REALTIME FILE

CVS-End Abuse – SANE/SAFE ExMS

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Ashley Brompton: Good afternoon everyone, this is Ashley Brompton with the Vera Institute of Justice. The webinar will begin in 5 minutes. If you have a question or need any assistance, please send us a message in the Q&A pod to the right of the PowerPoint. Also, if you would like to download a copy of the PowerPoint, you can do so by clicking on the file you wish to download in the Webinar Downloads box and then clicking "download file". Again, we will be starting at 2 pm ET, in about 5 minutes.

Ashley Brompton: Good afternoon everyone! Thank you for joining our webinar today. I'm Ashley Brompton with the Center on Victimization and Safety at the Vera Institute of Justice. I would like to welcome you to today's webinar. We are pleased to bring you this as part of our 2020 End Abuse of People with Disabilities webinar series.
We have just a few quick logistical items to go over before we begin today.

There are two ways to communicate with myself and my Vera colleagues, presenters, and other webinar participants today. First, the chat pod. The chat pod is used to communicate with the presenter and other attendees. You may use the chat box to introduce yourself and answer any questions the presenter may pose to the audience.

In addition to the chat box, there is a Q&A pod, which is used to communicate directly and privately with myself and my Vera colleagues. If you have technical difficulties or a question for the presenter, please post in the Q&A pod. If you post about a technical issue in the chat pod, my Vera colleagues providing technical support may not see your post. You may also post questions about the presentation in the Q&A pod.

Next, we'd like your assistance in testing the features of this webinar. First, let's test the captioning pod. The captioning pod is located in the bottom left hand corner of your screen directly below the PowerPoint presentation. The words I am speaking should appear in the captioning pod. Please note that if you are using the mobile app on your smartphone or tablet, you may be unable to see the captioning pod. Instead, you will see a message that says "unsupported content." If you are on a computer and CAN NOT see the captioning, please send us a message in the Q&A pod so that myself and my Vera colleagues can assist you.

Next, in the pod to the right of the presentation you should see our American Sign Language interpreter. How is the light? Can you clearly see the interpreter? If you can clearly see the interpreter and the lighting is good, please let us know in the chat pod. If you can't clearly see the interpreter, the lighting is too dim to see, or you need any other adjustments, please use the Q&A pod to contact us. I will now pause for a moment to see if anyone needs assistance and to allow time for our Interpreters to make any necessary adjustments. OK, great, if, at any time, you have
difficulty seeing the interpreter, please contact us in the Q&A pod. We note that interpreter

switches will occur approximately every 20 minutes.

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Participants are in "listen-only" mode, which means we should not be able to hear you, but you should be able to hear us. If you cannot hear the presenters speaking, if you are having any difficulties with the captioning or interpreters, or any other technical difficulties during the presentation, please enter a message in the Q&A pod, to the bottom, right of your screen. We plan to have time after the presentation for questions and comments. If you don't want to lose a question or comment during the
presentation, please feel free to go ahead and enter it in the Q&A pod and we will hold onto your questions until the end. Please DO NOT put questions in the chat pod.
If you would like to download a copy of today's presentation, you can do so by going to the pod in the bottom right hand corner of the screen. Select the document and click the Download File button.

We will be recording today's webinar. A link to the recording, as well as the PowerPoint, transcript, and ending survey, will be emailed to all participants following the webinar. The webinar recording will also be posted on the End Abuse of People with Disabilities website within one week.

A record of attendance will be available for download at the end of the webinar.
Our presenters today are Kim Day and Angelita Olowu.

Kim serves as the Grants Projects Director at the International Association of Forensic Nurses, providing oversight, content expertise and leadership on issues of Forensic Nursing Practice, Policy and Protocol. She continues to be the lead Technical Assistance provider for the Sexual Assault Forensic Examiner Technical Assistance Project that is funded by the US Department of Justice's Office on Violence Against Women. A forensic nurse examiner with 40 years of nursing experience-as well as program development and coordination expertise-Mrs. Day consults on all aspects related to the medical forensic examination in sexual assault cases, training standards, and the SAFEta.org website. In collaboration with expert faculty, Ms. Day has developed and delivers two-day multidisciplinary Regional Training for Communities that seek to create or improve medical forensic examination protocols.

Kim presents nationally and internationally on a variety of forensic nursing related topics, including sexual assault and abuse, intimate partner violence, strangulation, child maltreatment and program management and sustainability. In addition, she has written, edited and reviewed the state-specific protocols and customized protocols for hospitals, journal articles, sexual assault response teams, and tribal communities. I see someone in the chat pod is asking what SANE means, it stands for sexual assault forensic exam technical assistance.

Angelita Olowu serves as a Forensic Nursing Specialist at the International Association of Forensic Nurses, providing training and technical assistance.
She has 10 years of nursing experience, and has practiced as a Sexual Assault Nurse Examiner, SANE, since 2010. She received her certification for SANE-A sexual assault nurse examiner adult in 2015 and SANE-P sexual assault nurse examiner - pediatric in 2016. Within her role as a full-time forensic nurse at Hillcrest Cleveland Clinic Hospital in Cleveland, Ohio, Angelita provided education and leadership to the forensic nursing staff, guidance around her patient population to the Hospital, and community education and outreach to various entities including schools, colleges and universities, and others on prevention and caring for those who have experienced trauma of personal violence.

She has served as a member of a hospital based Domestic Violence Committee, a hospital-based Child Protection Team, and the Cuyahoga County Child Advocacy Center Advisory Committee. She is a member of various professional organizations including IAFN, the Cuyahoga County Sexual Assault Response Team, and the Civil Rights Task Force. Additionally, she serves on a committee with the Collaborative to End Human Trafficking. Thank you, Kim and Angelita, I now turn the presentation over to you.

>> Kim Day: To talk to you about the medical forensic exam in patients that may have disabilities. Our webinar is funded in part by the office on violence against women and I want to let you know the findings, conclusions and recommendations from expressed in these presentations are of those Angelita and myself, do not reflect the views of the Department of Justice, office against violence on women or IAFN. As part of our service, we are able to off IAFN members continuing nursing professional development at the completion of this training and the completion of an evaluation.

So when Ashley contacted us to provide this webinar, we talked about what do we want advocates to know about the medical forensic exam and some of the specific barriers that victims face and the nurses face in providing medical forensic exams and we wanted to talk about some of the ways to overcome some of the issues that we have as nurses and you as advocates may have also come up against, specifically in this patient population.

Let me talk a little bit about language right up front. One of the things that advocates often refer to people who have experienced sexual violence as victims or mostly survivors, but as a nurse, Angelita and I talk about our patients, so we're going to be using them interchangeably here

during what we're talking about to you.

So first let's kind of talk about what we do know about sexual assault and disabilities. First thing is there is not a whole lot that we do know there's limited research and if we're talking about people with disabilities that are men there's even less research than the wider field. There also is limited professional training in this area, so those of you that are advocates may have seen this in the hospitals that you respond to or the victims that you work with or the patients that we work with as nurses.

So some of the facts, in a study from the University of North Carolina Chapel Hill they found that women with disabilities had no higher chance of experiencing physical assault in the past year. However, had four times of experiencing sexual assault, so not only will women with disabilities be at a higher risk of assault compared to those without, but such violence may have a greater negative impact of the well being of the women who's health might be already compromised, so what we see on the slide here are the current and intimate partners are the common perpetrators, it says 48%, which is actually common for all women, and then women with disabilities, as I said had more than four times the odds of experiencing sexual assault in the past year and that is from the UNC Chapel Hill study.

People with intellectual or developmental disabilities are seven times more likely to experience sexual violence, and in specific, women with intellectual or developmental disabilities are 12 times more likely to experience sexual violence, which is really disturbing and these are from an NPR special tabulation that was done and they took the bureau of justice statistics national crime victims survey and pulled out some of the data from that. When we're talking about men, again, we say there is little with men, but 14% of men with disabilities report experiencing sexual violence at some point in their lifetime compared to 4% of men without.

This is actually taking that national crime victimization survey and putting it in a graphic representation, so on the slide there is a graph that shows just kind of the difference between the people with disabilities and the people without disabilities. You find on the curve that it is definitely they are separated by quite a bit, so the bureau of justice statistics national crime victimization survey defines a disability as a product of interactions among the individual's body, including their physical, emotional and mental health and physical and social environment in which they live, work, or play. According to the bureau of justice statistics, a disability exists when this interaction results in limitations of activity and with restrictions to the full participation at school, work, home, or in the community, so we know what we're working with here.

So I put this chart up here about sexual assault and adolescent girls this is girls at age 16 on this chart and it shows clearly that there is a much higher instance of forced intercourse in girls with severe disability, mild disability and minimal disability. The important thing to remember here is adolescents are more likely than their peers without disabilities are forced to have sexual intercourse, as we know which is rape. As we move forward, keep those statistics in your mind, as much as we don't want to keep the statistics in our mind.

So there is some unique dynamics in this patient population that we see and I put these different areas together. People with disabilities are more likely to need assistance with personal, private tasks that can lead to victimizations. They may be targeted for perceived vulnerabilities and as this third point on the slide about people with disabilities are often denied sexual education, which is really a barrier to reporting, as well as a vulnerability and it also means they are more likely to be perpetrated against.

They may face you communication barriers when they attempt to report the abuse and when we consider people with disabilities may be vulnerable to the point of someone else provide care for them that individual can also prevent them from reporting, remove access for their ability to report, so these are things that are kind of dynamics that we face in patients with a vulnerable -- with this vulnerable population.

Angelita is going to talk next about some of the barriers that we see as nurses for survivors with disabilities.

>> Angelita Olowu: Good afternoon, everybody. This is Angelita. So looking at the barriers in particular of the various different types of disabilities that we are already aware of, if you can kind of in the chat put some of the barriers that you think, A, a patient or survivor of sexual assault may experience just attempting to get a medical forensic exam or any kind of medical response to that exam. What kind of barriers do you think they may experience? Communication, history of false allegations, unaware of the crime, difficulty remembering the details, language, these are really good, executive function, misunderstanding of the communication, pressure, transportation, that is a good one, re-victimization, mobility issues, those are really good answers. We are going to go into some details about barriers as we continue on. Thank you for continuing to add in good examples of some of the barriers that can come up.

So just thinking about this patient population and all of the different components of responding to sexual violence, getting exams, if you're deciding to report, reporting, getting resources when we think about those, when you look at the chart, it is kind of broken down into the various categories and what exactly kind of barriers the patient can be experiencing, they can be experiencing barriers in terms of their family, caregiver, in the component of a provider, exam process, health care system, access, in the form of advocacy, issues with resources and services and from the forensic component, lab and law enforcement. We're going to go into the types of barriers into more detail in the next few slides.

So there are three specific types of barriers that we can think about for survivors that have all types of disabilities and the three main ones consist of physical barriers, communication barriers and attitudinal barriers, so moving forward to look at physical barriers in specific. Some of you mentioned, this but some of the physical barriers that can be experienced and this could be something you don't necessarily have to be medical to think about, especially from the advocate standpoint, I'm sure many of you have been responding to patients who experienced these kinds of barriers where there is no physical access to space for that patient to get an examination. If you are medical and you think about your own facilities, what kind of physical

space is there that is accessible? I don't just mean the physical space of the exam room itself, I'm thinking for the ability for the patients to get through the hallways, the ability for patients to get through the doorways of the exam room, not just people with mobile disabilities, but think about and we're going to talk about those with visual disabilities as well. Are the facilities accessible to all patients? Speaking directly about the exam itself, is the person doing the exam, no matter what kind of exam it is, is the exam able to adapt to whatever patient they are dealing with, is there a way the exam can be adjusted to be performed before that patient?

Next I want to talk about communication barriers. As we know, sometimes the communication barrier can be around the ability for the patient to hear, so if the patient is deaf or we have a patient that is a deaf patient or if we have someone that has low hearing, do we have the ability to have interpreters, do we have ASL interpreters available for that patient? A lot of times there is a lack of privacy for deaf survivors. We want to make sure we are appropriately providing the patient with the care they need and the way they deserved to be care for, so what can we do to make sure that is accomplished? What are the things that you're able to incorporate for these patients and these situations? We definitely need to have materials available for these patients in alternative formats. If I have a patient that has low visual disability, I am not going to give them something that is in small writing, small font that they are not able to read. I want something in appropriate font that will work for them.

There is a need for materials to be in plain language and a need for providers that are caring for patients to communicate for these patients in plain language that they are able to understand, so when I'm explaining to a patient what the exam process is going to be, I want to say it in plain language so they can understand and not use a lot of medical jargon and a lot of medical terminology. As I stated about the materials, when I'm providing discharge information, patient information, I want that to also be in plain language.

The other thing I want to mention really quickly, we understand it is not always possible to have an interpreter right away to be able to respond when we are dealing with patients who have experienced sexual assault and that can be a barrier, but we want to make the most out of what we can and if we have the able to make the accommodations to be able to do that. These are some of the best recommendations that we have to be able to offer, but we do understand that in rural areas that is not something that can be done. I wanted to point that out, but we want to accommodate the patient versus trying to switch things around that it is more convenient for us. We want to accommodate the patient.

Next, we're going to look at the attitudinal barriers that exist, lack of familiarity on how to conduct accessible exams among service providers. As you heard Kim say earlier in the presentation, there is not a lot of training that is provided. It is just not there. The research isn't there. It is all growing, so we have to make sure when we do hear about trainings, when we do have things that come up that we begin to take that information and gain on it and not just one provider is doing it, but we do it systemic within our practices. We know there is a lack of familiarity and interacting with people with disabilities and talking about accommodations. We have become more comfortable in speaking up, especially if we have the ability to see that things are not accessible and trying to find ways to make things accessible throughout the

health care systems and, also in the systems that we work with. I'm thinking about other members of our response to sexual assault, so this includes law enforcement that includes if you have an advocacy agency that is not accessible, having the conversation within your multidisciplinary teams on how we can make that look better across the board.

Agencies and medical facilities do not prioritize developing accessible procedure for people with disabilities, so that is kind of the same thing that I spoke about. Let's try to realize how important it is. We talk about how health care is patient centered, we need to make sure we make it patient centered for all. Kim is going to talk about solutions for forensic exams and sharing accessibility for survivors with disabilities. Are you there, Kim?

>> Kim Day: Can you not hear me?

>> Angelita Olowu: Now, I can.

>> Kim Day: I don't know what happened. Sorry. I meant to do a sound check. Ashley, is this better, worse? Ashley mentioned I sounded staticky before. Angelita was talking a little bit about some of the training that we get as health care providers and it really is limited and I was so happy when Ashley reached out to do this webinar for her series. We are now having Ashley do two webinars for nurses, sexual assault examiners and forensic nurses on service dogs and support animals for nurses, because we just don't have the training that we need to understand how to work with those types of assistance that people may have.

When we talked about addressing physical barriers, we need to talk about the actual exam space itself, which is the room and then we need to talk about the procedures that are used to facilitate the exam. So the space itself should be designed in a manner in which the patient can move around adequately in the room and you will see this as an example of an accessible exam room. The exam room should have wider doors, so anybody can get through them and this is true for everybody. We need to make sure the patient can move around the exam room without stumbling over something, without running into chairs. This exam room has too many chairs in my opinion, I don't know what Angelita says. Yes, Judith mentioned using universal design and I love that. I think every single room in an emergency room, in a hospital, should be accessible to all patients and they aren't at this point.

Angelita and I are involved in project where they are developing a new program and they were able to design the exam room to specification and it's wonderful because any patient will be able to come in that room and get around easily. Another thing that you'll see in this exam table here it can be lowered all the way to the ground, so people can move over to it. There needs to be an accessible route into and through the room. This is really important. If we can't get them in the room, how can we get them on the table and how can we make them comfortable to do the exam? We also need the door, as I mentioned, to be clear of any obstacles. It needs to be wide enough for people to get through. There needs to be maneuvering clearance once they are in the room and accessible hardware, including the exam table and equipment. Most exam tables themselves don't have side rails. They don't have railings to be able to have people move themselves once they are on the table and that is another consideration that should be

made when you are setting up an exam room and if you all are working with sexual assault programs or forensic nursing programs, I hope you will offer to be able to assist them when they are looking for purchasing new equipment to outfit their rooms, because you all that are advocates for people with disabilities are in the ideal place to have them come through, even have some of your clients come through and give comments on the exam space itself. There needs to be adequate clear floor space, as I mentioned before, so people don't fall or trip over something.

Also, we need to make sure this happens before the patient comes in, so I always say it is best to be prepared for everything, which nobody is prepared for everything, but some of these accessible exam room suggestions are just common sense if we're working with a patient population, which we are. So when we're talking about positioning and the exam table, I just put a few of the different things to consider on this slide there are just four different clouds on the slide, with just a few of the things that I talked about and this is altered balance or weakness for the patient. They may have spasticity or contractures and you have to be careful about skin pressure and I'm sure there are many more that you all know need to be considered when we're moving the patient into -- on to the exam table and we may be working with folks that are not able to be placed into what we consider the usual or typical positions and that doesn't mean that the patient is not able to have the exam. It just means that I, as the nurse, need to be creative in how I make specimens, how I position the patient for comfort and every single medical forensic exam and I'm sure Angelita will echo this, it is always adapted to the individual. Everyone has unique needs; we need to adapt the exam to fit that survivor or that patient.

One thing I would be remiss if I didn't mention this, for health care providers and for those of you who advocate with patients or female survivors that may have spinal cord injuries there is a -- there is a concern for a condition called autonomic dysreflexia, ADR, this is spinal cord lesions that occur above spine number six. It can be a lethal medical emergency causing severe hypertension and why do I put this here? Because it is not something that is might not be considered as a possibility and we need to be able to understand that. Are you still able to hear me? OK, -- Gloria lost sound, I want to make sure you can hear me. Angelita is going to talk about why does all of this matter. Why does accessibility matter?

>> Angelita Olowu: We're going to look at a settlement that occurred in 2005 with the Washington Hospital Center, which is one of the largest private hospitals in D.C. The settlement was one of the first of its kind. It required the hospital to provide access to hospital facilities and equipment for patients with mobility disabilities, as well as other disabilities. With the settlement, the hospital had to remove barriers throughout the entire hospital. They had to procure accessible exam tables for every department that uses exam tables and all new table and chairs were purchased and accessible. Kim mentioned this, because lot of times it is not thought about, not just the exam tables, but the regular waiting room chairs. Patients have to be able to utilize them and if it is not thought about and not done, no matter where you go in the facility, it is not helpful. It is a facility that cannot service everybody and that is the whole goal of a hospital to service anybody who walks through their doors.

There was a survey on all of the equipment and purchase -- sorry, there was a survey that was done to decide which equipment would be accessible and what was needed and where they needed to replace equipment, so that is a big deal for them to be able to do that as a huge hospital. There also was revisions to their policies. They were able to implement special procedures for patients with spinal cord injuries and provided training to staff to ensure the implementation of the new policies and trained the staff on how to use the equipment. It is not helpful to have new equipment if you don't know how to use it. It does not help to have new policies if everyone across the board does not learn them and how it affects their job and how to care for patients appropriately, so that was an important settlement. Really big.

We're going to go back to addressing barriers and talking about communication barriers. So thinking about our deaf survivors, we understand -- thinking about our survivors in general, we understand there are various disabilities and how their impact can look different thinking about our deaf survivors, survivors with low vision and patients that are blind and patients that have cognitive disabilities. Throughout some of the slides, you will hear us use the term cognitive disability, keep in mind that is a broad term and intellectual disability goes under need that as well. I just want to let you know Kim is having technical difficulties. If I pause or keep going, I just want to make sure she is good on her end.

Looking at people -- sorry, looking a the deaf people population and what kind of things will cause barriers for them? The patient may have difficulties accessing advocacy services, is there interpretation available? What other barriers could a deaf patient experience when it comes to facilitating a medical forensic exam? Can we throw a few suggestions in the chat box? Looks like communication with consent or withdraw of consent, absolutely, that is a really good one. Making sure they have access to be able to say, especially to withdraw a consent that they no longer desire to go along with something they agreed to do earlier. Access to American Sign Language in rural areas, absolutely. I will take the last one. English is the second language for some, American Sign Language signers, so it may not be accessible, perfect.

We need to make sure we actually ask the deaf person what their preference of communication is that is really, really important and knowing just as it was stated, English may not be their language of preference, making sure there is access to an interpreter is first and foremost important and they are comfortable, because thinking about the facilities that do have access to an in-person interpreter, sometimes they have to do a remote video interpreter, sometimes they have to do other ways and you need to make sure that patient is comfortable with the way you're able to provide that care. As we said already, keep in mind that in person is the preference, but is not always available.

Another really important thing and this goes for patients with all disabilities is to make sure we are communicating directly to that person, specifically for the deaf patient that we're not talking to the interpreter. That comes across so many times in various forms of disabilities where the patient is not being communicated to explicitly by the provider that is an important thing to hone in for people, especially providers. If you come across someone who is not doing that, have that conversation with them to help them understand why that is so important and to not rely on

note passing and lip reading, so note passing is not appropriate, but I personally have seen it done plenty of times in medical facilities and they come in and give them a piece of paper. We have to keep in mind that not everyone is on the same level, they don't speak the same language and some people don't write and you can't rely on lip reading. You may assume they can understand what you said and sometimes they shake their head and say they agree or understand and they do not, so do not do note passing or lip reading unless that is what the patient has requested.

>> Kim Day: This is Kim. I'm able to talk again. It is interesting because let's see, I think it was Jesse Zhang talked about the interpreters, the ASL interpreters not having the right training to effectively interpret the medical terms and situations, which is true. Yes, it is so true that is why when we're talking and training with nurse examiners on program development, one of the things that we stress that is important is contacting with the interpreters in your area or the places that have services that your patients will be going to and bringing them in for training. Have them train the nurses and have the nurses talk about the exam. Bring folks into the exam room, so they are comfort with where they need to stand during the exam, with some of the procedures that are done during the exam and feel free to ask questions to the nursing staff without the patient being there before they have to serve the patient. I think that is a really great -- go ahead.

>> Angelita Olowu: Also, about the terminology that is used. A lot of last time becomes an issue with the comfort -- the level of comfort with the terminology that is used when we're doing medical forensic exams and it is help to feel have that conversation ahead of time of exactly the type of things that we have to talk about and thinking about finding the words, the appropriate words to portray the questions that you're asking.

>> Kim Day: Right. That's great. So after we -- we want to talk also about people that may have visual disabilities and this includes blindness, as well as low vision and low vision is an issue that impacts many of our patients and the thing for us to remember as nurses is that they may not share this information. The nurse needs to be aware of the fact that the patient may not be -- may not disclose that right up front. What are some of the -- some of the clues that you may clue the nurse in to whether or not the patient may have a low vision disability? Some people may want to write that into the chat box. Squinting while reading paperwork or not being able to read the paperwork. I hope the nurse refuses to read the paperwork, not taking it, thank you, Kendall, so they won't talk. They may not be able to see it, sometimes they get frustrated if they are unable to see something. I know that -- I know that someone in my family has low vision and that is one way that they are able to tell me they are in a situation that they can't see is they become frustrated, some of the things that should clue the health care provider into this, you can use certain diagnosis, like if the patient has glaucoma, if they have cataracts, retinal detachment history, in some cases, if they come in and have a traumatic brain injury, which can happen during an assault or during a domestic violence incident, they can have macular degeneration and even things like arthritis and diabetes can affect vision. On the screen, we have things that we need to consider for this population is the exam, thinks the provider does themselves, the advocate, how can they advocate for that patient and the team itself there is often misconceptions about low vision services there can be a lack of awareness. The patient

will have needs for transportation that not every patient may have. It is as important to understand that they also have unique needs like every patient, but we need to be able to have somebody suggested using an iPad instead of traditional paperwork. Touch screens have inversion features that help people to be able to read better that is a great suggestion, CJ. This is why we need to have our advocates working with us as we're trying to prepare things like our paperwork and our exam space.

We should never make assumptions, actually about anyone, but about people's visual ability. We shouldn't touch, as a health care provider; I shouldn't touch or move ability aids or service animals, which Ashley is going to talk about on Friday for us.
We should describe the procedures before we are forming them. Making sure we get permission to touch the person before doing it, we should describe it and get permission to do it. One of the things about the medical forensic exam, I don't know how many of you all have been accompanied a patient for that, but we do goat informed consent upfront. We tell them about the exam, but we tell the patient at any point during the exam, we -- they can say no. Just because they sign a permission in the beginning of the exam for the exam to be done, we still continue to ask the patient throughout the process whether or not it is OK to continue, so that is just one of the things that we want to do and all forms and documents should be available in large font and I know they are not because I worked in an emergency room for years and years. I know they are not in large enough font. They should be available in Braille, but we should also understand that people that are blind may not be able to read Braille. Not everybody can and they should be available electronically by you a screen reader and we also, somebody mentioned this in the chat box, but we absolutely always should read it out loud to the patient, so we are sure they are getting the information that we need them to have. Angelita is going to talk more about cognitive and developmental disability suggestions.

>> Angelita Olowu: Yes, so in your handouts that came along with the webinar today or you will get following the webinar, you're going to find a flowchart that was incorporated. The flowchart is specifically around caring for victims of sexual assault that have disabilities. We think that is going to be helpful for you with making a process or making sure your community has a process in place that looks more universal, as well as we included pediatric national protocol consent for care. They have good techniques that can be utilized in getting consent from patients with disabilities; specifically around patients with cognitive disabilities that is what I'm going to talk about now is patients with a cognitive disability.

This is another one of the diagrams and it explains what the last couple -- looking at it what can be affected in the care of the patient and how would these different -- how would these different entities have to think about how they would adjust their role in caring for patient.

We talked a little bit about consent, but we want to make sure that consent is obtained and where that consent comes from may look different depending on the patient, depending on if they have a guardian, is this guardian their legal guardian? Do they have a guardian that is directly over their financial decisions and they can make their own medical decisions? We have to understand when it comes to the cognitive developments or delayed patient who is able to give consent and make sure we are obtaining the appropriate consent from them. As

Kim just mentioned, we have to have the consent from the patient and the patient has to be agreeable and willing to have the exam conducted and they have to understand that they have the ability to say no to any part of the exam and consent and assent continues throughout the entire process. It is not something that we will just ask in the very beginning and never go back to it that is something that is continued to be verbalized with that patient and make sure they understand. If we are noticing that the patient seems uncomfortable or cues coming up, we stop and reassess the situation and make sure it is OK to accommodate with the process of the exam. They have the right to decline any pieces, portions, or part of the exam any time throughout the process, so that is really important.

Education and instruction should be given so the patient understands and is comfortable with what we are offering to provide them, whatever that care is and these are things that should be across the board and know we're specifically talking about caring for the patient who experienced sexual violence, but this should be across the board not just in the care of the SANE nurse. We should adjust it to something that works for them, so if we need to provide videos for them. Can you hear me OK? I have an echo on my end.

>> Kim Day: Angelita is asking if you can explain assent.

>> Angelita Olowu: Consent is getting verbal permission and the written permission from the patient after they have been informed of everything and assent means the patient is willing to go along, so assent goes along when you have a guardian or another person that is giving you consent. It will be clear if I say pediatric patient. If I have a pediatric patient and they may not be able to say yes, I legally can sign this exam, so their parent says you can legally do the exam and I have to go to that pediatric patient and explain what I want to do them and they have to say OK, I agree, you can do this to me or they say no, I'm not comfortable with that. If they say no, I don't have the assent and I will not force them and cannot force them to do the exam. Any time you have someone to give consent for them, the person who is unable to consent for themselves, they have to be able to do assent. They have to be willing to do what you're asking them to do, if that makes sense. I hope that was helpful.

Some of the resources we can provide whether they are pictorial guides or videos, in your handouts there is a link to pictorial guides that you can use for patients and pass on to SANE nurses that you are working or any kind of advocacy program in your community and we need to direct the patient directly. Speak to the patient and not the support person or the guardian that is with them. I can't get a person's assent from them if I'm talking to someone else. I have to make sure they are clear on what I'm wanting to do with them and I need to make sure they are OK so that requires the conversation with them, cannot direct the conversation only to the parent or only to the guardian that is there with them.

The next one is suggestions to go along with providing the medical forensic exam, specifically. We want to have the opportunity to conduct the exam without the parent, caregiver or guardian present. The reason behind that is sometimes the perpetrator is the person providing the care, so we need to be able to assess the safety of that patient and sometimes it is not that person, but sometimes they may not be as willing to talk about what is happening if that parent or

caregiver or the guardian is present. They may feel more fearful and not open as much as they would if you're able to speak to them without that person there, so we want to try our best to make sure we're able to do that and, again, this is ideal, but if we have a person that we're not able to do that for, we just have to make sure we're trying our best to accommodate that patient and if this is a situation with not able to do that it is understandable, but ideally, you want to try to do that all of the time.

Encourage expressions of concern. I spoke about that as well. You want to make sure you are encouraging that patient to speak up, but also encouraging advocates, if you have an advocate working with you, to be observing verbal cues and nonverbal cues and the provider to do that as much as possible. Assess for coercion, a lot of times the caregivers are the perpetrator so we need to have that concern in the back of our minds and be assessing that while being with patient. Identify if the parent has a history of gynecological exams just to be able to experience any trauma and receiving medical care in the past. Many times a patient with disabilities will go for a regular exam and nothing that we're encouraging is happening in a visit and it is traumatizing to them. We want to care for this patient and I need to know if this happened to them in the past, not thinking of it as a sexual assault component, but thinking of it did something traumatic happened to this patient that I'm getting ready to retrigger for them. I want to adjust my care for that patient off of knowing that and that is important to have that conversation and have a conversation to understand what exactly has happened to them in the past and how the exams have went. That doesn't just, you know, it is not just the gynecological piece of it, but have they experienced breast exams where that is not something they are regularly doing.

Again, if the patient is coming to a sexual assault nurse examiner for reasons of being sexual assault, the nurse is still a nurse and there is a medical provider so they need to think about what the needs are for the patient that need to be address. You want to have a clear understanding of what you're about to do next and the patient is still consenting. Kim is gown the talk about attitude and no barriers now.

>> Kim Day: Thanks, Angelita those were great discussions points, especially about the patient often hasn't had a GYN exam before may not understand or they have had negative experiences with health care in general and one of the really important things is we never force this medical forensic exam on a patient. We don't hold them down or restrain them to have the exam that would be traumatizing and we don't do that.

How many of you have had -- seen in the health care arena, if you're an advocate for sexual assault patients, domestic violence patients, just an advocate for disabled community in general, what kind of attitudinal barriers have you seen in the health care arena? I know there are many of them. As a health care provider myself, I know there are, so if you want to put some suggestions of attitudinal barriers that you have seen in your practice or in your providing care for patients for people with disabilities. attitudinal barriers, mistrust of anyone, that is a good one. People don't believe older adults can with sexually abused and that is so true. People don't believe that people with disabilities can be assaulted or sexually abused. This person just misunderstood what happened, blaming it on the victim, blaming that they did not

understand the contact that happened, people being impatient and not believing the survivor. We see that. Angelita and I have both seen that. I think a lot of the other nurses on the call as have.

This is why it is important to partner with our disability agencies or for you if you're a disability agency provider to partner with your sexual assault nurse examiner programs, because we need the education and we need the assistance for getting our patients the resources they need, as well as looking at our process to make sure it is accessible for all patients. Somebody said, Mattia says she experiences resistance to the slower pace that is necessary for performing the exam with a survivor with a disability and I'm sorry that happens, but in the world of trying to get people in and out, often it can happen and it shouldn't be. It should be that the patient is the one that sets the pace for the exam, always.

Some of the other things to talk about, too, this is adapted from the center for disabilities in New York, the center for independence of the disabled in New York, but to the general things for health care providers, which you can share this with your SANE programs that you work with, your sexual assault nurse programs, your emergency departments that you work with. We said multiple times that the patient needs to be added directly. The nurse or the physician or whoever is providing care always should and this is for us, too, as the health care consumer. The role of the person caring for you should identify themselves by name and tell you what their role is. You may not get their first name and last name, sometimes for safety reasons we only give the first name, but they should be able to tell you what their role is, so when somebody comes in to draw blood, they should tell you their name and they are there to draw blood.

The health care provider can offer assistance, but they need to wait for the person to say yes or no and to give instructions on how that assistance will be accepted. We need to treat adults as adults. We often see that is not done and we respect boundaries, this is a critical area that I think people are just not even aware of that they are doing, so I think it needs to be pointed out and practiced, not to lean on a wheelchair or a device of a patient's they may be using for mobility. We need to listen attentively to people who have speech difficulties and that can sometimes take some time. Once you are working with someone, it often is -- it evolves overtime and we need to be at eye level when speaking to someone, not being high above them and we need to speak in plain language and that is not dumbing it down. I think somebody put that. We realize as nurses, we speak in medical jargon. We're so used it, says someone said in the beginning what is a SANE, we are so used to using the words that we don't realize we're using them. We need to practice using plain language and this is one of the things that Angelita and I when we're teaching new nurses to become sexual assault nurses, one of the hardest things for them to do is explain what the role is and about the exam in language that anybody can understand, so we have to practice that with them.

Another caveat for any patient is if you're not sure, as a provider, you need to ask them what their needs are or ask for permission and seek permission. Judith pointed out we need to use these for anyone and very true, very true. I wish everyone would use these for all patients.

One of the general tips is someone -- also we need to ask the patient how the provider can be of assistance to them, so they can verbalize or they can show you what they need. We should not assume that the person does not have a disability -- that the person has or does not have a disability. We also need to focus on what the patient needs to have a positive experience. Also provider should be asking the patient, if there are any additional needs to support them through the exam and this is true for people with disabilities, but also people without. This is a situation that most likely have never experienced before. It is the first time for them and we need to be sensitive to that and allow them to be able to take time to tell us what their needs are. Some patients may not want to disclose their disability and we have to respect that or the nature of it, but they may disclose additional support they need. They may not want to disclose their disability or the nature of the disability, but they may disclose that they need additional supports and if we don't ask, we won't find out.

So this slide has some questions on it for consideration when you're working -- I'm a nurse and I'm working to develop a program or I have a program that is already developed, I want to know what my resources are for working with patients with a disability in my community and I want to know within the medical facility that you may be accompanying patients to what are their supports and resources within the facility? So for both of us, the nurse I want to know what is in the communities to refer people to and as the advocate that might be coming in with a client with a disability, I want to know what are the resources within that facility to provide care for that patient. Also, what are your options when you are in need of accessible space realizing sometimes exam rooms are limited. They may not be accessible, is there another exam room that a patient can be taken to that is accessible? I would love it if all of you that are doing advocacy for patients with disabilities would go to those health care facilities, find out if you can do a tour of their exam room and, please, give feedback because we need that.

Also, is there additional staff that can assist in making adjustments necessary to accommodate the patient that needs the exam? I know that somebody mentioned the current outbreak of COVID-19, realize there is a lot of moving around in the health care system right now, some advocacy agencies are not able to do in-person advocacy at this point and what we're seeing is they are doing telephone support or tele-medicine support, using other mechanisms, but what I'm as hearing is some SANE programs are having trouble keeping their exam rooms because they are being confiscated, I use the word confiscated, but they are being reused for regular patient visits and that can be really disturbing.

Also, what are the community resources for patients that we see with disabilities? We want to know where we can discharge them to. Angelita, did you have anything to add here?

>> Angelita Olowu: No, I think you pretty much covered the basis there. I was going to touch on the point, which I think you already did about instead of moving our patient, the disabled patient, making accommodations to move the other patients and find a space that does not require the movement of the disabled patient, again, just accommodating the patient and not making the accommodations for the hospital versus the patient.

>> Kim Day: Yeah.

>> Angelita Olowu: You already touched on that.

>> Kim Day: Yep. We do have a few case studies that we want to talk about. I'm going to do the first one and Angelita has a couple of patients that she saw, but the first one is Angie who is a 40-year-old patient and has cerebral palsy and in this situation, the caregiver came with the patient. They brought them into the emergency department and when the nurse was asking the patient questions, because that's what we have to do is get a history from the patient, the caregiver answered the question opposed to the patient. So the patient looked unkempt meaning her hair was out of place, she had bruising on her thighs and buttocks and she was afraid when we offered to report what happened to her to the plus. What are warning signs that you all see in this -- in Angie's situation? Anybody? Put it in the chat box. Somebody said she should be screened for trafficking or yep, Veronica noted the caregiver was speaking for the patient, really true. The fearful -- the fear in the patient should be a red flag as she is a vulnerable adult. She is already a vulnerable adult. She may not be with cerebral palsy, it does not mean that you're not capable of caring for yourself. In this instance, she did have a caregiver. She could be in an abusive situation all over as, Babs says. The bruises are concerning, why is that, because they are on her thighs and buttocks. If she has it on her bony Providences like kids do, knee, elbow, shin, you would not be as concerned, but you look at places that are protected like the thighs and buttocks and if you're seeing bruising, you should be wondering, why am I seeing bruising? Her physical status of looking unkempt and unput together should be looked at. Elizabeth says fear of police is kind of norm and it is. Was she being neglected? So just the four bullets the nurse should use to plan the care for this patient.

One of the things that is critical is that we should separate Angie from her caregiver to talk to her by herself. This may be difficult for the patient, too, but we should always do this as nurses. Angelita is going to talk about Leon. Are you able to talk, Angelita?

>> Angelita Olowu: I was talking and I guess I was muted. So Leon would be an 18-year-old deaf patient, male. He arrived at the emergency department and the triage nurse provided him with pen and paper and told him to write down why he was there and he did so. He said he was sexually assaulted. He also wrote down he was concerned that the perpetrator is well known in his community, so based off of those few bullet points that we have here in the initial conversations with this patient, what stands out for you that would be a concern of how he is already being treated? Again, we can use the chat box that would be great. So Babs says he needs an ASL interpreter right away. Kelly did not ask if he wanted an interpreter and handed him a pen and paper, yeah, no communication. No way of attempting to communicate to see what his preference was. Did he want to write things down? Was he comfortable with that? They did not offer him an interpreter. They did not ask him how he normally communicates, does he have something on his phone to communicate with as well so that would have been a good question.

Make sure all reporting options is explained to Leon and does he have the ability for an anonymous exam that needs to be done, absolutely. Does he want to report at all? Being deaf and -- being deaf is one thing and the perpetrator is in his community, so one of the big things

that we want to think about when we are thinking about the deaf community, we're thinking about a deaf person in the community that they reside in is usually a close knit, small community, so finding out if that person actually wants to make any kind of a report is really important because we want them to feel safe, not just safe in their community, but safe in the hospital. We want them to be able to go back to the community that they are used to and able to be within their community and interact like they normally do and if everybody knows that person and he reports, is he going to be able to do this? Is he going to be comfortable doing so? Who does he want for support? What is his advocacy options, absolutely.

CJ just pointed out --

>> Kim Day: Angelita, Judith's comment that he already feels not as important as the perpetrator that is so true.

>> Angelita Olowu: I missed that. That is so true. CJ addressed this being a traumatic experience and how often voices are silenced because of that and these are good points and things we need to think about. Key parts were not just about the health care interaction, because that in of itself there are a lot of things that happen there and if no one spoke up about it and that same care would have potentially continued own, which would have him concerned about continuing his care and how can we make sure he has resources within his community and try his best to function on a regular, daily basis, those are good responses to that. I'm going to go to the next one. We have one more.

So Rhonda is a 32-year-old female who is a quadriplegic with a history of a traumatic brain injury. She arrived to the medical facility alone, via a private ambulance, so she was not brought in an emergency situation. She lives at home with her mom and her mom is her caregiver, but she has an uncle that lives at her home as well. She stated that she recalled her uncle administering her medications and her mom came back later and administered the medicine again. In this particular case, the patient did say to her mom she felt like her uncle administered meds to her and her mom said no, you must have been drowsy or dreamed that. What are the concerns we have with this scenario? Why did the uncle administer the meds? Exactly, why is her uncle giving her medication? Possible, purposeful drugging, why did mom not believe her, count the meds that her mother disregarded her feelings, her concerns. Some of the things from the medical standpoint is looking at her medication list and look at what kind of meds does she take, does she take meds that make her drowsy and she gets an additional dose, does that put her to sleep, putting her into a place where she is way more vulnerable where she does not remember being sexually assaulted. Does her mom disregard her feelings, is she like I'm the only one that takes care of her and the fact she came by herself. I would ask more questions to see if there is something going on and she is able to verbalize why she was there by herself. You guys have good points that you pointed out. I want to be able to leave a few minutes to wrap up the session. Janice says why did she come in, she came in because she was concerned something happened. She was with it. She did not have a neurologic deficit related to her brain injury and the meds she took made her drowsy, so she took them when the uncle gave them and she thought her mom sent her and her caregiver sent her in. She did disclose to mom that something was happening and mom dismissed it and so she told the

caregiver and the caregiver made arrangements for her to be brought in.

>> Kim Day: Ashley, are there any questions we need to answer?

>> Ashley Brompton: This is Ashley. There are a few questions, but we are running low on time, so we may choose one of them and if your question isn't addressed today, please e-mail. I'm going to put Kim and Angelita's contact information on the screen and there are links in the Powerpoint and an example of a pictorial guide, an example of a video tour of a nurse examiner program and talk about sexual violence resources. I'm putting Kim and Angelita's contact information up, so those questions that we didn't get to, you this be able to reach out via e-mail, but we have time for probably just one question. There was a question about collecting evidence from service animals and mobility aids, if you can provide recommendations about whether that needs to be done and how to go about doing that?

>> Kim Day: Sure, actually this is a good question. It is a great one, thank you. So as far as the assistive devices that a patient uses or things like the pad in a wheelchair or something that the patient is always using, we would never take those from the patient, so make sure that is never done. Evidence can be collected off the surface of items like that. We can use swabs to swab the surface, so say -- I'm thinking of a pad on a wheelchair in particular. We wouldn't take that. We wouldn't take the wheelchair. We wouldn't take a communication device. They can be swabbed themselves, as you know, as we are talking about things being cleaned off, D.N.A. can stick on surfaces and that is what we swab for. As far as the service dog, in general I would think there wouldn't be D.N.A. on the dog themselves, if there are things like -- what is it called -- the harness, do you know what the called on the dog? I'm going to ask you, Ashley because you're talking about service animals on Friday. There is a leash or something on them we can swab that also or if they have some kind of a harness on them that can be swabbed, also. The dog itself would not be swabbed. Does that make sense? Collar, someone called it a collar.

>> Ashley Brompton: Yeah, thank you so much, Kim. Unfortunately, that is all the time we have questions. If you have questions, please e-mail and Kim and Angelita are willing to take e-mails and response questions where there is a project dedicated to this work around sexual assault forensic exams, so please visit their website. It is also on the PowerPoint slide that you see in front of you. I am going to switch the screen for one moment. We do ask that you take our survey. It is linked just below the PowerPoint. It says webinar survey. You click that and click the browse to button. This survey takes a few minutes and helps you to share your thoughts with us so we can continue to meet your needs. The second survey you see there is for those of you who are looking to receive credit hours from the international association of forensic nurses there is a separate survey for that and, again, this is only for nurses, so if you are not a nurse, you don't need to worry about that second webinar survey, but please complete the first one. If you are a nurse, it would be great if you can complete both of them.

A PDF power point is available for download at the bottom right-hand corner of your screen. You see it in the file pod and click on. File. Record of attendance is only available by download or individual e-mail request. We will not e-mail them out as part of the follow-up materials e-

mail. For those who are interested in downloading a transcript of the webinar, you can do so by going to the captioning pod at the bottom of the screen and click on the button that says save. We will leave the webinar open for a few minutes to give you time to download this material. Thank you so much for coming today, particularly those who are dealing with so much right now related to COVID-19 and your responses, those of you who are in hard-hit communities. Our thoughts are with you and we appreciate you taking time to spend with us to talk about this important topic and thank you Kim and Angelita. We appreciate you sharing your expertise with us. Thank you, everyone.

>> Kim Day: Thank you.

>> Angelita Olowu: Thank you for joining.

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