference between this rate and the NIS–4 incidence rate is neither significant nor marginal (*p > .10)*

* The difference between this and the NIS–4 incidence rate is significant at *p < .05.*

† The difference between this and the NIS–4 incidence rate is statistically marginal (i.e., .10 > *p > .05).*

‡ Educational neglect is identical under the Harm and Endangerment Standards. It is included in both tables because it is in the summary categories in both standards: All Neglect and All Maltreatment.
Appendix D

Office of the Maine Attorney General: Sexual Assault Forensic Examiner Program*

The Sexual Assault Forensic Examiner (SAFE) Program provides training and technical assistance for healthcare providers that care for patients who have suffered sexual assault, and in the use of the Maine sex crimes kit for collection of evidence. This national model utilizes an interdisciplinary, community-based approach for the dignified and compassionate care and treatment of sexual assault patients.

What is a Forensic Examiner?
A Sexual Assault Forensic Examiner (SAFE) is a health care provider (primarily Registered Nurses) who has been specially trained to provide comprehensive care for the sexual assault patient, who demonstrates competency in conducting a forensic exam, and has the ability to be an expert or fact witness in court. Registered nurses, physician assistants, and physicians may participate in the training.

Community Based Response
The Sexual Assault Forensic Examiner Program is an essential component of the Sexual Assault Response Team (SART). Each county-based team includes local law enforcement, the District Attorney's office, SAFEs, and sexual assault support center advocates. Members of the SART share the common goal of creating a seamless, community-based response to the needs of sexual assault victim/survivors. As more is learned about the prevalence of sexual assault/abuse and the related low reporting rate, there is increased responsibility to improve the systems charged with responding to these crimes, and to provide a uniform, integrated, informed response to sexual assault. The key systems are healthcare providers, law enforcement, sexual assault centers and prosecutors. Each SAFE is an integral member of the SART responding to this need.

Benefits of the SAFE Program
Health care providers are often the first responders for survivors of sexual assault. Because of the time needed to assess and treat injuries, and collect forensic evidence, it is cost-effective to have a cadre of SAFEs on call to provide this care. By ensuring that trained health care providers are available to perform the medical-forensic exam, the waiting period to receive care is minimized, trauma from the assault is reduced, the needs of the patient are attended to, and evidence is collected in a manner that meets state standards and promotes successful prosecution.

Training Requirements
Training requirements for state SAFE certification are rigorous. Completion of the training requires commitment and time, taking up to a year to complete. The first step is completion of 40 hours of didactic content developed using educational guidelines established by the International Association of Forensic Nurses (IAFN), followed by an additional set of clinical components to gain proficiency in performing the medical-forensic exam. The requirements are consistent with standards created by the International Association of Forensic Nurses and adopted by the American Nurses Association.

* SANE and SAFE are used interchangeably. SAFE is used in Maine because of physician participants.
Appendix E1

The Questionnaire to Develop Face Validity: Permission to Adapt

151 Stanton Avenue
Auburndale, Massachusetts 02466-3005

617-527-7575
860-792-8095
Email joellenhawkins@mac.com

April 29, 2012

Dear Ms. Pressler:

I am writing to grant permission for use and modification of the content validity tool and for use of the Questionnaire to Determine Face Validity developed for a study with Dr. Janice Thibodeau and published in Nurse Practitioner in 1988.

Sincerely,

Joellen W. Hawkins, PhD, RN, WHNP-BC, FAAN, FAANP, FNAP
Professor Emeritus, Boston College William F. Connell School of Nursing
Writer in Residence, Simmons College, School of Nursing and Health Sciences
Appendix E2

The Questionnaire to Develop Face Validity

Date:

Dear Colleagues:

Thank you for agreeing to complete this questionnaire to determine face validity for SANEs’ Self-Perceived Competence Scale: Facilitating Factors and Barriers, the survey for my capstone practice project that partially fulfills the requirements for the Doctor of Nursing Practice program at Simmons College in Boston. The purpose of this face validity questionnaire is to assess one facet of the quality of the capstone survey. Do not be concerned with your knowledge of the content. I have chosen registered nurses with differing educational backgrounds who are not practicing SANEs so you will not focus on the content. After reviewing your responses and suggestions, I will revise the survey and send it to the panel of experts to establish content validity.

I do need you to complete the survey so you can provide an estimate of the administration time. Upon completion of the survey, please answer the questions that follow this note.

If you are unable to complete this questionnaire or if you have questions about the capstone survey, please feel free to contact me.

Thank you for agreeing to participate.

Hannah Pressler
Hannah Pressler
Doctor of Nursing Practice Student
Simmons College
School of Nursing and Health Sciences
Email: hpressler@gmail.simmons.edu
The Questionnaire to Develop Face Validity *

SANEs’ Self-Perceived Competence Scale: Facilitating Factors and Barriers

If you have a positive or yes response to any of the following questions, please indicate the item number next to the question and include a brief statement of the problem and/or your suggestion for improvement.

1. Did you have difficulty understanding an item?
   Yes___________ No___________

2. Are all words/terms clear and common?
   Yes___________ No___________

3. Are definitions provided for terms used in this project?
   Yes___________ No___________

4. Does any item asked about more than one concept?
   Yes___________ No___________

5. Can any of the items be stated more clearly?
   Yes___________ No___________

6. Are any items ambiguous? If so, how can those items be revised?
   Yes___________ No___________
   __________________________________________________________
   __________________________________________________________

7. Are any items too wordy or lengthy?
   Yes___________ No___________

8. Are any items repetitious?
   Yes___________ No___________

9. Are any items worded in such a way as to force a desired response?
Yes__________  No__________

10. Are there any “loaded,” “sensitive” or “embarrassing” questions?
    Yes__________  No__________

11. Are the instructions clear?
    Yes__________  No__________

12. Can the instructions be easily misinterpreted or misunderstood?
    Yes__________  No__________

13. Do you have any comments about the order of the questions?
    Yes__________  No__________
    ____________________________________________________
    ____________________________________________________

14. Do you have any comments about the format of the questions?
    Yes__________  No__________
    ____________________________________________________
    ____________________________________________________

15. Do you have any other comments or suggestions?
    ____________________________________________________
    ____________________________________________________
    ____________________________________________________

Thank you for taking the time to respond to this questionnaire.

* Adapted from Thibodeau & Hawkins (1988).

Hannah M. Pressler, Doctor of Nursing Practice Student
Simmons College
School of Nursing and Health Sciences
Email: hannah.pressler@gmail.simmons.edu
Appendix F1

Relevance Scale for Content Validity *

Date:

Dear Colleague,

As an expert SANE, I am requesting your assistance in evaluating the content validity of a survey that I developed for my doctoral capstone practice inquiry project. Your input will help me finalize the survey, SANEs' Self-Perceived Competence Scale: Facilitating Factors and Barriers.

The purpose of this capstone practice inquiry project is the exploration of pediatric sexual assault nurse examiners (SANEs) self-perceived competence as they examine prepubertal children and young adolescents. This anonymous survey also explores factors that facilitate pediatric SANEs competence, the availability of these facilitating factors to SANEs in their primary practice site, barriers to their ongoing competence and demographic information. All members of the International Association of Forensic Nurses (IAFN) will receive the link to this investigator developed web-based survey. Prior to sending the survey to IAFN membership, the content validity of each item needs to be established.

This capstone project will address the following questions:

6. What do sexual assault nurse examiners who examine pediatric patients identify as facilitators of competence?
7. What is the availability of facilitators of competence to sexual assault nurse examiners who examine pediatric patients?
8. What do sexual assault nurse examiners who examine pediatric patients identify as barriers to competence?
9. How do sexual assault nurse examiners who examine pediatric patients perceive their competence?

Instructions for completion of content validity questionnaire:

1. Read the Survey
2. Rate each item’s relevance to the research question addressing that section of the survey. The ratings are:
   - 1= Not relevant
   - 2= Somewhat relevant
   - 3= Quite relevant
   - 4= Highly relevant
3. There is an open ended question at the end of each section asking for additional comments. Please include your thoughts about why an item is not relevant, additional items that are pertinent to the concept measured in each section, rewording of items for additional clarity or anything you feel would improve the scales that measure each concept.
4. In the final survey, respondents will also respond to Likert scale type questions for most sections. In the section measuring factors facilitating pediatric SANE competence, choices for facilitating factor items will range from no extent, to a minimal extent, to a moderate extent, to a great extent. The section measuring barriers to competence has choices of not a barrier, slight barrier, moderate barrier and major barrier. When measuring self-perceived competence, choices range from not at all competent, slightly competent, somewhat competent to very competent.

5. The section measuring facilitating factors is followed by a section listing the same factors but asking if they are available or not available in a SANE’s practice site.

Please feel free to contact me with questions and comments about this questionnaire. I hope to present the results at the 2013 IAFN International Conference on Forensic Nursing Science and Practice as either a poster presentation or podium presentation.

Thank you for taking the time to respond to this questionnaire.

_________________

Hannah M. Pressler
Doctor of Nursing Practice Student
Simmons College
School of Nursing and Health Sciences
Email: hannah.pressler@gmail.simmons.edu
Relevance Scale for Content Validity: Factors that Support Pediatric SANE Competence

**Competence** is defined as the skills, experiences, insights, and abilities necessary to provide the best possible SANE care. Competence is not dichotomous - either competent or incompetent. It is a developmental process starting with beginner through novice, advanced beginner, competent, proficient, and ending with expert.

**Facilitating factors** are defined as factors/experiences that help SANES develop and maintain competence in their work as pediatric SANE.

This scale measures facilitating factors that help pediatric SANEs develop and maintain competence. Please read each item and rate it for its relevance in representing this concept.

<table>
<thead>
<tr>
<th>Item</th>
<th>Not relevant</th>
<th>Somewhat relevant</th>
<th>Quite relevant</th>
<th>Highly relevant</th>
</tr>
</thead>
<tbody>
<tr>
<td>a.</td>
<td>Scheduled peer review of <strong>all</strong> pediatric and young adolescent evaluations</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>b.</td>
<td>Video or photo documentation of <strong>all</strong> pediatric examinations</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>c.</td>
<td>Review of <strong>all</strong> pediatric evaluations by an expert child abuse physician or a child abuse nurse practitioner.</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>d.</td>
<td>Review of <strong>all</strong> acute pediatric evaluations by a child abuse physician or child abuse nurse practitioner within 24 hours.</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>e.</td>
<td>Examination of an adequate number of prepubertal pediatric patients annually for skills maintenance.</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>f.</td>
<td>Examination of an adequate number of young adolescent pediatric patients annually for skills maintenance</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>g.</td>
<td>Employer fiscally supports attendance at the IAFN Annual International Conference on Forensic Nursing Science and Practice</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
FACTORS THAT INFLUENCE PEDIATRIC SANE COMPETENCE

<p>| | |</p>
<table>
<thead>
<tr>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>h.</td>
<td>Mandatory ongoing <strong>state</strong> SANE certification</td>
</tr>
<tr>
<td>i.</td>
<td>Participation in a SANE mentorship program</td>
</tr>
<tr>
<td>j.</td>
<td>Technology for the review of video or photo documentation with child abuse pediatrician or child abuse nurse practitioner</td>
</tr>
<tr>
<td>k.</td>
<td>Pediatric specific forensic evidence collection kit</td>
</tr>
<tr>
<td>l.</td>
<td>IAFN SANE certification</td>
</tr>
</tbody>
</table>

Please add any comments or suggestions you have about this section. Include comments about why you feel items are not relevant, suggestion for rephrasing items and additional items that you feel would improve the measurement of factors that facilitate competence in pediatric SANEs.

________________________________________________________________________
________________________________________________________________________
________________________________________________________________________
Availability of Facilitating Factors that Support Pediatric SANE Competence

In the final survey, this section repeats the items listed in the previous section but asks respondents whether an item is available or not available in their practice site.

**How would you score the relevance of this section in representing the concept of development and maintenance of competence?**

<table>
<thead>
<tr>
<th>Not relevant</th>
<th>Somewhat relevant</th>
<th>Quite relevant</th>
<th>Highly relevant</th>
</tr>
</thead>
<tbody>
<tr>
<td>Asking whether a facilitating factor is present or absent in pediatric SANEs’ primary practice site is........</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**Please add any comments or suggestions you have about this section. Include comments about your scoring of the relevance of this section.**

________________________________________________________________________

________________________________________________________________________

________________________________________________________________________
Barriers To Competent Pediatric Sane Practice

The purpose of this section is to explore factors that can impede pediatric SANE practice.

**Barriers** are defined as factors/experiences that impede the development and maintenance of competence as pediatric SANEs.

This scale measures barriers to competence development and maintenance in pediatric SANEs practice. Please read each item and rate it for its relevance in representing this concept.

<table>
<thead>
<tr>
<th>Item</th>
<th>Not relevant</th>
<th>Somewhat relevant</th>
<th>Quite relevant</th>
<th>Highly relevant</th>
</tr>
</thead>
<tbody>
<tr>
<td>a.</td>
<td>Inadequate number of pediatric patients for SANEs to examine</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>b.</td>
<td>Limited SANE work schedule</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>c.</td>
<td>Geographic isolation</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>d.</td>
<td>Professional isolation</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>e.</td>
<td>Inadequate funding for continuing education</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>f.</td>
<td>Inadequate availability of continuing forensic education</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Please add any comments or suggestions you have about this section. Include comments about why you feel items are not relevant, suggestions for rephrasing items and additional items that you feel would improve the measurement of barriers to pediatric SANE competence.

________________________________________________________________________

________________________________________________________________________

________________________________________________________________________
Rating Self-Perceived Competence As A Pediatric Sane

The purpose of this section is the exploration of SANEs’ perceptions of their personal journey through pediatric SANE practice to competent SANE.

This section measures the individual SANE’s perception of their competence as a pediatric. Please read each item and rate it for its relevance in representing this concept.

<table>
<thead>
<tr>
<th>Item</th>
<th>Not relevant</th>
<th>Somewhat relevant</th>
<th>Quite relevant</th>
<th>Highly relevant</th>
</tr>
</thead>
<tbody>
<tr>
<td>a.</td>
<td>Ability to balance ethical decisions with legal responsibility in all pediatric sexual abuse/assault evaluations</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>b.</td>
<td>Ability to conduct age appropriate physical examinations on all prepubertal children</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>c.</td>
<td>Ability to conduct age appropriate physical examinations on young adolescent patients</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>d.</td>
<td>Ability to apply my state’s mandatory child abuse reporting laws</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>e.</td>
<td>Ability to provide care for a child or young adolescent who refuses an examination</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>f.</td>
<td>Use of digital video or single lens reflex camera for documentation of examination</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>g.</td>
<td>Modification of an adult sexual assault evidence kit for use in prepubertal pediatric examinations</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>h.</td>
<td>Applying Adams’ 2010 revision of <em>Guidelines for Medical Care for Children Who May Have Been Sexually Abused</em></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
i. Adhering to HIPAA regulations in caring for all suspected pediatric sexual abuse/assault patients

j. Applying current CDC pediatric guidelines for STD testing, prophylaxis and treatment

Benner described the five developmental stages of practice in the journey to skill and knowledge acquisition in clinical practice as novice, advanced beginner, competent, proficient, and expert.

The following question continues the exploration of a SANE’s journey through these developmental stages.

| How do you rate your current level of clinical knowledge and practice as a pediatric SANE? |
|----------------------------------|----------------------------------|----------------------------------|----------------------------------|
| Novice                          | Advanced beginner                | Competent                        | Proficient                       | Expert |

Please add any comments or suggestions you have about this section. Include comments about why you feel items are not relevant, suggestion for rephrasing items and additional items that you feel would improve the measurement of pediatric SANE competence.
These final two questions solicit SANEs’ opinions on the number of patient examinations that SANEs need to complete annually to attain and maintain competence.

<table>
<thead>
<tr>
<th></th>
<th>Not relevant</th>
<th>Somewhat relevant</th>
<th>Quite relevant</th>
<th>Highly relevant</th>
</tr>
</thead>
<tbody>
<tr>
<td>How many young adolescents do SANEs need to examine every year to maintain clinical competence?</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>How many prepubertal children do SANEs need to examine every year to maintain clinical competence?</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

*Note. This relevance scale for content validity has been adapted from Polit & Beck (2008), Figure 18.1. p.482.*
### Appendix F3

#### Relevance Scale for Content Validity: Scored

1. **Facilitating Factors that Support Pediatric SANE Competence (Question 3)**

This scale measures facilitating factors that help pediatric SANEs develop and maintain competence. Please read each item and rate it for its relevance in representing the concept of facilitating factors of pediatric SANE competence.

<table>
<thead>
<tr>
<th>Item</th>
<th>Not relevant (1)</th>
<th>Somewhat relevant (2)</th>
<th>Quite relevant (3)</th>
<th>Highly relevant (4)</th>
</tr>
</thead>
<tbody>
<tr>
<td>a. Scheduled peer review of all pediatric and young adolescent evaluations</td>
<td>0 (0.0%)</td>
<td>1 (10.0%)</td>
<td>2 (20.0%)</td>
<td>7 (70.0%)</td>
</tr>
<tr>
<td>b. Video or photo documentation of all pediatric examinations</td>
<td>0 (0.0%)</td>
<td>0 (0.0%)</td>
<td>3 (30.0%)</td>
<td>7 (70.0%)</td>
</tr>
<tr>
<td>c. Review of all pediatric evaluations by an expert child abuse physician or a child abuse nurse practitioner</td>
<td>0 (0.0%)</td>
<td>0 (0.0%)</td>
<td>3 (30.0%)</td>
<td>7 (70.0%)</td>
</tr>
<tr>
<td>d. Review of all acute pediatric evaluations by a child abuse physician or child abuse nurse practitioner within 24 hours</td>
<td>0 (0.0%)</td>
<td>2 (20.0%)</td>
<td>2 (20.0%)</td>
<td>6 (60.0%)</td>
</tr>
<tr>
<td>e. Examination of an adequate number of prepubertal pediatric patients annually for skills maintenance</td>
<td>0 (0.0%)</td>
<td>0 (0.0%)</td>
<td>4 (40.0%)</td>
<td>6 (60.0%)</td>
</tr>
<tr>
<td>f. Examination of an adequate number of young adolescent pediatric patients annually for skills maintenance</td>
<td>0 (0.0%)</td>
<td>1 (10.0%)</td>
<td>1 (10.0%)</td>
<td>6 (60.0%)</td>
</tr>
<tr>
<td>g. Employer fiscally supports attendance at the IAFN Annual International Conference on Forensic Nursing Science and Practice</td>
<td>0 (0.0%)</td>
<td>3 (30.0%)</td>
<td>5 (50.0%)</td>
<td>2 (20.0%)</td>
</tr>
<tr>
<td>h. Mandatory ongoing state SANE certification</td>
<td>0 (0.0%)</td>
<td>2 (20.0%)</td>
<td>3 (30.0%)</td>
<td>5 (50.0%)</td>
</tr>
<tr>
<td>i. Participation in a SANE mentorship program</td>
<td>0 (0.0%)</td>
<td>2 (20.0%)</td>
<td>4 (40.0%)</td>
<td>4 (40.0%)</td>
</tr>
<tr>
<td>j. Technology for the review of video or photo documentation with child abuse pediatrician or child abuse nurse Practitioner</td>
<td>0 (0.0%)</td>
<td>0 (0.0%)</td>
<td>3 (30.0%)</td>
<td>7 (70.0%)</td>
</tr>
</tbody>
</table>
FACTORS THAT INFLUENCE PEDIATRIC SANE COMPETENCE

k. Pediatric specific forensic evidence collection kit

<table>
<thead>
<tr>
<th></th>
<th>Not relevant</th>
<th>Somewhat relevant</th>
<th>Quite relevant</th>
<th>Highly relevant</th>
</tr>
</thead>
<tbody>
<tr>
<td>0</td>
<td>(0.0%)</td>
<td>4 (40.0%)</td>
<td>2 (20.0%)</td>
<td>4 (40.0%)</td>
</tr>
</tbody>
</table>

Note. N = 10 for all items.

2. Availability of Facilitating Factors that Support Pediatric SANE Competency (Question 5.a-l composite)

Please read each item in Section 2 of the survey and rate the entire section for its relevance in relation to the research question, "What is the availability of facilitators of competence to sexual assault nurse examiners who examine pediatric patients?"

<table>
<thead>
<tr>
<th>Item</th>
<th>Not relevant (1)</th>
<th>Somewhat relevant (2)</th>
<th>Quite relevant (3)</th>
<th>Highly relevant (4)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Asking whether a facilitating factor is present or absent in pediatric SANEs’ primary practice site is...</td>
<td>1 (10.0%)</td>
<td>3 (30.0%)</td>
<td>1 (10.0%)</td>
<td>5 (50.0%)</td>
</tr>
</tbody>
</table>

Note. N = 10.

3. Barriers to Competent Pediatric SANE Practice (Question 7)

This scale measures barriers to competence development and maintenance in pediatric SANEs practice. Please read each item and rate it for its relevance in representing the concept of potential barriers to pediatric SANE competence.

<table>
<thead>
<tr>
<th>Item</th>
<th>Not relevant (1)</th>
<th>Somewhat relevant (2)</th>
<th>Quite relevant (3)</th>
<th>Highly relevant (4)</th>
</tr>
</thead>
<tbody>
<tr>
<td>a. Inadequate number of pediatric patients for SANEs to examine</td>
<td>1 (10.0%)</td>
<td>1 (10.0%)</td>
<td>1 (10.0%)</td>
<td>7 (70.0%)</td>
</tr>
<tr>
<td>b. Limited SANE work schedule</td>
<td>0 (0.0%)</td>
<td>4 (40.0%)</td>
<td>1 (10.0%)</td>
<td>5 (50.0%)</td>
</tr>
<tr>
<td>c. Geographic isolation</td>
<td>0 (0.0%)</td>
<td>2 (20.0%)</td>
<td>3 (30.0%)</td>
<td>5 (50.0%)</td>
</tr>
<tr>
<td>d. Professional isolation</td>
<td>0 (0.0%)</td>
<td>1 (10.0%)</td>
<td>2 (20.0%)</td>
<td>7 (70.0%)</td>
</tr>
<tr>
<td>e. Inadequate availability of continuing forensic education</td>
<td>0 (0.0%)</td>
<td>1 (10.0%)</td>
<td>3 (30.0%)</td>
<td>6 (60.0%)</td>
</tr>
</tbody>
</table>

Note. N = 10 for all items.
### 4. Rating Self-Perceived Competence as a Pediatric SANE (Question 9)

This section measures the individual SANE’s perception of their competence as a pediatric. Please read each item and rate it for its relevance in representing the concept of self-perceived competence of pediatric SANEs.

<table>
<thead>
<tr>
<th>Item</th>
<th>Not relevant</th>
<th>Somewhat relevant</th>
<th>Quite relevant</th>
<th>Highly relevant</th>
</tr>
</thead>
<tbody>
<tr>
<td>a. Ability to balance ethical decisions with legal responsibility in all pediatric sexual abuse/assault evaluations</td>
<td>0 (0.0%)</td>
<td>1 (10.0%)</td>
<td>3 (30.0%)</td>
<td>6 (60.0%)</td>
</tr>
<tr>
<td>b. Ability to conduct age appropriate physical examinations on all prepubertal children</td>
<td>0 (0.0%)</td>
<td>0 (0.0%)</td>
<td>1 (10.0%)</td>
<td>9 (90.0%)</td>
</tr>
<tr>
<td>c. Ability to conduct age appropriate physical examinations on young adolescent patients</td>
<td>0 (0.0%)</td>
<td>0 (0.0%)</td>
<td>1 (10.0%)</td>
<td>9 (90.0%)</td>
</tr>
<tr>
<td>d. Ability to apply my state’s mandatory child abuse reporting laws</td>
<td>0 (0.0%)</td>
<td>1 (10.0%)</td>
<td>1 (10.0%)</td>
<td>8 (80.0%)</td>
</tr>
<tr>
<td>e. Ability to provide care for a child or young adolescent who refuses an examination</td>
<td>0 (0.0%)</td>
<td>0 (0.0%)</td>
<td>2 (20.0%)</td>
<td>8 (80.0%)</td>
</tr>
<tr>
<td>f. Use of digital video or single lens reflex camera for documentation of examination</td>
<td>0 (0.0%)</td>
<td>0 (0.0%)</td>
<td>6 (60.0%)</td>
<td>4 (40.0%)</td>
</tr>
<tr>
<td>g. Modification of an adult sexual assault evidence kit for use in prepubertal pediatric examinations</td>
<td>0 (0.0%)</td>
<td>1 (10.0%)</td>
<td>3 (30.0%)</td>
<td>6 (60.0%)</td>
</tr>
<tr>
<td>h. Applying Adams’ 2010 revision of <em>Guidelines for Medical Care for Children Who May Have Been Sexually Abused</em></td>
<td>0 (0.0%)</td>
<td>1 (10.0%)</td>
<td>2 (20.0%)</td>
<td>7 (70.0%)</td>
</tr>
<tr>
<td>i. Adhering to HIPAA regulations in caring for all suspected pediatric sexual abuse/assault patients</td>
<td>0 (0.0%)</td>
<td>1 (10.0%)</td>
<td>2 (20.0%)</td>
<td>7 (70.0%)</td>
</tr>
<tr>
<td>j. Applying current CDC pediatric guidelines for STD testing, prophylaxis and treatment</td>
<td>0 (0.0%)</td>
<td>0 (0.0%)</td>
<td>1 (10.0%)</td>
<td>9 (90.0%)</td>
</tr>
</tbody>
</table>

*Note.* $N = 10$ for all items.
5. **Benner’s Five Developmental Stages to Achieve Skill and Knowledge Acquisition (Question 10)**

The following question continues the exploration of a SANE’s journey through these developmental stages. Please rate this question’s relevance to the concept of competence level in a pediatric SANE.

<table>
<thead>
<tr>
<th>How do you rate your current level of clinical knowledge and practice as a pediatric SANE?</th>
<th>Not relevant (1)</th>
<th>Somewhat relevant (2)</th>
<th>Quite relevant (3)</th>
<th>Highly relevant (4)</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>0 (0.0%)</td>
<td>0 (0.0%)</td>
<td>3 (30.0%)</td>
<td>7 (70.0%)</td>
</tr>
</tbody>
</table>

Novice
Advanced beginner
Competent
Proficient
Expert

**Note.** N = 10.

6. **The Relationship Between Self-Perceived Competence and IAFN Certification (Questions 13, 15, 16, 18)**

How do the following items relate to the research question, "What is the relationship between International Association of Forensic Nurses national certification and how sexual assault nurse examiners who examine pediatric patients perceive their competence?"

<table>
<thead>
<tr>
<th>Item</th>
<th>Not relevant (1)</th>
<th>Somewhat relevant (2)</th>
<th>Quite relevant (3)</th>
<th>Highly relevant (4)</th>
</tr>
</thead>
<tbody>
<tr>
<td>13. If the state where you practice as a SANE requires ongoing state certification, what certification does it require?</td>
<td>1 (10.0%)</td>
<td>2 (20.0%)</td>
<td>3 (30.0%)</td>
<td>4 (40.0%)</td>
</tr>
<tr>
<td>15. What requirements does your state have for state certification renewal?</td>
<td>1 (10.0%)</td>
<td>2 (20.0%)</td>
<td>3 (30.0%)</td>
<td>4 (40.0%)</td>
</tr>
<tr>
<td>16. Are you International Association of Forensic Nurses (IAFN) SANE certified?</td>
<td>2 (20.0%)</td>
<td>0 (0.0%)</td>
<td>2 (20.0%)</td>
<td>6 (60.0%)</td>
</tr>
<tr>
<td>18. If you do not have IAFN certification, what is/are your reason(s)?</td>
<td>3 (30.0%)</td>
<td>1 (10.0%)</td>
<td>2 (20.0%)</td>
<td>4 (40.0%)</td>
</tr>
</tbody>
</table>

**Note.** N = 10 for all items.
7. Number of SANE Evaluations Needed Annually for Competence (Questions 11, 12, 25, 26)

How would you rate the following item in relation to the concept self-perceived competence in the research question, "How do sexual assault nurse examiners who examine pediatric patients perceive their competence?"

<table>
<thead>
<tr>
<th>Item</th>
<th>Not relevant (1)</th>
<th>Somewhat relevant (2)</th>
<th>Quite relevant (3)</th>
<th>Highly relevant (4)</th>
</tr>
</thead>
<tbody>
<tr>
<td>11. How many prepubertal children do SANEs need to examine every year to maintain clinical competence?</td>
<td>0 (0.0%)</td>
<td>0 (0.0%)</td>
<td>4 (40.0%)</td>
<td>6 (60.0%)</td>
</tr>
<tr>
<td>12. How many young adolescents do SANEs need to examine every year to maintain clinical competence?</td>
<td>0 (0.0%)</td>
<td>0 (0.0%)</td>
<td>4 (40.0%)</td>
<td>6 (60.0%)</td>
</tr>
<tr>
<td>25. Approximately how many prepubescent children do you personally examine annually?</td>
<td>1 (10.0%)</td>
<td>0 (0.0%)</td>
<td>2 (20.0%)</td>
<td>7 (70.0%)</td>
</tr>
<tr>
<td>26. Approximately how many young adolescents do you personally examine annually?</td>
<td>1 (10.0%)</td>
<td>0 (0.0%)</td>
<td>3 (30.0%)</td>
<td>6 (60.0%)</td>
</tr>
</tbody>
</table>

*Note. N = 10 for all items.*
Appendix F4

Conversion to Dichotomous Relevance Scale for Content Validity

Relevance Scale for Content Validity: Factors that Support Pediatric SANE Competence

1. Facilitating Factors that Support Pediatric SANE Competence (Question 3)

<table>
<thead>
<tr>
<th>Item</th>
<th>Not relevant</th>
<th>Relevant</th>
<th>CVI</th>
</tr>
</thead>
<tbody>
<tr>
<td>a.</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Scheduled peer review of all pediatric and young adolescent evaluations</td>
<td>1</td>
<td>9</td>
<td>.9</td>
</tr>
<tr>
<td>b.</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Video or photo documentation of all pediatric examinations</td>
<td>0</td>
<td>10</td>
<td>1.0</td>
</tr>
<tr>
<td>c.</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Review of all pediatric evaluations by an expert child abuse physician or a child abuse nurse practitioner</td>
<td>0</td>
<td>10</td>
<td>1.0</td>
</tr>
<tr>
<td>d.</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Review of all acute pediatric evaluations by a child abuse physician or child abuse nurse practitioner within 24 hours</td>
<td>2</td>
<td>8</td>
<td>.8</td>
</tr>
<tr>
<td>e.</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Examination of an adequate number of prepubertal pediatric patients annually for skills maintenance</td>
<td>0</td>
<td>10</td>
<td>1.0</td>
</tr>
<tr>
<td>f.</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Examination of an adequate number of young adolescent pediatric patients annually for skills maintenance</td>
<td>1</td>
<td>9</td>
<td>.9</td>
</tr>
<tr>
<td>g.</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Employer fiscally supports attendance at the IAFN Annual International Conference on Forensic Nursing Science and Practice</td>
<td>3</td>
<td>7</td>
<td>.7*</td>
</tr>
<tr>
<td>h.</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Mandatory ongoing state SANE certification</td>
<td>2</td>
<td>8</td>
<td>.8</td>
</tr>
<tr>
<td>i.</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Participation in a SANE mentorship program</td>
<td>2</td>
<td>8</td>
<td>.8</td>
</tr>
<tr>
<td>j.</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Technology for the review of video or photo documentation with a child abuse pediatrician or child abuse nurse practitioner</td>
<td>0</td>
<td>10</td>
<td>1.0</td>
</tr>
<tr>
<td>k.</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Pediatric specific forensic evidence collection kit</td>
<td>4</td>
<td>6</td>
<td>.6†</td>
</tr>
</tbody>
</table>

a.-k. Composite (Mean) | .84

Note. N = 10 for all items. CVI = Content Validity Index.

*Item g.: CVI of .7. Recommended CVI for 10 experts is .76. This item will be changed to reflect the comments of experts to include local, state and national child abuse conferences.

†Item k.: CVI of .6. This item will be eliminated from the survey.
2. **Availability of Facilitating Factors in Your SANE Practice Site (Question 5 composite)**

<table>
<thead>
<tr>
<th>Not relevant (1, 2)</th>
<th>Relevant (3, 4)</th>
<th>CVI</th>
</tr>
</thead>
<tbody>
<tr>
<td>Asking whether a facilitating factor is present or absent in pediatric SANEs’ primary practice site is...</td>
<td>4</td>
<td>6</td>
</tr>
</tbody>
</table>

*Note. N = 10. CVI = Content Validity Index.*

3. **Barriers To Competent Pediatric Sane Practice (Question 7)**

<table>
<thead>
<tr>
<th>Item</th>
<th>Not relevant (1, 2)</th>
<th>Relevant (3, 4)</th>
<th>CVI</th>
</tr>
</thead>
<tbody>
<tr>
<td>a. Inadequate number of pediatric patients for SANEs to examine</td>
<td>2</td>
<td>8</td>
<td>.8</td>
</tr>
<tr>
<td>b. Limited SANE work schedule</td>
<td>4</td>
<td>6</td>
<td>.6 †</td>
</tr>
<tr>
<td>c. Geographic isolation</td>
<td>2</td>
<td>8</td>
<td>.8</td>
</tr>
<tr>
<td>d. Professional isolation</td>
<td>1</td>
<td>9</td>
<td>.9</td>
</tr>
<tr>
<td>e. Inadequate availability of continuing forensic education</td>
<td>1</td>
<td>9</td>
<td>.9</td>
</tr>
</tbody>
</table>

a.-e. Composite (Mean) .80

*Note. N = 10. CVI = Content Validity Index.*
4. Rating Self-Perceived Competence As A Pediatric SANE (Question 9)

<table>
<thead>
<tr>
<th>Item</th>
<th>Not relevant (1, 2)</th>
<th>Relevant (3, 4)</th>
<th>CVI</th>
</tr>
</thead>
<tbody>
<tr>
<td>a.</td>
<td>Ability to balance ethical decisions with legal responsibility in all pediatric sexual abuse/assault evaluations</td>
<td>1</td>
<td>9</td>
</tr>
<tr>
<td>b.</td>
<td>Ability to conduct age appropriate physical examinations on <strong>all</strong> prepubertal children</td>
<td>0</td>
<td>10</td>
</tr>
<tr>
<td>c.</td>
<td>Ability to conduct age appropriate physical examinations on young adolescent patients</td>
<td>0</td>
<td>10</td>
</tr>
<tr>
<td>d.</td>
<td>Ability to apply my state’s mandatory child abuse reporting laws</td>
<td>1</td>
<td>9</td>
</tr>
<tr>
<td>e.</td>
<td>Ability to provide care for a child or young adolescent who refuses an examination</td>
<td>0</td>
<td>10</td>
</tr>
<tr>
<td>f.</td>
<td>Use of digital video or single lens reflex camera for documentation of examination</td>
<td>0</td>
<td>10</td>
</tr>
<tr>
<td>g.</td>
<td>Modification of an adult sexual assault evidence kit for use in prepubertal pediatric examinations</td>
<td>1</td>
<td>9</td>
</tr>
<tr>
<td>h.</td>
<td>Applying Adams’ <strong>2010 revised</strong> Guidelines for Medical Care for Children Who May Have Been Sexually Abused</td>
<td>1</td>
<td>9</td>
</tr>
<tr>
<td>i.</td>
<td>Adhering to HIPAA regulations in caring for all suspected pediatric sexual abuse/assault patients</td>
<td>1</td>
<td>9</td>
</tr>
<tr>
<td>j.</td>
<td>Applying current CDC pediatric guidelines for STD testing, prophylaxis and treatment</td>
<td>0</td>
<td>10</td>
</tr>
</tbody>
</table>

**a.-j.** Composite (Mean) .95

*Note. N = 10. CVI = Content Validity Index.*
### 5. Benner’s Five Developmental Stages to Achieve Skill and Knowledge Acquisition (Question 10)

<table>
<thead>
<tr>
<th>Question</th>
<th>Not relevant (1, 2)</th>
<th>Relevant (3, 4)</th>
<th>CVI</th>
</tr>
</thead>
<tbody>
<tr>
<td>How do you rate your current level of clinical knowledge and practice as a pediatric SANE?</td>
<td>0</td>
<td>10</td>
<td>1.0</td>
</tr>
<tr>
<td>Novice</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Advanced beginner</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Competent</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Proficient</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Expert</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

*Note. N = 10. CVI = Content Validity Index.*

### 6. The Relationship between Self-Perceived Competence and IAFN Certification (Questions 13, 15, 16, 18)

<table>
<thead>
<tr>
<th>Item</th>
<th>Not relevant (1, 2)</th>
<th>Relevant (3, 4)</th>
<th>CVI</th>
</tr>
</thead>
<tbody>
<tr>
<td>13. If the state where you practice as a SANE requires ongoing state certification, what certification does it require?</td>
<td>3</td>
<td>7</td>
<td>.7</td>
</tr>
<tr>
<td>15. What requirements does your state have for state certification renewal?</td>
<td>3</td>
<td>7</td>
<td>.7</td>
</tr>
<tr>
<td>16. Are you International Association of Forensic Nurses (IAFN) SANE certified?</td>
<td>2</td>
<td>8</td>
<td>.8</td>
</tr>
<tr>
<td>18. If you do not have IAFN certification, what is/are your reason(s)?</td>
<td>4</td>
<td>6</td>
<td>.6</td>
</tr>
</tbody>
</table>

*Composite (mean) .70

*Note. N = 10. CVI = Content Validity Index.*
### 7. Number of SANE Evaluations Needed Annually for Competence

<table>
<thead>
<tr>
<th>Item</th>
<th>Not relevant (1, 2)</th>
<th>Relevant (3, 4)</th>
<th>CVI</th>
</tr>
</thead>
<tbody>
<tr>
<td>11. How many prepubertal children do SANEs need to examine every year to maintain clinical competence?</td>
<td>0</td>
<td>10</td>
<td>1.0</td>
</tr>
<tr>
<td>12. How many young adolescents do SANEs need to examine every year to maintain clinical competence?</td>
<td>0</td>
<td>10</td>
<td>1.0</td>
</tr>
<tr>
<td>25. Approximately how many prepubescent children do you personally examine annually?</td>
<td>1</td>
<td>9</td>
<td>.9</td>
</tr>
<tr>
<td>26. Approximately how many young adolescents do you personally examine annually?</td>
<td>1</td>
<td>9</td>
<td>.9</td>
</tr>
</tbody>
</table>

**Composite (mean)**

| Composite (mean) | .95 |

*Note. N = 10. CVI = Content Validity Index.*

### 8. Entire Survey CVI = .83
Appendix G

Permission to Distribute Survey to IAFN Members

International Association of Forensic Nurses

December 6, 2012

Dear Hannah,

On behalf of IAFN, I have reviewed both your survey and your request to distribute your survey to the IAFN Member Community. I am pleased to approve your use of the IAFN Member Community social network to distribute the link to your survey.

Thank you for your considerable effort on this project. I look forward to reviewing a published account of your results, perhaps in the Journal of Forensic Nursing.
December 17, 2012

Hannah Pressler
SNHS
Simmons College
Boston, MA 02115-5898

RE: Your application dated 12/5/2012 regarding study number 12-044: Factors that Influence Sexual Assault Nurse Examiner Competence: A Pilot Study

Dear Ms. Pressler:

I have reviewed your request for expedited approval of the new study listed above. Your study is eligible for expedited review under the DHHS (OHRP) designation 45 CFR 46.110 (7).

This is to confirm that I have approved your application. The protocol is approved through your protocol dated 12/05/2012. You must obtain informed consent from all subjects; however, signed written consent is not required.

You are granted permission to conduct your study as described in your application effective immediately. The study is subject to continuing review on or before 12/14/2013, unless closed before that date.

Please note that any changes to the study as approved must be promptly reported and approved. Some changes may be approved by expedited review; others require full board review. Contact Valerie E. Beaudrault (617-521-2415; fax 617-521-3063; email: valerie.beaudrault@simmons.edu) if you have any questions or require further information.

Sincerely,

[Signature]

Teresa Fung
IRB Member and Primary Reviewer
Appendix II

Invitations to IAFN Members to Participate in a Capstone Project

Date: December 28, 2012

Dear colleagues:

In several days, you will receive via IAFN Member Community e-mail with a request to fill out a web-based survey for a capstone practice inquiry project that Hannah Pressler, MHS, PNP, is conducting. This capstone inquiry project *Factors That Influence Sexual Assault Nurse Examiner Competence: A Pilot Project* is in partial fulfillment of the Doctor of Nursing Practice degree requirements at Simmons College, School of Nursing and Health Science in Boston, MA.

This project (study number 12-044) has been approved by the Simmons College Institutional Review Board.

You are receiving this e-mail as many people like to know ahead of time that they will be contacted. The project will attempt to determine what factors support and hinder self-perceived competence in SANEs who examine prepubertal children and young adolescents.

A question of particular interest is, “Are supportive factors available in rural as well as urban population centers?” In other words, what factors do you as pediatric and adolescent SANEs think are important to help you be competent SANEs and are they present in your practice?

Thank you for your time and consideration.

_Hannah M. Pressler_
Hannah M. Pressler, MHS, PNP-BC
Doctor of Nursing Practice Student
Simmons College
School of Nursing and Health Science
Boston, MA
Invitation

SANEs’ Self-Perceived Competence Scale: Facilitating Factors and Barriers.

Date: January 2, 2013

Dear colleagues,

My name is Hannah Pressler and I am a Doctor of Nursing Practice student at Simmons College, School of Nursing and Health Science in Boston, MA. As a requirement for completion of my DNP, I am working on my capstone practice inquiry project Factors That Influence Sexual Assault Nurse Examiner Competence: A Pilot Project. This capstone inquiry project is in partial fulfillment of the Doctor of Nursing Practice degree requirements. I invite you to participate in this project.

This project (study number 12-044) has been approved by the Simmons College Institutional Review Board.

This project includes a web-based investigator developed survey. All IAFN members have received this IAFN Member Community e-mail; however, the survey was developed primarily for SANEs who examine prepubertal children and young adolescents under the age of 14 years. If you are a SANE who examines prepubertal children and young adolescents, I would appreciate your participation. Completion of the survey should take approximately 15 minutes. If you are an adult/adolescent SANE, I would appreciate your completion of questions in Section I of the survey and in Section VI, demographic and certification questions.

Your participation in this project will not incur any personal risks. The survey is completely anonymous and cannot be linked to your name or e-mail address. Participation in this research study is voluntary. This is a web-based survey on the SurveyMonkey application. SurveyMonkey will store the surveys and takes every precaution to protect your privacy and confidentiality.

You are free to decide not to participate in this study or to terminate your participation at any time without adversely affecting your relationship with IAFN or incurring any penalty or cost. IAFN has agreed to assist with distribution of the survey but is not responsible for the contents of the survey. There is no financial incentive or prizes association with completion of this survey nor is there any financial risk to participants.

Benner described the developmental stages that nurses experience as they pass from novice practitioner through stages of advanced beginner, competent, and proficient to expert practitioner. The purpose of this survey is the exploration of the stage of competence. The survey will consist of rating questions concerning competence, factors that facilitate competence, their availability in your practice site, factors that hinder competence, and background questions. This study will provide valuable information about what you as pediatric SANEs identify as important in the development of competence. The results of this survey may be published or developed into a poster presentation for a future IAFN conference.
Please accept my sincere thank you in advance for your cooperation in this study.

If you have any questions about this study, please contact Hannah Pressler at hannah.pressler@gmail.simmons.edu If you have any additional questions about your rights as a participant in this project that I have not answered, or if you have any concerns about the project, you may contact the Simmons College Human Protections Administrator in the Office of Sponsored Programs at (617) 521-2414 or my research committee chair, Judy Beal, DNS, Dean, Simmons College School of Nursing and Health Sciences (617) 521-2139.

Logging into the secure SurveyMonkey site and completing the survey will be considered your consent to participate in this project.

This is the web-link to the survey: http://www.surveymonkey.com/s/HMPresslerCapstone. If you have any questions or comments about this study, I would be happy to talk with you. My contact information is below. If you include your phone number in an e-mail, I shall gladly call you to respond to questions. I will not be able to link your name with the contents of any one survey.

Thanks again for your participation,

Hannah Pressler
Hannah Pressler
Doctor of Nursing Practice Student
Simmons College
School of Nursing and Health Sciences
Email: hannah.pressler@gmail.simmons.edu
Dear Colleagues,

My name is Hannah Pressler and I am a Doctor of Nursing Practice student at Simmons College, School of Nursing and Health Science in Boston, MA. As a requirement for completion of my DNP, I am working on my capstone practice inquiry project entitled SANE’s Self-Perceived Competence Scale:Facilitating Factors and Barriers. This capstone practice inquiry project is in partial fulfillment of the Doctor of Nursing Practice degree requirements.

This project (study number 12-044) has been approved by the Simmons College Institutional Review Board.

Two weeks ago I sent an email to all IAFN Member Community members with a web-based survey link addressing factors that support and hinder competence in pediatric SANE’s and SANE’s who examine young adolescents.

If you have already responded to this questionnaire, thank you very much. If you have not responded, please consider doing so.

I am writing again because of the importance that your survey has in the process of obtaining accurate conclusions. If you have not completed the survey, I implore you to do so. This is a completely anonymous survey. Your responses will be part of the aggregate data collected. There is no way to connect completed surveys with participants.

This project includes a web-based investigator developed survey. All IAFN members have received this IAFN Member Community e-mail; however, the survey was developed primarily for SANE’s who examine prepubertal children and young adolescents under the age of 14 years. If you are a SANE who examines prepubertal children and young adolescents, I would appreciate your participation. Completion of the survey should take approximately 15 minutes. If you are an adult/adolescent SANE, I would appreciate your completion of questions in Section I of the survey and in Section VI, demographic and certification questions.

Your participation in this project will not incur any personal risks. The survey is completely anonymous and cannot be linked to your name or e-mail address. Participation in this research study is voluntary. This is a web-based survey on the SurveyMonkey application. SurveyMonkey will store the surveys and takes every precaution to protect your privacy and confidentiality.

You are free to decide not to participate in this study or to terminate your participation at any time without adversely affecting your relationship with IAFN or incurring any penalty or cost. IAFN has agreed to assist with distribution of the survey but is not responsible for the contents of the survey. There is no financial incentive or prizes association with completion of this survey nor is there any financial risk to participants.

By clicking on the link provided and logging into the secure site, you are agreeing to participate in this capstone practice inquiry project. This is the web link to the survey:

If you have any questions about this study, please contact Hannah Pressler at hannah.pressler@gmail.simmons.edu  If you have any additional questions about your rights as a participant in this project that I have not answered, or if you have any concerns about the project, you may contact the Simmons College Human Protections Administrator in the Office of Sponsored Programs at (617) 521-2414 or my research committee chair, Judy Beal, DNS, Dean, Simmons College School of Nursing and Health Sciences (617) 521-2139.

If you do have any questions or comments about this study, I would be happy to talk with you. My contact information is below. If you include your phone number in an e-mail, I shall gladly call you to respond to questions. I will not be able to link your name with the contents of any one survey.

Thank you again for your participation,

**Hannah Pressler**  
Hannah Pressler  
Doctor of Nursing Practice Student  
Simmons College  
School of Nursing and Health Sciences  
Email: hannah.pressler@gmail.simmons.edu
Appendix I2

Informed Consent

Relevance Scale for Content Validity: Facilitating Factors that Support Pediatric SANE Competence

Dear Colleagues,

My name is Hannah Pressler. I am a forensic pediatric nurse practitioner, IAFN member and Doctor of Nursing Practice student at Simmons College, School of Nursing and Health Science in Boston, MA. I am completing my capstone inquiry project, Factors That Influence Sexual Assault Nurse Examiner Competence: A Pilot Project. This project is in partial fulfillment of the Doctor of Nursing Practice degree requirements.

This project (study number 12044) was approved by the Simmons College Institutional Review Board. Carey Goryl, IAFN's CEO has reviewed the survey, SANEs' Self-perceived Competence Scale: Facilitating Factors and Barriers and she has granted permission to use the IAFN Member Only Community to distribute the link to the survey to its members.

This project includes a web-based investigator developed survey. All IAFN members have received this IAFN Member Community email; however, the survey was developed primarily for SANEs, advanced practice nurses and other advanced practitioners who examine prepubertal children and young adolescents under the age of 14 years. If you examine prepubertal children and young adolescents, I would appreciate your participation.

Completion of the survey should take approximately 15 minutes. If you are an adult/adolescent SANE, advanced practice nurse or other advanced practitioner who examines older adolescents or adults for sexual assault, I would appreciate your completion of questions in Section I of the survey and in Section VI, background and certification questions. Thank you for taking the time to read this request.

Your participation in this project will not incur any personal risks. The survey is completely anonymous and cannot be linked to your name or email address. Participation in this research study is voluntary. SurveyMonkey will store the surveys and takes every precaution to protect your privacy and confidentiality.

You are free to decide not to participate in this study, to terminate your participation at any time or to skip questions without adversely affecting your relationship with IAFN or incurring any penalty or cost. IAFN has agreed to assist with the distribution of the survey but is not responsible for the content of the survey. This survey does not reflect the opinions of the staff or officers of IAFN. There is no financial incentive or prizes associated with completion of this survey nor is there any financial risk to participants.

The results of this survey may be published or developed into a presentation for a future IAFN conference.

Please accept my sincere thank you in advance for your participation in this study.
If you have any questions about this study, please contact me at hannah.pressler@gmail.simmons.edu. If you have any additional questions about your rights as a participant in this project that I have not answered, or if you have any concerns about the project, you may contact the Simmons College Human Protections Administrator in the Office of Sponsored Programs at (617) 521-2414 or my research committee chair, Judy Beal, DNSc, Dean, Simmons College School of Nursing and Health Sciences (617) 521-2139.

The completion of this survey will be considered your consent to participate in this project.

If you have any questions or comments about this study, I would be happy to talk with you. My contact information is below. If you include your phone number in an email, I shall gladly call you to respond to questions.

Thanks again for your participation,

Hannah M. Pressler  
Doctor of Nursing Practice Student  
Simmons College  
School of Nursing and Health Sciences  
Email: hannah.pressler@gmail.simmons.edu
Appendix I.3

SANEs’ Self-Perceived Competence Scale: Facilitating Factors and Barriers.

Introduction:

This survey is designed to explore both facilitating factors and barriers to achieving and maintaining clinical competence for SANEs who examine prepubertal children and young adolescents and to collect demographic and certification data from all SANEs. This survey consists of questions that will ask you to rate various influences on competence and your self-perception of competence.

This survey should take approximately 15-20 minutes to complete.

This survey is completely anonymous.

Please click here to confirm that you have read the informed consent containing the link to this survey.

SECTION I: SCREENING QUESTIONS

The purpose of Section I is to provide information about respondents to this survey including inclusion criteria for the project and for background and certification data.

For the purpose of this survey:

SANE includes but is not limited to examiners identified as Sexual Assault Nurse Examiners, Forensic Nurse Examiners, Sexual Assault Forensic Examiners, etc. whether Adult/Adolescent, Pediatric, or both. SANEs may be nurses, advanced practice nurses, physician assistants or physicians.

Adult/adolescent SANEs provide care for female or male adolescents and adults.

Individual SANE programs set the lower age limit for adolescent evaluations. For the purpose of this survey, the investigator is including all female and male pediatric patients who are pubertal (sexual maturity rating/Tanner stage of 2 – 5) and 14 years of age or older.

Young female adolescents are pediatric patient who is pubertal (sexual maturity rating/Tanner stage of 2 – 5 and have entered menarche (have started their menses) but are younger than 14 years of age.

Pediatric SANEs provide care to all female and male pediatric patients from birth through young adolescence (birth until 14th birthday).

1. Are you a Sexual Assault Nurse Examiner (SANE)?
   
   Yes: ________  
   
   No: ________  

(Your response to question 1 will direct you to the next section of this survey).
2. My SANE practice includes:

   - Only pediatric patients: _________
   - Only adult/adolescent patients: _________
   - Both pediatric and adult/adolescent patients: _________

(Your response to question 2 will direct you to the next section of this survey).
SECTION II: FACILITATING FACTORS THAT SUPPORT PEDIATRIC SANE COMPETENCE

The purpose of Section II is to explore factors that facilitate or support the development of competence in your pediatric SANE practice.

For the purpose of this survey:

Competence is defined as the skills, experiences, insights, and abilities necessary to provide the best possible SANE care. Competence is not dichotomous - either competent or incompetent. It is a developmental process starting with beginner through novice, competent, proficient, and ending with expert.

Facilitating factors are defined as factors/experiences that help SANES develop and maintain competence in their work as a SANE.

Question 3:

Please rate the extent to which each of the following can help with the development and maintenance of competence for SANEs who examine prepubescent children and young adolescents.

Please rate each item, regardless of whether it is available at your practice sites

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<thead>
<tr>
<th></th>
<th>To no extent</th>
<th>To a minimal extent</th>
<th>To a moderate extent</th>
<th>To a great extent</th>
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</thead>
<tbody>
<tr>
<td>a. Scheduled peer review of all pediatric and young adolescent evaluations</td>
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<tr>
<td>b. Video or photo documentation of all pediatric examinations</td>
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<tr>
<td>c. Review of all pediatric evaluations by an expert child abuse physician or a child abuse nurse practitioner.</td>
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<tr>
<td>d. Review of all acute pediatric evaluations by an expert child abuse physician or a child abuse nurse practitioner within 24 hours.</td>
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<tr>
<td>e. Examination of an adequate number of prepubertal pediatric patients annually for skills maintenance</td>
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</table>
f. Examination of an adequate number of young adolescent pediatric patients annually for skills maintenance

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| g. | Mandatory ongoing **state** SANE certification |
|    |   |

h. IAFN certification

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i. Participation in a SANE mentorship program

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</table>

j. Availability of pediatric and forensic continuing education relevant to SANE care of pediatric patients.

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k. Employer fiscally supports pediatric and forensic continuing education relevant to SANE care of pediatric patients.

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**Question 4 is open ended. Please take as much space as needed to answer this question.**

4. Are there other factors you can identify that support the development and maintenance of competence as a pediatric SANE?

_____________________________________________________________________
_____________________________________________________________________
_____________________________________________________________________
SECTION III: AVAILABILITY OF FACTORS IN YOUR PRIMARY PRACTICE SITE THAT FACILITATE PEDIATRIC SANE COMPETENCE

The purpose of Section III of the survey is to determine whether the following factors identified in the literature and by pediatric experts as supporting competence are available to you in your pediatric SANE practice. Please respond by checking available or not available.

**For the purpose of this survey:**

*Available* is defined as *present at your primary practice site or readily accessible* (e.g. digitally by computer/Internet or phone 24/7)

**Question 5:**

Please check whether the following are available or not available at your practice site(s)

<table>
<thead>
<tr>
<th></th>
<th>Available</th>
<th>Not available</th>
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</thead>
<tbody>
<tr>
<td>a. Video or photo documentation of all pediatric examinations</td>
<td></td>
<td></td>
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<tr>
<td>b. Review of all video and photos by a child abuse pediatrician or child abuse nurse practitioner</td>
<td></td>
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<tr>
<td>c. Review of all pediatric evaluations by a child abuse physician or child abuse nurse practitioner</td>
<td></td>
<td></td>
</tr>
<tr>
<td>d. Review of all acute pediatric evaluations by a child abuse physician or child abuse nurse practitioner within 24 hours</td>
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<tr>
<td>e. Technology for the review of video or photo documentation with child abuse pediatrician or child abuse nurse practitioner</td>
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<tr>
<td>f. Employer fiscally supports attendance at pediatric and forensic continuing education relevant to SANE care of pediatric patients.</td>
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<tr>
<td>g. Opportunity to examine an adequate number of prepubertal pediatric patients annually for skills maintenance</td>
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<tr>
<td>h. Opportunity to examine an number of young adolescent (post-menarche) patients annually for skills maintenance</td>
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<tr>
<td>i. Mandatory ongoing state SANE certification</td>
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<tr>
<td>j. Participation in a SANE mentorship program</td>
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</tbody>
</table>
Question 6 is open ended. Please take as much space as needed to answer this question.

6. Are there other factors you can identify that support the development and maintenance of competence as a pediatric SANE that are available in your primary practice?

_____________________________________________________________________

_____________________________________________________________________

_____________________________________________________________________
SECTION IV: BARRIERS TO COMPETENT PEDIATRIC SANE PRACTICE

The purpose of Section IV of this survey is to explore factors that can impede pediatric SANE practice.

For the purpose of this survey:

**Barriers** are defined as factors/experiences that impede the development and maintenance of competence as pediatric SANEs.

**Question 7:**

*Please rate the extent to which each of the following can be a barrier to the development and maintenance of competence for SANEs who examine prepubescent children and young adolescents.*

*Please rate each item, regardless of whether it is available at your worksite.*

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<tr>
<th></th>
<th>Not a barrier</th>
<th>Slight barrier</th>
<th>Moderate barrier</th>
<th>Major barrier</th>
</tr>
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<tbody>
<tr>
<td>a. Inadequate number of pediatric patients for SANEs to examine</td>
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<tr>
<td>b. Limitation of number of hours available to work as a pediatric SANE</td>
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<td>c. Geographic isolation</td>
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<tr>
<td>d. Professional isolation</td>
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<tr>
<td>e. Inadequate funding for continuing education</td>
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<tr>
<td>f. Inadequate availability of continuing forensic education</td>
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</table>

**Question 8 is open ended. Please take as much space as needed to answer this question.**

8. Are there other factors you can identify as barriers to the development and maintenance of competence as a pediatric SANE?

_____________________________________________________________________
_____________________________________________________________________
_____________________________________________________________________
**SECTION V: RATING SELF-PERCEIVED COMPETENCE AS A PEDIATRIC SANE**

The purpose of Section V is the exploration of your perception of your personal journey through pediatric SANE practice to competent SANE.

Please be as honest as possible. You cannot be identified by your responses.

**Question 9:**

Please rate your competence as a SANE. Please be as honest as possible. You cannot be identified by your responses.

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<tr>
<th></th>
<th>Not at all competent</th>
<th>Slightly competent</th>
<th>Somewhat competent</th>
<th>Very competent</th>
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</thead>
<tbody>
<tr>
<td>a.</td>
<td>Ability to balance ethical decisions with legal responsibility in all pediatric sexual abuse/assault evaluations</td>
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<tr>
<td>b.</td>
<td>Ability to conduct age appropriate physical examinations on all prepubertal children</td>
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<td></td>
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<tr>
<td>c.</td>
<td>Ability to conduct age appropriate physical examinations on young adolescent patients</td>
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<tr>
<td>d.</td>
<td>Ability to apply my state’s mandatory child abuse reporting laws</td>
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<tr>
<td>e.</td>
<td>Ability to provide care for a child or young adolescent who refuses an examination</td>
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<tr>
<td>f.</td>
<td>Use of digital video or single lens reflex camera for documentation of examination</td>
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<tr>
<td>g.</td>
<td>Modification of an adult sexual assault evidence kit for use in prepubertal pediatric examinations</td>
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</table>
### FACTORS THAT INFLUENCE PEDIATRIC SANE COMPETENCE

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<tbody>
<tr>
<td>h.</td>
<td>Applying Adams’ <strong>2010 revision</strong> of <em>Guidelines for Medical Care for Children Who May Have Been Sexually Abused</em></td>
</tr>
<tr>
<td>i.</td>
<td>Adhering to HIPAA regulations in caring for all suspected pediatric sexual abuse/assault patients</td>
</tr>
<tr>
<td>j.</td>
<td>Knowing current CDC pediatric guidelines for STD testing, prophylaxis and treatment</td>
</tr>
<tr>
<td>k.</td>
<td>Applying current CDC pediatric guidelines for STD testing, prophylaxis and treatment</td>
</tr>
</tbody>
</table>

### Question 10:

Benner described the five developmental stages of practice in the journey to skill and knowledge acquisition in clinical practice as novice, advanced beginner, competent, proficient, and expert.

The following question continues the exploration of your journey through these developmental stages.

10. **How do you rate your current level of clinical knowledge and practice as a pediatric SANE?** Check only one response

Novice _________  
Advanced beginner _________  
Competent _________  
Proficient _________  
Expert _________

Questions 11 & 12 are open-ended questions soliciting your opinion on the number of patient examinations that SANEs need to complete annually to attain and maintain competence.

**Enter a positive number or 0.**

11. In your opinion, how many young adolescents do SANEs need to examine every year to maintain clinical competence? _________

12. In your opinion, how many prepubertal children do SANEs need to examine every year to maintain clinical competence? _________
SECTION VI: THE RELATIONSHIP BETWEEN CERTIFICATION & COMPETENCE

Questions 13 – 18 inquire about SANEs’ experience with state and national SANE certification.

13. If the state where you practice as a SANE requires ongoing state certification, what certification does it require?
   a. Adult/adolescent SANE certification only (State specific): ________
   b. Pediatric SANE certification only (State specific): ________
   c. Both adult/adolescent and pediatric SANE certification (State specific):
      ________
   d. Generic forensic nurse certification: ________
   e. My state does not require certification state certification: ________
   f. My state requires IAFN certification dependent on age parameters of SANE practice: ________

14. If the state where you practice as a SANE requires ongoing state certification, what certification does it require?
   a. Adult/adolescent SANE certification only (State specific): ________
   b. Pediatric SANE certification only (State specific): ________
   c. Both adult/adolescent and pediatric SANE certification (State specific):
      ________
   d. Generic forensic nurse certification: ________
   e. My state does not require certification state certification: ________
   f. My state requires IAFN certification dependent on age parameters of SANE practice: ________

15. What requirements does your state have for state certification renewal? (Check all that apply).
   a. Continuing education: ________
   b. Practice requirements (hours): ________
   c. Practice requirements (number of examinations): ________
   d. Attendance at Mock Trial: ________
   e. My state has no requirements for certification renewal): ________
   f. My state does not require certification: ________
16. Are you IAFN SANE certified: _____________
   a. IAFN-P but not IAFN-A certified: ________
   b. IAFN-A but not IAFN-P certified: ________
   c. IAFN-P and IAFN-A certified: ___________
   d. ANCC Advanced Practice Forensic Nurse Certification: _______
   e. I am not IAFN certified: __________
   f. I am not yet eligible for IAFN SANE certification but plan to become IAFN SANE certified: ________
   g. I am not yet eligible for IAFN SANE certification and do not plan to become IAFN SANE certified: ________

(Your response to question 16 will direct you to the next section of this survey).

17. If you do not have IAFN SANE certification, what is/are your reason(s)?
   a. My practice site requires certification in my primary practice specialty: ______
   b. My practice site does not require SANE certification: _________
   c. Cost of certification: ______
   d. I am not a nurse: _______
   e. I am not interested in certification: ________
   f. I have state certification: ______
   g. I am an advanced practice nurse (APN) with APN specialty certification: ______
   h. I have Advanced Practice Forensic Nurse certification from ANCC: ______
   i. I am not yet eligible for IAFN certification: ______
   j. I cannot meet the clinical requirements: ______
   k. I cannot meet the continuing education requirements: ______
   l. Other (please specify): _______

18. If you are IAFN SANE certified or ANCC Advanced Practice Forensic Nurse Certified (or plan to become certified when you are eligible), what is/are your personal reason(s) that are not state, program or workplace requirements. (Check all that apply.)
   a. Displays my pride as an IAFN member: _________
   b. Symbol of my competence as a SANE: ________
   c. Demonstration of my self-respect and professional fulfillment as a
FACTORS THAT INFLUENCE PEDIATRIC SANE COMPETENCE

SANE: ________

d. Certification is a professional goal: ________
e. Other: (please specify) ________

SECTION VII: BACKGROUND INFORMATION

Questions 19-29 are about you and your SANE practice. You cannot be identified by your responses to these questions.

19. For how many years have you been an adult/adolescent SANE? (Use 0 if you are not an adult/adolescent SANE; use whole numbers; use 1 if you have practiced for less than 1 year.)
Enter a whole positive number or 0 _______

20. For how many years have you been a pediatric SANE? (Use 0 if you are not a pediatric SANE; use whole numbers; use 1 if you have practiced for less than 1 year.)
Enter a whole positive number or 0 _______

21. In a typical MONTH, how many hours do you practice as a SANE?
Enter a whole positive number or 0 _______

22. When I work as a SANE, my practice site is most often located in an:
a. Inner city area: _______
b. Metropolitan area (not inner city): _______
c. Suburban area: _______
d. Rural area: _______
e. Frontier area: _______
f. Other (please specify): _______

23. Where is your SANE practice? (Check all that apply)
a. Hospital Emergency Department (E.D.) _______
b. Child Advocacy Center (C.A.C.) _______
c. Federally Funded Health Center _______
d. Other (please specify) _______

24. If you practice in an emergency department, describe the type of hospital:
a. Large Urban Academic/Medical Center _______
b. Urban Community Hospital _______
c. Suburban Community Hospital _______
d. Rural Community Hospital _______
25. Approximately how many young adolescents do you examine annually? ______

26. Approximately how many prepubescent children do you examine annually? ______

27. What is the highest degree you have completed?
   a. Nursing Diploma ________
   b. Associate degree ________
   c. Bachelor's degree nursing ________
   d. Master's degree nursing ________
   e. DNP nursing ________
   f. PhD nursing ________
   g. Other degrees including non-nursing bachelor’s degree (please specify) ________

28. If you are an advanced practice nurse or advanced practitioner, how do you identify yourself? (Please check all that apply):
   a. Nurse practitioner ________
   b. Certified nurse midwife ________
   c. Clinical nurse specialist ________
   d. Physician Assistant ________
   e. Physician ________
   f. I am not an advanced practice nurse or advanced practitioner ________
   e. Other (please specify) ________

29. Do you have any comments or questions?
   No ________
   Yes ________ (please elaborate)
SECTION VIII: THANK YOU FOR YOUR PARTICIPATION

Dear Colleagues,

Thank you for taking the time to open this survey. Although your willingness to participate is appreciated, this survey was developed for SANEs. If you are a SANE and find yourself on this page, please hit the "previous" button and you will return to the survey. Everyone else, please hit the done button and you will exit the survey.

I hope to present the results of this project as a poster presentation at IAFN's 21st Annual International Conference on Forensic Nursing Science and Practice in 2013 in Anaheim, CA.

Hannah M. Pressler  
Doctor of Nursing Practice Student  
Simmons College  
School of Nursing and Health Sciences  
Boston, MA  
[Email Address]
This is the last page.

If you wish to make any changes, press "Prev" to go back through the survey and change your answers as needed.

If you are truly finished, please press "Done." Your responses/data will be automatically saved.
References


FACTORS THAT INFLUENCE PEDIATRIC SANE COMPETENCE


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