CHAPTER 4

27 FORENSIC PATIENT CATEGORIES

It only took seconds. Thomas had heard this so many times before from so many of his patients. Thomas felt completely helpless and overwhelmed. How could it happen so quickly? He was sure there was something he should have done, but what? He was so adamant about not being a victim and he made sure he never put himself in such a compromising position. He had heard so many stories and had been trained well. It was his job to help, not become a victim.

Introduction

Historically, throughout Australia, forensic nursing has been associated with prison and mental health patient populations. There are vast amounts of educational programmes, hospital guidelines, legal requirements, nursing pathways, and published literature that address these two forensic patient categories (*Mental Health Act*, 1996, Health Department of Western Australia, 2007, *Prisons Act*, 1981, Hospital B & C policy and procedure manuals). However, there very few educational programmes, hospital guidelines, or published literature that address nursing care issues for the majority of the forensic patient categories.

One explanation for the lack of comprehensive forensic educational material in Western Australia is the absence of published literature identifying and categorising existing forensic patient populations. The researcher could only find one published study that scientifically researched and identified the existence and types of forensic patient populations. In 1998, Pasqualone published the findings from her Masters in Forensic Nursing thesis entitled *An examination of forensic categories among patients seen at a community hospital emergency department* in which she identified 24 forensic patients categories who presented to a USA emergency department for medical care during a 60 day period. Later, in 2003, Pasqualone revised her work to include three additional forensic patient categories (G. Pasqualone, personal communication, June 22, 2003).

In order to develop a practical forensic educational package that would address the current void for nurses, the researcher first believed it essential to identify the different type of forensic patients Western Australia nurses treated on a regular basis.

The ability to replicate Pasqualone's (1998) results was pivotal to the researcher developing functional and comprehensive educational material for Western Australia nurses. Without establishing a clear target population, any educational material developed may not have been suitable, applicable or helpful to Western Australia nurses working in the ED. Therefore, to establish who the forensic educational package should target and the type of forensic issues that required consideration, the researcher was first compelled to identify the forensic patient categories that existed in Australia and to compare these with Pasqualone categories.

This was because; firstly, there is significant diversity between Australia and the USA in regards to each country's national policies, healthcare systems, legal requirements and statutes. Secondly, it was done to determine whether the same forensic patient populations encountered within the USA research would be identified within the Western Australia healthcare setting.

During the replication study, a majority of the parameters and conditions outlined in Pasqualone's (1998) methodology were copied. There were a small number of variations that occurred in the replication study that were unavoidable. For example, hospital bed numbers varied between the two hospitals varied (229 in the USA and 82 in Western Australia). Additionally, the Western Australia replication study was set over 30 days instead of Pasqualone's 60 day study. The time differences in which data was collected occurred because no new data was collected and no new forensic categories emerged after 30 days.

Pasqualone's original Master's thesis was conducted on the east coast of United States and published in 1998. Pasqualone reviewed 3436 medical charts of patients who had presented to the ED within an unspecified sixty-day period. A list of patient's initial complaints and/or final medical diagnosis that could be classified as forensic were kept and separated into specified categories. In addition to the chart reviews, Pasqualone identified some forensic categories that were associated with USA mandated reporting laws such as child abuse, elder abuse, firearm injuries, and animal bites.

Pasqualone's 1998 Master's research identified 24 categories of forensic patients. Later, in 2003, Pasqualone reviewed and updated her research findings which are yet to be published (G. Pasqualone, personal communication, June 22, 2003). Three new forensic patient categories were identified that needed to be included into her original research. The three new forensic categories include; Victims of mass destruction/terrorism; End of life decisions/Do Not Resuscitate; and Control of Communicable diseases. The version of Pasqualone's work that was utilized as a guide for the Western Australia replication study related to the updated list of 27 forensic patient categories (see Table 1.1). The forensic categories listed in Table 1.1 occur in the descending order of frequency with the last three places (25 – 27) designated to the three new forensic patient categories.

The working definition of a forensic patient utilised in both this study and Pasqualone's (1998, p. 18) research is defined as "any patient whose presenting symptoms and/or discharge diagnosis have legal implications as a forensic case". Furthermore, a forensic category was defined by Pasqualone (1998, p. 18) as "a classification of traumatic injuries or subtle violence, whether physical or psychological, which results in an interface of the health care and legal systems".

There has been no other published research about forensic patient categorisation other than Pasqualone's work. Because this research was conducted in the USA, it was unclear whether all of Pasqualone's 27 patient categories would be appropriate to include in an educational package designed specifically for the Western Australia healthcare setting. Without replicating Pasqualone's study, any diversity in country, culture, law and healthcare systems may be overlooked. Therefore, a replication of Pasqualone's (1998) study was conducted for two main reasons: (1) to investigate whether the USA findings could be applied to an Australian setting and (2) whether there were forensic categories that needed to be added or eliminated to address the Australian population. The discussion below will describe how the replication study took place and explain the results.

Replication of Pasqualone's Study

There has not been any published Australian research which describes and evaluates successfully implemented forensic nursing education packages, only articles that support such development (Evans and Wells, 1999; Saunders, 2000; Baston and Simms, 2002; Pavlik, 2004; Hofner, et al., 2005). Therefore, in order to develop a comprehensive forensic nursing educational package that addresses the healthcare issues and patient populations in Western Australia, an investigation was required. Below is a discussion about the replication study that took place.

Methods

The setting for the Western Australia replication study of Pasqualone's (1998) forensic patient category research was conducted in a outer metropolitan hospital (designated as Hospital A –[HospA]) whose ED and surrounding community demographics were similar to those discussed in Pasqualone's research. After gaining approval from the University and Hospital ethics committees, data for the Western Australia study was collected retrospectively over a 30-day period in August 2003.

Pasqualone's (1998) study was conducted in the state of Massachusetts which lies on the east coast of the United States. The community hospital was situated in a suburb outside the Boston city perimeter. The suburb in which the study took place was predominantly dense and urban. The total population averaged 58,000 but increased during the day to over 116,000 as a result of commuter traffic into the city.

Hosp A is a small community hospital located outside of main city perimeter in Western Australia that serves approximately 127,337 people. Hosp A sees a similar number of patients per year (28,000) to the hospital utilised in Pasqualone's (1998) research (22,500). The total nursing staff numbers in each hospital ED was also similar. HospA had a total ED nursing staff number of 38 while the hospital used in Pasqualone's study had a total ED nursing staff number of 30.

There were two major differences between the two research sites which was bed capacity and the average number of patients seen per day. HospA has only an 82-bed

capacity compared to 229-bed capacity stated in Pasqualone's study. In addition, the average number of patients seen in the ED per day in Pasqualone's study was 59 while HospA saw an average of 95 patients.

Pasqualone (1998) used a 60-day sample (n=3436) to represent a typical ED sample in her USA study. The system of categorisation occurred as a retrospective study by reviewing ED medical records during the 60 day time frame. As the medical records were reviewed, a flow sheet was kept of patients who fell into each predetermined forensic patient category.

Pasqualone did not disclose which months were sampled in her study, nor could a specific month be chosen to represent a typical hospital year in Western Australia. Therefore, August 2003 was chosen as the arbitrary month to represent a current and typical Western Australia emergency department sample for the replication study. Months that were anecdotally believed to be particularly busy (June and July) or usually slow (January) were excluded from consideration.

All individuals who presented to HospA's emergency department for treatment during the month of August 2003 had their records reviewed. However, for an ED chart to be generated, individuals must be assessed by the triage nurse and register with the ED clerk. Only patients registered as ED patients from the period of August 1, 2003 commencing at 0001 to August 31, 2003 at 2359 were considered for this retrospective chart review.

Data collection

The medical records manager at HospA was approached for assistance and advice on how best to obtain all of the required medical records required for this retrospective study. The researcher, for the purpose of consistency and reliability, reviewed all patient charts during this ED audit.

Hosp A utilises the Emergency Department Information System (EDIS) to triage patients. This system does not allow the triage nurse to describe the presenting complaint of each patient. Instead, the triage nurse must choose from a predetermined list. Due to the brief and sometimes nondescript options available

within the system, the researcher reviewed each patient's triage information, nursing progress documentation, doctor's notes, and final medical diagnosis so that all information could be assessed. From the information reviewed, the researcher decided whether the patient fell into a currently described forensic category or whether a new category would be more appropriate.

Through the EDIS system, a printout of all patients who attended the ED during the month of August 2003 was provided to the researcher. The hospital medical record staff collected all of the available charts from each August day. The charts for each day in August were reviewed over a period of four weeks. There were some charts that could not be made available to the researcher for a variety of reasons. For example: some charts were misplaced and misfiled and could not be located, some patients did not check in with the clerk after being assessed with the triage nurse and therefore did not generate an ED record, all after hour maternity admissions register with the ED clerk then go directly to the maternity ward (although an ED chart is never generated in these cases, the visit is documented on EDIS as an ED patient), and some ED records were unable to be located in the occupational and physiotherapy office suites.

The researcher developed a simple tool, similar to the tool described in Pasqualone's (1998) research. The 27 forensic categories were listed down the page and a running tally was kept of how many patients during each day fell into each of the existing forensic categories. All of the ED records were extensively reviewed to ensure that the possibility of a new forensic category, not yet identified by Pasqualone, was not overlooked. There were two specific variances that occurred during this replication study that will be discussed below.

In Western Australia, any patient who came to the ED requesting the morning after pill (MAT) had to sign a consent form before consulting with a physician and receiving the requested medication. Because of the consent requirement, this patient population would be considered forensic due to the legal implications of the consent form. There was no specific category for patients who requested the MAT in Pasqualone's (1998) research. The researcher was informed by the ED medical director that the reason patients had to sign a consent form before being prescribed

MAT was that there had been previous litigation against doctors. The litigation surrounding this issue was associated with medical malpractice and negligence. This researcher was unable to locate any literature that reflected case law regarding legal action taken against Western Australia doctors related to this issue. Therefore, a new category was not developed for this patient population. Instead, these patients were placed under the forensic category of medical malpractice and negligence which was already included in Pasqualone's study.

Another variance that arose during the data collection phase related to those patients brought to the ED by police under Western Australia's *Criminal Code 236* (CC236). In October 2002, legislation was approved by the WA parliament which allowed nurses and physicians to collected evidence from those individuals who were charged with an offence, even if the patient did not give consent. Previously, evidence collection was exclusively collected only by physicians. Because these individuals are always brought to the ED in police custody, any patient who came into the ED under CC236 was placed under the "Client in Police Custody" forensic category identified in Pasqualone's (1998) research.

Sample

The sample population for this replication audit included patients (n = 2385) that presented to the ED during the month of August 2003. Although the computer print out noted that there were 2724 patients seen during the month of August 2003, only 2385 patient charts could be located and made available for review by the researcher. Some of the reasons charts were unable to be found and the reasons for discrepancies between the number of charts generated and those reviewed included: patients leaving before checking in with the clerks; patients who visited the ED more than once during a single day; maternity assessments which are not seen by ED staff; misfiled charts unable to be located; charts locked up in the physiotherapy and occupational therapy department; and charts on wards with admitted patients unable to be accessed. Although the researcher did not expect such a discrepancy, the majority of the charts were reviewed and no new forensic categories were identified from the 2385 patient records.

The average number of forensic patients seen per day was 10.4 (13.5% of patients assessed each day). The ranges of forensic patients assessed in the ED per day were two to 28 (3.2 to 21.9% of each day's average). Additionally, there were 40 patient charts whose forensic status was unable to be identified. The majority of non-determinable cases had injury related complaints (see Table 4.1). The problem in all 40 cases was a lack of documentation in both the nursing and doctor's notes.

Table 4.1: Demographic Findings of the Replication Chart Review

Forensic Chart Review Findings		
	Number of cases	Frequency %
Total number of charts reviewed	2385	
Number of forensic patients seen during August 2003	322	13.5
Number of non-determinable patient charts reviewed	40	1.68
Range of forensic patients seen per day	2 – 28	3.2 – 21.9

For example, one medical chart corresponded to a small child who came into the ED with a laceration to his head. The notes in the nurse's documentation read "lac" while in the doctor's documentation read only "lac to head". There was no mention in the notes about the mechanism of injury, whether any or what type supervision was present, or if this was a witnessed injury. Due to the inability to rule out non-accidental or child abuse related mechanism, this researcher was not able to confidently dismiss this case as not being forensic or possibly forensic in nature.

Another example included a 40 year old woman who presented to the ED with a final medical diagnosis of a fractured arm. Once again the medical notes read "patient fell and hurt arm". Due to the high rates of undetected and undocumented cases of domestic violence, this researcher was not comfortable dismissing such presentations as accidental without further documentation.

Instrument

Since there was only one previous study completed on this topic there were no data collection tools available. The author of the previous study, Pasqualone, was

contacted by phone (November 10, 2002) and a similar type of tool used in the original study was constructed by the researcher. The 27 forensic categories were listed on a sheet of paper for each day of August 2003. A tally was kept of each patient's chart that correlated to one of the 27 forensic categories.

Unlike Pasqualone's (1998) study, in Western Australia there are only two types of patient categories that healthcare professional are mandated by law to report; coroners cases and communicable diseases. Because of the limited legal requirements in Western Australia, extreme care was taken to review each chart. All of the available documentation for each patient visit was carefully reviewed to ascertain whether the presenting complaint and/or final medical diagnosis was or had the potential to be classified into one of the existing 27 forensic categories or required a new forensic category.

Confidentiality

Permission to conduct the chart audit was achieved from University of Notre Dame, Australia Ethics Board as well as from HospA's Ethics Board. Names of the patients involved in this audit were not recorded and therefore remained anonymous. The information correlating to their visit(s) to the ED during August 2003 were the only documents reviewed. Tally marks were utilised to indicate what forensic category correlated to the patient's complaint and/or final medical diagnosis. No patient names, medical record numbers, or other identifying patient data was documented or collected. No documentation was made as to which staffs was responsible for any of the medical notes reviewed.

Data analysis

The purpose of this replication study was to review the available medical charts and investigate the types of forensic patient categories present within the Western Australia (WA) healthcare system. The type of statistics carried out on this data was confined to descriptive statistics (see Table 4.2) as this type of analysis follows the protocol described in Pasqualone's (1998) research.

The number of patient charts reviewed for each day was recorded along with the number and specific forensic categories that were represented each day. In total,

there were 40 charts that were unable to be deciphered if a forensic category was applicable. The inability to determine whether a forensic category could be correlated to the patient's medical complaint or final diagnosis was due to inadequate chart documentation by all healthcare professionals involved in the patient care (nurses and physicians and specialists).

Table 4.2: Frequency Comparison between Western Australia (WA) and USA 27 Forensic Patient Categories

27 Forensic Patient Categories							
Forensic Category		Frequency %		Forensic Category		Frequency %	
		WA	USA			WA	USA
1	Substance abuse	2.6	4.66	**15**	Elder abuse and neglect	0.08	0.25
2	Occupational-related injury	2.35	8.41	**16**	Firearm injury	0.08	0.01
3	Assault and battery	2.31	0.58	**17**	Organ and tissue donation	0.08	0.02
4	Transportation injury	1.84	5.61	**18**	Questioned death cases	0.08	0.29
5	Forensic psych	1.3	1.43	**19**	Abuse of the disabled	0.04	0.58
6	Child abuse	0.59	2.06	**20**	Sexual assault	0.04	0.05
7	Personal injury	.5	3.64	**21**	Clients in police custody	0.04	0.05
8	Control of Communicable diseases	0.38	N/A*	**22**	Burns over 5% BSA	0.04	0.01
9	Human and Animal bites	0.25	.40	**23**	Transcultural medical practices	0	0.02
10	Medical malpractice and/or negligence	0.25	0	**24**	Victims of mass destruction and terrorism	0	N/A*
11	Not For Resuscitation (NFR)	0.21	N/A*	**25**	Food and drug tampering	0	0
12	Domestic Violence	0.21	0.17	**26**	Product liability	0	0.02
13	Toxic Exposure	0.13	0.75	**27**	Gang violence	0	0
14	Sharp force injury	0.08	0.03				

*Due to the addition of these specific forensic categories in 2003, figures from Pasqualone's study were not available.

From all of the data collected a variety of quantitative statistics were calculated. The number of forensic patients seen per day was documented as a whole number as well as a percentage of the total number of patients seen per day. In addition, the range and associated percentage of forensic patients per day was calculated. All of the data collected was analysed with the total number of charts review equalling 2385 and the total number of forensic patients equalling 322 (see Table 4.1).

The top 10 forensic categories were compared to the top 10 categories identified by Pasqualone (1998). The top 10 categories were taken as those forensic categories that received the top total number of patients assigned to each of the categories (see Table 4.3). The number and type of forensic categories was compared with Pasqualone's (1998) 27 categories. Overall, the data gathered in this replicated Western Australia study served to verify and corroborate the international application of Pasqualone's 27 forensic patient categories (see Table 4.4).

Table 4.3: Top 10 Forensic Patient Categories – Totals and Frequencies

Top 10 Forensic Patient Categories				
	Forensic Category	Total number of patients per forensic category	Frequency %	
			Western Australia 2003	Pasqualone 1998
1	Substance abuse	62	2.6	4.66
2	Occupational-related injury	56	2.35	8.41
3	Assault and battery	55	2.31	0.58
4	Transportation injury	44	1.84	5.61
5	Forensic Psych	31	1.3	1.43
6	Child abuse	14	0.59	2.06
7	Personal injury	12	0.5	3.64
8	Control of Communicable diseases	9	0.38	N/A*
9	Human and Animal bites	6	0.25	0.40
10	Medical malpractice and/or negligence	6	0.25	0

*Due to the addition of these specific forensic categories in 2003, figures from Pasqualone's study were not available.

The overall results from the replication study indicated that all the 27 forensic patient categories identified by Pasqualone were representative of the types of forensic patients regularly seen in Western Australia emergency departments. By establishing who the forensic patient populations are that Western Australia nurses treat within the ED regularly, a more effective and comprehensive educational package can be developed. The discussion below will include a detailed description of each of the 27 forensic patient categories.

Table 4.4: Comparing Top 10 Forensic Patient Categories between Western Australia and the USA

Top 10 Forensic Patient Categories		
Rank	Western Australia 2003	Pasqualone 1989
1	Substance abuse	Occupational-related injury
2	Occupational-related injury	Transportation injury
3	Assault and battery	Substance abuse
4	Transportation injury	Personal injury
5	Forensic Psych	Child abuse & neglect
6	Child abuse & neglect	Forensic Psych
7	Personal injury	Toxic exposure
8	Control of Communicable diseases	Abuse of the disabled
9	Human and Animal bites	Assault and battery
10	Medical malpractice and/or negligence	Human and Animal bites

27 Forensic Patient Categories

Before considering if all 27 forensic patient categories were to be included within the forensic educational package, investigations needed to be conducted as to the appropriateness and applicability of each category to Western Australia law, culture, and healthcare requirements. The following is a discussion about each of the 27 forensic patient categories considered for this research; how they apply to the Australian setting, any specific Western Australia laws and/or policies pertaining to and affecting each forensic patient category, and how the category affects or impacts nursing or care provided by nurses.

Since the commencement of this research project in 2003, there have been some changes to Western Australia laws that would have affected the content of the forensic educational package. The legislative changes have been influenced by local, national and international events. The legislature changes affected 10 of the 27 forensic patient categories (Substance Abuse, Child Abuse, Medical Malpractice and/or Neglect, Not For Resuscitation, Domestic Violence, Toxic Exposure and Environmental Hazards, Elder Abuse and Neglect, Organ and Tissue Donation, Sexual Assault, and Clients in Police Custody). Therefore, a discussion of the relevant changes associated to each of the 10 forensic patient categories will be included at the end of each of the 10 forensic patient category discussions.

Often the forensic aspects of patient care are not always apparent when a patient first arrives at the ED. Initial information provided to nurses and other healthcare professionals may not contain all of the facts. Sometimes that missing information (knowingly or unknowingly) can have significant impact on whether an individual will be capable of successfully pursuing compensation through legal channels (Pasqualone, 2003). For example, if a nurse cannot accurately identify and assess that a patient has specific forensic needs, essential interventions such as the collection and preservation of forensic evidence may be missed.

Within each of the forensic patient categories, the researcher will address any current state or federal legal mandate reporting requirements and any other legal information that may affect an individual's chance of pursuing a civil litigation suit. Lastly, any medical associated issues that a patient may face due to their association with a particular forensic patient category will also be included. This is done with a view to clarify pertinent medico-legal issues associated with each of the forensic categories.

Substance abuse

Generally drugs are defined as any substance that alters normal brain function. Therefore, a drug not only includes substances like heroin and cocaine, but also includes tobacco and alcohol, over-the-counter as well as prescribed medications. According to the Diagnostic and Statistical Manual of Mental Disorders [DSM-IV-TR] (American Psychiatric Association 2000, p. 191), substance abuse is referred to

as a substance-related disorder that is “related to the taking of a drug of abuse (including alcohol), to the side effects of a medication, and to toxin exposure”.

Within the DSM-IV-TR (American Psychiatric Association, 2000, p. 191), substances are grouped into 11 classes including: alcohol; amphetamine or similarly acting sympathomimetics; caffeine; cannabis; cocaine; hallucinogens; inhalants; nicotine; opioids; phencyclidine (PCP) or similarly acting arylcyclohexylamines; and sedatives, hypnotics, or anxiolytics. Additionally, there are many prescribed and over-the-counter drugs, that in high doses, can also cause substance-related disorders such as anticholinergic agents and cardiovascular medication. However, symptoms of such medications disappear when the medication dosage is lowered or stopped altogether. Furthermore, the DSM-IV-TR has also noted that exposure to other chemicals such as nerve gas, ethylene glycol (antifreeze), heavy metals (lead or aluminium), and carbon monoxide can also lead to substance-related disorders. Overall, the criterion sited within the DSM-IV-TR for substance abuse includes; a maladaptive pattern of substance use leading to clinically significant impairment or distress, over a 12 month period.

The manifestations of alcohol, tobacco and drug use and abuse are seen daily in ED’s throughout Australia. The effects of such substances are seen across all sections of society regardless of race, age, culture, gender, and educational background (Drug and Alcohol Office of Western Australia, 2003). Alcohol-related problems are one of the four major public health problems in Australia (Health Department of Western Australia, 2007). Increasingly, healthcare professionals are treating patients who have taken multiple substances and are affected by drug interactions. It is important that all nurses are able to identify and minimize the harm patients may suffer through drug intoxication, withdrawal and dependence (Crespigny, Talmet, Modystack, Cusack and Watkinson, 2003).

The Australian National Council on Drugs (ANCD) is the principal advisory body for the Australian Federal Government on drug policy. The ANCDs role is to ensure that the voice of the community is heard in relation to drug related policies and strategies. Changes to the Western Australia legislation and regulations for minor cannabis offences stemmed from recommendations of the Western Australia

Community Drug Summit held by the Western Australia Government in August 2001. The Cannabis Control Bill 2003 passed both houses of Parliament in 2003 and the *Cannabis Control Act 2003* came into effect on 22 March 2004. The Act introduced the Cannabis Infringement Notice (CIN) Scheme, a prohibition with civil penalties scheme for minor cannabis possession and cultivation offences by adults (Lenton et al., 2005).

Today, while the possession of cannabis for personal use remains illegal, the punishment varies depending on the amount an individual has in their position when caught. For example, an adult who is caught in position of up to 15 grams of cannabis is eligible for an infringement notice with a penalty of $100 and an adult who is caught in position of a used smoking implement may only attract a penalty of $100 (Lenton et al., 2005). Furthermore, Lenton et al., found that some people thought that the new legislation meant that cannabis use would be 'legal'. Therefore, the legislation changes would need to be clarified to all study participants. All participants would need to realize that possession of cannabis remains illegal even though the likelihood of a criminal penalty had been reduced in many instances.

Occupation-related injuries

In Western Australia, the Workers' Compensation and Rehabilitation Commission was established in May 1982 and the *Occupational Safety and Health Act* initiated in 1984. Then, in January 2005, WorkCover Western Australia Authority replaced the Workers' Compensation and Rehabilitation Commission under section 94(1) of the *Workers' Compensation and Injury Management Act 1981* (WorkCover, 2004). WorkCover Western Australia is the statutory authority responsible for the administration of the workers' compensation system within Western Australia.

Throughout Western Australia in 2002/03, there were 41,838 workers' compensation claims lodged to insurers (Australian Bureau of Statistics, 2004). In Australia, data on occupational injuries and diseases are principally compiled from administrative records of Commonwealth, State and Territory compensation authorities by the National Occupational Health and Safety Commission (NOHSC). According to NOHSC (Resource Assessment Commission, 2004), an occupational injury can be defined as:

> All employment-related injuries which are the result of a single traumatic event occurring while a person is on duty or during a recess period and where there was a short or non-existent latency period. This includes injuries which are the result of a single exposure to an agent(s) causing an acute toxic effect**.**

In addition, NOHSC (Resource Assessment Commission, 2004) defines an occupational disease as:

> All employment-related diseases which result from repeated or long-term exposure to an agent(s) or event(s) or which are the result of a single traumatic event where there was a long latency period (for example, the development of hepatitis following a single exposure to the infection).

Nurses care for many individuals who hurt themselves while working. It is important that thorough documentation be completed as to how any work related injury occurred and what treatment was necessary. While many injuries heal without further incident, there are some injuries that leave individuals permanently scared or unable to work for the rest of their life. Without accurate medical documentation, any attempt for compensation can be hindered or unattainable.

Assault and battery

The words assault and battery are often used interchangeably; however, in civil court proceedings there is a distinction between the two words (Wallace, 2001; Staunton and Chiarella, 2003). For example, assault charges can be laid upon another person who just shakes their fist and threatens another. However, for battery charges to be laid there must be an application of the fist placed upon another individual. Nurses need to be educated about both the civil and criminal aspects of assault and battery. Both issues are of extreme importance and confront healthcare personnel regularly.

Nurses who provide treatment to patients must be aware of protecting an individual's personal space. The issue of consent and trespassing against a person fall under the area of law that relates to assault and battery. Providing treatment without the patient's consent (or the consent from a person entitled to act on behalf of the patient) constitutes battery (Wallace, 2001). Therefore, if a nurse provides treatment without consent the patient has a right to be compensated (Staunton and Chiarella, 2003).

Most often, the issue of assault is dealt with as a criminal offence. The criminal action of assault does not usually apply to nurses or healthcare professional. For criminal assault charges to be pursued, the application of force upon another person as well as an actual intent to cause harm to the person has to be established. Although there are such cases of criminal offences throughout medical history, the issue of civil wrongs is more relevant to healthcare professionals (Wallace, 2001; Freckelton and Petersen, 2006).

According to the *Western Australia Criminal Code1996 s.222* (2005), assault is defined as:

> A person strikes, touches, or moves, or otherwise applies force of any kind to the person of another, either directly or indirectly, without his consent, or with his consent if the consent is obtained by fraud, or who by any bodily act or gesture attempts or threatens to apply force of any kind to the person of another without his consent… (p. 109-110)

Nurses working in EDs provide treatment for victims of assault regularly. Across Australia, between July 2003 and 2004 there were approximately 2,534,500 incidents of assault with 17,888 of these assaults (aggravated and non-aggravated) reported to the Western Australia police (Australian Institute of Criminology, 2005). As wounds from assaults heal, the most often called upon document during legal proceedings are medical records. Therefore, it is imperative that nurses recognize that accurate documentation can impact their patient's pursuit of justice.

In addition to medical treatment provided for physical injuries, healthcare professionals need to be mindful about any psychological problems that may surface following an incident of assault. Some patients may need referrals upon discharge for psychiatric follow up care or information about which authority they need to report the incident to (ie. Police). Often, after a traumatic event, the follow up reporting to authorities can be confusing. Therefore, nurses can help their patients by providing the phone numbers and locations of which police station they can lodge their complaint. Providing such information takes the guesswork and confusion away for victims.

Motor vehicle trauma – Transportation injury

Trauma is a leading cause of death and disability in Western Australia. In 2002, there were 36, 378 road crashes reported to the police with 10,705 casualties and 179 fatalities. More men (126) than women (53) were killed and the majority of fatalities were aged 25 to 39 years (Road Safety Council, 2005). Examples of vehicles under this category include; cars, motorcycles, dirt or trail bikes, trucks, caravans, motorised scooters, and quad bikes. Overall, any vehicle that has threads or is on wheels is included under this category (Pasqualone, 1998).

Injuries sustained during motor vehicle collisions result from a variety of blunt or sharp force mechanisms. Usually, victims who sustain motor vehicle trauma receive their injuries from impact with the interior of the car, impact with external objects (other vehicles, trees, poles), ejection from vehicles, and fire and/or explosion (Lynch, 2006; Hammer, Moynihan, and Pagliaro, 2006). Such impact often results in an injury that leaves an imprint. Pattern injuries such as; imprints from number plates, the presence of glass fragments, and other wounds caused by impact from internal and external vehicle instrumentation and bumpers can provide the evidence investigators require to recreate the crash scene. In addition, such information can provide nurses and ED physicians with clues about the types of injuries that may be present thus assisting with treatment plans for trauma patients (Lynch, 2006).

For example, a car driver can sustain dicing injuries to the right side of their face due to tempered glass pieces from the side windows and chest trauma from impact with the steering wheel. In addition, the driver and any front passenger may sustain longitudinal sharp injuries to the face due impact from laminate glass in the windshield. Furthermore, the front passenger may sustain skin impressions resulting from the impact with dashboard logos (Lynch, 2006). All of this information can prove vital for hospital staff trying to care for and treat victims of motor vehicle trauma.

In addition to identifying trauma sustained by the patient, collecting clothes and any trace evidence is important. Some examples of important evidence includes; small fragments of glass, paint, plastic, metal pieces, and plant material. All evidence collected could prove invaluable in trying to recreate what happened prior to and

after any accident and who was seated where in the vehicle before the accident occurred. All of this information could prove vital to patients during legal proceedings.

Forensic psychiatric clients

Research suggests that many nurses working in the general hospital setting feel unprepared to skilfully care for patients with mental health problems (Sharrock and Happell, 2002; Armstrong, 2000; Bailey, 1998). Psychiatric Forensic Nurses can assist ED nurses to assess the needs of a specific population whose mental illness and behaviour often intertwine with the legal system. Patients within this category usually refer to individuals who suffer from mental illnesses and who are offenders of a criminal act or engaged in self-abusive behaviour (Mason, 2002). Predominant examples of problems that patients in this category might present to an ED with include; sexual deviant behaviour, Munchausen's by proxy syndrome, suicide, and substance abuse (Pasqualone, 1998; Fulton, 2000; Lynch, 2006).

A common mental health problem confronting ED nursing staff is that of suicide. Suicide is defined as "death caused by purposeful actions or omissions by the victim" (Bell, 2004). In 2002, 246 people died by suicide in Western Australia. In 2002, Western Australia had a suicide rate that was higher than the national average. In total, psychiatric disorders were diagnosed in 34% of men and 57% of women who committed suicide (Australian Bureau of Statistics, Census data, 2004).

This forensic category often proves to be the greatest challenge for many ED nurses who do not have extended education and experience working within the mental health field (Sharrock and Happell, 2002; Heslop, Elsom, and Parker, 2000; Bailey, 1998). Nurses who work in the field of mental health have extensive and specialised training. One of the ways many hospitals are choosing to deal with this specialised patient population is by working closely with mental health professionals in a team approach (Fry and Brunero, 2005).

Child abuse and neglect

Child abuse and neglect is a complex issue with no single defining characteristic. Child abuse which is commonly referred to as "child maltreatment", can be grouped

into four categories including; physical abuse, sexual abuse, neglect, and emotional or psychological abuse (Hobbs, Hanks, and Wynne, 1999). Rarely is child abuse an isolated incident, in actual fact, child abuse usually occurs over a period of time and involves more than one of the above categories (Southall, Samuels, and Golden, 2002).

Adults harm or neglect children due to a number of reasons. Some reasons include; problems with alcohol and drugs, not coping with the demands of being a parent, having no support system to help with parenting responsibilities, an inability to control anger, and difficulty managing because of their own past trauma (Hobbs, Hanks, and Wynne, 1999). The Department of Community Development (which has been replaced with two new departments: the Department for Child Protection, and the Department for Communities) is the Western Australia state based agency that is responsible for receiving and responding to reports on child abuse and neglect. Through the current *Child Welfare Act 1947* and the more recently passed *Children and Community Services Act 2004*, powers of the Department of Community Development was to receive, assess allegations of child abuse and neglect, and take action to protect children and young people have strengthened.

With the exception of Western Australia, all healthcare professionals in Australia are mandated by statutory law to report any suspected child abuse to the authorities. In 1992, the Department of Health and the former DCD initiated the Reciprocal Child Protection Agreement Procedures (Department of Community Development, 2002). The agreement was a collaborative effort between Western Australia Police Service, Princess Margaret Hospital for Children, King Edward Memorial Hospital for Women, Disability Services Commission, Department of Education, Department of Justice, Department of Health, and the State Coroner of Western Australia. The agreement impressed the need for agencies to collaborate and co-ordinate responses to secure the safety and welfare of children.

In 1996, the Reciprocal Child Protection Agreement was updated to include the Department of Health Guidelines for the Clinical Management of Child Abuse and Neglect. The updated document stipulates that public hospitals can hold a child under the age of six years for up to 48 hours if medical professionals believe that the

child is at risk of being maltreated *Child Welfare Act s29(3a)*. Such information is very important for ED nurses to ensure the safety of their paediatric patients.

In 2006, an investigation was commissioned by the Western Australia Government into the workings of the Department for Child Protection. This investigation was in direct response to revelations surrounding the death of baby Wade Scale (Taylor, 2007). Former top Western Australia health bureaucrat, Ms. Prudence Ford, recommended that the DCD be split into a new agency to be known as the Department of Child Protection and another called the Department of Communities. Ms. Ford stated in her Ford Report that the child protection system in Western Australia was "close to collapse", and proved inefficient causing public confidence to be shaken following a series of preventable child deaths and inquiries into allegations of abuse in care (Taylor, 2007).

Since the Labor government came to power in 2001, Western Australia politicians have strongly resisted calls to force people dealing with children in their professional capacity to report any suspicions of abuse (Ford Report, 2006). However, on 7 March, 2007, Western Australia Premier Alan Carpenter, against recommendations by the Ford report, announced that Western Australia would require doctors, nurses, teachers and police to report evidence of child sexual abuse as part of the Government's response to the Ford Review of Western Australia's child protection system. Prior to this, the groups of people mandated to notify their concerns or suspicions to the child protection authority was limited to court personnel, counsellors and mediators; licensed providers of child care, and outside school hours care services. Therefore, participants would need to be informed that in addition to the reporting of some communicable diseases and unexplained deaths (outlined in the *Coroners Act),* the reporting of any suspicions of child abuse was now compulsory under Western Australia law.

Personal injury

According to Australian law, personal injury is considered to be "any disease or injury sustained by an individual to his or her person, including broken limbs, for which another is legally liable. It may destroy or impair, whether permanently or

temporarily, a person's existing physical or mental condition, or produce pain and suffering: *Teubner v Humble* (1963) 108 CLR 491" (Nygh and Butt, 1998, p.335).

There are many types of personal injuries that are seen in the ED everyday. Pasqualone (1998) cited a variety of accidental injuries under this category. However, for this study, accidental injuries will include those involving automobiles, boats, fire and explosions, and slips and falls (Bogart, 1998, p.164). In order for ED nurses to recognise patients who fall into this forensic category, nurses need to explore the mechanism of injury during their history assessment. In addition to verbal questioning, nurses must ensure that meticulous documentation is recorded to ensure that all events are accurately recorded.

Control of communicable diseases

Under public health legislation, healthcare providers are required to report certain notifiable diseases to health authorities (*Health Act* 1911). The first of the two mandated reportable forensic category in Western Australia for healthcare professionals is the reporting of communicable diseases. A list of the notifiable disease for Western Australia is listed in Appendix 24.

Western Australia State law requires notifications to the Department of Health of certain communicable diseases therefore, the notification of such diseases does not breach the *Privacy Act 1988* (National Privacy Principle 2.1 (g)). The information provided to the Department of Health regarding any notification is kept strictly confidential. It is important for nurses to know such facts about the reporting of communicable diseases as some patients may need reassurance and support should any of their health issues involve such actions.

Human and animal bites

Every human bite mark, like fingerprints, is individual and unique. A human bite mark found upon a victim can always be considered a non-accidental pattern injury frequently associated with sexual and physical violence (Lynch, 2006; Hobbs, Hanks, and Wynne, 1999; Spitz, 1993). Some of the most common areas where bite marks are found on victims include; breasts, buttocks, inner thighs, and back. Having knowledge regarding the prevalence of such injuries allows nurses to assess and

intervene appropriately. A human bite mark can be traced back to a specific individual with the assistance of a Forensic Odontologist. A Forensic Odontologist utilises their specialist knowledge and skills to examine and assess each pattern injury. Characteristics of interest include; tooth size, dental arch, dental work such as caps and fillings, and wearing patterns to definitively identify an individual (Spitz, 1993).

The reporting of animal bites to government agencies is not compulsory in Western Australia however it is in the USA and therefore was included under this forensic patient category. The reasoning behind the USA mandate reporting laws for animal bites centers around the need of authorities being able to track the epidemiology of rabies. Although rabies is not a disease seen in Western Australia, the incidence of animal bites was included in this study because of the legal implications associated with possible compensation claims (being mauled by a dog). In addition, there is some research that describes theoretical support for an association between dog bites and the possible incidence of child abuse. Being pack animals, studies on dog behaviour have shown that dogs act aggressively toward lesser-ranked members. Similar behaviour was seen when dogs were observed in human-animal interactions (Conniff, 1999; and Budiansky cited in Vaisman-Tzachor, 2001, p. 19).

A case study by Vaisman-Tzachor (2001) proposed that when a family dog attacks a minor family member, the aggressive pattern of behaviour may suggest existing abuse against a child. If nurses and other healthcare professionals have an appreciation and awareness about such possibilities, there is more of a likelihood that a complete inquiry about the dog biting incident will occur. Only then can an accurate assessment of the situation be made which could prevent abuse to a child or intervene to prevent further abuse.

Malpractice and negligence

Negligence, which is also referred to as malpractice, is an important topic that all healthcare professionals need to have extensive, up-to-date knowledge about. Once an individual gives their consent for treatment, a professional relationship between the individual and healthcare professional is established. From that point forward, the professional relationship has legal implications. Such legal implications can

include a law suit filed against a healthcare professional if an individual feels that proper care was not provided to them. In such a situation, the individual has the right, under Western Australia law, to seek damages by suing for negligence (Wallace, 2001). A negligence claim, under Western Australia law, uses what is referred to as “tort” law. Tort law defines what constitutes a legal injury, and establishes the circumstances under which one person may be held liable for another's injury. Usually, such harm must be proven to have occurred to an individual because of a breach in duty. In other words, the law of torts seeks to put the injured individual in the position they would have been in had they not been injured by another person acting negligently (Forrester and Griffiths, 2005; Wikipedia, 2008).

Medical negligence is defined as “breach of the standard of care owed by a medical professional to a patient in medical treatment” (Nygh and Butt, 1998, p. 287). Under Western Australia law, there are three main elements that a person must prove before medical negligence can proven in a court of law. The three elements include (1) proving the individual was owed a duty of care, (2) there was a breach in that duty of care through some act or omission by the healthcare professional, and (3) due to the act or omission by the healthcare professional, the patient experienced physical, mental, or financial harm (Wallace, 2001; Forrester and Griffiths, 2005).

Nurses have a regulatory organisation that has established *standards of care* that discuss nurses’ duty under which they must act (Nurses Board of Western Australia). If a patient feels that he/she has been put at risk or harmed due to an act or omission by any healthcare professional, the patient may initiate a lawsuit against the nurse or physician. According to Wallace (2001, p. 196), a duty of care is owed not only to patients but to “anyone whose personal wellbeing and property may be harmed by failure to take reasonable care of a patient”.

In Western Australia, the role and duties of healthcare professionals or hospitals in relation to emergency treatment are addressed under common law principles. This area of Western Australia law is based on the general principles of negligence in a court of law. A duty of care arises once the healthcare professional realises that there

is a need for services (Wallace, 2001). Therefore, if a hospital operates an emergency ward, all individuals who pass through the doors are owed a duty of care.

Triage nurses in the ED are considered specialist nurses and require special skills and judgement (Wallace, 2001). They share, with the hospital, an obligation to properly assess each individual for their need of treatment and refer the individual onto a physician if any doubt arises as to their medical stability and/or condition. It is essential for every nurse to fully understand what the Western Australia law, the Australian Nursing and Midwifery Council and the Nurses Board of Western Australia has identified as state and national standards of practice and Code of Professional Conduct for every nurse. Having such knowledge provides nurses with the confidence to work within their scope of practice and establish parameters of expectation. Nurses must take responsibility for their professional practice and act accordingly to safe guard themselves against the possibility of malpractice litigation.

In January 2004, the morning after pill was made available from pharmacies without a prescription. Therefore, any patient who presents to a Western Australia emergency department would now receive a script for the medication or encouraged to buy the medication over the counter as many EDs do not stock this drug. Due to the Medicare system in Australia, individuals who qualify for pensions cards would be able to buy the morning after therapy cheaper if a prescription was provided by a physician. Participants would need to know about this alteration in legislation in order to act as an advocate for their patient and ensure all individuals were able to access the requested medication.

End of life decisions - Not for resuscitation (NFR)

Everyday, healthcare professionals face the difficult decisions of whether to discontinue life support systems from patients. In the USA, documents known as a medical power of attorney or living wills often assist healthcare professionals to make these decisions (Lynch, 2006). In Western Australia, however, no such documents or guidelines exist within the legislation. In fact, Western Australia law stipulates that no matter how unbearable a person's medical situation and no matter how much or how often a patient expresses their wish to die, healthcare professionals cannot actively hasten death [*R v Cox* (1992)]. However, judges for common law

cases have ruled that someone may administer increasingly potent doses of pain relief drugs even if it is likely to hasten a patient's death [R v Adams (1957); Wallace, 2001].

Within the medical profession, the Greek term 'euthanasia' is considered to mean the deliberate bringing about the death of a person or the withholding of treatment which causes death (Wallace, 2001). Under Western Australia law, such acts are considered a crime. Any individual associated with or found assisting with a death can be charged with murder or manslaughter under current Western Australia law. In addition to a charge of murder or manslaughter, the act of withholding treatment could also be considered criminal and/or civil negligence. For these reasons, nurses need to be aware of such consequences and work within legal parameters.

Currently, Western Australia has no legislation that provides for advance health care planning. Therefore, in the event that a person loses the capacity to make his or her own decisions regarding the type of medical treatment they would consent to, medical personnel have no legal documents to consult. Furthermore, the law relating to the withdrawal or withholding life-sustaining measures in circumstances of terminal illness or permanent unconsciousness, and the provision of palliative care, is perceived by many healthcare professionals as uncertain. For the patient, this can lead to uncertainty about whether, in the absence of a formal legislative framework, his or her wishes will be carried out.

The *Western Australian Acts Amendment (Advance Health Care Planning) Bill 2006* established a scheme whereby individuals, who are 18 years or over and have full legal capacity, can ensure that, in the event that they become mentally incompetent and require medical treatment their wishes can be made clear in an advance health directive. The bill also clarifies the circumstances in which an enduring guardian chosen by an individual can be utilised. Lastly, the bill clarifies and expands the protection from criminal and civil liability given to healthcare professionals.

The *Guardianship and Administration Act 1990* and the *Western Australia Criminal Code* are to be amended to provide protection for health professionals under section 259. Alterations clearly state that, "healthcare professionals are exempt from

criminal responsibility for the administration in good faith of reasonable medical treatment, even when death ensues" (p. 33). Such an amendment encompasses care provided to individuals in the palliative care environment. In addition, protection from criminal responsibility is extended, by the inclusion of section 259(2) in the *Western Australia Criminal Code*, to the withholding or withdrawal of medical treatment in good faith, even when death ensues.

Lastly, a minor amendment to section 5PA of the *Civil Liability Act 2002* supplements the definition of "health professional" to include nurses. The Bill, however, does not change the position at common law level whereby a healthcare professional is under no obligation to provide treatment that is not clinically indicated. In other words, patients are not legally entitled to demand certain treatment. Similarly, the legal position regarding euthanasia will not be changed. Euthanasia will remain an illegal act.

All of the above legislative changes are vital for nurses to know about. The changes affect many practice issues such as who can provide consent and are nurses protected by law if they refuse to proved care that is not clinically indicated. Finally, to fully act as a patient advocate, nurses need to explore the issue of what type and extent of medical treatment patients' desire. Changes to the above cited legislation enables nurses to now consider such patient requests.

Domestic violence

Many use the term "domestic violence" interchangeably with "family violence". Irrespective of the term used, both refer to acts of violence that occur between family members. Domestic violence is a serious crime that can affect all aspects of life including; physical and mental health, the ability to work, quality of relationships with friends and family, and social problems within the wider community. Violence may take the form of physical, emotional, verbal and sexual abuse as well as social isolation and economic domination (Berkowitz, 2004).

Every year in Western Australia, between one and two percent of adult women will be assaulted by their partner. Although domestic violence victims can be both men and women; nine out of 10 victims are women. The women most at risk are those

below the age of 40 years (Hegarty, Hindmarsh and Gilles, 2000; Bonner, 2002). Furthermore, police data indicate that Aboriginal women as well as rural and poorer women are at a greater risk and experience more intimate partner violence than other reported groups (Crime Research Centre, 2005). Lastly, a study by Baun and Moore (2003), suggest that the prevalence of domestic violence among the gay and lesbian communities occurs at the same or greater frequency as within the heterosexual community.

In many domestic violence cases, the final consequences for the victim are fatal. In Australia, almost two in five homicides occur between family members (Department of Justice, 2002). In Western Australia, approximately 45% of all murders are committed by family members and about 70% of all female homicides are committed by relatives. In contrast, only 5.7% of male homicides resulted from episodes of domestic violence (University of Western Australia Crime Research Centre, 2000; Berkowitz, 2004).

Other targets for domestic violence are children living in the home. Often children become intentional victims of physical violence (30 - 70%) or are inadvertently harmed as they watch the abuse or try to intervene to protect one of the parents. Children (boys more often than girls) who are exposed to such violence during childhood are at a greater risk of becoming offenders themselves (Sirotnak, Grigsby, and Krugman, 2004). In Western Australia, domestic violence is not a mandated reportable offence. In fact, until the early 1990s, Western Australia law showed little recognition or had no common law implementation linked with domestic violence associated stalking and restraining-orders.

The injuries associated with domestic violence can leave long lasting physical and emotional scars. Women, who are the predominant victims of domestic violence, often present to ED’s as a consequence of their abuse. Boyle, Robinson and Atkinson (2004) reported that about one percent of patients attending an ED had direct complaints of domestic violence. Because the incidence of disclosure is low, it is imperative that nurses and other healthcare professionals increase their awareness about the prevalence of such violence. Such educational information may provide

ED nurses with the skills they need to more easily recognize signs of domestic violence.

Many victims of domestic violence who come to the ED for treatment do not disclose or seek help for injuries associated with their domestic violence experiences (Berkowitz, 2004; Freedberg, 2005). Additionally, many hospital EDs do not routinely screen for such problems. Nurses working in EDs need to know about the Western Australia legal provisions to better advocate for their patients and provide them with options that may protect them from further violence. Early recognition can provide the opportunity for intervention thus decreasing the number of violent experiences victims encounter (Freedberg).

New domestic violence legislation came into effect December 1, 2004 in Western Australia. Changes were made to the *Acts Amendment (Family and Domestic Violence) Act 2004.* There were five main changes to the Act including:

1. Police powers to issue an on-the-spot restraining order that lasts 24 hours without the consent of the victim or up to 72 hours with the consent of the victim.
2. Allowing police and welfare officers to apply for restraining orders to protect children from exposure to domestic violence.
3. Increased penalties of up to two years jail and a $6,000 fine for breaching a violence restraining order.
4. The ability (in specific situations) to grant life-long restraining orders in extreme cases.
5. When a violence restraining order is made, the court or magistrate will also make an order prohibiting the respondent from having a firearm license or any guns.

Such information would be vital for all participants to know about in order for them to receive consent from patients in regards to contacting police. For example, if a participant gained the patient's consent to contact the police and did not inform the patient that changes to Western Australia law allowed police to issue an on-the-spot restraining order that lasts 24 hours without the consent of the victim, the patient would be able to claim that they were not fully informed before giving consent. Therefore, all participants would need to be aware of the new legislative changes.

Toxic exposure and environmental hazards

Nurses can be exposed to toxic substances both directly and indirectly. Within the hospital setting there are a number of chemicals that are hazardous to nurses and other healthcare professionals. The O*ccupational Health and Safety Act 1984* in Western Australia sets out specific requirements for ensuring that workplaces are safe and healthy for all people. Hospital staff have access to information about all chemicals located in their work area. There are specific safety information files in case of accidental or toxic exposure located in each hospital ward (Occupational Health and Safety manuals in HospB and HospC). In addition, there is often occupational health and safety (OHS) staff who are specially trained to provide employees with safety information and monitor the work environment for unsafe work practices.

Patients who come to the ED for treatment can expose nurses and other healthcare workers in the hospital to toxic chemicals and environmental hazards. Exposure to toxic and hazardous materials can occur at work, in the home or through the environment (James and Nordby, 2003). Therefore, individuals may present to an ED feeling unwell with no known history of toxic exposure. As a result, ED nurses may be put at risk of toxic exposure. There are over 40,000 industrial chemicals on the market throughout Australia. The Australian Government regulates industrial chemicals under the *Industrial Chemicals (Notification and Assessment) Act 1989* and *Industrial Chemicals (Notification and Assessment) Regulations 1990.*

A new OHS Bill, *Australian Workplace Safety Standards Bill 2005* discusses the "Duty of Care" issue that individuals have in order to protect the health and safety of others in the workplace. Such "duty" is placed on all employers; employees; and any other persons or tradesman who have had an influence on the hazards in a workplace (Workcover, 200). It is hoped that with such provisions in place that toxic exposure can be reduced and that any ill effects from harmful materials will be minimized. ED nurses with the knowledge about OHS regulations could help provide a safe working environment for themselves and their patients.

Sharp force injuries

Sharp force injuries result whenever a sharp-edged object is pierced through or drawn over the skin. Examples of objects that can cause such injuries include; a sharp knife, razor blade, glass, screwdriver, scissors, fork or axe. Distinguishing features of a sharp force injury are the sharp and non-abraded skin edges (Spitz, 1993). Sharp force injuries can be further categorised into punctures, incisions, cuts, slices, chop wounds, as well as therapeutic and diagnostic wounds (DiMaio and DiMaio, 1993; Spitz; Lynch, 2006). Sometimes during an assault, a victim will sustain injuries while trying to ward off blows from an assailants weapon. The resulting injuries are called “defence wounds”. Usually, defence wounds are found on the hands, forearms, feet, and lower legs.

When a patient presents to an ED with sharp force injuries it is imperative that the size, location and appearance of all wounds be documented carefully before they are altered by medical treatment. Such documentation may assist investigators to later recreate the incident and help identify the weapon. Nurses can help preserve such information by keeping detailed notes on all wounds. By incorporating high-quality wound documentation as an essential component of everyday practice, nurses can improve the standard of their nursing records. Accurate documentation could prove very valuable should a nurse be required to testify in court as to the types and characteristics of injuries which were treated.

Elder abuse and neglect

Although elder abuse has been documented and reported upon since the mid-1970s, it still remains the least acknowledged and reported type of human violence (Bennett, Kingston, and Penhale, 1997). However, over the past 15 years, there has been a greater awareness emerging as to the serious nature and prevalence of elder abuse (Schofield and Mishra, 2004). In Western Australia, about one in 25 people over the age of 65 years experience abuse or are mistreated by someone they trust (Advocare, 2005).

Elder abuse can be classified as any behaviour that causes physical, psychological, financial or social harm to an older person (Council on the Aging, 1997; Schofield and Mishra, 2004). The results of elder abuse cause significant social, legal,

psychological, and medical problems. Elder abuse occurs across all social and economic groups, in urban and rural settings, and in all religious and racial groups. Elder abuse is often representative of a pattern of abusive behaviour that has occurred throughout a domestic relationship (Schofield and Mishra; Lynch, 2006).

The majority of abusers (80-90%) are close family members, usually the victim's spouse, adult child or some other close relation (Schofield and Mishra, 2004). Many of the abusers are often dependent on the victim for a place to live or for money. For some couples, the stressors of later life, particularly declining health, can exacerbate an already tension-filled and unhappy marriage and result in abusive behaviour.

The most common reasons for the elderly not reporting abuse include; being afraid of retaliation; family rejection; afraid of being put into an institution; and feeling ashamed and embarrassed to tell someone that a family member mistreats them (Advocare, 2005). The Aged Rights Advocacy Service (ARAS) in 98/99 reported that the elderly often experience more than one form of abuse at a time from someone close to them. The two most frequent types of abuse reported were psychological abuse (35%) and financial abuse (34%).

In Western Australia, Advocare (2005) was established under a national advocacy program by the Commonwealth Department of Health and Family Services and the Health Department of Western Australia. Advocare provides services such as; advocacy, education, support, information and referrals for the elderly. Because the majority elder abuse cases remain undetected, nurses are in a privileged position to make a difference in the rate of detection. Nurses can form close relationships with their patients which can result in gaining valuable insight into and assist in early detection. With the aging population within Australia increasing, the actual number of victims is also likely to increase in the next few years (National Center on Aging Abuse, 2005; Schofield and Mishra, 2004). Nurses can increase their knowledge and understanding about the pattern and risk factors of elder abuse so intervention plans can be instigated.

According to Bennett, Kingston, and Penhale (1997), the interest towards elder abuse by nurses and other medical personnel is limited compared with child abuse and domestic violence. It is important that nurses learn about presenting symptoms that may indicate abuse and/or neglect. Allowing ignorance to reign hinders prevention, diagnosis and interventions.

In April 2007, the "*Aged Care Amendment Bill 2007*" was passed through the Western Australia Parliament. This bill altered sections of Schedule 2 – Reporting assaults of the *Aged Care Act 1997*. The Amendment Bill stipulates that owners and staff of residential aged care facilities are now required to report incidents involving alleged sexual or serious physical assault to the police and to the Office of Aged Care Quality and Compliance.

A central element of this reform was the introduction of compulsory reporting of sexual and serious physical assault in aged care homes. This move by the federal government was seen as a significant increase in the number of legislative measures initiated to protect aged adults. Again, such a law that mandates healthcare professionals to report suspected abuse would need to be included in the educational package. Without such information included in the package, nurse would be ill-informed and may unknowingly be in breach of the law.

Firearm injuries

In 2001, there were 333 firearm related deaths across Australia. Australia in comparison to other countries, such as USA or South Africa, has a relatively low incidence of firearm injuries. In 2001, firearm deaths only accounted for 4.2% of all reported deaths across Australia (Mouzos and Rushforth, 2003). In Australia, firearm related fatalities are studied under five main categories: suicide, homicide, accidents, legal intervention (ie deaths as a result of law enforcement officers performing their duties), and those deaths classified as undetermined by the coroner (Mouzos and Rushforth).

Clinically, there are many facets of wound management associated with firearm injuries. Bullets interact differently with the tissues it encounters. Therefore, accurate documentation and proper evidence preservation is the key for nurses to provide

optimum patient care (Silva, 1999). Furthermore, according to Western Australia law, health professionals must notify police if they become aware that a person who possesses a firearms license becomes mentally unstable (Mouzos and Rushforth, 2003). Realization of such a circumstance may arise during the normal course of care for an ED nurse. It would be important for nurses to know that such a law exists so that the safety of her patient could be maintained.

Organ and tissue donation

The sudden death of a loved one can be an extremely difficult and emotional time for family members. Unfortunately, this situation can occur in the ED setting. Such an emotional upheaval can be compounded and complicated when discussions about organ donation are brought up shortly before or after a patient dies (Neades, 2001). Nurses can have a significant impact on the issues of organ donation as they are the hospital personnel who often develop an early rapport with a patient's family. Therefore, ED nurses need to be aware of the laws and hospital policies which govern organ donation so that they are able to provide correct information to families should questions arise (Ingram, Buckner, and Rayburn, 2002).

In all Australian jurisdictions except Western Australia, death is defined by statutory law as "the irreversible cessation of blood in the body or the irreversible loss of all function of the brain". Within Western Australia, however, death is defined under terms set out within the *Human Tissue and Transplant Act 1982*. The *Act* stipulates that a diagnosis of 'brain death' can only be established when a clinical examination is conducted by two physicians. The two physicians must establish that an individual's brain has been very severely damaged and that the loss of function is not due to reversible factors such as drugs. The *Act* further stipulates that to confirm a diagnosis of brain death, the following clinical examination tests must all be absent; facial reaction, swallowing, coughing, blinking, eye movements and pupil reflexes, and the ability of the patient to breathe without mechanical assistance.

In Western Australia, if organ donation is to occur, two doctors, one of whom must be a registered specialist, must each establish the diagnosis of 'brain death' and neither of the two doctors can be involved with the organ transplantation process.

After the two physicians confirm the irreversible loss of all functions of the brain, time of death is then certified official. According to the *Human Tissue and Transplant Act:*

> tissue cannot be removed from the body of the person unless 2 medical practitioners (each of whom has carried out a clinical examination of the person, each of whom has been for a period of not less than 5 years a medical practitioner and one of whom holds specialist qualifications in general medicine, neurology or neurosurgery or has such other qualifications as are accepted by the Executive Director) have declared that irreversible cessation of all function of the brain of the person has occurred (Section 24[2]).

Most organ and tissue donation occurs after death; however, some donations (kidneys, bone, and bone marrow) can occur from living donors. Organs such as the heart, lungs, liver, kidneys and pancreas are usually donated by patients who have died from severe brain injury and who are in intensive care units receiving artificial ventilations Western Australian Agency for Organ and Tissue Donation (n.d.). DonateWest is the Western Australia state-wide agency that promotes and organises organ and tissue donation and associated transplantation. DonateWest came into operation in July 2000 and is funded by the Western Australia Department of Health.

In 2004, there were 218 organs successfully transplanted across Australia, 23 of which came from Western Australia (Australian and New Zealand Organ Donor Registry, 2005). Western Australia law requires that permission be obtained from the deceased's next of kin prior to taking of any organs even if the deceased have expressed their wishes to donate their organs in the past. Any objections made by relatives relating to organ and tissue donation take priority once an individual has died. In Western Australia, the next of kin in the order of who must be sought for consent to conduct any organ and tissue donation include the following: current spouse, son or daughter 18 or over, parent, and then brother or sister 18 or over (Wallace, 2001).

The *Human Tissue and Transplant Amendment Bill 2005* resulted out of the need to increase the availability of live organ donors. Live kidney donation have become more common and are widely accepted as a treatment for end stage renal disease; however, the amendment is not restricted to only kidney transplantation. This Bill eliminated the past restriction on live organ donation. There is a requirement,

however, for Ministerial approval before such treatment is carried out. This stipulation was included to ensure that any trading in tissue and organs were within the intent of the legislation. Once more, these changes to legislation could have a significant impact on someone's life. Therefore, nurses must be kept informed about such information that concern patient options.

Questioned death cases

In the event that a patient's death cannot be explained or dies unexpectedly, Western Australia healthcare professionals are required to report such cases to the authorities. There are six situations that are stipulated by the *Coroners Act 1996* as types of incidents, healthcare personnel are obligated to report to the Coroner. Such cases include:

1. An unknown cause of death
2. The deceased person had not been seen by a doctor within three months before their death
3. A person died within one year of an accident to which the cause of death may be attributed
4. A person died while in police custody
5. The person died within 24 hours of the administration of an anaesthetic
6. A person died a violent or unnatural death

When healthcare professionals notify the Coroner of an individual's death, the investigation of all associated circumstances surrounding the death as well as determining cause and manner of death rest with the Coroner. According to the *Western Australia Coroners Act*, once the Coroner becomes involved, all medical records, personal property and the individual body becomes the responsibility of the Coroner. To enable the Coroner to perform their legal duties, healthcare professionals must be aware of their legal obligations and comply with all regulations.

The types of patient cases that must be reported to the Coroner should be known by all nurses working in the ED. Nurses should be aware that the removal of all personal property (clothes, jewellery, mobile phones, wallets etc) must be authorised by the Coroner before taking off or giving such articles back to patient's relatives. In addition, ED nurses needs to be aware that if an autopsy is ordered by the Coroner, that the removal of all medical interventions such as breathing tubes, intravenous

lines and catheters must first be authorised by the Coroner. Any variation from the above practices could compromise the Coroner's investigation. Therefore, nurses need to be aware of their legal roles and responsibilities which, at times, could prove challenging for ED nursing staff.

Abuse of the disabled

More than half a million Western Australians have some type of disability. In 2003, approximately 20 percent of the Australian population suffered from some form of disability (Australian Bureau of Statistics, 2004). The *Disability Services Act 1993* defines disability as a condition that: is attributable to an intellectual, cognitive, neurological, sensory or physical impairment or a combination of those impairments; is permanent; and may or may not be episodic in nature. Disabilities can result in a person having a substantial reduction in their capacity to communicate, interact socially, participate in learning activities, or move independent. Therefore, disabled individuals are one of the most vulnerable populations because they may not be able to call for help, voice their protest, struggle or run away. The main types of disabilities are categorized into physical, sensory, psychiatric and intellectual. In Western Australia, physical disabilities are the most common (73 per cent), followed by mental/behavioral (17 per cent) and sensory (10 per cent). Many people with disabilities have multiple disabilities (Australian Bureau of Statistics, Census Data, 2004).

The Australian Bureau of Statistics Census Data indicates that 381,500 people in Western Australia (20% of the population) have some level of disability. Furthermore, 5.6% of the total population (101,400) have profound or severe core activity restrictions and need some type of help or supervision with one or more of the tasks associated with daily living. Lastly, 93% of people with disabilities live in the community, either independently or with family or friends. According to ABS, by the year 2021, it is estimated that the number of people with disabilities in Western Australia is will increase by more than 200,000, due mainly to our ageing population. Due to the vulnerability of such a patient population, ED nurses need to vigilant when caring for such individuals so that any signs of abuse or neglect can be detected and reported to authorities.

Sexual assault

According to the Australian Bureau of Statistics (2003) the incidence of sexual assault for women in Australia is similar to that of the USA, approximately 13 percent. Furthermore, it is estimated that about one in 20 men will be sexually assaulted during their life (Dunn, 2005). Sexual assault is less likely to be reported to law enforcement agencies than any other violent crime. Research indicates that there is a significant attrition between sexual assault cases that are reported to police and successful prosecutions (Sexual Assault Resource Centre, 2005).

Due to the shame and isolation that many male victims of sexual assault experience, the reported incidence by male sexual assault victims is lower than for female victims (Elliot, Mok, and Briere, 2004). In addition, there is a common myth that gay men are the only perpetrators of such crimes. This is not necessarily the case as both gay and straight men commit this type of crime. However, such violation to a man's sexual identity can lead to depression, sexual dysfunction, and other mental health problems (Elliot, Mok, and Briere).

According to the *Western Australia Criminal Code* (s.319, p 144), an adult person can be charged with sexually penetration if:

> (a) there has been penetration to the vagina (includes the labia majora), the anus, or the urethra of any person with any part of the body of another person or by an object manipulated by another person except when penetration is carried out for proper medical purposes;
> (b) if any part of the penis of a person is introduced into the mouth of another person; or
> (c) if there has been engagement in cunnilingus or fellatio.

Sexual violence against a person is a serious crime and one which can have long lasting and detrimental affects on the victim's physical and mental well-being and those close to the person (Lynch, 2006). Due to the seriousness and complexity of issues surrounding the disclosure of a sexual assault, many ED staff feel insecure about discussing the topic with patients. Healthcare workers usually fear having inadequate training to deal with patient needs, adding to a patient's emotional distress and being to busy to spend time with a patient (Hurst, 2003).

Victims of sexual assault regularly present to the ED for treatment. Sometimes victims of sexual assault may not always disclose an incident of sexual assault. Instead, individuals may present to the ED for medical care associated with sexual health issues. For example, a female patient may present with concerns regarding pregnancy or the possibility of contracting a sexually transmitted disease (Mein and McNulty, 2004).

As with other types of violent crime, the speed of recovery is often dependent upon how well the victims is supported. Support needs to come from healthcare professionals, family, friends, and speciality agencies that have training within this field of victim support (Dunn, 2005). ED nurses can provide the initial support and help all victims of sexual assault require. Referrals to appropriate support organisations and responding with empathy and sensitivity can significantly aid the recovery process (Hurst, 2003).

In 2005, the Ministerial Council of Drug Strategy, from the state of Victoria, requested that there be a review of the criminal law relating to drink spiking (Department of Justice, 2006). Prior to this, “slipping” a drug into someone's drink wasn’t an offence in Western Australia unless the victim was also assaulted, robbed or police could prove the offender's motives. Therefore, to address this problem, all Australian states and territories agreed to adopt uniform laws to close all loopholes regarding this issue (ABC NEWSONLINE, 2006).

The Western Australia Parliament adopted a single broad offence under section 304 of the *Western Australia Criminal Code*. In addition, section 293 of the *Western Australia Criminal Code* makes it now unlawful to administer a stupefying drug with the intention of committing an indictable offence. Lastly, section 192 of the *Western Australia Criminal Code* now makes it unlawful to administer a stupefying drug in order to have unlawful carnal knowledge of a person (Model Criminal Code, 2006, p22).

Due to previous stipulations in the law, proving the offender’s motives, some people may have been apprehensive about reporting such a crime to the police. With the changes to the law that removes the victim’s responsibility of proving an offender’s

motive more people may be willing to report their suspicions. Therefore, nurses need to understand how important such legal changes could have upon a victim. The inclusion of such an issue would need to be included into the legal and ethical workshop to encourage optimum forensic patient care.

Clients in police custody

From time to time, the police escort individuals into the ED for medical treatment. It is not uncommon for the required medical treatment not to be associated with the reasons for their incarceration. However, the facts remain that some individuals may pose a danger to the ED staff and other patients. Therefore, caution should taken by all hospital staff when caring for patients in police custody. Law enforcement officers who accompany the individual to the ED can assist staff and ensure that a safe environment is provided for all concerned.

In October 2003, the *Western Australia Criminal Code section 236* (CC236) was changed. Such changes have had a big impact on ED nurses in Western Australia. The code now stipulates that nurses are allowed to collect forensic samples from individuals in police custody who have been charged with an offence. Prior to this change in legislation, such duties rested exclusively with physicians.

One of the greatest challenges related to the legislative changes within the *Western Australia Criminal Code* is that there has been no training supplied to healthcare professionals regarding how to properly collect forensic samples. Therefore, many nurses and doctors do not feel comfortable collecting forensic evidence when police bring individuals to the ED so that the doctors and nurse can collect forensic sample. Anecdotally, the most common issues faced by police are confusion and resistance from both nurses and physicians. ED staff's lack of compliance anecdotally centers around four major issues including: (1) their lack of knowledge surrounding what Western Australia law stipulates; (2) their limited or no experience with forensic sample collection; (3) a lack of time; and (4) their not wanting to have to attend and testify in court.

There has been little circulated documentation released to hospitals and clinical staff that outlines roles, responsibilities, and legal ramifications once healthcare

professionals become involved with forensic evidence collection under CC236. In addition, there are many unknowns that surround CC236 for healthcare professionals. Firstly, for example, under CC236, forensic samples can be collected without an individual's consent. Such an act is in direct conflict with one of the most fundamental principles in healthcare and has caused great internal conflict for many nurses and physicians. Anecdotally, many healthcare professionals do not believe that the consequences of defying such a fundamental medical principle are shielded by the CC236 legislation. In the end, due to the lack of hospital policy, the choice to comply with police requests is left up to individual healthcare professionals (T. Smith, personal communication, September 15, 2004). Therefore, nurses need education about this issue. Only then can individuals assess, understand and decide where they stand professionally and legally.

The *Criminal Investigation Bill 2005* is an amalgamation of statutory police powers currently available to police by virtue of the *Police* Act and the *Western Australia Criminal Code.* The bill draws on legislation from the United Kingdom, Queensland and New South Wales. Sections of the *Criminal Investigation Bill* explain which healthcare professionals (doctor or nurse) can legally collect the different types of forensic evidence from an individual in police custody. The applications of the Bill's content will supersede rules concerning forensic evidence collection that is set out by the current edition of Western Australia's *Criminal Code s236*. This bill was enacted in July 2007.

The implications of this Bill are extensive. Under this Bill, nurses can be called upon to collect forensic samples. However, without knowledge about the contents of this Bill, nurses may unknowingly collect samples, by law, they are not allowed to collect. Therefore, discussions about the Bill's content would be essential to include in the workshop content. If such information was not included in the educational package, its contents would not be complete or just.

Burns over 5% body surface area (BSA)

Burns can be described as superficial, partial and full thickness. Such tissue injuries can be caused by chemicals, electrical, radiation, hot objects, flame, and hot vapour and liquids (DiMaio and DiMaio, 1993; Spitz, 1993). Although many burns are a

result of an accident, the possibility of deliberate intent should not be forgotten. In Pasqualone's (1998) original study, the state of Massachusetts mandated the reporting of any burn injury extending to 5% or more of body surface area. The same mandates do not apply in Western Australia, however, due to correlations of large area burns and their links with abuse or intentional mechanisms (seen in Bali bombing victims and child abuse), this category was included in the Western Australia study.

It is important that the affected BSA be examined in conjunction with the burn pattern before a conclusion be made about the mechanism of injury (Hobbs, Hank, Wynne, 1999). Nurses need to understand the ramifications that can be associated with these types of injuries and be able to recognise burn injury patterns such as tissue sparing, splattering, circumferential and horizontal demarcation. Such assessment is important as a proportion of burns in young children (often equal or greater than 5% BSA) is due to abuse (Klein and Herndon, 2004).

Transcultural medical practices

There is an ever increasing diversity of culture across Australia. In 2002-03, approximately 125,300 persons or 52% of Australia's population growth resulted from net overseas migration (Australian Bureau of Statistics, 2005). The countries from which Australia has received the greatest influx of migrants include; China, India, Africa, and the Middle East. Such diversity will only increase in the coming years due to the influx of immigrants from all over the world that choose Australia to be home. Such demographics call on all healthcare professionals to improve their understanding and awareness of cultural differences among patients and how this impacts the provision of healthcare services.

There are some culturally specific medical practices that occur regularly and are seen as unacceptable within Australia. For this research, transcultural medical practices refers to activities and procedures that are not commonly accepted medical practices throughout Australia or are against the law. Examples of such practices included in Pasqualone's (1998) research and those that will be considered for this research include; female genital circumcision, coining, cupping, pica, tribal scarring, and any religious organisation where medical treatment is withheld due to religious beliefs

(Miller, 1995). The listed examples are not meant as a criticism to any particular culture, instead they are a focus of the practices Pasqualone considered strictly from a legal and patient health and safety stand point.

According to the *Western Australia Criminal Code s306*, any person who performs female genital mutilation on another person is guilty of a crime. There is no allowance for a defence of consent by a parent or guardian in Western Australia legislation. Furthermore, any person who takes a child out of Western Australia or arranges for a child to be taken from Western Australia for the purpose of subjecting the child to female genital mutilation is committing a crime. It is vital that nurses understand the law about this topic and are able to discuss such issues with their patients.

Current literature discussing aspects of providing transcultural nursing care use the phrase of nurses and healthcare professional becoming "culturally competent" (Gustafson, 2005; Lynch, 2006). Increasing ones awareness through education can be a start. There is a delicate balance between respecting individual beliefs and over looking a criminal offence. For all nurses, addressing cultural diversity is an important challenge. Therefore education is imperative in order to address deficits between cultural practices and to ensure patients have their health needs met.

Victims of catastrophic and mass destruction or acts of terrorism

The affects of this category has been felt by people all over the world. Whether the cause is natural, accidental or intentional, the experiences and results of such disasters can leave long lasting physical and psychological side effects upon people. Many of these effects are dealt with on a daily basis by nurses and physicians in the ED.

This category was added in 2003 by Pasqualone. There have been many unfortunate examples of this category in recent years, some directly affecting Western Australia hospitals and their staff. The direct effects of the Bali and London bombings highlight the importance of the continued inclusion of this forensic patient category. Other examples include; September 11 attacks on New York's World Trade Center, numerous suicide bombers in the Middle East, the South-East Asian tsunami, the

underground railway bombing in Spain, and most recently, hurricane Katrina in the USA (Clarke 2003; CNN.com, 2005; Wikipedia, 2005).

Food and drug tampering

There are two different authorities within the Australian Government Department of Health and Ageing that focus on issues reviewing and regulating food and drug standards within Australia. The Therapeutic Goods Administration (TGA) regulates Australia's medicines, medical devices, blood, tissues and chemicals. The TGA monitors a range of activities to ensure that therapeutic goods available in Australia are of an acceptable standard. A 'therapeutic good' is broadly defined as a good which is represented in any way to be, or is likely to be taken to be, for therapeutic use (*Therapeutic Goods Act 1989* s7). In addition, the *Therapeutic Goods Act* specify the requirements for inclusion of therapeutic goods, including advertising, labelling, product appearance and appeal guidelines. However, some provisions, such as the scheduling of substances and the safe storage of therapeutic goods, are covered by State or Territory legislation.

Product tampering and substandard manufacturing of products are two ways food and drugs can become contaminated and/or poisoned. Signs and symptoms of any contamination may not always appear immediate (Pertel-Ashouwak, 2005). Instead, individuals may experience a delayed onset of a reaction. Such a delay of signs and symptoms can depend upon the route of exposure, chemical form, and dose. An example highlighting this category occurred across Australia in 2003. Hundreds of natural health products (such as Nature Own Vitamins) were removed from supermarket shelves due to contamination during production ("Recall of", 2003).

At the center of this scandal was the Pan Pharmaceuticals manufacturer. Numerous Australian citizens became ill after ingesting various drugs produced at the Sydney plant. Some individuals sought medical treatment with no understanding of what the true cause was or origin of their health complaints. According to The Age Newspaper ("Recall of", 2003), "Forty batches of the tablets were responsible for 19 people being hospitalised and 68 others experienced potentially life-threatening adverse reactions".

When illnesses result from intentional or unintentional chemical contamination, detecting, medical documentation is vital. Without comprehensive assessments and documentation, the epidemiology of symptoms may be hindered. In addition, any legal proceedings or tracking of poisoned persons may prove difficult without accurate medical support. Nurses can provide an important link for managing such a complex incidence.

Product liability

Product liability can be defined as "a responsibility or onus imposed by the law of contract and tort, or by consumer legislation on a manufacturer, distributor, or supplier to warn consumers appropriately about possible detrimental or harmful effects of a product and to foresee how it may be misused" (Nygh and Butt, 1998, p. 351). The majority of patients that seek medical care in the ED for injuries incurred from faulty products primarily originate from products with sharp edges, faulty electric wiring, or loose and broken pieces (Pasqualone, 1998). Other products that Pasqualone includes in this category are those products that burn, explode and emit toxic substances. Since most injuries heal and leave little trace or true representation of the original damage, recognition and thorough documentation is paramount in such cases.

Memories fade with time and healthcare professionals care for numerous patients each day. Over time it is unrealistic to expect that precise details of any single injury, sustained by any particular individual will be accurately recalled by the attending nurse without reviewing documentation made during the patient's visit. Therefore, carefully documented medical histories recorded at the time of the patients' presentation to the ED may be the only evidence the patient and nurse can rely upon to describe any sustained injuries.

Gang violence

There are many definitions used to describe what a "gang" is or is not. However, for the purpose of this study, a gang will refer to a group of people who associate together or act as an organized body for anti-social reasons (White, 2002; Lozusic, 2003). The word "gang" is not defined in any criminal code within any Australian jurisdiction. Gang related violence can be seen in prisons, schools (fights or

bullying), and throughout the Australian community (ethic and bike gangs). There is very little empirical material in Australia that would tell us how many “gangs” exist, who is in them and what they do (Lozusic).

Prison gangs meet the group criterion which has been included in the definition of gang for this study. In prison, gangs often form as a means of self-defence and a need to belong (Lozusic, 2003). As prison groups grow in size, formal rules are established, and members are expected to follow behaviours that may include; drug trafficking, prostitution, murder and extortion (Compton, 2005). The often violent gang activity within prisons not only put other prisoners at risk but also the nurses working within the system who care for these populations.

Within Australian schools, gangs can be associated with group fights, group bullying of individual students, vandalism against school property, and intimidation and/or violence towards teachers. White (2002) believes that gangs form for a variety of reasons including; alienation from schooling, peer pressure, family issues, and the need for protection. There are ethnic groups that have also been tied to and classified as criminal gangs within Australia. In 2005, evidence of ethnic tensions within Australia was clearly evident when the Cronulla riots took place in New South Wales (“Mob violence”, 2005).

ED nurses are exposed to the violence resulting from gang activity, nurses need also to be aware of issues associated with gang activity. For example, nurses may treat patients who bring weapons and/or drugs on their person into the ED. Since nurses are responsible for providing the care of both the victim and perpetrators of violence, there maybe occasions when an ED provides care to both types of patients within the same department. Such circumstances not only leave nurse vulnerable but also other patients. Therefore, clear guidelines and policies need to be known to all nurses on how such situations will be dealt with. Having such knowledge reduces the risk of potential dangerous situation.

Conclusion

The overall results from the replication of Pasqualone's (1998) study concluded that the 27 forensic patient categories can be applied at an international level. Therefore, the forensic educational package developed for this study centred the educational material specifically around the patient populations included in the 27 forensic patient categories.

The effectiveness of the educational package and all of the study data will be thoroughly discussed in Chapter 5. To assist with the processing of all of the information provided in the reporting of data analysis contained in Chapter 5, the data will occur under headings which correlate to the study objectives.

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Thomas had seen that look before. It was in the eyes of his colleagues, Daniel's family and the others who stood silently in the immediate area. They all stood motionless with fear and disbelief. Thomas was still on the floor, eye level with Daniel as the rage continued to pour out. A small sobbing child clung to his father's neck as they stood at the entrance of a nearby cubical.