

Transforming forensic care in level-one emergency departments in Gauteng through emancipatory practice development

by

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Dedication

This research is dedicated both
to the brave healthcare providers who are not afraid to provide care
to the forensic population in their emergency departments,
and
to all the victims of violence and crime brave enough to seek justice.

Declaration

I, Celia J. Filmalter, declare that this thesis, entitled, **“Transforming forensic care in level-one emergency departments in Gauteng through emancipatory practice development”** is my own work, and that all the sources used or quoted in this research study have been indicated and acknowledged by means of complete references. Furthermore, I declare that this work has not been submitted for any other degree at any other institution.

Researcher's signature

Witness's signature

Date signed

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Abstract

Healthcare providers in emergency departments encounter victims of violence and crime daily. Such victims of violence and crime enter emergency departments in need of medical attention, and they carry forensic evidence on their bodies. Healthcare providers offer medical attention, but, in the process, they may inadvertently destroy forensic evidence – this may later deny a forensic patient the right to justice. The guidance available to healthcare providers in their training is often unclear, and the legislation and policies on forensic care are somewhat ambiguous, and are left open to the interpretation of the healthcare providers. In this context, this research provides insight into how emancipatory practice development transformed forensic care in three level-one emergency departments in Gauteng, South Africa.

The research approach used was action research, in a critical realist paradigm. An emancipatory practice development conceptual framework was applied. The study was conducted with the participants, using collaborative, inclusive and participatory processes. The research commenced with an exploration and explanation of the existing forensic care practised in emergency departments. Then the actual and expected forensic roles and responsibilities were explored with healthcare providers. Next, action plans were developed and implemented. Finally, the outcomes of the research were collaboratively evaluated.

The findings indicated that limited forensic care was already being provided at the time of the study. The research increased awareness of forensic care in the participating departments, as healthcare providers took the initiative to preserve evidence better, making use of the knowledge and resources acquired while participating in the research. The participants pointed out that the emancipatory practice development process followed required outsider initiation, combined with sustained support and fostering of relationships. Finally, they indicated that the research process had connected the research to the practice for them.

This study demonstrated that emancipatory practice development may increase awareness of forensic care, and may encourage the healthcare providers involved to take ownership. It may simultaneously contribute to changes in existing practice. Based on the findings, healthcare providers' forensic roles and responsibilities were structured into a framework to guide their practice. Furthermore, the steps taken to follow a systematic approach, as required by the emancipatory practice development conceptual framework, have been clarified – this may provide some guidance to other researchers who wish to use the same process.

Key words:

clinical forensic medicine

emergency department

emergency nursing

emancipatory practice development

forensic care

practice development

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List of Acronyms and Abbreviations

ACLS	Advanced Cardiac Life Support
DNA	Deoxyribonucleic Acid
ePD	Emancipatory Practice Development
SANE	Sexual Assault Nurse Examiners
SAPS	South African Police Service
SART	Sexual Assault Response Team
UNODC	United Nations Office on Drugs and Crime
WHO	World Health Organization

CHAPTER 1: ARRIVING AT THE SCENE

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1.1 Describing the scene

Every trauma patient in an emergency department is a forensic patient until proven otherwise (Lynch 2013). Trauma patients are those patients who have suffered life-threatening to minor, intentional or unintentional injuries arising from external forces. The intentional and unintentional injuries that forensic patients present with are mostly caused by interpersonal violence such as “sexual assault; physical assault; domestic violence; child or elder abuse; substance-, drug- and alcohol-related injuries or violence; or drunken driving” (South Africa 2012:26).

People who are injured through violence and/or crime are likely to seek medical attention in emergency departments (Çalışkan & Özden 2012; Lynch 2011). When victims of violence and/or crime enter an emergency department, there may be evidence on their bodies that can assist the justice system to verify aspects of criminal and/or violent events (Joyner & Duma 2010). Emergency healthcare providers tend to focus on life-saving management, resuscitation and referral, rather than on attending to preservation and collection of evidence; for example, when a trauma patient enters the emergency department, regardless of the cause of the injury, wounds are exposed for examination, cleaned and sutured. However, this necessary treatment can cause the loss, contamination and/or destruction of evidence (Çalışkan & Özden 2012). This implies that the manner in which evidence is currently handled in emergency departments may eventually compromise and deny a victim’s human right to justice (Johnstone 2011; United Nations 1985).

According to Johnstone (2011), healthcare providers, especially nurses, strongly emphasise care, but may overlook the need for justice. Van Hooft (2011) argues that healthcare providers should indeed provide the necessary care, but should not ignore the justice perspective that can enable them also to provide forensic evidence. The finer points of the exact roles and responsibilities of health care providers, as well as of how they can address the needs of victims of violence and crime seem elusive (Vetten, Leisegang & Haken 2010; Smythe et al. 2008). Nevertheless, healthcare practitioners’ roles and responsibilities are prescribed by a wide range of legislation and policies, which obligate healthcare practitioners to protect and empower patients (including victims of violence and crime) that make use of healthcare services (Rowe & Moodley 2013; Moyakhe 2011). It is therefore important that healthcare providers know and understand their forensic roles and responsibilities to advocate for justice, fairness and the protection of the patients in their care (Mokyakhe 2011).

In order to address the need for justice, fairness and the protection of victims of violence and crime, healthcare providers must have knowledge of and possess skills regarding the implementation of

forensic science (Henderson, Harada & Amar 2012; Wyatt et al. 2011). In studies conducted in Turkey (Çalışkan & Özden 2012) and South Korea (Cho, Cha & Yoo 2015), it has been found that emergency nurses were aware of the forensic patients in their care, but did not have the necessary knowledge and skills to implement relevant interventions, because during their training these nurses had limited exposure to aspects of forensic care. The situation in South Africa is probably similar, as neither medical doctors nor nurses have much exposure to the knowledge and skills required to provide forensic care to living victims of violence and crime (Jina et al. 2013). However, violence and crime have been declared a major health burden, and everyone should be regarded as a potential victim, regardless of race, gender, social or economic status (Harrendorf, Heiskanen & Malby 2010).

Healthcare providers in emergency departments who are not sensitized to the forensic needs of a patient may miss an opportunity to advocate for justice and protection for the patient. Fox and Cook (2011) suggest that if patients perceive healthcare providers insensitive, they might not disclose their need for the management of evidence and referral to the criminal justice system, because they fear blame from the healthcare providers, and/or because the victims know the perpetrators. In the seemingly chaotic environment of an emergency department, saving lives and treating patients in the shortest amount of time to allow new patients to enter tends to take precedence over identifying forensic patients and collecting evidence (Eisert et al. 2010). Furthermore, as McBrearty (2011:25) points out, patients might be so focused on the injuries they have suffered that “victimisation may not be apparent”. If medical management damages and/or destroys evidence present on a forensic patient, this may compromise the patient’s case – Kelley and Campbell (2013) report that in the United States of America the police are only able to refer a limited number of cases to the prosecuting authorities with adequate evidence.

Healthcare providers in emergency departments are ideally placed to identify, collect and preserve evidence, and to document injuries within minutes to hours of the injury. In view of this, Ward et al. (2012) have called for an assessment of the ability of healthcare services to screen and manage victims of violence and crime, but to date (July 2016) no such assessment appears to have been published. Generally, it appears that healthcare providers in emergency departments are unclear about forensic procedures, and should be provided with training and guidelines to manage forensic patients and evidence, as well as to understand the criminal justice system (Jancey, Meuleners & Phillips 2011). In already short-staffed emergency departments, there may be limited time and funding to send healthcare providers on the kinds of extensive course required to prepare them adequately for their forensic roles and responsibilities (Eisert et al. 2010). To address this need, a number of sets of guidelines have been developed to assist healthcare providers to manage forensic patients, but these guidelines are often underdeveloped by parties

who do not take into consideration the context in which patients and healthcare workers function (Henderson et al. 2012; Eisert et al. 2010). These authors argue that healthcare providers who need to care for forensic patients should be involved in the development of practices to care for the forensic patient population in order to increase ownership and implement actions leading to change.

1.2 Background to the study

The health burden of violence and crime is a worldwide phenomenon. According to the World Health Organization (WHO), South Africa ranks amongst the countries with the highest crime rates (WHO 2014). The crime statistics published every year suggest that crime rates in South Africa are decreasing, but the Institute for Security Studies (2015) and De Kock, Kriegler and Shaw (2015) claim that the reality may be quite different, as the data used to compile crime statistics may lack validity and reliability. It is also possible that victims of violence and crime may have lost confidence in the police, and therefore do not report cases of interpersonal violence (Institute for Security Studies 2015). Furthermore, the Institute for Security Studies (2015) argues that the statistics provided by the Department of Health are not suitable to oppose or confirm the decrease in violence and crime claimed by the South African Police Service (SAPS).

Crime statistics relevant to this study relate to contact crimes, which are synonymous with interpersonal violence. It is the victims of such violence who are most likely to seek medical attention in emergency departments. Contact crimes include attempted murder, assault with intent to commit grievous bodily harm, common assault, sexual offences and aggravated robbery. Such crimes made up 34% of crime reported to the SAPS (2015) in the period from 2013 to 2014. The potential number of forensic patients (trauma patients) managed in the three emergency departments that participated in this study accounted for approximately 39% of the total number of patients managed at these hospitals per month from 2013 to 2014. This percentage is similar to the percentage of crime which is related to contact crimes reflected by the SAPS's statistics. Moreover, it is estimated that in South Africa, every 35 seconds a person is sexually assaulted (SAPS 2015); this increases the chance that healthcare providers will come into contact with this category of forensic patients.

As a South African emergency nurse with ten years' clinical experience, I was responsible for managing a sexual assault clinic in an emergency department for three years. In addition, I have four years of experience as an academic involved in the education of nurses doing a post-graduate degree in emergency nursing. These experiences made me realise that aspects of forensic care in emergency medicine have been neglected, and require ongoing research. The community of practice of which I am a member was approached in 2012 by a trauma co-ordinator from a level-one emergency department in

the private healthcare sector to seek opportunities and support for research undertaken in, and for the sake of, practice. In our discussions, we identified the rendering of forensic care to victims of violence and crime as a priority topic for emergency departments in the private sector. Sexual assault victims were at the centre of the discussion – the private hospital group concerned has already provided extensive services to victims of such crimes, but seemed oblivious to the existence of other categories forensic patients. This trend was also noted in the literature (see Section 3.5.3.3).

The discussions led to the initiation of communication with the emergency department of an academic hospital in the public sector, to enquire whether or not forensic care was a topic that needed attention in the public sector too. It was established that this public emergency department referred sexual assault victims to the local medico-legal crisis centre for management and that forensic patients treated by healthcare providers in the public emergency department included gunshot, stabbing and assault victims. The need to transform forensic care in emergency departments was confirmed by emergency nurses, emergency doctors, one of the emergency nurse lecturers and a clinical facilitator involved in the public sector emergency department. Both the private and public sector emergency departments thus confirmed the challenge of balancing forensic care with emergency procedures, as also identified by Wilkinson (2011), Glittenberg, Lynch and Sievers (2007) and Markowitz (2007).

1.3 Problem statement

South African crime statistics show that a large number of victims of violence and crime may seek medical attention at emergency departments. Hence, healthcare providers in emergency departments need to be made aware of potential forensic patients, healthcare providers' forensic roles and responsibilities, and the training and education needed and available to equip them with the knowledge and skills they need to care for victims of violence and crime. Given the shortage of healthcare providers in South Africa, as well as financial and time constraints, training has to be focused. It has to be provided in a short space of time, preferably without removing healthcare providers from the emergency department where they work. The challenge is therefore to assist healthcare providers who are in need of forensic knowledge and skills to fulfil their roles and responsibilities by offering training with as little disruption as possible to the services provided. Moreover, there is an urgent need to clarify the responsibilities and obligations of healthcare providers regarding victims of violence and crime, as these responsibilities and obligations are thus far only implied in South African legislation (Aschman, Meer & Artz 2012).

Traditionally, in healthcare, training follows a top-down approach, as the topics and method(s) of education are pre-set by the South African Department of Health. In this regard, however, it is worth noting that although extensive efforts have been made to implement preventative and management guidelines regarding gender-based violence, no evidence of change could be found in healthcare services in this respect (Abrahams et al. 2012). This suggests that a bottom-up approach may be a better option: healthcare providers may be more inclined to take ownership of change and assist in transforming existing forensic care in emergency departments if they are involved in defining the existing problem, and in creating and implementing possible solutions.

In view of the need for a bottom-up approach to initiate changes, I selected emancipatory practice development as the process to follow in attempting to transform forensic care in the participating emergency departments. The benefits of emancipatory practice development include its proven ability to bring about positive change amongst healthcare providers' practice and patient outcomes (Manley, McCormack & Wilson 2008).

1.4 Significance of the study

In the past, as a result of their lack of knowledge concerning forensic care, healthcare providers have been accused of standing by and of being mere eyewitnesses while the human rights of patients are being infringed (Lukhozi 2009). The infringement of human rights by violence and crime is a global concern (Singh 2012; WHO 2002). Healthcare providers therefore have a duty to render forensic care to victims of violence and crime (Johnstone 2011; Joyner & Duma 2010; United Nations 1985). In this study, healthcare providers, especially nurses, became more aware of their roles and responsibilities towards forensic patients, possibly due to the emancipatory practice development process followed. These healthcare providers acknowledged that they found it a challenge to practise emergency care while incorporating aspects of forensic science in order to render forensic care, as proposed by De Leeuw and Jacobs (2010) and Joyner and Duma (2010). The study could indirectly assist more forensic patients to pursue their human right to justice, as less evidence may be contaminated and/or destroyed during medical procedures in the three participating emergency departments in future. Furthermore, during the study, a framework relating to the forensic roles and responsibilities of healthcare providers was conceptualised (see Section 8.7). The framework was based on the views of participating healthcare providers and a realist synthesis. The framework (see Figure 10.2) may be used as a starting point for further refinement and development of the forensic roles and responsibilities of healthcare providers to improve outcomes for forensic patients.

Internationally, there has been a call for an initiative to develop the knowledge, skills and culture of emergency healthcare providers regarding forensic care (Eldredge et al. 2010; Kelleher & McGilloway 2009). According to Henderson et al. (2012), and Lynch and Duval (2011), the focus of such an initiative should be on the forensic aspects of the identification, collection, preservation and documentation of evidence, as well as on maintaining the chain of evidence. The intentional and unintentional activities that were initiated during this study were based on the needs identified by the participants; these activities also addressed the aspects raised by Henderson et al. (2012), and Lynch and Duval (2011) in a contextual manner. The results and actions of this study could potentially increase an awareness of the need for forensic care and may possibly influence the curricula of the basic and post-basic education of nurses and medical doctors, especially in South Africa.

Furthermore, the two level-one private emergency departments and the one academic hospital that participated in this study were able to engage in research activities, thereby providing leadership in the emergency care environment, as called for by Hardcastle et al. (2011). The emancipatory practice development process implemented during the study may also have empowered the participants in the respective emergency departments to embark on their own studies, as they were involved in the process and could form an understanding of research activities and methods.

1.5 Research question

The study was guided by the following core research question:

How does emancipatory practice development transform forensic care in level-one emergency departments in Gauteng?

1.6 Aim and objectives

The aim of the study was to facilitate an emancipatory practice development process, with the intention of transforming forensic care in level-one emergency departments in Gauteng.

The objectives for the study were the following:

1. Explore, describe and explain the forensic care that exists in emergency departments
2. Determine and explain the forensic roles and responsibilities of healthcare providers
3. Collaboratively recommend actions to be taken to transform forensic care in level-one emergency departments

4. Facilitate, evaluate and refine collective actions taken to transform forensic care emergency departments
5. Evaluate the outcomes of the emancipatory practice development process on the transformation of forensic care

1.7 Paradigmatic perspective

I selected critical realism as the paradigm for this study (see Section 4.4.2.1). This choice is contextualised and explained here.

Critical social theory seems to be the preferred paradigm for emancipatory practice development (Shaw 2013:68). However, authors such as Fairbrother, Cashin, Mekki, Graham and McCormack (2016), Parlour and McCormack (2012), and Wilson and McCormack (2006) acknowledge that critical realism forms the foundation for critical social theory, because both these paradigms strive towards emancipation and an understanding of causalities. Bunniss and Kelly (2010) point out that emancipation lies at the heart of critical realism. Emancipation is concerned with equality, justice and the search for “how things could change for the better”, as well as with every individual’s ability to realise his/her potential. These attributes are extended by action research scholars, who insist that it is not enough to understand the social world; they believe that actions should be taken to change it (Houston 2014; Bunniss & Kelly 2010). However, critical realists acknowledge that some social problems are unsolvable. Those who adhere to a critical realist approach make no promises that outcomes will be the same in different contexts, although they strive towards emancipation to transform unwanted, unneeded and oppressive sources to achieve the liberating outcomes needed (Borg, Young & Munksgaard 2013; Archer et al. 1998).

Critical realism intends to provide new and practical ways to approach problems and gain new insights by focusing on practice-based research (Schiller 2016; Tashakkori & Teddlie 2011). In order to allow new insights, critical realism embraces emerging and eclectic collections of design and methods, with the intention of capturing the rich ontology of people interacting with the world and each other (Schiller 2016; Houston 2010).

1.7.1 Ontology

Roy Bhaskar was predominantly responsible for the development of critical realism. His intention was to provide new and practical ways to approach problems and gain new insights (Tashakkori & Teddlie 2011; Archer et al. 1998). Bhaskar explains that what exists (ontology) is unquestionably different to

how we come to know in the world (epistemology) (Burgoyne 2010; Bhaskar & Lawson 1998:5). In order to explain the ontology of critical realism, Bhaskar (1979) differentiates between three domains of ontology, namely the real, the actual and the empirical. The *real* domain represents all the mechanisms that exist in the world, such as relations, structures, customs, reasons and resources that generate events (Gorski 2013; Houston 2010). The identification of mechanisms that cause events can assist critical realists to gain a better understanding of cause and effect – the causality of what occurs. The *actual* domain is comprised of events that have occurred, even if the cause/causality has not been observed or explained (Gorski 2013; Clark 2008). The *empirical* domain refers to the level of experience and perspectives that have been triggered and can be directly observed (Gorski 2013). In order to explain the stratified ontology of critical realism I contextualised the example as provided Schiller (2016).

My contextualised example are as follows: in the world outside emergency departments, there are generative mechanisms such as customs, traditions, behaviours and legislation – these represent the *real* domain. Mechanisms in the real world then in turn cause people (in this study, that refers specifically to victims of violence and crime) to seek medical attention in healthcare facilities where patients may (or may not) obtain medical and forensic care. Evidence collected by healthcare professionals may (or may not) eventually be used in order to prosecute a perpetrator. These events happen and represent the *actual* domain of the ontology. The *empirical* domain refers to the participating emergency departments where the causes and causalities of the mechanisms triggered can be experienced and explained.

Critical realists seek to understand and explain what causes an event and what the outcomes (the causality) are by attempting to reveal the sequential cause and causality in all three domains by triggering mechanisms in a particular context and then noting the outcomes of the event (Clark 2008). Therefore uncovering the mechanisms that give rise to the causality in the empirical domain (and the information that becomes known through direct or indirect experiences) is at the core of critical realism (Defroge & Shaw 2012). In order to gain a deeper understanding of the causes and causalities of events, it is important to explain how, according to critical realists, we come to know in the world.

1.7.2 Epistemology

How we come to know in the world and how I came to know in this study formed the epistemology of the study. Critical realists are by nature eclectic. They attempt to cross philosophical, methodological, professional and disciplinary boundaries in the hope of developing refined explanations and solutions

for challenges in practice (Angus & Clark 2012; Patomäki & Wight 2000). In the interests of transparency and accountability, I acknowledge that I embarked on the study with a number of preconceived ideas stemming from my own convictions and professional tradition. I believe that people are equal, and that neither a social or institutional rank, nor a title, makes anyone a better or smarter person. This belief influenced my choice of methodology and my decision to engage in a change process: both action research and practice development prescribe collaboration, inclusion and participation, which are all in line with my belief in inherent equality.

As the co-ordinator of a sexual assault centre, I observed that many healthcare providers avoid patients who have been sexually assaulted. These healthcare providers do so for personal and professional reasons, including the possible re-experience of abuse as secondary trauma and fear of being subpoenaed to testify on the forensic evidence in court. Hence, to encourage collaboration and participation, the topic with which I chose to approach the emergency departments was forensic care, a broad and less threatening topic.

I also acknowledge that I did not want the only outcome of my research to be just another report on a library shelf. To ensure that there would be outcomes in the *empirical* domain, action had to be taken to transform forensic care. Forensic care is a complex problem that requires interdisciplinary social interaction, following a systematic process. Emancipatory practice development provided the process to be followed and a clear goal of what the participants and I were working towards. Action research provided the route we followed in “how we got there”. The eclectic nature of critical realism allowed me intellectual freedom and flexibility. It also allowed me to use a blend of different methods that were applicable to the practice under review, and that could be easily followed by healthcare providers working in the participating emergency departments who might want to embark on different research projects of their own in future. The realist synthesis and realist evaluation developed by Pawson (2013) also assisted me in reviewing the literature on the expected forensic roles and responsibilities of healthcare providers, and in undertaking and presenting the evaluation that concludes the study.

Bhaskar (1988) warns that it is an epistemic fallacy to believe that humans are at the centre of all knowledge, which is in any case constantly made and remade. In order to understand the contributions of this study, I therefore described the methods used throughout the study in detail, so that the way in which mechanisms were triggered, and the causes and causalities which are revealed, are not left to unguided interpretation.

1.8 Concept clarification

The key concepts used in the study are clarified below to ensure greater understanding, clarity and consistency throughout the study. The concepts are also operationalised within the context and for the purposes of the study.

1.8.1 Transforming

Transforming denotes the purposeful use of a change process to facilitate improvements in attitude, communication, structure and actions to enhance to the practice capacity of practitioners (Chase et al. 2015; Assid 2011; Daszko & Sheinberg 2005). Transformation starts with increased awareness of the existing practice and of the changes required. The process of transformation is uncertain and unpredictable, but it embraces collaborative, participatory learning, and taking action on the basis of any new knowledge gained (Ennals 2014; Ospina & Anderson 2014).

For the purposes of this study, transforming is defined as facilitating an emancipatory practice development process to improve the awareness, communication and structures related to forensic care by means of participatory and collaborative actions. The transformation focus of this study implies increased empowerment and the facilitation of positive change in the participating emergency departments.

1.8.2 Level-one emergency department

According to the Trauma Society of South Africa, a level-one emergency department is a major trauma centre that is mostly – but not necessarily – university-based and has access to specialised services for 24 hours of the day (Hardcastle et al. 2011). Research and prevention is a key responsibility of level-one emergency departments. When interventions are successfully implemented, such interventions can possibly be modified and used in other levels of emergency departments. In Gauteng, only two emergency departments are accredited by the Trauma Society of South Africa. Both are in the private healthcare sector. These emergency departments are not affiliated to a university, but meet the accreditation criteria for level-one emergency departments.

For the purposes of this study, an academic hospital in Gauteng in the public healthcare sector was also included. This academic hospital provides specialised services 24 hours of the day. It is affiliated to a university, but it is not accredited as a level-one emergency department by the Trauma Society of South Africa.

In the remainder of this thesis, for the sake of brevity, the level-one emergency departments are referred to only as emergency departments.

1.8.3 Forensic care

Forensic care entails identifying, collecting, preserving and documenting evidence and injuries, using scientific terms, and maintaining the chain of evidence (Henderson et al. 2012). Therefore forensic care implies the application of medical knowledge and skills in cases (to patients) that can potentially interact with the legal process (Lynch 2013; Darnell 2011; Wyatt et al. 2011). In the context of this study, forensic care refers to the care provided to victims of violence and crime in the three emergency departments that participated in the study. Emergency care is characterised as time-sensitive, acute, unscheduled and episodic (Meisel, Carr & Conway 2012; Fernandes 2011). For the purposes of this study, forensic care is thus defined as the time-sensitive identification and collection of evidence, and the scientific documentation of acute, unscheduled and episodic injuries of patients who may interact with the criminal justice system, and to the healthcare providers' maintaining the chain of evidence in the emergency department.

1.8.4 Victims of violence and crime/Forensic patients

Forensic care is provided to victims of violence and crime – people who have suffered a wide range of physical (and often mental and psychological) injuries due to interpersonal violence such as attempted murder, assault with the intent to commit grievous bodily harm, common assault, sexual offences and aggravated robbery, all of which have legal implications (South Africa 2012; WHO 2009). The aforementioned definition is adopted for this study, and the concepts “victim(s) of violence and crime” and “forensic patient(s)” are used interchangeably.

1.8.5 Healthcare provider

The concept “healthcare provider” refers to doctors registered in terms of the *Health Professions Act* as amended by the *Health Professions Amendment Act, No. 59 of 2007* (South Africa 2007b), and to nurses registered in terms of the *Nursing Act, No. 50 of 1978* (South Africa 1978) and the *Nursing Act, No. 33 of 2005* (South Africa 2005). For the purposes of this study, the concept healthcare provider is therefore used to refer to both registered doctors and nurses working in emergency departments.

Legislation such as the *National Health Act, No. 61 of 2003* (South Africa 2003), the *Criminal Procedure Act, No. 51 of 1977* (South Africa 1977) as amended, and the *Criminal Law (Sexual Offences and*

Related matters) Amendment Act, No. 32 of 2007 (South Africa 2007a) describes the duties of healthcare providers, and refers to “medical practitioners or nurses”.

1.8.6 Emancipatory practice development

Before clarifying emancipatory practice development, it is important to define practice development. Practice development is explained by Manley et al. (2008:268) as follows:

A continuous process of developing person-centred cultures. Enabled by facilitators who authentically engage with individuals and teams to blend personal qualities and creative imagination with practice skills and practice wisdom. The learning that occurs [then] brings about transformations of individual and team practices sustained by embedding both process and outcomes in corporate strategy.

For the purposes of this study, the term emancipatory practice development is used to refer to the change process that guides interactions between participants while they generate new knowledge. Emancipatory practice development is a form of practice development that not only improves outcomes and practitioners’ self-understanding, but also assists practitioners to arrive at a point at which they can critique their own social and or education (nursing), work and work settings (Manley et al. 2008).

According to the literature, emancipatory practice development is divided into three phases, namely enlightenment, empowerment and emancipation. Wilson and McCormack (2006) describe enlightenment as the phase during which healthcare providers become aware of the changes that are required. Through empowerment, the healthcare providers then gain information in order to be able to act on the changes that they have identified. Finally, emancipation is achieved when enlightened and empowered healthcare providers take action to reform their practice in the context of their work (Wilson & McCormack 2006). In this study, facilitation focused on guiding healthcare providers through the phases of enlightenment and empowerment, in order for them to address the forensic care of victims of violence and crime.

1.8.7 Practice development facilitator

A practice development facilitator is a healthcare provider who is identified within a participating population and who is committed to change – such a person should be sensitive, flexible and reflexive to people and situations (McCormack, Manley & Titchen 2013). The role of a practice development facilitator is complex. For the participants in this research, their role evolved in the course of the study. More detail on the practice development facilitators and their role is provided in Section 5.5.2.

1.9 Setting the stage

The emergency departments (one public and two private) involved in this study provide care ranging from general medical care to specialised medical care to patients, 24 hours per day, 365 days per year (see Table 1.1). Patients admitted into the three participating emergency departments are classified as either medical or trauma patients. On average, trauma patients made up 39% of the patients managed in these three emergency departments. Their injuries are captured as assaults, burns, dog bites and human bites, head injuries, gunshot wounds, lacerations, stab wounds, motor vehicle accidents, pedestrian vehicle accidents and trauma of unknown origin.

Considering that all trauma patients are in need of forensic care until otherwise proven (Lynch 2013:2), it is a matter of concern that no statistics on the causes of the injuries or police involvement are kept. Moreover, the available statistics are merely an indication that the nurses in the emergency departments have knowingly or unknowingly come into contact with forensic patients.

South African emergency departments are frequently overcrowded and are chaotic at times, challenging the ability of healthcare providers to manage the patients in their care. The number of beds and permanent nursing staff and doctors available are summarised in Table 1.1.

Table 1.1: Number of beds, permanent nursing staff and doctors in the participating emergency departments

Emergency Department	Number of beds	Number of permanent nursing staff	Number of doctors
A (public emergency department)	31	70 (23 are registered nurses)	23
B (private emergency department)	14	28 (22 are registered nurses)	22
C (private emergency department)	14	33 (15 are registered nurses)	25
Total	59	131 (60 are registered nurses)	70

The physical setting, description and staffing of the trauma units of both public and private hospitals are important details to note in this study, because they are indicative of the quality of care and of the facilities, which in turn have an impact on the patients and on the morale of the healthcare providers. The differences between these two types of emergency department are described in terms of the

physical settings of these emergency departments and how they operate, as well as how this in turn influences the staff and patients.

This information supports the interpretation of the type of workplace culture experienced in each of the three participating emergency departments. It is customary in emancipatory practice development endeavours to assess workplace culture directly, in order to clarify the context and customs of the people involved in a study (Manley, Solman & Jackson 2013). However, I decided to report on the workplace culture in these three departments based on my perceptions, experience and interactions with the participants of the study. As a critical realist, I believe that workplace culture is situated in the real domain of what exists and that it cannot easily be measured or observed “just as it is”, because culture is generated by people in a certain setting at a specific time and it continuously changes, due to human actions, as Archer (2002) posits.

1.9.1 The public emergency department

Public hospitals are part of the South African government’s system to deliver health services to the country’s population. These hospitals are often under-staffed and over-utilised, and they focus on the poor and on the general population (Breier, Wildschut & Mqgqolozana 2015). The public emergency department (Emergency Department A) that participated in this study manages approximately 1 600 patients per month. The emergency department is divided into six areas:

- a triage area where patients undergo a preliminary sorting;
- a trauma resuscitation area of four beds staffed by three registered nurses;
- an open area for trauma and paediatric patients divided by drawing curtains between beds – four beds at one end of this area are allocated to paediatric patients, and a further eight beds at the other end are allocated to adult trauma patients; the area is staffed by two registered nurses and three other staff;
- a male medical area with six beds that looks like a normal room in the hospital, staffed by a registered nurse and a staff nurse;
- an open plan female medical area with seven beds, staffed by two registered nurses and three staff nurses;
- a fairly isolated area for ventilated medical patients, to which two registered nurses are allocated.

The emergency department is usually overcrowded with patients and disorganised. Due to this, in my engagement with the healthcare providers, I got the sense that they were somewhat overwhelmed by their working environment and its limitations. New patients in need of care constantly arrive when the

patients already there have not yet been transferred to wards because there are staff shortages in the wards, or there are no beds available. The overcrowding of the emergency department also contributes to a loss of privacy and dignity of the patients, when more beds are pushed in than the areas are designed for, in order to accommodate as many patients as possible. A patient may be passed from one medical discipline to another, and none of the disciplines wants to take responsibility for the care of the patient.

I noted communication breakdowns between all the healthcare providers, especially between the unit managers and nursing staff. I perceived this communication gap as indicative of a situation where nurses were talked *at*, and no effort was made to talk *with* them. I also became aware that the healthcare providers talked over and about patients, but seldom directly to the patients. Moreover, according to hospital policy, all healthcare workers should communicate in English, but some nurses and doctors slipped into their home language, making it impossible for some patients and other team members and patients to understand what they said.

The effectiveness of teamwork depends on the ability of shift leaders to work together and organise care activities. However, team effectiveness at the public emergency department was hampered by the division into six areas and the sheer size of the emergency department, as well as by communication challenges. During busy, disorganised and overcrowded periods, some nurses were observed to be sitting around, some hiding in the many shadows, nooks and crannies of the emergency department, while other nurses rushed and scurried to attend to the necessary care activities. The workplace environment also contributed to high absenteeism and turnover among the nursing staff and the doctors. This working environment is less than ideal, and learning opportunities are rare. A group of nurses did initiate a little black book system that contained information and formulas to assist them in their daily care activities, but this was only shared between some of the registered nurses.

1.9.2 The private emergency departments

Private hospitals are hospitals that are privately owned, and are run as commercial enterprises to cater for middle to high income earners (Breier et al. 2015). The two private emergency departments are housed in more compact areas than that which houses the public emergency department. They are neater and there is better lighting in this physical work environment. The private emergency departments respectively manage around 1 800 and 2 700 patients per month. The average length of stay per patient is one to four hours, after which patients are either transferred to wards or released after treatment. Services are rendered to patients with medical insurance – as they are paying

customers, care has been taken to ensure some privacy. Both the private emergency departments have separate cubicles and the resuscitation area in each is away from the high traffic areas of the unit. Both the emergency departments have private rooms to render more discreet services to victims of sexual assault, and all staff have been trained to perform the specific procedures required.

During my engagement with the nursing staff I perceived team effectiveness to be more satisfactory than the team work in the public hospital's emergency department. However, there is a great deal of competition between the two emergency departments – Emergency Department B is well-known for its trauma care, and many celebrities and political leaders have been treated there, while Emergency Department C is perceived as the “stepchild” of the private hospital group. Although nursing staff at Emergency Department C manage the most gunshot victims in the province of Gauteng, they are hardly recognised by the top management of the hospital group.

Communication is done in much of the same manner as in the public emergency department, where staff are talked *to* and talked *at*, but not talked *with*. Learning opportunities are provided in the same manner as the communication – topics are chosen by the clinical nurse specialist, with no input from staff members.

1.10 Outline of the thesis

The thesis is divided into 12 chapters. An outline of the thesis is provided in Table 1.2. This outline shows how the three parts of the research process are connected, namely the shift from a “laboratory” to the collaborative field work with the participants, and back to the “laboratory”. The initial “laboratory” phase involved the proposal development, the literature review, an explanation of the change process itself, including practice development, emancipatory practice development and the conceptual framework that guided the study, and the principles and working of emancipatory practice development. The work with the participants formed the main focus of the study, and explored the change process in the empirical domain of the three emergency departments. The final “laboratory” phase involved a realist evaluation, and compiling conclusions and recommendations and suggestions for further research.

Table 1.2: Outline of the thesis

Orientation and Methodology				
Chapter		Description		
Chapter 1		Arriving at the scene – the chapter provides a general introduction to the study and presents the rationale for this study. The chosen research paradigm, questions and objectives formulated for the study are set out. The context of the study is explained and a short description of the research process is provided.		
Chapter 2		Methodology of the investigation – this chapter contains a discussion of action research as the methodology chosen for this study.		
Research Process				
Part	Area of Action	Chapters	Description	Actions
I	Laboratory (away from the participants)	3 and 4	In Part I, the research process was done in the “laboratory” away from the participants. In this part of the study the first two action research cycles are described.	<ul style="list-style-type: none">Chapter 3 – Cycle 1: Canvassing the literature. In this chapter, the manner in which the literature was searched and reviewed is described. The chapter foregrounds the fact that the literature available on forensic care in emergency departments is limited. The discussion of the existing literature includes a description of the development of forensic medicine, the international call for forensic knowledge and skills, the current state of affairs in South Africa and a profile of local forensic populations. The chapter also looks at the initiatives taken to expand forensic knowledge among healthcare providers in the country.Chapter 4 – Cycle 2: The change process. The chapter explains practice development, emancipatory practice development and the conceptual framework that guided the study. The discussion includes the principles and working of emancipatory practice development, as well as an explanation of how it was applied in this study.
II	Collaboration (with participants)	5 to 10	The document then moves to Part II (Cycle 3) the collaborative part of the study, which was conducted with the participants. This forms the main part of the study. Cycle 3 is made up of three sub-cycles as described in the actions column of this table.	<ul style="list-style-type: none">Chapter 5 – Making contact This chapter explains who the participants of the study were, how relationships were established and maintained, as well as the values and beliefs held by the participants. <u>Sub-cycle1:</u> <ul style="list-style-type: none">Chapter 6 – The first glance This chapter looks at the existing practice to establish what is already being done.Chapter 7 – Through the looking glass This chapter captures the actual forensic roles and responsibilities of healthcare providers.Chapter 8 – Under the magnifying glass This chapter contains the healthcare providers’ expectations regarding their roles and responsibilities, as established by a realist synthesis. Furthermore, the framework developed to capture the healthcare providers’ forensic roles and

				<p>responsibilities is discussed in relation to the findings of Chapters 6, 7 and 8.</p> <p><u>Sub-cycle 2:</u></p> <ul style="list-style-type: none"> Chapter 9 – Putting plans into action. <p>The action plans proposed are discussed, as well as the actual actions that were implemented during the study.</p> <p><u>Sub-cycle 3:</u></p> <ul style="list-style-type: none"> The collaboration of the study comes to an end in Chapter 10 – Processing the evidence <p>The chapter contains the evaluation, relating forensic care and the emancipatory practice development change process followed in the study.</p>
III	Laboratory (away from the participants)	11 and 12	Part III (Cycle 4) moves back into laboratory and undertakes a realist evaluation.	<ul style="list-style-type: none"> Chapter 11 – Considering the process evidence. Chapter 12 – Adjournment <p>In this final chapter, I discuss the potential contributions of my study, make recommendations and propose possibilities for future research.</p>

1.11 Summary

Chapter 1 introduced the focus of the study. The aim and objectives of the study were outlined, and a short description of the research process was provided. A brief description of the emergency departments was offered as background on the context in which the study was conducted. The chapters that follow in the remainder of the study were then outlined, in order to demonstrate the flow of the study.

Chapter 2 discusses action research as the chosen methodology for the study. The methodology is explained in detail early in the thesis, because all the activities in the research process revolve around the chosen action research cycles (look, think and act).

CHAPTER 2: METHODOLOGY USED IN THE INVESTIGATION

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2.1 Introduction

In Chapter 1, an overview of the study was provided to orient the reader and indicate key problems regarding forensic care faced in practice. Chapter 2 introduces action research as the methodology that I used in this study. First, a theoretical discussion is presented on action research as a methodology. This is followed by descriptions of how action research work and the working principles that must be adhered to in doing action research. I then present action research as my chosen methodology. The rigour and ethical principles of action research are considered, and I discuss the application of these in this study. Finally, I reflect on my methodological choice and the main challenges I encountered in conducting action research in this study.

2.2 Action research methodology

For the purposes of the study, methodology is conceptualised as the manner in which knowledge is constructed by applying specific methods to collect and/or generate and interpret data,¹ based on the work on action research by McAteer (2013), Tomal (2010), Tashakkori and Teddlie (2010), and Sapford (2006). John Dewey (1859-1952) and Kurt Lewin (1890-1947) are regarded as the founders of action research – Dewey recommended that enquiries should follow a systematic process through action, and Lewin demonstrated the credibility of action research (Bargal 2014; Ospina & Anderson 2014; Adams 2010). Action research as a methodology has been used for the last 70 years to provide practical solutions to various communities to improve their service to consumers or to facilitate social change (Titchen 2015; Stringer 2014). This kind of research has gained momentum in the healthcare professions over the last two decades (Titchen 2015; Williamson 2012b).

Over the years, different kinds of action research have been formulated. In Table 2.1, I provide a summary of the types of action research described by Kemmis, McTaggart and Nixon (2014), as well as the origins of each type.

¹ In this study, data were both collected (for example, in the various literature reviews) and generated (for example, using the talking wall, the nominal group technique and the focus group sessions). Hence, the terms are not used interchangeably, but are specifically chosen to reflect the precise data gathering activity.

Table 2.1: Summary of some types of action research

Kind of action research	Brief description	Origins and influence	Source
Industrial action research	The research is consultant-driven, with the emphasis on collaboration with workers at all the levels of an organisation regarding work democratisation and the research process.	Lewin Tavistock Institute of Human Relations Research Centre for Group Dynamics	Kemmis et al. (2014) Neuman (2014) Herr and Anderson (2014)
Action science	Action science is concerned with creating practical knowledge that can be used to improve services and practice, and its aim is the development of reflective practitioners.	Argyris and Schön	Kemmis et al. (2014) Friedman and Putnam (2014) Herr and Anderson (2014)
Action learning	Action learning is a method of learning through doing and engaging in self-challenging activities and experimentation to change. The action learning formula posited by Revans is $L = P + Q$ (Learning = Programmed knowledge + questioning insight).	Revans	Kemmis et al. (2014) Rigg (2014)
Soft systems approaches	The soft systems approach is a pragmatic research method that can assist organisations to create a detailed picture of a problem. Then they can collaboratively act, learn and reflect to evolve new knowledge and understanding.	Checkland	Kemmis et al. (2014) Steinfort (2014)
Participatory action research	This kind of research involves collaboration between researchers and local communities that are often marginalised in bringing about social change.	Freire Liberation theology Neo-Marxism	Kemmis et al. (2014) Pant (2014b) Williamson (2012a) Herr and Anderson (2014)
Classroom action research / classroom-based action research	This kind of research is concerned with teachers' judging and improving their educational practices.	Elliot Corey	Convery (2014) Kemmis et al. (2014)
Critical participatory action research	In this kind of research, practitioners examine their practice for any illogical, unsustainable or unfair behaviour, and work to overcome or avoid the identified behaviour through individual and collective reflection.	Carr, Kemmis and McTaggart	Kemmis et al. (2014) Kemmis and McTaggart (2014)

Source: Adapted from Kemmis et al. (2014:8-12)

To supplement the summary provided in Table 2.1, I also considered Williamson's (2012a) description of varieties of action research – he mentions human inquiry, cooperative inquiry and action science/action inquiry, participatory action research, action research and feminism, and appreciative inquiry. Whichever term is preferred to denote action research, these varieties of action research all share a number of principles, in that action research involves a cyclical, systematic enquiry into the challenges faced by practitioners in their practice, while collaboratively seeking ways of improving the practice within the boundaries of its context (Coghlan & Brydon-Miller 2014; Stringer 2014; Tomal 2010). Furthermore, action researchers acknowledge the complex nature of practice, with its multi-layered demands and human relations (Stringer 2014; McAteer 2013). Within the complex context of the practice environment, action researchers aim to facilitate practical improvements that will benefit practitioners and promote social justice in the community they serve (Prasad 2014; Adams 2010; Tomal 2010).

Given the complex nature of practice and the fact that participants are human and form part of intricate social structures, Kemmis and McTaggart (2014) caution that the cycles followed in action research do not always follow a specific sequence; nor can the step-by-step progression of *look*, *think* and *act* necessarily be actualised. Coghlan and Gaya (2014), McAteer (2013), Herr and Anderson (2014), and Brydon-Miller et al. (2003) also caution researchers that action research is dynamic and “messy”. In order to guide action researchers through the cyclic systematic enquiry, I considered it important to take a closer look at how action research works.

2.3 How action research works

Action research follows a cyclical process. The most basic of these processes is *look*, *think* and *act* (Stringer 2014). Action research cycles have been adapted to fit the purposes of specific studies, and some authors opted to rename the steps in the cycle and/or insert additional steps as needed, as depicted in the examples in Figures 2.1 to 2.3.

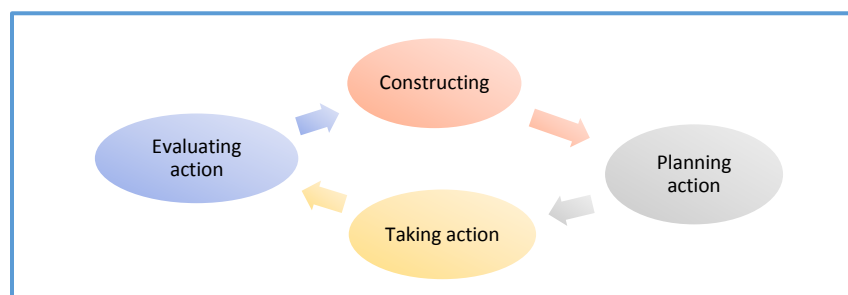


Figure 2.1: Coghlan and Brannick's (2013) action research cycle

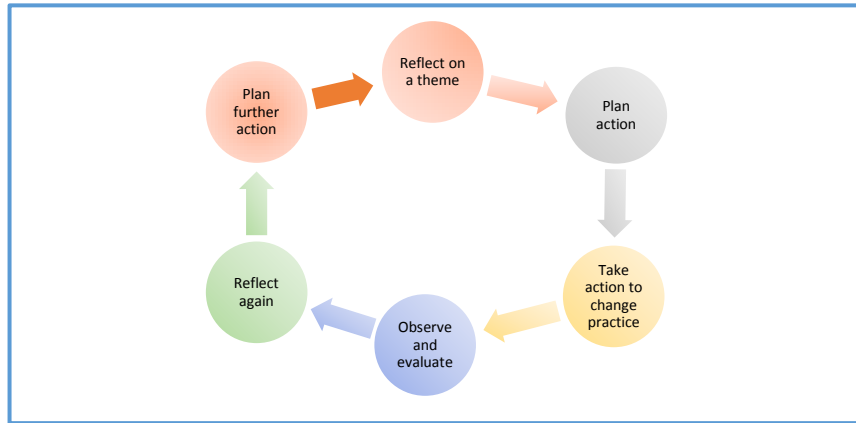


Figure 2.2: Williamson's (2012b) adaptation of Hart and Bond's (1995) action research cycle

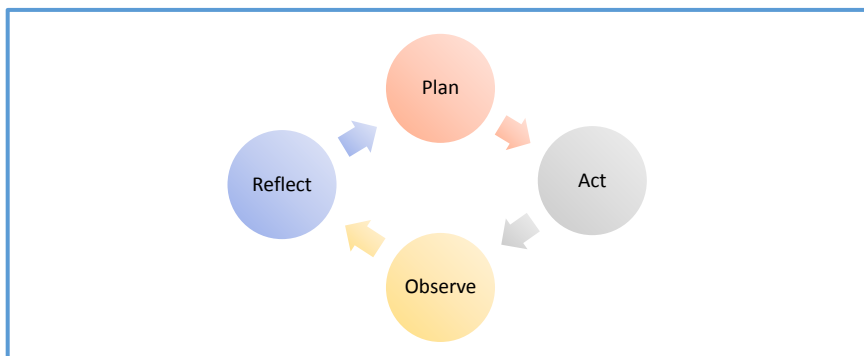


Figure 2.3: Kemmis and McTaggart's (1999) action research cycle

The cycles illustrated in Figures 2.1 to 2.3 predict only one cycle, but in any action research study, there may be several cycles of action that follow one another, and in each case, the next cycle is influenced by the outcomes, results or findings of the previous cycle (Hill 2014; Costello 2011). In this study, in order to keep the reporting as uncomplicated as possible, Stringer's (2014) basic cycle of action research (see Figure 2.4) was used to report on and record the study. The decision to apply Stringer's model of action research was based on the fact that this cycle was easy to follow and explain to practitioners, and did not add to the existing challenges that had to be addressed in order to change their practice.

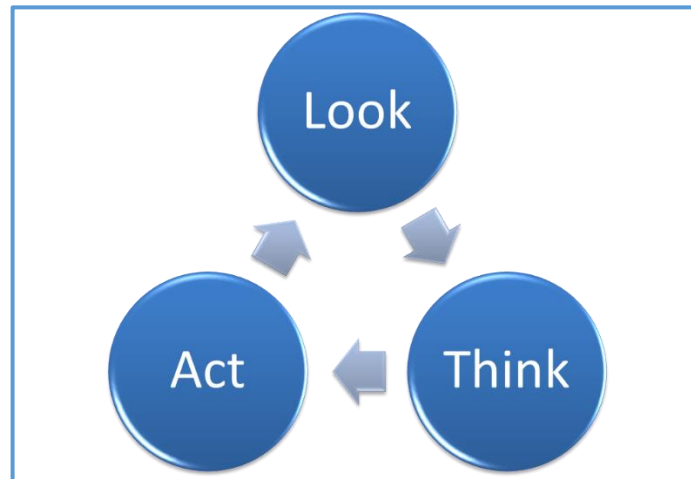


Figure 2.4: Stringer's (2014) action research cycle

The *look phase* is the starting point of the cycle and is synonymous with observation (Stringer 2014). Typical activities in the *look phase* include examining the scene to clarify the starting point of the research or of the next cycle, and assisting in the identification of the issue, the people involved and the events that occur in a specific context (Hill 2014; Stringer 2014). The *think phase* is a reflective phase where the findings of the *look phase* are explored and analysed, while considering the people who are involved in and may be affected by the issue to generate some understanding (Kemmis et al. 2014; Stringer 2014). The *act phase* includes planning and implementing the action needed to resolve or diminish the identified issue. This phase feeds directly into a next look, think and act cycle. Each act phase is followed up by an evaluation of the actions taken to ascertain their effectiveness and to identify possible adaptations that need to be made (Kemmis et al. 2014; Stringer 2014). In order to assist practitioners to move through the cycles, the working principles of action research can be followed, as discussed below.

2.4 Working principles of action research

Kemmis et al. (2014), Pant (2014b), Stringer (2014), and Williamson (2012a) emphasise that action research is done *with* participants and not *on* them. The participants in action research studies are accepted as co-researchers, and engagements between the researchers and these participants as co-researchers are based on the working principles, which include relationships, communication, participation and inclusion (Stringer 2014).

2.4.1 Relationships

Action researchers build relationships with the participants in their research and the organisations with which the participants are associated (Stringer 2014; Tomal 2010). These relationships should promote feelings of equality – the researcher should not be regarded as the expert and the participants as amateurs (Stringer 2014; Tomal 2010). Power and knowledge should be shared to bring about change in the way practitioners practise. Power should be “to” and “with” the participants (Stringer 2014; Geventa & Cornwall 2008). In order to ensure that participants do not feel threatened, relationships between the researcher and the participants, and between the participants themselves need to be respectful and supportive (Stringer 2014; Grant, Nelson & Mitchell 2008). However, it is also important to acknowledge that relationships and power dynamics typically do exist between participants prior to the initiation of a study and that this will influence relationships, communication, inclusion and participation throughout the study (Pant 2014b; Townsend 2014). In order to ensure sound relationships during the study, clear and open communication is essential.

2.4.2 Communication

Communication builds bonds between participants and between the participants and the researcher (Kemmis et al. 2014; Grant et al. 2008). Communication is a form of feedback which allows for an exchange of information and ideas so that new ways of thinking and acting can be explored (Kemmis et al. 2014; Tomal 2010). Communication can take various forms, and is not limited to listening, face-to-face meetings, telephone calls, text messages and e-mails – the form it takes should depend on the choice of and convenience for the participants in the study (Wilson & Flicker 2014; Grant et al. 2008). Communication forms the basis from which relationships develop and are nurtured to enhance collaboration, inclusion and participation (Stringer 2014; McIntosh 2010).

2.4.3 Inclusion

Action research occurs in a specific context, so no person involved in the context can be excluded unless the person chooses to be excluded voluntarily (McCormack 2014; Stringer 2014). The social justice implications of action research make it important to include the people and/or organisations that are involved in decision-making and implementation processes that may have a direct or indirect effect, or a positive or negative influence on activities (Pan, Tang & Gulliver 2012; Stakeholder Participation Working Group of the 2010 HIA in the Americas Workshop 2011). In this study, the healthcare

providers of three emergency departments were therefore involved. A collaborative stakeholder analysis was done (see Section 5.3.3).

2.4.4 Participation

Participation is fundamental to ensure that research is done *with* participants and not *on* them (McCormack 2014:639; Pant 2014b; Sullivan, Hegney & Francis 2013). Participation implies empowerment, which can only be achieved through active participation, collaborative decision-making and power-sharing (Pant 2014a; Saija 2014). Empowered decision-making is in turn based on communication and consensus between participants (Pant 2014b).

The mechanics and working principles of action research necessitate a qualitative evolutionary design that responds to the needs of the participants, based on their contextual boundaries. Costello (2011) and Waterman et al. (2001) urge action researchers to allow the research process, data generation and analysis methods to develop throughout the study, by means of relationship-building, communication, inclusion and participation amongst participants and the researcher. The action research methodology and evolutionary design used in this study made it possible to strive towards answering the research question by achieving the aim and objectives of the study.

2.5 Applying action research principles in this study

I chose action research as the methodology for this study due to my ontological and epistemological stance and the premises of scholars in the field. The human agency (people) referred to in critical realism is important for any change that is required to challenge and transform the current status quo for the better. Some action research scholars claim that practice can be changed with the collaboration of practitioners (Sarvestani et al. 2016; Voigt et al. 2014). More specifically, Sarvestani et al. (2016) and Rigg (2014) argue that action research can improve healthcare by enabling practitioners to reflect on their current practice, enabling them to initiate changes and gain a deeper understanding of their practice and the patients they care for. The ongoing cyclical process of action research may enable practitioners to understand that there is always room for improvement and that therefore their practice cannot be static.

Action research is a democratic process (Brydon-Miller, Greenwood & Maguire 2003) that respects practitioners' being and context. Knowledge is constructed with the participants in their own context and therefore practitioners have a high degree of ownership of the project, possibly increasing the sustainability of change driven by the practitioners themselves. In addition, the messiness of action

research (which action research scholars acknowledge) can be used to an advantage to prepare practitioners for the unpredictability of where the journey might take them. In this study, the relationships formed and lessons learnt were a sociable process that enriched the lives of the practitioners who participated in the study and in my own life.

However, action research has some limitations, as action research scholars freely acknowledge. The first of these limitations is that the highly contextual nature of an action research study and its outcomes makes it difficult to transfer the findings to other settings. In the course of this study, this limitation meant that the question of “How valid is action research?” was put to me many times. To enhance the validity of the process used as well as the outcomes, it is necessary to explain how the action research cycles were applied (see Section 2.5.1), how rigour was ensured (see Section 2.6) and which ethical principles were adhered to (see Section 2.7).

2.5.1 Applying action research

When I undertook this study for my PhD, I followed the advice of Zuber-Skerritt and Perry (2002), who recommend that researchers in action research studies for degree purposes take on a dual role, namely an academic role and a facilitator role. The diagram in Figure 2.5 is a representation of my application of the action research cycles, which were separated into three sets for the purpose of this study.

In the diagram and the rest of the report, I use the metaphor of a laboratory for Part I and Part III of the study, relating mainly to my academic role and preparation for and reflection on my facilitator role, which did not involve participants directly. Part II contains the main work of the study, namely the work with the participants (my active facilitator role), which I refer to in terms of its main characteristic, namely collaboration.

In the diagram, for the sake of simplicity, the three parts of the cycle are separated by dotted lines into three blocks. However, each part is closely connected to all the others in the bigger picture of the study as a whole (see Figure 2.5, overleaf), as the dotted loops connecting cycles suggest.

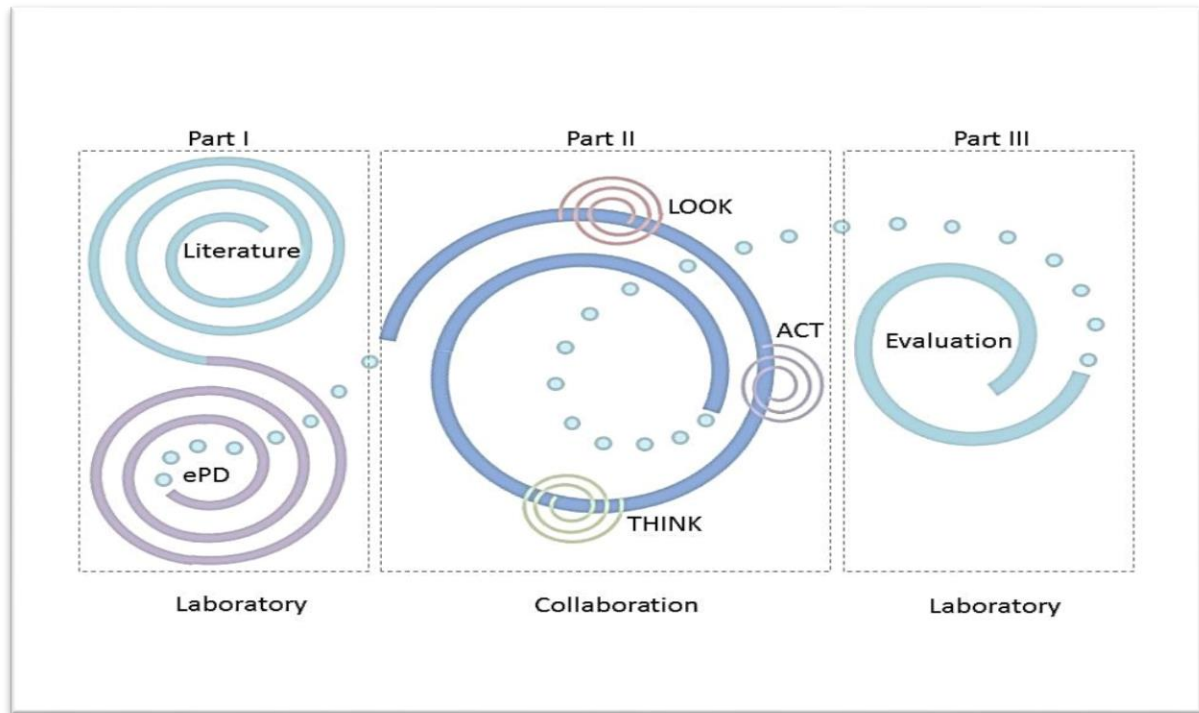


Figure 2.5: Application of action research cycles

My academic role was mostly performed away from the participants during the proposal development and preparatory work. This forms Part I of the study, which I refer to as the “laboratory”. This includes the first two cycles of the study. The first cycle represents the exploration and review of the literature to identify the gaps in the existing literature (see Chapter 3). On the basis of the literature, and in view of the identified research problem, emancipatory practice development is introduced as the change process chosen to transform forensic care in a systematic manner (see Chapter 4). The gaps identified in the literature assisted me (and later the practitioners) in deciding on what actions should be taken. Emancipatory practice development as a change process guided the activities around the actions and formed the foundation for the ways of working chosen for this study.

The first two cycles prepared me for Part II, the collaborative part of the study, where participants were actively involved in the processes followed to transform forensic care in emergency departments (see Chapters 5 to 10).

Part III of the study represents another cycle in the metaphorical “laboratory”, where I evaluated the research outcomes and wrote up the thesis (see Chapters 11 and 12).

2.6 Rigour in action research

Rigour refers to the quality of a research process and the findings of the research. Action research leaders and scholars have dedicated much thought and effort in their publications to justifying action research as a trustworthy research methodology, against the background of traditional positivist and naturalist research methodologies (Stoudt 2014; Tomal 2010; Melrose 2001). Where rigour is concerned, some action researchers have adopted and adapted terms used in traditional research methods, such as trustworthiness (Stringer 2014) or validity (Herr & Anderson 2014) to prove the quality of their research and findings. Other action researchers have developed their own criteria in the form of questions to evaluate the quality of action research, such as Bradbury and Reason (2006), Koch and Kralik (2006), Waterman et al. (2001), and Gomm, Needham and Bullman (2000). To increase the rigour of action research, Levin (2012) suggested that the term “academic integrity” be introduced into action research as equal to trustworthiness.

As I used action research with qualitative methods, I adopted the model of trustworthiness developed by Lincoln and Guba (1985), considering the credibility, transferability, dependability, confirmability and authenticity of the study. Each of these criteria is discussed below.

2.6.1 Credibility

Credibility refers to the believability and truthfulness of the research (Baskerville 2014; Springer 2014; Lincoln & Guba 1985). The activities I employed to achieve credibility were the following:

- *Selection of appropriate participants for the research* (Jensen 2008): Healthcare providers of all categories working in emergency departments come into contact with, and manage victims of violence and crime. Hence, knowingly or unknowingly, their actions and especially their observations and documentation have an impact on people’s right to justice. In this study, the participating healthcare providers acknowledged their responsibility to do research and provide leadership for emergency departments. Therefore, the healthcare providers of all categories working in the identified emergency departments were selected as participants (see Section 5.3).
- *Prolonged engagement*: This pertains to the amount of time spent with the participants to build trust and relationships, and to collect and/or generate and analyse data (Stringer 2014; Lincoln & Guba 1985). The capacity of the practice development facilitators (see Section 5.5.2) to understand their situations, raise awareness, plan and act was increased during the study, as proposed by Patton (2002). Negotiating and maintaining access was a continuous process that started in December

2013 and ended in October 2015. Access was negotiated, as discussed in Section 5.2, and was maintained through regular site visits and meetings with the practice development facilitators (see Annexure E for a timeline of the visits). Data generation activities were discussed in detail for each phase and the objectives were designed to enable participants' access and opportunities to participate and voice their perceptions and ideas. The prolonged engagement enabled me to become a familiar face in the emergency departments with whom participants could relate.

- *Triangulation*: This is the process of using different data generation methods from a variety of sources to clarify and increase understanding of the phenomenon under study (Stringer 2014; Lincoln & Guba 1985). Triangulation was achieved by including three emergency departments, one in the public sector and two in the private sector. Data generation and analysis were done for each emergency department individually, and then the analysis of the data was collated to identify the commonly held awareness and opinions. Data were generated from different categories of healthcare providers, including nurses, paramedics and doctors. The data generation methods used are discussed for each phase and objective in the chapters that follow.
- *Member checking*: Dick (2014) refers to this aspect as participant validation. This principle suggests that the participants of a study should be granted access to the results, as well as opportunities to give input, both in the initial data and after data analysis, so that consensus can be reached (Springer 2014; Lincoln & Guba 1985). In this study, the "talking wall" that was used for data generation in the third cycle (see Section 6.3) allowed for continuous member checking to take place. The raw data and the data analysis were displayed on the "talking wall", and the participants were encouraged to give feedback on whether they agreed with findings or not. Even though no comments were written down on the pages, the wall did stimulate discussions about forensic care in the emergency departments between the participants and me, in which I could confirm that my initial analysis was in line with the participants' ideas and perceptions. I am not certain whether or not these conversations about forensic care continued in my absence, as this was not reported to me. However, the practice development facilitators reported that they had conversations amongst themselves about the data that were generated. They also indicated their subsequent increased understanding of forensic care in emergency departments.
- *Peer debriefing*: This refers to a method of exploring the various aspects of the research process, focusing on the generation of new knowledge (McNiff & Whitehead 2006; Lincoln & Guba 1985). In this study, the generation of new knowledge was established by engaging in critical conversations with my supervisors and critical colleagues in the academic field, to clarify and challenge the claims I made based on my findings. During the proposal development, I was part of a PhD proposal development programme that organised validation groups where the details of the proposal were

challenged and alternatives were discussed, as advised by McNiff and Whitehead (2006). During the research process, I was continuously assisted by my supervisors and peers, whom I consulted throughout the process of generating and analysing data and writing up the findings.

2.6.2 Transferability

Transferability denotes the possibility of applying a study's findings to other contexts (Springer 2014; Jensen 2008; Lincoln & Guba 1985). In action research, transferability is left to consumers of the research, who decide how transferable the findings of the study are to a specific or similar context (Baskerville 2014; Dick 2014). However, researchers are responsible for providing detailed descriptions of the context so that the contextual boundaries of the findings are clear to those who read about the research (see Section 1.9). In this thesis, the population (see Section 5.2), the purposive selection of participants (see Section 5.3), the data generation and data analysis methods are therefore described in detail in order to assist readers of the study to gain some understanding of the processes and procedures used in the research.

I attempted to provide a thick description of the purpose and process used in the study to enable readers to make an informed decision about how transferable the findings are to specific or similar contexts. There are no guarantees that the findings of this study will be transferable, but foundational work has been done to create awareness regarding the forensic care provided in emergency departments.

2.6.3 Dependability

Lincoln and Guba (1985) and Springer (2014) refer to dependability as the logical, traceable and documented process of an inquiry. Patton (2002) refers to dependability as emanating from a "systematic process, systematically followed". A timeline (see Annexure E), logs and personal field notes were kept to ensure that the activities during the research process can be traced. The overall research methodology is described and discussed, and the data collection/generation and data analysis methods are discussed for each phase and for each objective, step-by-step, to ensure clarity for the readers. When the research process and activities deviated from the initial planned process and activities, this is made clear to enable other researchers to learn from my experience and to seek alternative processes and activities. Furthermore, I also describe the challenges faced during the research process, when impromptu decisions had to be made. I highlight the influence these

challenges and decisions had on the study's practice development facilitators and on me (see Section 7.3.4).

2.6.4 Confirmability

Confirmability entails a clear description of the process followed to generate and analyse data, so that the research process can be reconstructed (Baskerville 2014; Jensen 2008). I attempted to provide a clear description of the processes and procedures followed, and justify the decisions made during the data generation and analysis (see Sections 6.3, 6.4, 7.3, 8.2, 8.3, and 10.3). In order to show that the interpretation of the findings was rooted in the perceptions and experience of the participants, evidence is provided in the form of photographs of actual documents used during the research process. The original documents are available for auditing purposes, thereby providing a trail of evidence.

2.6.5 Authenticity

According to Coghlan (2014a) and James (2008), authenticity pertains to the ability of research to benefit society, provide participants with equal access to the research inquiry, initiate actions and empower participants. During the research period, the benefit to society of this study could not be assessed, but there is potential for victims of violence and crime to be enabled to pursue their right to justice. The participants had equal access to the research inquiry, as the data were generated and analysed collaboratively (see Sections 6.4, 7.4, 8.4 and 10.4). Furthermore, the data that were themed were displayed on the "talking wall".

The actions that were planned and implemented during this study are discussed in detail in Section 9.2 and support the authenticity of the study. The participants were empowered, especially the practice development facilitators, as most of the work was done with them. The fundamental participants received the information, and the practice development facilitators reported activities and progress to me and the other participants (see Table 9.1 for a summary of the action plans and implemented actions).

2.7 Ethical considerations

The research was conducted by people and with people, requiring adherence to the ethical principles applicable when human subjects are involved in research. The ethical principles were applied somewhat differently than in traditional research, given the collaborative, inclusive and participatory nature of action research (Stringer 2014; Eikeland 2006) and emancipatory practice development.

Access to the research sites was negotiated with the internal review boards of my academic institution, and then continued to the research sites, followed by access to the participants, as advocated by Gelling (2010).

After the participants had been introduced to the research topic, they received participant information leaflets and informed consent forms. Informed consent is sometimes seen as controversial in action research, as the direction of the research transpires from the interaction, context and relationships amongst participants (Bellman 2012b; Williamson & Prosser 2002). Even though some of the nurses did not return their consent forms and chose not to participate in the research, the process did not cease – it could continue with those who agreed to participate voluntarily, as suggested by Coghlan and Shani (2005). Consent was approached as a process, and written consent was obtained during Part I. As new staff members were appointed, they were informed of the research and were given an opportunity to volunteer to participate (Bellman 2012). In order to ensure that participants stayed informed, the data that were generated were discussed with the participants and the main themes of the specific phases were placed on the “talking wall” in the staff tearooms for comment and discussion. The practice development facilitators were also kept informed about the details of the research process with the purpose of making it possible to undertake further research – on other issues identified – after the thesis research on forensic care had been completed.

Prevention of harm was ensured by following democratic approaches of negotiating access, clarifying expectations, values and beliefs, and by engaging in critical reflective conversations, as proposed by Bellman (2012). Once access had been negotiated and the participants had been informed of the expectations required for participation, the data generation at the research sites proceeded with the assistance of practice development facilitators. The data generation, analysis and results were transparent, and are described as part of data generation and analysis in Chapters 6, 7, 8, and 10.

The study was introduced to the three participating emergency departments just after the first cycle (Part I) in preparation for the study. Most of the healthcare providers in the three emergency departments were thus aware of the research activities. In the collaborative phase (Part II) the values and beliefs of the practice development facilitators were clarified, and then this was done for each of the emergency departments as a whole. Values and beliefs formed the basis of the vision each emergency department held in respect of the research and practice development programme, and guided the interaction and support between the fundamental participants, the practice development facilitators and myself, as recommended by Sayer (2011).

Furthermore, to prevent harm, the ethical principle of honesty and integrity was adhered to (Bellman 2012b), as I openly acknowledged that I was not an expert in either the research process or in forensic care, but wanted the participants to join me on the journey to transform forensic care in level-one emergency departments. In order to minimise harm to myself (Bellman 2012b), I kept a reflective diary and relied on guidance from my supervisors. The collaborative, inclusive and participatory nature of the research generated a support network made up of the practice development facilitators, the fundamental participants and me. However, the close relationship that developed and the collaborative generation of knowledge and understanding challenged the ethical principle of confidentiality and anonymity.

During the negotiation process, the three health care organisations and potential participants were informed of the possibility that they might be identified, even if no names were mentioned, because the identity of the staff of level-one emergency departments is information that is in the public domain. Approval to conduct the research and consent from the participants was nevertheless procured. According to Bellman (2012b), as well as Williamson and Prosser (2002), anonymity and confidentiality must be negotiated with participants. Participants could not stay anonymous, as they were actively involved in the research process, but their individual contributions are shared in the thesis without revealing the source of the data. Findings from the data analysis were displayed in the staff tearoom, where participants were encouraged to write additional comments if they had questions or concerns. Confidentiality was maintained by not revealing the identities of the organisations or participants in the dissemination of the data. In addition, the participants were requested to respect the process and to treat the contributions of others as confidential and with respect. Notwithstanding these precautions, I could not guarantee this for any of the participants, and the participants were made aware of this beforehand.

2.8 Reflection on my methodological choice

Although action research has been increasingly accepted in the last few years, this approach to research and its methodology are still under scrutiny. When I was still developing my proposal, I was asked at many of my proposal presentations: “Where is the Science?” I also faced comments such as: “I don’t like action research, as there is no way of knowing where it will take you.” I have also come to realise that some people are born to do action research, and others are not.

Stringer (2014) points out that the science in action research should not be measured and judged in the same manner in which standardised research based on pure positivist or interpretivist methodologies is

measured. He rather advises action researchers to acknowledge that human behaviour is complex and influenced by their social life, experience and context. The social world is ordered and re-ordered and tasks and activities are prioritised and re-prioritised in action research by involving stakeholders and facilitating their moving through the minefield of change with the ultimate purpose of better outcomes. The science of action research relies on comprehensive description of the events, the involvement of participants and the actions that are taken to change existing practice (Stinger 2014; Williamson 2012c). In this thesis, I therefore attempted to provide a comprehensive description of the events that occurred and how these events were generated to demonstrate the science in the methods, as well as reveal the “how” and “what” mechanisms that were triggered in order to stay true to critical realism. The involvement of participants is described in Section 5.5.

Another concern that I share with other action researchers relates to the criteria for the rigour of the study (Dick 2014). As the qualitative data were generated and collated throughout the study, trustworthiness as it pertains to action research was used to demonstrate rigour. Additional ethical limitations came into play because anonymity and confidentiality in action research cannot be guaranteed. Both the management of the three participating healthcare facilities and the participants were informed of the fact that anonymity and confidentiality were not likely, as participants all knew the identities of level-one emergency departments and information about their staff is in the public domain. However, care was taken to keep the identity of individual responses and participants confidential.

During my contact sessions I also became aware of the dynamics of each of the emergency departments and realised that there were groups of people, especially in Emergency Department A, that were not civil or courteous towards each other. I had a conversation with the unit manager about this, as I was involved with the context and participants, who informed me that the problem was being addressed. To the credit of the staff, I did not observe discourteous behaviour towards the patients under their care.

The longer I engaged with the emergency department, the greater my perception that I had become a sounding board for the practice and personal problems of staff. In order to accommodate the participants, I listened to what they said, and tried to use my facilitation skills to try to guide them towards their own solutions. I had a research focus and had to work within a time limit, but had to balance the demands of the research, practice and participants. On several occasions, however, the balance shifted more towards practice and participants, slowing the progress of the research and

research actions. This allowed the participants to feel valued and appreciated, making them more willing to work with me.

Another challenge I encountered was the difficulty in getting the participants into action mode. Upon reflection, I realised they were not used to being involved in the planning, decision-making and execution of planned action. One of the managers commented that I must be very slow, as my research seemed to take forever, and I was always talking to the nurses in the emergency department – other researchers before me were only seen once or twice and then they were done. This comment confirmed my suspicion that healthcare providers have limited exposure to action research studies and that the “practice development” they tell me they are engaging in is in fact the application of a traditional top-down approach.

In addition to the challenges imposed by the multiple human interactions necessary in this study, the writing up of this research led to much internal and external conflict. In action research, there is a strong tradition of writing in the first person, but doing so was difficult for me, as my prior exposure to research had been more traditional. As the literature points out, the progression of action research tends to be messy (Coghlan & Gaya 2014; Herr & Anderson 2014; McAteer 2013; Brydon-Miller et al. 2003) and is not a linear process. However, for the sake of organising the material clearly, I structured the thesis to present a rather linear view. I did so in line with McNiff and Whitehead’s (2006) recommendation that in writing up action research in a thesis or article, researchers should feel free to organise the content as it makes most sense to them personally. McNiff and Whitehead (2006) only urge action researchers to ensure that a report includes descriptions and explanations of what was done, the reason for doing it, and a statement indicating whether or not the results were what the researcher hoped for. It should also inform readers of how the description and explanation fit into personal theory, and the importance thereof. Furthermore, the reflexivity required by action research did not come naturally to me, as I found it difficult to write without allowing my emotions to take over. With the guidance of my supervisors and increased reflexivity, over several rewritings of my reflections, the message became less emotional and more scientific.

I also had to find a balance between the guidelines of the University of Pretoria, research traditions in the Nursing Department and the accepted style, action research and practice development. Therefore, I have sometimes limited the use of first-person writing as I explained and discussed the details of the methods used, while attempting to describe the application of the core principle of collaboration, inclusion and participation used in the study.

2.9 Summary

In this chapter, I have described action research as my methodology of choice. It was chosen for its capacity to generate contextual practical solutions with participants to change practice for the better. The application of action research cycles in this study were described in Section 2.5.1.

I now move to Part I of the thesis, where I introduce and discuss the theoretical perspective, based on a literature review, to identify gaps in the knowledge and practice. I also discuss emancipatory practice development as the change process that guided me and the participants throughout the study.

OVERVIEW OF PART I (CHAPTERS 3 AND 4): IN THE LABORATORY

In PART I of the study, I describe the first two action research cycles that I engaged in (see the left block in Figure 3.1). As I have already indicated, I refer to this part of the research using the metaphor of time in a laboratory to indicate that the activities I performed, as well as the looking, thinking and acting, did not occur in collaboration with the participants, as access had not yet been finalised at this stage.

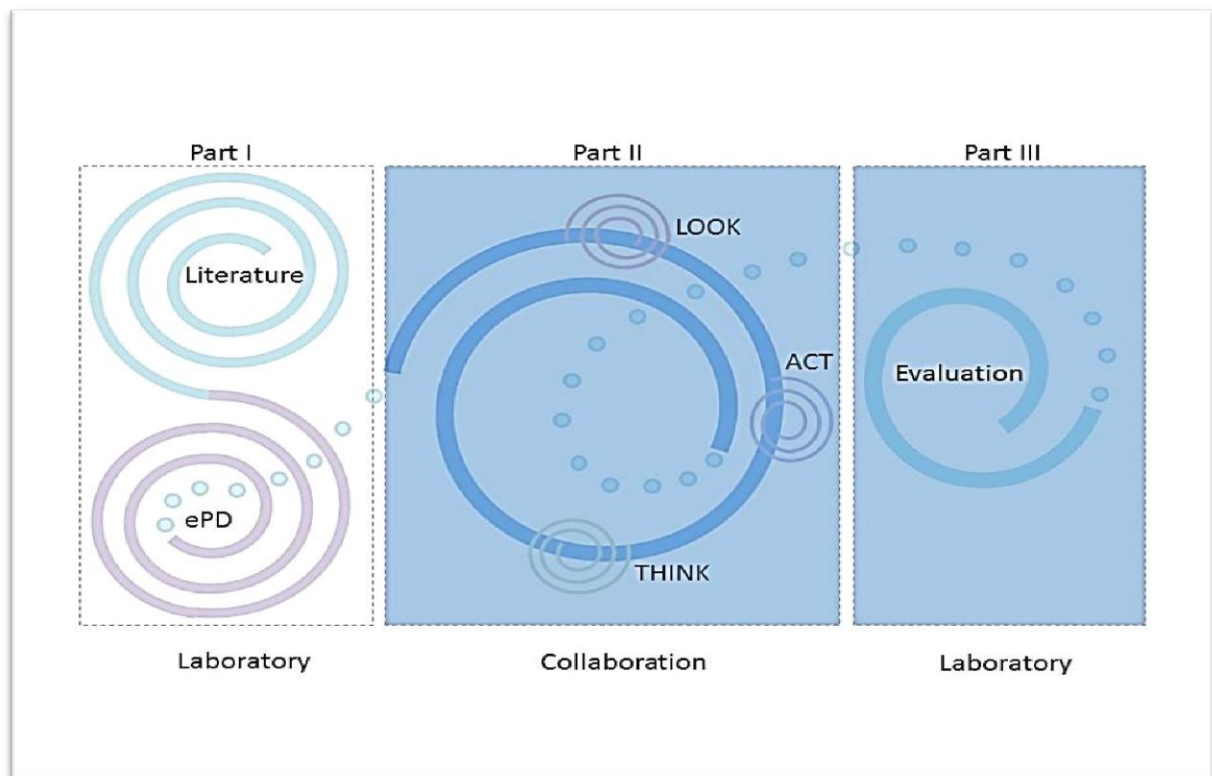


Figure 3.1: Overview of Part I

In Chapter 3, I show how I applied the first action research cycle to canvas existing literature in order to provide an overview of forensic medicine. The literature was explored to contextualise the existing situation around forensic care. I identified two gaps, namely the absence of a framework for forensic roles and responsibilities, and a guide for transforming forensic care in emergency departments. These gaps informed the majority of my actions during the study.

From the literature review it was evident that calls have been made to improve forensic care, but only limited evidence could be found regarding the implementation of initiatives to improve forensic care. As I believe that change in practice should be done *with* the people in practice, I searched for a change process that could provide guidance and direction to transforming forensic care in emergency departments. I chose emancipatory practice development as a process to bring about change, as discussed in Chapter 4 (Cycle 2).

The gaps identified in the literature and emancipatory practice development as the change process guided the actions, activities and ways of working in this study. The ways of working adhered to during the collaborative part of the study were collaboration, inclusion and participation. The application of these aspects during the study is discussed in PART II (in Chapters 5 to 9).

CHAPTER 3: CANVASING THE LITERATURE

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3.1 Introduction

In Chapter 3, I discuss my exploration of the existing literature on forensic care in emergency departments (first action research cycle). I deliberate on the findings captured in the existing literature and indicate the two major gaps in that literature that were addressed during this study, namely the absence of a framework for forensic roles and responsibilities, and a guide for transforming forensic care in emergency departments. The chapter concludes with a call to action after considering the findings from the literature base. The call to action urged me to look for a change process that could assist me in transforming forensic care in emergency departments.

The existing literature was examined to gain an understanding of the development of clinical forensic medicine in order to position emergency departments as facilities where healthcare providers can offer forensic care, and to profile the forensic population. The literature was reviewed by applying part of the action research cycle proposed by Stringer (2014), which foregrounds those actions that may lead to transformation (see also Williamson 2012a; Brydon-Miller, Greenwood & Maguire 2003). In this study, the transformation in question is the transformation of forensic care in emergency departments. I used the first two steps of looking and thinking from the basic process of action research suggested by Stringer (2014) to review the literature.

The existing literature indicates that forensic care in emergency departments should be provided by forensically prepared healthcare providers. Virginia Lynch, the founder of forensic nursing, argues that forensic nursing is not a sub-speciality to emergency nursing or intensive care nursing, but a speciality in its own right that is still under development (Douglas 2014). In South Africa, shortages of human and financial resources are evident in the healthcare sector. Currently, healthcare providers in emergency departments are well situated to provide forensic care, but, although some work has been done to train forensic nurses, there is little evidence in the literature on any work done by doctors to promote clinical forensic medicine. The reality faced by emergency healthcare providers is that victims of violence and crime generally seek medical attention in emergency departments and that these healthcare providers are expected to provide care for the physical, psychological and justice needs of patients (Lukhozi 2009).

3.2 Looking at the literature

The *look* phase of a literature study represents the search strategy and identification of the literature to be reviewed for a study. Relevant literature was searched for and sourced via four electronic

databases, namely CINAHL, Health source: Nursing/Academic Edition, MEDLINE and Scopus. The search terms used were “forensic medicine”, “medical jurisprudence”, “juridical medicine” and “medico-legal medicine” combined with “emergency medicine” and “emergency department”, without any date restriction. The search terms were chosen because they are associated with applying medical knowledge to matters of the law (Wyatt et al. 2011; Payne-James 2005), and they were combined with “emergency medicine” and “emergency department” to include the specific context of the study.

My initial search of the existing literature resulted in the identification of 1 385 sources. The search was then refined to include full-text English language sources only, excluding “pharmacology”, “toxicology”, “pharmaceutics”, “biochemistry”, “genetics” and “molecular biology”. These terms were excluded because, even though the terms are related to medicine, the disciplines of pharmacology, toxicology, pharmaceutics, biochemistry, genetics and molecular biology do not deal directly with patients. This process resulted in 420 articles.

Next, the titles and short descriptions of the identified articles were scanned, and articles containing the terms “multimedia/digital”, “forensic odontology”, “forensic documents,” or “engineering sciences” in either the title or keywords were eliminated, reducing the sample to a total of 237 articles. The abstracts of the remaining articles were read, and articles that referred to the “need for forensic education”, “forensic medicine in the emergency department”, “forensic services that are needed in the emergency department”, and the “need for nurses and/or doctors to have forensic knowledge and skills” were included in the final pool of articles reviewed. As a result, a total of 57 articles were identified as relevant to this study and were reviewed in detail. The 180 articles that were omitted from the review primarily pertained to forensic psychiatry, forensic psychology and forensic care in correctional facilities.

The 57 articles in the eventual detailed literature review also included additional articles identified through snowball sampling. In tracing the history of forensic medicine, Eckert was identified as the author of the first article published on the “issue of living forensic medicine” in 1983 (Lynch 2011). The original article could not be located, but an adaptation of the article was found in the *American Journal of Medicine and Pathology* (Eckert 1990). In the Google Scholar search to locate the above article, a comprehensive letter from Uva (1995) to the editor of *Academic Emergency Medicine* regarding clinical forensic medicine was also identified and included.

My review of Dougherty (2011) suggested that more in-depth knowledge could be gained regarding the categories of forensic patients from a prior listing by Pasqualone in 1998. I regarded it as important to include this article, as it assisted me in identifying the type(s) of patients who usually receive attention

in emergency departments and which ones do not, requiring ongoing research in that area. The identified categories were re-confirmed and updated in a replication study conducted in Western Australia (Pasqualone & Michel 2015), which was also included in this review.

3.3 Thinking about the literature

Thinking about the literature included exploring, analysing and interpreting the information gathered while *looking* at the literature. The identified literature was reviewed, and relevant sections of the articles were highlighted. The literature was then reread a second time. During this second review, the information was organised to address five concepts that had been identified, namely the development of clinical forensic medicine, the call for forensic knowledge and skills, a profile of the forensic population, initiatives to expand existing forensic knowledge and skill, and contextualising the current situation in South Africa.

3.3.1 An abridged description of the development of clinical forensic medicine

Forensic science is a speciality field that applies a vast variety of scientific knowledge to assist in matters of law (Lynch 2013; Singh 2012; American Academy of Forensic Sciences 2010; Saferstein 2007). The scientific knowledge areas used for assisting in matters of law are criminalistics, digital and multimedia forensic science, forensic engineering sciences, jurisprudence, forensic medicine, odontology, pathology/biology, physical anthropology, psychiatry and behavioural science, forensic documentation, toxicology and a developing multi-disciplinary field that includes forensic nursing and forensic voice analysis (Wyatt et al. 2011; American Academy of Forensic Sciences 2010). The forensic science that I focus on in this study is clinical forensic medicine, a sub-speciality of forensic medicine. Forensic medicine, as the foundation of clinical forensic medicine and therefore forensic care, refers to the application of medical knowledge to assist in matters of the law or in the legal process (Wyatt et al. 2011; Wecht 2005). Medical knowledge held by healthcare providers can be applied to assist in solving crimes, and to honour victims' human right to justice, regardless of whether or not a patient survives or is deceased. Singh (2012:184) claims that forensic medicine has assisted "national and state agencies to maintain law and order for many years". Evidence of the existence of forensic medicine can be traced back to Ancient Egypt, with specific reference to death investigations (Wyatt et al. 2011; Wecht 2005; Smith 1951).

Forensic medicine has captured the attention, imagination and practice of scientists, medical professionals and the public as a whole, especially in the last two decades, as is evident from a number

of television programmes (both documentaries and fiction) and movies, as well as the scientific and fictional literature (Starr 2013; Wyatt et al. 2011; Schweitzer & Saks 2006). The most popular and “famous” aspect of forensic medicine is forensic pathology, an area that investigates death with legal implications, and that has been described in records dating back to 1850 BC (Smith 1951). Living forensic patients are generally perceived to receive less attention from the media and the scientific community, compared to deceased forensic patients (Starr 2013; Wyatt et al. 2011; Schweitzer & Saks 2006).

Clinical forensic medicine is a subdivision of forensic sciences that pertains to the living victims of violence. In this field, healthcare providers use their medical knowledge to care for and assist victims and the criminal justice system after a crime or violent incident has occurred. Clinical forensic medicine entails identifying, collecting, preserving, documenting and processing evidence, while maintaining the chain of evidence gathered from a living victim of violence and crime (Starr 2013; Kodikara 2012; Payne-James 2005; Uva 1995). Research conducted in clinical forensic medicine has gained momentum since the 1980s because of a growing awareness of “human rights and civil liberties” (Donnelly 2012:92). However, the exact scope and definition of clinical forensic medicine is still considered vague by Stark and Payne-James (2014), who argue that more healthcare providers (including doctors and nurses) actually practise clinical forensic medicine than is generally realised.

Many living victims of violence and crime seek medical attention, and most of them are likely to end up in an emergency department (Pasqualone 2015; Cucu et al. 2014; Limmanson et al. 2013; Lynch 2011; McGillivray 2005). Clinical forensic medicine is currently an emerging specialty that requires ongoing research. Most of the patients in emergency departments are potential forensic patients; therefore healthcare providers should be able to provide forensic care, as described in Section 1.8.3. In the course of this study, healthcare providers working in the participating emergency departments were informed and trained on aspects of forensic care, possibly preparing them to provide better services to the forensic patients in their care in future.

3.3.2 Calls for forensic knowledge and skills

The needs of the living victims of violence and crime were first recognised by Eckert (1990), who called for the development of clinical forensic medicine knowledge as an integral part of emergency medicine (Eckert 1990). The importance of equipping emergency physicians and emergency nurses with the knowledge and skills required for clinical forensic medicine was reconfirmed by Lynch (2011), Rege

(2011), Wiler and Bailey (2007), and Uva (1995). These authors acknowledged that emergency medicine is, by its very nature, intertwined with forensic science.

Healthcare providers in emergency departments have a unique opportunity to identify, collect, preserve and document evidence that can be used for the successful prosecution of a perpetrator (Henderson et al. 2012; DeVore & Sachs 2011; Eisert 2010; Uva 1995). Nurses can thus become an effective link between the healthcare system and the criminal justice system (Pasqualone 2015; Henderson et al. 2012). Members of the criminal justice system, including prosecutors, the police and forensic pathologists, often praise the services of the forensically prepared nurses with whom they work (Lynch 2011). However, a continuous relationship between healthcare and the criminal justice system is required, as emergency healthcare providers are increasingly subpoenaed by the criminal justice system to testify in court on matters relating to injuries due to violence, insurance- and industry- or occupation-related incidents and injuries (Wiler & Bailey 2007). However, doctors and nurses may shy away from forensic patients, because these healthcare providers would prefer to avoid going to court (Ryan 2000).

Nonetheless, caring for forensic patients both physically and emotionally is no longer regarded as sufficient. The time has come for healthcare providers in emergency departments to take up their forensic roles and responsibilities (Henderson et al. 2012; Lynch 2011). As long as violence and crime exist in our societies, forensic patients will need to be cared for in emergency departments. This can only be accomplished effectively if adequate education and training opportunities are made available to the healthcare providers who work in emergency departments (Eisert 2010; Ryan 2000).

3.3.3 Profile of the forensic population

Violence is steadily increasing throughout the world. In 1996, violence was declared an international challenge by the WHO and was found to be the leading cause of death of people between the ages of 15 and 44 years (Sharma 2003; Krug et al. 2002; WHO 2002). The exact number of living victims of violence and crime is unclear, as many victims of violence do not report incidents to the authorities or do not seek healthcare for the injuries sustained during such violence, possibly because they fear intimidation and re-victimisation (WHO 2014; Phelan 2012).

In addition, the available information on living forensic patients has not been collated on a database anywhere, in contrast to information on people killed in violence and crime (Degutis 2013). The scarcity of reliable statistics is exacerbated by the quality of the data provided by member countries to the WHO

and other organisations, such as the United Nations Office on Drugs and Crime (UNODC), which aims to provide a global account of violence and the number of people affected by violence (WHO 2014; Harrendorf et al. 2010). Some of the member countries either do not keep the necessary statistics, or are suspected of not reporting on selected aspects in order to provide a report that is more positive than the reality. Nevertheless, despite the absence of specific statistics, it has been established that it is primarily defenceless women, children and the elderly who bear the brunt of violence (WHO 2014). In particular, victims of sexual assault have been given ample attention in the literature. While this focus on sex-related injury is justified, it must be remembered that forensic patients include more than defenceless women, children, the elderly, and sexual assault victims. In this study, I kept in mind the fact the wide range of forensic patients who may need care in emergency departments.

3.3.3.1 The vulnerable population

The WHO classifies women, children, the elderly, and mentally and physically disabled people as the most vulnerable population (WHO 2014; Moynihan 2013). The abuse that this vulnerable population is often exposed to may remain undisclosed in many cases, as most of the victims know the perpetrators. In some instances, perpetrators will even accompany the victims to the emergency department, where these perpetrators will pretend to be concerned loved ones (Aschman et al. 2012). The presence of the perpetrator complicates, or may derail, the work in emergency departments, because of the victim's fear and/or intimidation associated with the perpetrator's behaviour.

Women and the elderly who have been physically abused frequently visit or are brought to emergency departments, but the exact cause of their injuries may be missed if healthcare providers lack sufficient knowledge and skill to identify the tell-tale signs of abuse (Yildiz, Selimen & Dogan 2014; Phelan 2012). The identification of child abuse may be even more difficult, as children sustain many injuries and bruises during normal play activities. It follows that healthcare providers constantly need to be highly alert to signs of abuse when providing care to children in an emergency department (Adams et al. 2012; Newton & Vandeven 2010). Nurses working in emergency departments should keep a record of all patients and should ensure that the history tallies with the injuries found on a patient. However, it should be noted that in cases of emotional abuse, victims may not present with any physical injuries.

3.3.3.2 Sexual assault victims as a prominent category of forensic patients

One category of forensic patients that has received much attention is sexual assault victims. Global organisations such as the WHO and several member and non-member countries have formulated legislation, written policies and mobilised resources to combat the high number of sexual assaults that

occur in the world every day. In the United States of America and the United Kingdom, for example, nurses have expanded their role to sexual assault nurse examiners (SANE) in the last three decades, providing forensic care to both adult and paediatric victims of sexual assault (Cowley, Walsh & Horrocks 2014; Maier 2011; Seng et al. 2004; Houmes, Fegan & Quintana 2003).

In order to provide comprehensive services to sexual assault victims, sexual assault response teams (SARTs) have been instituted. The SART model for care includes the immediate response of “law enforcement, crime laboratories, counsellors and victims’ advocates, prosecutors, as well as healthcare providers” (Busch-Armendariz & Vohra-Gupta 2011:34; San Diego County Board of Supervisors 2001:6). These services have been evaluated and have been found to contribute significantly to the overall care experienced by the victims of sexual assault. This shift has also resulted in an increase in the conviction rate of perpetrators (Campbell et al. 2011; Fehler-Cabral, Campbell & Patterson 2011; Ledray 2010; Sampsel et al. 2009). Despite their initial successes and the high incidence and global awareness of sexual violence, there have been funding challenges for sustaining SANE programmes and training new SANEs (Maier 2011). SANE programmes that are hospital-based have fewer funding concerns than those funded by the government and state departments (Maier 2011). SARTs also face unique challenges because multi-professional teams provide the service (Greeson & Campbell 2012), which can result in conflict arising from “organisational barriers, conflicting goals, role confusion and conflict as well as confidentiality” (Greeson & Campbell 2012:88-91).

Regardless of the special programmes initiated for victims of sexual assault, such victims typically still seek medical attention, post-exposure prophylaxis and emergency contraception in emergency departments (Cucu et al. 2014; Patel et al. 2013; Mollen, Goyal & Frioux 2012; Kobernick, Seifert & Saunders 1985). Therefore healthcare providers in emergency departments must be able to assess sexual assault victims forensically while collecting evidence, and providing age- and gender-appropriate treatment and referrals (Mollen et al. 2012; DeVore & Sachs 2011). Studies conducted by Linnarsson et al. (2012) and Kent-Wilkinson (2010) reported evidence of training and policies on the management of sexual assaults on women and children, but no published evidence was found of training or policies regarding other victims of violence or other categories of forensic patients.

3.3.3.3 Other categories of forensic patients

The victims of sexual assault and abuse-vulnerable populations are only a part of the complete profile of the forensic population. Forensic patients have already been organised into 27 categories (Pasqualone 2015; Pasqualone & Michel 2015; Dougherty 2011; Lynch 2011; Sharma 2003), of which

12 (indicated in the table with an asterisk) involve injuries directly related to violence and crime. The categories identified are presented in alphabetical order in Table 3.1.

Table 3.1: Categories of forensic patients

Abuse of the disabled*	Malpractice and/or negligence
Assault and battery*	Occupation-related injuries
Burns >5% of body surface area	Organ and tissue donation
Child abuse and neglect*	Personal injuries*
Clients in police custody	Product liability
Control of communicable diseases	Questioned death
Domestic violence*	Sexual assault*
Elder abuse and neglect*	Sharp force injuries*
End-of-life decisions – Not for resuscitation	Substance abuse
Firearm injuries*	Toxic exposure
Food and drug tampering	Transcultural medical practices
Forensic psychiatric clients	Transportation injuries
Gang violence*	Victims of mass destruction/terrorism*
Human and animal bites*	

Source: Pasqualone (2015:40)

These categories were identified in the United States of America and Australia, where there is specific legislation around each category, but differences may occur in countries with other legal foundations (Pasqualone 2015; Sharma 2003). Nurses should be made aware of the forensic patient population so that they can identify and provide appropriate care and refer this specific population when needed. Linnarsson et al. (2012) suggest that healthcare providers in emergency departments are only partly prepared for providing forensic care to sexual assault and child abuse victims, and are even more ill-equipped to care for other categories of forensic patients.

3.3.4 Current situation in South Africa

In South Africa, violence is categorised as one of the major health burdens, together with chronic illness and mental health, HIV and tuberculosis, maternal, neonatal and child health (Fourie 2014). The healthcare sector's response to the challenges related to violence has been somewhat distorted and fragmented. Sexual assault has received much attention, in line with other countries in the world, and

possibly due to the extra stimulus of the fact that Interpol has branded South Africa the “rape capital of the world” (Bornman et al. 2013). Sexual assault care centres such as Provincial Medico-legal centres and Thuthuzela care centres have been established to take care of women and children who have been sexually assaulted, but the effectiveness and impact of these centres are difficult to establish, as these organisations are not open to external independent evaluations (Bornman et al. 2013; Vetten et al. 2010).

Another step taken to address the challenge of violence was the promulgation, in March 2012, of Regulation 176, entitled *Regulations regarding the rendering of clinical forensic medicine services*. This regulation requires clinical forensic services to be provided to victims of sexual assault, physical assault, psychological trauma, domestic violence, substance-, drug- and alcohol-related injuries or violence, drunken driving, child abuse and elder abuse (South Africa 2012). Many of the victims named in the regulation, including sexual assault victims, seek medical attention at emergency departments (Abdool & Brysiewicz 2009:16), in line with the trend worldwide, as reported in the international literature (Pasqualone 2015; Cucu et al. 2014).

It is crucial for healthcare providers working in emergency departments to possess forensic knowledge and skills. If they lack such knowledge and skills, evidence may be compromised or destroyed, injuries may be misinterpreted, and criminal cases may even be withdrawn as a result (Joyner & Duma 2010). Keeping in mind that some forensic patients face life-threatening conditions, the focus of treatment should be on saving the patient's life, but limiting the contamination of evidence remains important (Joyner & Duma 2010).

Thus far, undergraduate programmes in medicine and nursing in South Africa have allocated little, if any, time to forensic education (Jina et al. 2013). Nevertheless, Abdool and Brysiewicz (2009) found that nurses in emergency departments acknowledge the importance of forensic knowledge and skills, even though they have never received any formal training in forensic skills. Currently, forensic nursing is offered as a nursing speciality only at the University of the Free State (Du Rand & Viljoen 2002). Other universities in South Africa have not yet followed suit, because the regulating body for nursing, the South African Nursing Council, did not recognise forensic nursing as a speciality until 2014.

The South African Nursing Council (2014) has published the competencies of forensic nurses and has stated that forensic nursing overlaps with many other nursing disciplines, including emergency nursing. The existing curricula for emergency nursing courses include some forensic aspects in the teaching content. It is hoped that this study may eventually assist some emergency nurses to be better prepared

for their forensic roles and responsibilities. In order to provide guided assistance to all healthcare providers in emergency departments in South Africa, it is important to profile forensic patients, so that the extent of the forensic care provision required can be clarified.

3.3.5 Initiatives to expand existing forensic knowledge and skills

To date, limited research has been conducted on the forensic education and training of healthcare providers working in emergency departments (Henderson, Hadara & Amar 2012; Eisert et al. 2010). However, several articles theorise how forensic care should be provided in emergency departments (Henderson et al. 2012; McGillivray 2005). In Table 3.2, I summarise some studies that were initiated to identify and expand the forensic knowledge and skills of healthcare providers in emergency departments.

Table 3.2: Studies expanding forensic knowledge and skills of healthcare providers in emergency departments

Author	Focus of the research	Number of participants	Findings
Alsaif et al. (2014)	Determining the forensic qualifications of nurses working in emergency departments and their knowledge of the principles of forensic care. Data collection: Self-administered questionnaires.	96 nurses	There is a strong need to train and educate nurses with forensic knowledge and skills. Nurses seemed willing to take up their forensic roles, despite their fear of the legal and cultural issues present in Saudi Arabia. However, some nurses viewed the specifically forensic needs of patients as non-urgent, and argued that a nurse trained in forensics can provide care to forensic patients.
Cucu et al. (2014)	Determining forensic knowledge, skills, roles and responsibilities, as well as further forensic training needs in Romania. Data collection: Self-administered questionnaires.	30 nurses	The need for the forensic education of nurses was emphasised.
Linnarsson, Benzien and Årestedt (2014)	Describing nurses' views of forensic care provided to victims of violence and their families. Data collection: Self-report questionnaires.	457 nurses	The need for nurses to receive training and education was confirmed.
Henderson et al. (2012)	Describing and comparing the forensic knowledge, practice and experience of ED nurses and physicians. Data collection: Electronic survey.	134 healthcare providers (Nurses and doctors, exact number of participants in each category not reported).	No statistically significant difference was found between the forensic knowledge and skills of nurses and doctors. Specific training needs that were identified included procedures for forensic assessment, evidence collection, documentation and expert witness testimony.

Author	Focus of the research	Number of participants	Findings
Eisert et al. (2010)	Developing evidence-based forensic guidelines and providing training for healthcare providers and other staff present during care of forensic patients. Data collection: Collaborative methods.	1 emergency physician, 7 emergency nurses and 1 forensic technician.	A guideline was developed and emergency nurses were trained accordingly. In an effort to save resources, the forensic guideline was incorporated into a core emergency nurse course. The inclusion of forensic education as part of the curriculum for future trauma courses was considered.
Young, Wells & Summers (2004)	To assess the effectiveness of clinical forensic rotation while training for a fellowship with the Australasian College of Emergency Medicine. Data collection: Questionnaires	12 Registrars (doctors)	Respondents agreed that rotation improved their awareness of the medico-legal responsibilities, their ability to care for especially victims of physical assault, and their ability to communicate with the police, prosecutors and other role players in the criminal justice system.

The studies summarised in Table 3.2 indicate that in these prior studies, the main instrument used to collect data was questionnaires. The use of questionnaires carries the risk of social desirability bias (Linnarson et al. 2012). Nonetheless, the findings of these studies indicate a distinct need for further development of the forensic knowledge and skills of healthcare providers working in emergency departments. The specific knowledge and skills needed and the manner in which they are transferred are put forward as topics for possible further research.

According to Henderson et al. (2012), there has also been little research describing how forensic care is actually provided in emergency departments. Even though various authors, professional councils and organisations of healthcare providers as well as governments acknowledge the need for forensically trained healthcare providers in emergency departments, acting on this acknowledgement has been a slow process (Putre 2013; Henderson et al. 2010; Reijders, Giannakopoulos & De Bruin 2008; Rutty 2006; Sharma 2006). According to Henderson et al. (2010) and Reijders et al. (2008), this slow progress may be ascribed to the lack of role clarification and of research providing insight on how forensic care is delivered at the ground level in emergency departments.

3.4 Call to action

Violence and crime are a reality of everyday life, regardless of the location where or the context in which people live, and victims may survive or die. In the discipline of forensic medicine, many resources and much research are invested in pathology, focusing on the already deceased victims of violence and crime. The need to provide forensic care to living victims of violence and crime was only recognised 26 years ago. During my search through the literature, I still felt that living victims of violence and crime

were largely neglected. This made me think of a “confession” by a forensic pathologist during a conference presentation – he said that he liked dead people.

Healthcare providers may avoid living forensic patients as a protection mechanism, because everyone is a potential victim of violence and crime; as long as it happens at arm’s length, the risk and the fear that it might become a personal reality can be ignored to some extent. Healthcare providers who have themselves experienced violence or crime may fear being re-traumatised by dealing with victims.

In addition, victims of violence and crime may hold distorted ideas of forensic evidence because of the portrayal of crime scene investigations in the media. Many victims of violence and crime may not even seek medical attention for fear of the perpetrator, or discrimination. In an attempt to provide services and protection to victims of violence and crime, many countries have made the reporting of certain types of violence and crime mandatory, such as child and elder abuse, sexual assault and domestic violence. The re-victimisation of forensic patients during the medical procedures needed to examine the patients and collect appropriate forensic samples has also been reported in the literature. Initiatives to provide forensic care to sexual assault victims have received particular attention, as is evident from the training of SANEs in the United Kingdom and the SART model used in the United States. However, the sustainability of these practices and models are often under threat due to the economic constraints currently faced.

Emergency departments that already knowingly or unknowingly provide care to victims of violence and crime are ideal sites for providing forensic care. Emergency and forensic medicine are intertwined, and healthcare providers working in emergency departments are already aware of, and have some knowledge regarding, the mechanisms of injuries, anatomy and physiology, wound care and documentation. Many calls have been made for the integration of forensics into curricula for emergency nurses and doctors, as well as for the development of the forensic skills of emergency healthcare providers who are already in practice.

Healthcare providers acknowledge that they have forensic roles and responsibilities, but it is unclear what exactly these roles and responsibilities entail. In this study, I therefore developed a framework for the forensic roles and responsibilities of healthcare providers, providing a foundation for further improvement and refinement of the framework.

The literature I reviewed indicated that prior data pertaining to forensic care in emergency departments was mainly collected by means of self-administered questionnaires, generating descriptive quantitative data that highlighted the need for further training and education. The need for improved knowledge and

skills regarding forensic care has been established and re-established, but little direction has been provided in the literature regarding possible strategies for preparing healthcare providers to care for the forensic population.

The incorporation of forensic aspects into the curricula of doctors and nurses training and courses is a possible solution in the long term, but for forensic care to become a reality in practice, changes in practice are necessary. In this regard, changes in practice have been described as entailing a complex process that is important for progression, where participants control the changes made to their practice (Mitchell 2013; Aragón & Macedo 2010). Participation of and control by healthcare providers faced with the care of forensic patients could lead to the formation of human agency that could empower both the healthcare providers and the victims of violence and crime.

In order to embrace collaboration, inclusion and participation, I decided on emancipatory practice development as the change process to use in this study, as it provided a possible direction for transforming forensic care in the participating emergency departments.

3.5 Summary

In the literature review in this chapter, I discussed the history and development of clinical forensic medicine, as well as the intertwined relationship between clinical forensic care and healthcare providers' work in emergency departments. The literature revealed that prior studies in the field of forensics and emergency medicine have found that healthcare providers are in need of additional forensic knowledge and skills, but there was limited evidence on what strategies have been implemented, or could be implemented, to change the status quo. In Chapter 4, I discuss emancipatory practice development (Part I, Cycle 2) as the change process that I followed to transform forensic care.

CHAPTER 4: THE CHANGE PROCESS

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4.1 Introduction

In Chapter 3, I provided a history of the development of forensic care and noted calls for changes to current practice. In Chapter 4, I discuss the second cycle of action research. First, practice development, and specifically emancipatory practice development, are *looked at* as the change process selected for this study. The *thinking* phase in this cycle occurs when connections between action research and practice development are explored to demonstrate similarities and differences. The chapter concludes with the conceptual framework proposed in the study, which represents the *act* phase of this cycle. Even though no real action was performed, the conceptual framework provided a guide for the activities needed to transform forensic care in emergency departments.

4.2 Looking at practice development

Practice development has been evolving since the 1970s, acknowledging that the people involved in caring for patients are part of a context and fulfil diverse roles in their daily lives, which in turn influence patient outcomes (McCormack, Manley & Titchen 2013). Practice development has been tried and tested in long-stay healthcare settings for older people (Clissett, Porock, Hardwood & Gladman 2013) and for people with mental health challenges with good results; practice development is also gaining momentum in other healthcare disciplines (McCauley et al. 2014).

Practice development scholars distinguish between three approaches to developing practice. The first is technical practice development, which focuses on knowledge and follows the traditional method of a top-down approach. The second is emancipatory practice development, which requires working with people involved in practice through collective action and decision-making. The third approach to practice development is transformational practice development, which incorporates critical creativity and focuses primarily on the people involved in care, such as patients, their families and the caregivers, rather than on “tasks and services” (Shaw 2013). The literature reviewed in Chapter 3 mainly describes the perspectives on forensic care of healthcare providers in emergency departments. There was limited evidence or discussion on the involvement of staff and their specific contexts regarding the ways in which the studies influenced practices in rendering care to forensic patients (see Section 3.5.5).

Emancipatory practice development was selected as the change process to be implemented in this study, because emancipatory practice development has been found to be a process that can enable practitioners to change their practice while learning which steps to take in order to do so (Parlour & McCormack 2012; McCormack et al. 2009). The participants of this study therefore potentially gained

forensic knowledge and skills they need to provide improved forensic care, and simultaneously learned how to apply the process to other challenges that occur in their daily practice. This approach was also chosen because it addresses a gap in the existing literature.

4.2.1 Emancipatory practice development

Emancipatory practice development has been defined in Section 1.8.6. In order to assist the participants through enlightenment, empowerment and then to emancipation, three methodological principles were adopted, in line with McCormack et al. (2013). These methodological principles are collaboration, inclusion and participation. These principles are very closely related to the working principles of action research, which include relationships, communication, inclusion and participation (see Section 2.4).

Manley and McCormack (2003) state that emancipatory practice development can improve any aspect of patient care or service delivery. This influenced my decision to transform forensic care through emancipatory practice development as a change process. I also noted that in recent years, the practice development community has moved its focus to person-centredness as the ultimate goal to be achieved in healthcare through emancipatory practice development, as is evident in the work of Dewing, McCormack and Titchen (2014), as well as McCormack, McCance and Maben (2013). Person-centredness has been described as a way of treating people as individuals with respect, and building mutual trust and understanding relationships (McCormack & McCance 2010). The person-centred framework that was developed by McCormack and McCance in 2010 and presented in Figure 4.1 (overleaf) indicates three circles needed to achieve person-centred outcomes.

I interpreted the framework as a sequential process that must be addressed in order to reach person-centred outcomes. First, the pre-requisites of professional competency, developed interpersonal skills, commitment to the job, clarity of values and beliefs and knowing the “self” have to be addressed (as indicated in the outer circle). This is followed by attention to the care environment, which includes an appropriate skills mix, a system that facilitates shared decision-making, effective staff relationships, supportive organisational systems, shared power, the physical environment and the potential for innovation and risk-taking (McCormack & McCance 2010), as shown in the second circle (see Figure 4.1).

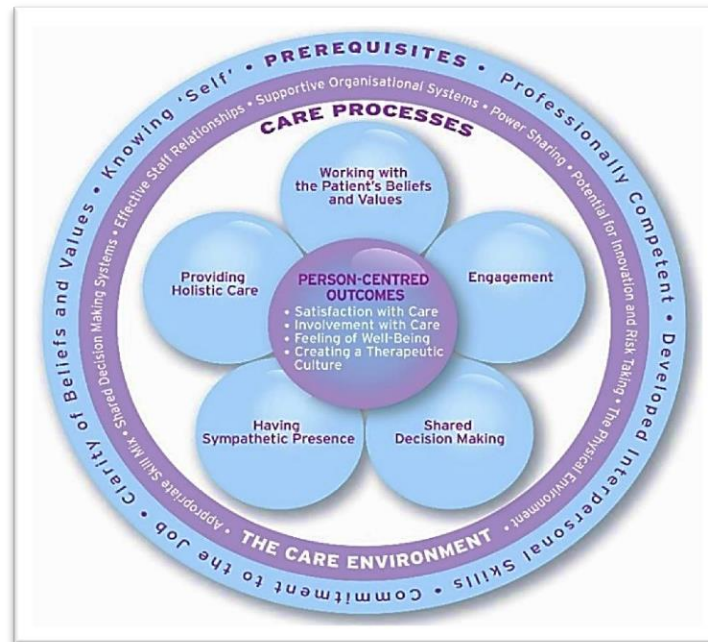


Figure 4.1: Person-centred framework (McCormack & McCance 2010:3)

The middle circle depicts the care process that must be in place to provide person-centred care, although scholars in practice development have argued that person-centredness might not be attainable all the time, and that healthcare providers should at least attempt to provide person-centred care in all contexts (McCormack, McCance & Marben 2013). I acknowledge that person-centeredness is important, especially for forensic patients who are prone to secondary victimisation, and that person-centredness in forensic care should be pursued after the challenges of the pre-requisites above and the care environments have been attended to.

The attempts to provide person-centred care in acute care settings and especially emergency departments have exposed unique challenges not reported in long-term care settings. I agree with Goode, Melby and Ryan (2014), and McCance, Gribben, McCormack and Laird (2013), who argue that time limitations, resources, understaffing and changing contexts hamper healthcare providers in their attempts to provide person-centred care. Furthermore, emergency departments' physical environments, the demand for absolute concentration to perform certain medical care procedures and the flow of patients through the department contribute to a lack of person-centred care (McConnell, McCance & Melby 2016). McConnell et al. (2016) emphasise that most practice development and person-centred studies in emergency departments focus on pre-requisites, the care environment and outcomes. The possibility of more person-centred care in acute care settings may be attainable but a major mind shift

from healthcare providers, patients and organisations would be required (McConnell et al. 2016; McBrien 2009).

Taking into consideration that multiple calls have been made to incorporate forensic care into healthcare providers' training and education (Putre 2013; Henderson et al. 2010), and the limited evidence that such changes have been implemented (Donnelly 2012:92), it is clear that the prerequisites for providing person-centred care to forensic patients are not met (Henderson et al. 2012; McGillivray 2005). In the South African context in particular, it is not common to clarify values and beliefs at unit level. Where values are considered at all, this is mostly a task undertaken by management, and the outcomes (if any) are channelled from management to practitioners in the various units. The healthcare environment is bureaucratic and hierarchical, following a top-down approach to decision-making (Gilson, Elloker, Olckers, & Lehmann 2014).

In view of the above, I decided to situate my study in the two outside circles, focusing on the prerequisites for and care environment of a person-centred framework, in order to prepare healthcare providers who provide forensic care to victims of violence and crime to move towards person-centred care. In addition, I openly acknowledge that the manner in which I built relationships with the participants was based on the principles of working with values and beliefs, engagement, shared decision-making and having a sympathetic presence, as advocated by McCormack and McCance (2010).

4.2.1.1 How emancipatory practice development works

In the literature, key elements of emancipatory practice development (McCormack, Henderson, Wilson & Wright 2009) have been identified, as well as ways of working when engaging in emancipatory practice development (McCormack 2014). I explain my understanding of the guidance provided by the methodological principles, key elements and ways of working in Table 4.1.

Table 4.1: Methodological principles, key elements and ways of working

Principles	Key elements	Ways of working
Collaboration	Work with values, beliefs and assumptions, challenging contradictions	Focus on being person-centred and both process- and outcome-oriented
	Develop moral intent	Establish and work with shared values as the benchmark for practice
	Enable others to "see the possibilities"	Develop a shared vision for future practice
		Develop and maintain collaborative working relationships

Principles	Key elements	Ways of working
		Reward success by celebration, recognition and acknowledgement
Inclusion	Focus on the impact of the context on practice, as well as practice itself	Work with ethical processes that emphasise collaboration, inclusion and participation
	Foster widening participation and collaboration by all involved	Analyse stakeholders' roles and ways of engaging stakeholders
Participation	Develop the critical intent of individuals and groups	Use creative, reflective and active learning strategies that generate a culture of high challenge with high support
	Use self-reflection and foster reflection in others	Establish an evaluation framework that is integrated with the development work and based on collaboration, inclusion and participation
Stated end goal	Changing practice	

Sourced: Combined and adapted from McCormack (2014), McCormack et al. (2013) and McCormack et al. (2009)

In order to assist practitioners through the phases of emancipation, the three methodological principles of collaboration, inclusion and participation are absolutely essential. Collaboration can be attained by challenging existing practices, while allowing the people involved to identify alternative possibilities to solve identified predicaments. In the context of the intention of building collaborative relationships, it is essential to clarify values and beliefs to establish ways of working, and to determine future direction for the practice (see Section 5.6). Furthermore, achievements should be celebrated so as to motivate the people involved to continue with their emancipatory practice development endeavours. The participants involved in the collaboration should include a wide range of stakeholders that are concerned with or have influence in or on the context and/or practice (see Section 5.3.3). The participation of these identified stakeholders should be made purposeful by developing stakeholder's reflection skills, engaging in active learning activities through a high challenge/high support culture and collaborative evaluation of the process and outcomes. The outcomes should indicate whether or not changes in practice have occurred.

In addition to the methodological principles that must be adhered to when undertaking emancipatory practice development, there are other principles that should be taken into consideration for all practice development activities. Two sets of principles for practice development have been proposed, one set by Dewing, McCormack and Titchen (2014) and the other by McCormack, Manley and Titchen (2013). I compare these principles in Table 4.2 (overleaf).

Table 4.2: The principles of practice development

Dewing, McCormack and Titchen (2014:11)	McCormack, Manley and Titchen (2013:5)
Work towards a shared common vision	Achieve person-centred and evidence-based care
Make continuous process of improvement and innovation towards <ul style="list-style-type: none"> increased effectiveness in person-centred care long-term sustainable transformation of the culture and organisation of care 	Direct attention at the micro-system levels
Bring it about by teams developing their knowledge and skills through reflection and work-based learning	Integrate work-based learning focusing on active learning in the workplace
Ensure that teams are committed to systematic, rigorous and continuous process of change	Integrate and enable both the development of evidence from practice and the use of evidence in practice
Be real	Use complex methodology that involves internal and external stakeholders
Reflect on the perspective of patients/residents and families	Use key methods based on methodological principles that are operationalised and contextualised
	Use a set of processes including skilled facilitation
	Integrate evaluation approaches that are collaborative, inclusive and participatory

Source: Adapted and combined from Dewing, McCormack and Titchen (2014:11) and McCormack, Manley and Titchen (2013:5)

At first glance, these two sets of principles, published a year apart, were difficult to follow – practice development is a complex process that is difficult understand. Upon closer examination, I realised that these sets of principles were related. Close scrutiny of each difference and similarity revealed parts of the DNA (deoxyribonucleic acid) of practice development. The sets of principles developed by Dewing, McCormack, Titchen (2014:11) and McCormack, Manley and Titchen (2013) both indicate the importance of person-centredness as a way to improve the effectiveness of healthcare services. People who engage in practice development should embrace all stakeholders, including providers and receivers of care, even their significant others (McCormack et al. 2013). Hence, for practice development endeavours to be successful, the focus must be the workplace itself, as close to direct patient care as possible. Acknowledging the workplace as the context for change enables practitioners to engage in work-based learning, while developing and using evidence from and in practice, which in turn assists teams to be open and committed to change, focusing on providing better care. These principles stipulate that in order to obtain the buy-in of teams, the methodological principles of collaboration, inclusion and participation should be contextualised and operationalised. Such

contextualisation and operationalisation of the methodological principles can be achieved by the clarification of values and beliefs, skilled facilitation by practitioners committed to being real in a person-centred way and integrative evaluation approaches.

The two sets of principles are however sufficiently different to lead novice researchers astray, and sufficiently vague to allow a researcher's interpretation to be biased, riddled with the researcher's own epistemic fallacies, as his/her interpretation is based on his/her own context and experience. For the purposes of this study, I do not believe that the principles of practice development are a rigid set of rules; they are more fluid and flexible, as long as the methodological principles of collaboration, inclusion and participation are adhered to and evidence is provided. There is no single right way of doing practice development. This fluidity and flexibility contributed to my decision to use emancipatory practice development as the change process in this study, as it provided structure for the activities necessary to change practice relating to forensic care with the healthcare providers in the emergency departments. Action research was used to guide how the activities happened.

4.3 Practice development and action research

After I had looked at practice development, I had to consider how practice development and action research are connected. Manley and McCormack (2003) indicate that, amongst other things, action research is used to bring about change in practice. This argument has been corroborated by the Canterbury Christ Church University (2016).

There are many matches between practice development and action research. The complex context of practice and human interaction is widely acknowledged, making it imperative to work in practice, and with as many stakeholders as possible. It is not enough to examine existing practice – action should be taken to learn in and from practice to create practical knowledge. In order to achieve practical knowledge, a number of principles must be adhered to, such as the working principles of action research (see Section 2.4) and the methodological principles of emancipatory practice development (see Section 4.2.1.1).

The similarities between practice development and action research are evident, as emancipatory practice development recommends the principle of collaboration amongst all the role players. The working principles of action research distinguish clearly between relationships and communication, and it is obvious that collaboration is not possible without building relationships and honest and open communication – what is referred to in practice development as authentic engagement (McCormack et

al. 2013). The principle of inclusion is the same in both emancipatory practice development and action research; it implies that all the people involved in or affected by the phenomenon under review should participate. Participation, the last of the principles, suggests that, if possible, participants should participate in as many as possible (if not all) of the processes developed and decisions made. The actions and directions taken during a study should respond to the needs of the participants and not those of researchers. This in turn implies that power should be shared between a researcher and the participants in a study, and that the researcher should surrender his/her role as a knowledgeable expert in order to create high levels of ownership from the participants. Furthermore, both action research and practice development require the implementation of facilitation to guide participants through the research process in order to bring about change that will benefit a particular practice and the relevant stakeholders – in this study, both forensic care practice and the patients. Practice development summarises the benefit to a particular practice, practitioners and patients with the term person-centredness.

There are a few differences between practice development and action research. First, action research focuses on social justice and may therefore be interpreted as more politically motivated. Practice development explicitly addresses the issue of the clarification of values and beliefs, as well as the use of evidence-based practice, while the literature on action research does not address these topics. This silence could possibly be ascribed to the fact that the knowledge generated by action research is highly context-bound, so what and how evidence is put into practice is unique in every setting.

For the purposes of my study, I adhered to the interconnected methodological principles of emancipatory practice development, as well as the working principles of action research.

4.4 Emancipatory practice development as change process

Based on the discussion in the existing literature and my understanding of emancipatory practice development, I selected emancipatory practice development as the change process to be implemented in this study. It therefore represents the *act* part of the action research cycle. Emancipatory practice development is a process that can enable practitioners to change their practice, while learning which steps to take in order to do so (Parlour & McCormack 2012; McCormack et al. 2009). Hence, the participants in this study could potentially gain forensic knowledge and skills, and learn how to apply the process to other challenges that occur in their daily practice.

In theory, by applying emancipatory practice development, practitioners can learn in and from the practice through collaboration, inclusion and participation, with the goal of generating new knowledge and changing their culture and the context of their practice (McCormack et al. 2013). Nevertheless, there is some cynicism around claims of emancipation by means of research (Shaw 2013:84), based on the fact that not all participants or societies become emancipated after an emancipatory study (McCabe & Holmes 2009). It follows that even though emancipatory practice development was used as a change process in this study, I cannot claim that the participants involved were necessarily emancipated at the end of the study.

The concept of emancipation has political connotations – the process seeks social justice for the oppressed (Creswell 2010; Grant & Ramcharan 2010). This feature of emancipation is in line with the forensic aspect of this study. I assume that due to oppression from internal or external sources, healthcare providers may take very little notice of the special needs of victims of violence and crime. Healthcare providers may even further oppress victims of violence and crime seeking medical attention and justice by misinterpreting, destroying and/or providing incomplete documentation of evidence or injuries. Hence, I believe that oppressed healthcare providers may in turn become oppressors who deliberately or inadvertently deny victims of violence and crime their right to justice. In this regard, healthcare providers have been accused of being mere spectators when human rights are being violated in front of them, whereas they are perceived by the world as being custodians of human rights (Lukhozi 2009:67). This was one of the reasons for my choice to use emancipatory practice development in an attempt to assist healthcare providers in emergency departments to pursue social justice for victims of violence and crime. The healthcare providers implicitly became aware of their own oppression and the possible consequences of their actions on victims of violence and crime. This awareness seemed to lead to explicit actions (see Section 9.3) to transform forensic care in the three participating emergency departments. The process of gaining support from the participants through emancipatory practice development followed three phases, namely enlightenment, empowerment and emancipation.

Enlightenment, sometimes also referred to as awareness, is usually implemented as the first step to emancipation, as it reveals existing situations and the roles that participants may play in existing situations which are in need of change (Kagan et al. 2009; Rose & Glass 2008; Wilson & McCormack 2006; Wittmann-Price 2004). The second step of empowerment includes gathering resources and information that can be used during actions, in this case, by healthcare providers (Wilson & McCormack 2006; Wittmann-Price 2004). The last phase, emancipation, incorporates the intentional generation of

knowledge and actions of healthcare providers to change their healthcare (and forensic) practice and the context of their environment positively (Woodhams & Lupton 2014; Rose & Glass 2008; Wilson & McCormack 2006).

4.4.1 Associated challenges and limitations of emancipatory practice development

Arguments against practice development have been raised by Rudge, Holmes and Perron (2011), as well as Walker (2009). Walker (2009) argues that practice development entails only a short-lived fashion in nursing and that it involves a process that is already in use by many healthcare professions. Rudge et al. (2011) even perceive practice development as a barrier to the modern role changes required in nursing. These authors reason that the work lines of accountability have already become indistinct and that practice development as it is defined will be responsible for blurring the lines of authority and responsibility even further (Rudge et al. 2011). However, neither Walker (2009) nor Rudge et al. (2011) expand their arguments to address more than the definition of practice development.

McCormack, Manley and Titchen (2013:5) acknowledge that practice development is still evolving as a methodology and/or a complex intervention. Given the evolutionary process of development, I believe that a final definition of practice development is still to be decided. The body of work on practice development suggests that practice development as an approach is still relevant: a third textbook on practice development was published in 2013 by McCormack, Manley, and Titchen, and the *International Practice Development Journal* has been publishing online bi-annually since 2011. Practice development and specifically emancipatory practice development have been used in studies ranging from gerontology (Conway & Fitzgerald 2004) and nurse leadership programmes (Martin et al. 2014; Boomer & McCormack 2010) to critical care nursing (Carter, Daniel & Place 2011) and midwifery (McCormack 2010). All the above-mentioned studies report that practice development can facilitate changes in practice, while ensuring high levels of ownership from all stakeholders involved in the particular studies. Novice researchers (like myself) or practitioners who want to embark on a practice development journey should be cautious, because it is easy to get lost in the literature, which provides only limited information on the specifics of how to engage in the prescribed practice development activities. The only guidelines are principles, key elements and ways of working, as well as key skills that are further complicated by each setting's context, culture and dynamics. Burke (1995) warns that "change is messy and never as clear as we have written in our books and articles".

4.4.2 The conceptual framework of the study

In order to facilitate the navigation by the participating healthcare providers through emancipatory practice development and to follow a systematic approach to the research process, I devised a conceptual framework (see Figure 4.2) by adapting Garbett and McCormack's (2002) conceptual framework of practice development.

The original conceptual framework has been adapted for different studies, and in the recently published workbook for practice development (Dewing, McCormack & Titchen 2014). Both the original and the newly adapted frameworks situate person-centred cultures at the centre of the practice development framework. However, the focus of my study was on transforming forensic care in the emergency environment, where person-centredness was found to be a challenge (as discussed in Section 4.2.1). Therefore the conceptual framework in its original and adapted forms was unsuitable to my study, because certain pre-requisites and care environment needs had to be included and emphasised. During a personal contact session with Professor McCormack in 2014, I tabled a first draft of my study's conceptual framework. He had no objections in principle to my decision not to place person-centred care at the centre of my conceptual framework.

The conceptual framework as I adapted it for this study is presented in Figure 4.2.

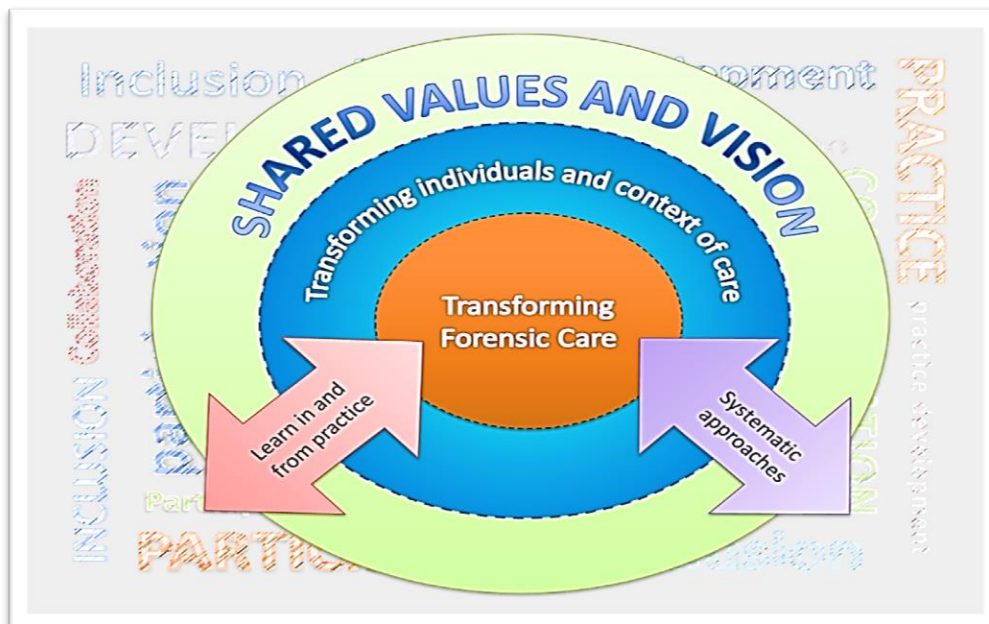


Figure 4.2: Conceptual framework guiding the research process
(adapted from Garbett & McCormack 2002)

Below, I discuss the conceptual framework guiding the research in terms of its paradigmatic location, the meaning of the arrows, shared values and vision, transforming individuals and a context of care, and transforming forensic care.

4.4.2.1 Paradigmatic location

The conceptual framework of this study is located in a critical realist paradigm (see Section 1.7), which is often associated with emancipatory practice development (Parlour & McCormack 2012), action research (Houston 2010) and mixed method research (Maxwell & Mittapalli 2010). Critical realism is summarised by Patomäki and Wight's (2000:218) statement that the "world out there is linked to the world in here". Critical realism as a paradigm acknowledges that reality is complex, and is influenced by pre-existing social structures, human agency (people) and possibilities for action (Clark 2008). Phenomena under study using critical realism are consequently approached by embracing complexities present in the real world, and there is no attempt to control or simplify reality, people or culture as they exist or develop (Angus & Clark 2012; Clark 2008). Critical realism is concerned with the context, culture and emancipation of human agency, as well as the structures surrounding these aspects (Deforge & Shaw 2012; Easton 2010). Critical realism was developed predominantly to gain new insights into reality and human behaviour (Maxwell & Mittapalli 2011; Archer et al. 1998).

Bhaskar explains that critical realism has a stratified ontology that is more important to understand than its epistemology (Burgoyne 2010; Bhaskar & Lawson 1998). Bhaskar differentiates between three domains of ontology, namely the real, the actual and the empirical (see Section 1.7.1). In this study, I focused on the empirical domain, which is the level of experience and perspectives that are triggered and examined (Gorski 2013:665). The empirical domain in this study was informed by the review of the existing literature, which highlights the need to transform forensic care into service provision at a higher level, and not simply to theorise on what is supposed to happen. In essence, this relates to the use of a change process.

In pursuit of changing things for the better, I assisted the participating healthcare providers through facilitation to develop answers and actions by collaborating with each other and with other agencies involved with victims of violence and crime to form a better understanding of the problems relating to forensic care. Collaboration between human agencies is necessary to gain a better understanding of the existing circumstances and practices, as well as desired changes and outcomes (Houston 2001).

The outcomes critical realist studies are described and explained by retroduction or abduction, and no foregone conclusions are made (Houston 2010). Retroductive reasoning does not propose

generalisation, as it is context-dependent, but focuses on the underlying mechanisms that may cause tendencies and outcomes (Lawson 1998). In a world where knowledge is freely available, it is important to understand how and why knowledge is generated and used in practice (Gorski 2013).

The findings of this study are context-bound. Hence, I provide detailed explanations of the approach and collaboration followed to reach the conclusions, and consider the possible ways in which the practice and practitioners could potentially have been influenced by the research process. Therefore, the conceptual framework contains the words “practice development”, “collaboration”, “inclusion” and “participation”. These words formed the basis of all actions taken during the study, as advised by Manley, Titchen and McCormack (2013:50). In order to ensure the collaboration, inclusion and participation of the participants, access to the emergency departments as well as to the healthcare providers had to be established and maintained. Strategies to ensure this are discussed in Chapter 5.

4.4.2.2 Meaning of the arrows in the conceptual framework

The arrow on the left side of the conceptual framework (Systematic approach) is important to indicate the successful outcomes of practice development (McCormack, Manley & Titchen 2013; Garbett & McCormack 2002). In this study, the use of emancipatory practice development required the participants to become aware of their practice (enlightenment) and to identify the structures and mechanisms that could hinder changes in practice and in the workplace culture (McCormack et al. 2004). The participants had to be provided with knowledge and skills that could enable them to change their practice.

The arrow on the right side of the conceptual framework (Learn in and from practice) is a key element of practice development, because learning is triggered by situations in practice, and learning can occur by having meaningful discussions with peers and collaboratively searching for answers (Manley et al. 2013; Manley, Titchen & Hardy 2009). Patients in need of forensic care present at emergency departments every day. Healthcare providers in this study were encouraged to identify their learning needs pertaining to the forensic care they provide when working with victims of violence and crime. This identification of learning needs assisted the participants in the development of action plans to develop their own practice further.

The systematic approaches used, together with learning in and from their own practice, assisted the participants in this study to move through the three phases of emancipatory practice development, namely enlightenment, empowerment and emancipation. These systematic approaches are not comprehensively explained or analysed in any of the practice development literature that was sourced;

Dewing, Harmon and Nolan (2014) commented in this regard that the implementation of systematic approaches implies some challenges. However, one could assume that the key steps of a practice development journey are the systematic approach referred to in the conceptual framework. The key steps start with “knowing and demonstrating values and beliefs”, “developing shared vision”, followed by “describing and measuring where we are starting from”, making “a practice development plan”, having “ongoing integrated action, evaluation, learning and planning”, after which come “sharing and celebrating” (Dewing et al 2014; McCormack et al 2013). The purpose of the key steps is to move towards a “safer and more effective person-centred care” with the ultimate “vision for a person-centred culture” (Dewing et al 2014:7).

For the purposes of this study, the specific systematic approach used is illustrated in Figure 10.4 and discussed in Section 10.6.2. Action research was used in the change process of emancipatory practice development, so the study did not follow a linear process. Instead, the systematic approaches set out provided signposts of the activities that took place in order to transform forensic care.

4.4.2.3 Shared values and vision

The first step in the systematic approach was comprised of activities to clarify the shared values and the vision of the participants in the study. In order to make the changes required and to establish rules of engagement, values and beliefs regarding forensic care were clarified. Every person holds values that are influenced by others, and social structures shape relationships and self-understanding that can be beneficial or detrimental to any actions people take (Sayer 2011; Bhaskar 1998). Values are the foundations that guide the action(s), interactions and expectations of individuals and groups (Manley et al. 2013; Sayer 2011; McCormack et al. 2004). However, values are often treated as “personal” and “subjective” and are only expressed when people are questioned about them (Sayer 2011:26:28). The dotted line in the conceptual framework (see Figure 4.2) between the shared values and vision and the transformation of the individual and context of care indicates that there is a reciprocal influence between values of the participants and the actions they will engage in (see Section 5.6 for a clarification of values and beliefs).

4.4.2.4 Transforming individuals and contexts of care

The transformation of individuals and contexts in the circle of care (see Figure 4.2) represents the methodology and methods used in this study to conduct the research that assisted healthcare providers to move closer to their vision (McCormack, Manley & Titchen 2013). In order to ensure collaboration, inclusion and participation, I used action research as the methodology for this study, because the

working principles of action research and methodological principles of emancipatory practice development are similar (Manley & McCormack 2003:27; Stringer 2007:28-36). Action research is discussed in detail in Chapter 2. To encourage the participants' ownership of the research, the methods used for data generation and analysis were collaborative, inclusive and participative (see Sections 6.3, 6.4, 7.3, 7.4, 8.3, 8.4, 10.3 and 10.4).

4.4.2.5 Transforming forensic care

Transforming forensic care is the ultimate intention of the study, but this transformation could only be achieved in the presence of a shared vision and collaboration, inclusion and participation (McCormack, Manley & Titchen 2013). The literature review revealed that forensic care has long been on the agenda of emergency medicine, but that the ability of healthcare providers in an emergency department to deliver forensic care has been understudied. I hope to add value to delivering forensic care in emergency departments with this study, especially in South Africa. The transformation that took place is discussed in Chapter 9.

4.5 Summary

The need to take action and do research with healthcare providers regarding the forensic care they provide led me to choose emancipatory practice development as a change process for this study. This guided the formulation of a related conceptual framework for the study and to the relationships formed during the process. Chapter 4 concludes Part I of the study.

Part II presents the collaborative part of the study in Chapters 5 to 10. In Chapter 5, I discuss how I gained access to and prepared the context and participants for this study.

OVERVIEW OF PART II (CHAPTERS 5 TO 10): COLLABORATION IN THE FIELD

Part II of this thesis presents the time spent in the field in collaboration with the participants and makes up the bulk of the study, as Figure 5.1 shows. Part II makes up Cycle 3 of the study and includes three action research sub-cycles.

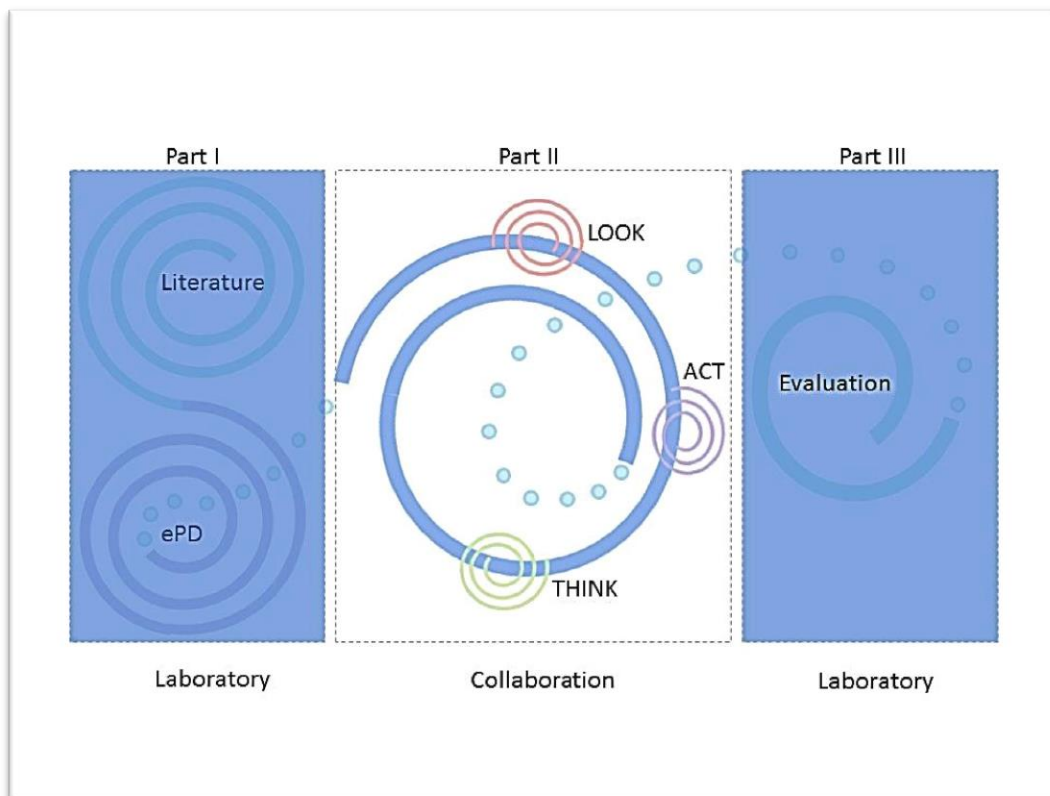


Figure 5.1: Overview of Part II

In Chapter 5, I introduce the participants, as well as the relationships that were established and maintained throughout the study. Specific attention is paid to the relationships between the practice development facilitators and myself, as well as our positionality. Furthermore, the values and beliefs held by the participants in each emergency department were clarified to create shared visions for each department and to provide rules of engagement in an effort to establish collaboration, inclusion and participation. After access was negotiated the *look* cycle was initiated.

The *look* cycle (the pink spiral, Sub-cycle 1, which is made up of a further three cycles that are interconnected to form the baseline of existing practice) is discussed in Chapters 6, 7 and 8. In Chapter 6 – First glance, the existing forensic practices are explored in collaboration with the participants in the emergency departments. In Chapter 7 – Through the looking glass, the expected forensic roles and responsibilities are discussed. Once the key themes had been identified, as set out in Chapter 6, these themes were combined with the themes discussed in Chapter 7 to capture the essence of the forensic roles and responsibilities that the participating healthcare providers were aware of at the start of the study. Chapter 8 – Under the magnifying glass, contains the healthcare providers' expected roles and responsibilities, as established by a realist synthesis. In order to explain the forensic roles and responsibilities to victims of violence and crime and make more sense of them, the findings from a talking wall, a nominal group technique and a realist synthesis were combined. From the combined findings, I constructed a framework to capture and explain the forensic roles and responsibilities of healthcare providers (as set out in Figure 8.4).

The *look* cycle informed the *act* cycle (purple spiral, Sub-cycle 2) and is discussed in Chapter 9 – Putting plans into action. The *act* cycle captures the actions planned by the practice development facilitators based on suggestions made by the participants during data generation sessions. The actions implemented and the unintended actions that occurred are presented in three smaller cycles of *look*, *act*, *think* that transpired during the *act* cycle.

Following the *look* and *act* cycles, the collaboration with the participants in the field came to an end, as discussed in Chapter 10 – Processing the evidence, which shows the *think* cycle (green spiral, Sub-cycle 3). The evidence was processed by the practice development facilitators in the form of an evaluation and reflection on the outcomes, ways of working and emancipatory practice development as a change process.

CHAPTER 5: MAKING CONTACT

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5.1 Introduction

In Chapters 3 and 4, the first two cycles of the study were discussed as a period that I spent in the “laboratory” away from the participants. In Chapter 5, I address the population, the sample for the study and how access was gained and maintained. The participants were made aware of the vast number of stakeholders that have an actual and a possible influence regarding the rendering of forensic care in emergency departments. After the stakeholders had been identified, a values and beliefs clarification exercise was conducted in order to establish a shared vision of forensic care. The purpose of this was to address the outer circle, namely shared values and vision, in the conceptual framework (see Figure 4.2).

5.2 Population and access

In order to do research with practitioners, I selected healthcare providers working in emergency departments as the population for this study, because emergency departments have been identified as sites where victims of violence and crime seek medical attention. The accessible population was healthcare providers in three level-one emergency departments in the Gauteng province in South Africa. These types of emergency departments (see Section 1.8.2 on conceptual definitions) are tasked with taking the lead in emergency care provision and transferring knowledge and skills to other levels of emergency departments. Nurses remain a constant in these departments, so they were identified as the target population.

In order to access the study’s target population, I had to negotiate access to the target population. Gaining access involves an academic and ethical process that researchers must follow while building rapport with participants, allowing them and the researchers to gather meaningful data in order to answer the research question (Jensen 2008). The process of negotiating access traditionally starts with gaining approval from an internal review board at a researcher’s academic institution, and then moves to the research site, followed by gaining access to the intended participants (Gelling 2010). For this study, I initiated negotiations for access nine months prior to applying for approval of the research proposal by the internal review board at the University of Pretoria. The purpose of starting early negotiations was to make the emergency departments and potential participants aware of the proposed research and to create some familiarity between the participants and myself, as suggested by Gelling (2010).

Action research and emancipatory practice development advocates a bottom-up approach to research (Huzzard & Johansson 2014; Smith 2012), but to initiate this study, the management of the three selected emergency departments were first informed of the research and the potential benefits the study held for the healthcare providers and forensic patients. Once permission to undertake the study had been granted by the Research Ethics Committee of the Faculty of Health Sciences at the University of Pretoria and the review boards from the three selected hospitals (see Annexure A), further negotiations for access were undertaken with the gatekeepers who control the right of admission to these participants and the research sites, as suggested by Gelling (2010). The specific gatekeepers that were personally approached in this study included the unit managers (nurses) and the heads of department (the medical doctors) who had the power to allow or prevent the research process, as suggested by Stringer (2014).

Meetings were set up with the unit managers first. During these meetings, the unit managers were provided with an information leaflet (see Annexure B) and contact details were exchanged. The unit managers of the three research sites were open to and enthusiastic about the research, so the research proposal was sent to them electronically to offer background information and to elicit their input. The unit managers did not suggest any changes to the proposal.

Next, meetings were set up with the heads of department through the unit managers, who had access to information about the availability of the heads of department. The medical doctor in charge of Emergency Department A was open to and enthusiastic about the research, and also pledged the assistance of the doctors in the unit. By contrast, the heads of department of Emergency Departments B and C took note, but were indifferent to the research – they only enquired whether the University of Pretoria's review board had given its permission. They did not obstruct the research in any way, or actively participate in any way. I communicated the apprehension that I experienced during the meetings with the doctors to the unit managers, who informed me about how their systems worked, as well as the fact that the doctors of Emergency Departments B and C did not really engage with the nurses. I was a little concerned, but was reassured by the suggestion of Walker et al. (2013), Lee (2011) and Propp et al. (2010) that when nurses conform to change, other healthcare providers follow suit.

I therefore approached the nursing staff with the knowledge that they would play a vital role in the study. With this in mind, times and opportunities for information sessions were negotiated with the unit managers of each unit. Two information sessions were scheduled for each emergency department around the hand-over time at the three emergency departments to enable access to the majority of staff

members. Each person attending the first information session received the information leaflet (see Annexure B) regarding the research, and additional information leaflets were left with the unit managers to hand out to staff who could not attend. During the information sessions, a need was expressed for practice development facilitators as key informants of the research.

Most of the participants were somewhat wary during the first information session – they did not make eye contact and some were openly bored. I got the impression that they were afraid that participating in the research would just add to their workload. During the second information session, many of the participants who had attended the first session were present again, and they seemed more relaxed and asked questions about the research. At the second information session, the potential participants also received the participant information letter and informed consent form (see Annexure B I). The dates of the first two information sessions are shown in Figure 5.2.

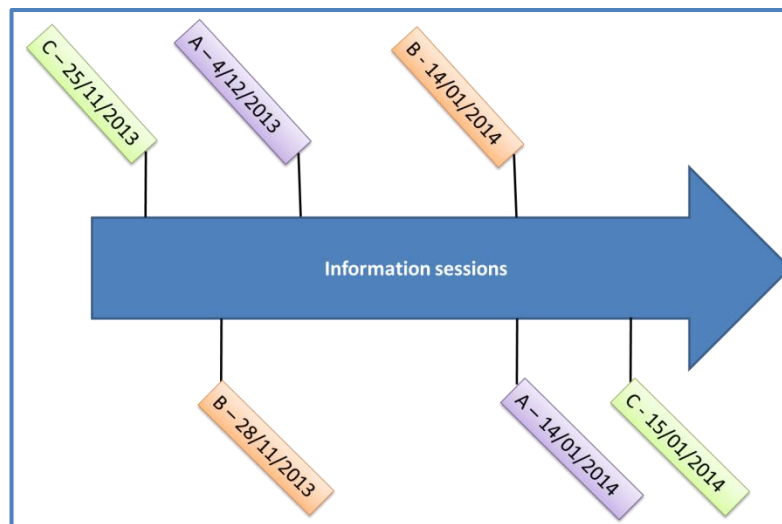


Figure 5.2: Dates of information sessions

On 14 January 2014, I had two information sessions: in Emergency Department B during the morning handover, and in Emergency Department A during the evening handover. The topic of forensic care sparked the interest of some of the potential participants, although some remarked that it is no use if evidence is collected and correctly handled in the emergency department but then mismanaged by the police. As I was acutely aware of the fact that many people in South Africa have fallen victim to violence and crime, either directly or indirectly, and that the prosecution rate was poor (Ward et al. 2012), I knew I had to tread lightly. I therefore suggested that if the evidence is collected correctly by healthcare providers, it might be easier to require accountability from the police. Although some nurses nodded in

agreement, some were still unconvinced. However, I decided to focus on the nurses who had hope and were willing to participate, as advocated by Nugus, Greenfield, Travaglia and Braithwaite (2012).

5.3 Selection of participants

Participants were sampled purposively with the intention of selecting participants who were directly involved in the phenomenon under investigation (forensic care) and who could provide rich perspectives, as well as find solutions to existing challenges, as suggested by Tomal (2010) and Saumure and Given (2008). Purposive sampling aligns well with critical realism – in this regard, Houston (2010) and Archer (2000) explain that people's choices, meanings, creative endeavours, understanding and reasons are based on the knowledge created in their specific context. Purposive sampling was therefore used to identify participants who could contribute to transforming forensic care and would potentially gain from the process and outcomes of an emancipatory practice development process. After the population had been accessed through meetings and information sessions, I categorised the participants into three groups. These groups were practice development facilitators (the participants most involved in the research process, in this case, registered nurses who volunteered to become practice development facilitators for the research), fundamental participants (the nurses working at the ground level), and boundary partners (other stakeholders identified who could potentially influence the study).

5.3.1 Practice development facilitators

The practice development facilitators were the key drivers of the research process. They volunteered from the group of fundamental participants. The practice development facilitators became co-researchers who provided guided support to the fundamental participants, as recommended by Hardy et al. (2012), and McCormack and Dewing (2010). I invested time and effort in the practice development facilitators in an attempt to sustain the transformation in forensic care in the emergency departments, and to equip them with procedures and processes that would help to solve problems they might experience in their practice.

In Emergency Department A, two people immediately volunteered to be practice development facilitators. In Emergency Department B, the unit manager asked if she was allowed to be a practice development facilitator. Given the collaborative, inclusive and participatory nature of the study, I agreed. In Emergency Department C, at first, no one volunteered to be a practice development facilitator, but during an information session, some enquired whether there would be any remuneration

for taking part in the study, and they informed me that they did not want to take part in the study if they were not to be financially compensated. I then explained to them that I did not have the financial resources to compensate them financially, and that when payment is involved, there is always a greater likelihood of distortion in the findings of a study. Nevertheless, three people in Emergency Department C eventually volunteered to be practice development facilitators. The processes and procedures used in the research process and the involvement of the practice development facilitators are discussed in the subsequent chapters of this study. The practice development facilitators received an information letter and an informed consent form (see Annexure B II). At the end of the study, there were eight practice development facilitators across the three emergency departments. Five of these practice development facilitators were in the original group who volunteered, and three practice development facilitators were added because the original volunteers had to be replaced after changing employers.

5.3.2 Fundamental participants

The fundamental participants were the nurses working in the participating emergency departments (see Table 1.1). The status of the fundamental participants was not subordinate to mine, or that of the practice development facilitators. Communication was kept open by informal conversations in the tearoom, answering questions around the research project and the forensic care they provided. Around the time when the information sessions were held, a high-profile case where forensic evidence played an important role in the cases for the prosecution and the defence captured the public's interest, and many details were broadcast on national television. This sparked the enthusiasm of the nurses in the emergency departments and served as a prompt for informal discussion.

The fundamental participants were consulted for the purposes of data generation. They were also informed of the results obtained following the data analysis. Data generation, analysis and dissemination are discussed in detail in the subsequent chapters.

5.3.3 Boundary partners

The concept of "boundary partners" is borrowed from Outcome Mapping, a programme that focuses on behavioural change as an outcome (Earl, Carden & Smutylo 2001). Boundary partners refer to participants that exist on the boundary of the researcher and other participants' influence (Olivari & Hearn 2013; Earl et al. 2001). In the beginning, I set out to include the 70 doctors working in the emergency departments (see Table 1.1) as either practice development facilitators or fundamental

participants. However, doctors became boundary partners instead, as they were interested in, but disengaged from, the study. Even though doctors did participate in the data generation, as described in Cycle 5 (see Section 7.2), many of the doctors who are directly involved in forensic care chose not to participate actively. None of the doctors opposed or obstructed the study.

Aside from doctors, other boundary partners of the study were identified through a stakeholder analysis. The rationale for the stakeholder analysis was to identify groups and individuals who were involved and who could influence the management of victims of violence and crime from incident to prosecution, either directly or indirectly. Due to the involvement and influence of stakeholders in any undertaking, they have a partial responsibility to act in order to change things for the better (Bryson 2004). In this study, the stakeholder analysis identified various organisations and individuals involved, as well as their possible influence, support and power, as suggested by Wang, Ge and Lu (2012) and Bryson (2004).

A stakeholder analysis is a popular practice in the fields of development, management and policy development (Wang et al. 2012; Brugha & Varvasovzky 2000). The processes applied in the stakeholder analysis in this study was a blend of the stakeholder analysis procedures described by the Stakeholder Participation Working Group of the 2010 HIA in the Americas Workshop (2011) and in the work of Reed et al. (2009), the Registered Nurses Association of Ontario (2002), Schmeer (2001), and Varvasovzky and Brugha (2000). The stakeholder analysis was done to identify role players that could provide information, and could specifically assist with the direction needed for action to transform forensic care.

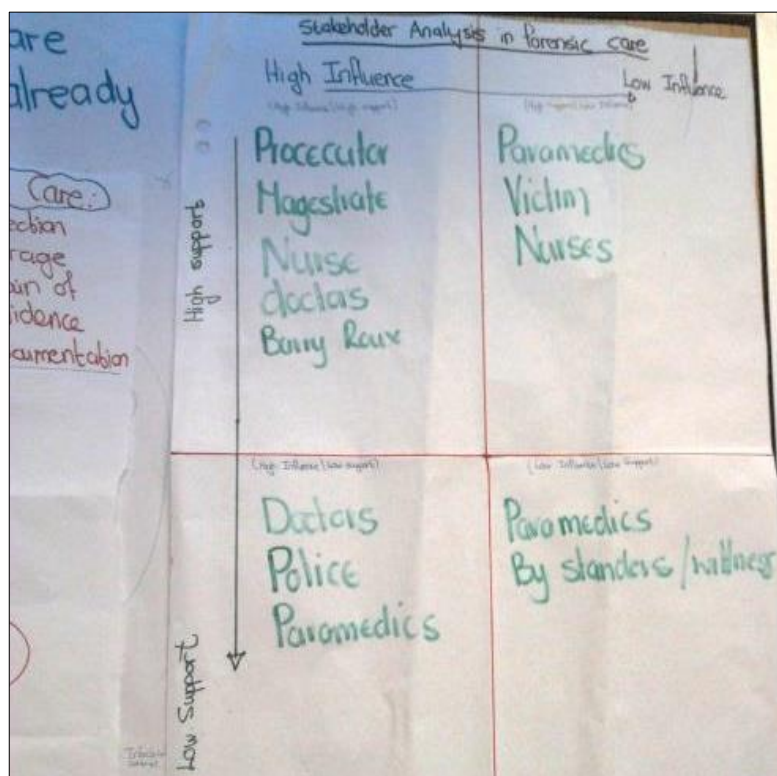
The stakeholder analysis for this study was done in each unit by the practice development facilitators and the fundamental participants. The purpose of assigning the stakeholder analysis to the participants of each unit was to encourage the nurses to think more widely than their immediate environments and to help them realise to what extent they were able to make a difference in the forensic care provided to victims of violence and crime. To assist the practice development facilitators, they were each provided with a hand-out on how to conduct a stakeholder analysis and the process was discussed with them. The process for the stakeholder analysis involved the following:

- *Defining the purpose of the stakeholder analysis:* The purpose of the stakeholder analysis guides who and what is important for the purpose of achieving the objectives of a study.
- *Identifying the stakeholders:* Lists of the possible stakeholders were developed by using the snowball technique as advised by the Stakeholder Participation Working Group of the 2010 HIA in the Americas Workshop (2011). The lists originated emerged from the literature, clinical experience

and my informal discussions with healthcare providers working in the three participating emergency departments.


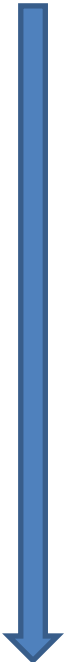
- *Assessing the influence and support of stakeholders on the objectives stated:* The interest, influence and support of each identified stakeholder were taken into consideration by the participants in the stakeholder analysis.
- *Performing triage of stakeholders:* After the potential influence of stakeholders was assessed, the practice development facilitators and the fundamental participants plotted the stakeholders onto a stakeholder influence versus support grid.
- *Engaging with stakeholders:* Stakeholders included fundamental participants and boundary partners with whom contact needed to be established and relationships needed to be formed.

An example of a stakeholder analysis is provided below, in Photograph 5.1 (the stakeholder analysis of the other two emergency departments are included in Annexure C). In Table 5.1, a summary is provided of the stakeholders identified in all three emergency departments, and of where they were plotted in terms of their potential influence and support roles.



Photograph 5.1: Stakeholder analysis from Emergency Department B

Table 5.1: Summary of the stakeholder analysis

		Potential Influence 	
		High	Low
Potential Support 	High	(High influence / High support) <ul style="list-style-type: none"> Prosecutor (B, C) Magistrate (B) Nurses (A, B) Doctors (A, B, C) Patient (C) SAPS [Police] (C) Laboratories (C) Management (A, C) Forensic pathology services (Government mortuary)(C) 	(High support / Low influence) <ul style="list-style-type: none"> Paramedics (B) Victims (B, C) Nurses (B) Prosecutor (C) Counsellors (C) General practitioners [GPs\–Doctors] (C) Physiotherapists (C) Administrative clerks (A)
	Low	(High influence / Low Support) <ul style="list-style-type: none"> Doctors [Specialist (surgeons)] (A, B) Paramedics (A, B) First responder/Witness (A) Cleaners (C) Counsellors (C) Management (C) Nation government (including provincial and district management) for policies and guidelines (A) SAPS [Police] (A, C) Forensics services (A) Social services (A) 	(Low influence / Low support) <ul style="list-style-type: none"> Paramedics (B) Bystanders / witnesses (A, B) Porters (C) Fellow patients (C) Patients (A)
A Emergency Department A B Emergency Department B C Emergency Department C			

The participants listed stakeholders involved in forensic care similar to those identified by Lynch (2011), namely doctors, nurses, counsellors, social and forensic services, role players from the criminal justice system (the police [SAPS], magistrate and prosecutor) as well as the government. In addition, they also identified role players in the direct healthcare environment, including paramedics, administrative personnel, laboratories and management. During the contact sessions in the emergency departments, I asked about the stakeholders that were plotted in more than one quadrant of the table. A variety of answers were given. In Emergency Department A, the practice development facilitators explained that they plotted some stakeholders as they experienced them in the current situation, but also where they thought the stakeholders ought to be. Participants in Emergency Department B indicated that the position in which they plotted a stakeholder depended on which paramedic they were thinking about, as

well as the category of nurse. According to some participants, registered nurses have high influence and a high support role, but other categories of nurses have a high support role and low influence, given their limited scope of practice.

During further discussion with the practice development facilitators, it transpired that the identification of the stakeholders was context-bound – it depended on how the participating nurses perceived their stance and power in relation to other identified stakeholders in each of the emergency departments. The fact that some stakeholders were plotted in more than one quadrant also suggests that the roles and responsibilities of the various stakeholders involved in forensic care have not yet been clarified. I also wondered about the fact that paramedics were plotted in all four quadrants and whether they did not play a bigger and more important role in forensic care. However, during the realist synthesis, very little mention was made regarding the role of pre-hospital healthcare providers in forensic care. I did not pursue this topic, as the role of paramedics in forensic care was not the focus of my study. However, further research should be undertaken in this regard.

5.4 Challenges related to the participants

Each of the categories of participants posed their own challenges in this study. The practice development facilitators from among the fundamental participants who volunteered to take on this role were recognised as leaders in their emergency departments; each of them was a shift leader. They were knowledgeable of the processes and had most of the skills necessary to work in and lead their emergency department. However, the practice development facilitators had limited experience in research, although they had either been a participant in a survey or had been involved in the development of a “traditional” research proposal at an undergraduate level. During our conversations, I explained to them that they were the key drivers or co-researchers, and this made them nervous. In order to alleviate their anxiousness, I adopted a high frequency, low intensity support system (as discussed in Section 5.5.1).

I became aware that the practice development facilitators were very dependent on me and waited for me to give them instructions on what the next steps should be. I wanted to overcome the “expert” label, as recommended by Stringer (2014) and Tomal (2010), but it was difficult to do so, and at times frustrating when this label persisted. I could easily have instructed the practice development facilitators on exactly what and how research activities should be done, but that would have left them still unable to attempt their own research endeavours in future. Therefore my engagement with the practice

development facilitators encouraged me to work harder on my own facilitation skills, which at that stage were not well honed.

The pace of the research activities was much slower than I had initially anticipated. The practice development facilitators kept working at a slow and steady pace, however, possibly increasing their sense of ownership of forensic care in their emergency departments.

Most of my energy and time were spent on engaging and developing the practice development facilitators. I guided the practice development facilitators to engage with the fundamental participants. In addition, I spent a limited amount of time with the fundamental participants, mostly answering questions regarding possible forensic patients and how they were managed in the unit. I was satisfied during my engagement that the fundamental participants were aware of the study and were to some extent involved in the research. However, I did not formally evaluate how the fundamental participants perceived either my engagement, or that of and with the practice development facilitators. This is acknowledged as a limitation to my study in Section 11.5.2.

The boundary partners created unique challenges. Most of the doctors working in the participating emergency departments were indifferent to the study but some did participate in some of the data collection sessions. Access to and contact with boundary partners who were not part of the healthcare setting was difficult. Meetings with the SAPS were granted three to five months after the practice development facilitators requested a meeting. However, access to other boundary partners identified in the “high influence / high support” quadrant of the stakeholder analysis (see Table 5.1), such as prosecutors, magistrates, laboratories, and the forensic pathology services could not be successfully pursued. The main reasons for not approaching these stakeholders was a lack of time, and lack of knowledge about the protocol and procedures to be followed to approach them. The lack of transparent and accountable communication pathways between these stakeholders is indicative of the fragmentation of forensic services in South Africa, and is another area where more research is recommended.

5.5 Positionality

Positionality refers to the roles, interactions and relationships that develop during a study and form the basis of collaborative, inclusive and participatory knowledge construction within the specific context of the study (Rowe 2014, Streck 2012; Finley 2008). For some researchers, positionality incorporates attributes such as culture, gender, race, socio-economic status and others, as these attributes may

influence the interactions and relationships that develop during a study (Tisdell 2008; Merriam et al. 2001).

In addition, positionality may refer to the question of whether a study involves outsider or insider research (Herr & Anderson 2014; Kemmis et al. 2014; Ospina & Anderson 2014; Kerstetter 2012). Insider research refers to research conducted in the researcher's own familiar environment and context, amongst familiar people (Greene 2014; Ravitch & Wirth 2007). Outsider research entails research initiated by a researcher who is not part of or inside the environment or context under investigation and that the researcher is unfamiliar with (Rowe 2014:628; Sherry 2008:433). Both insider and outsider research imply unique positionality challenges regarding collaboration, inclusion and participation (Greene 2014; Smith et al. 2010). These authors and Kerstetter (2012), and Dwyer and Buckle (2009) point out that most of the time the researcher and the participants are "somewhere in between" being insiders and outsiders.

According to Rowe (2014) and Merriam et al. (2001), positionality also relates to power, and to power dynamics between the researcher and the participants that must be acknowledged and negotiated. It is important to remain aware that positionality is flexible, as a range of positions and roles are required in an action research study. Hynes, Coghlan and McCarron (2012) and Ravitch and Wirth (2007) refer to this as a dual positionality. Dual positionality implies that a researcher is also a participant and that participants are also researchers. Below, for the purposes of this study, my positionality as the researcher, the positionality of the practice development facilitators and the other participants are discussed.

5.5.1 My positionality

As the researcher, I had to complete this academic endeavour and fulfil the role of facilitator during the research process. My academic role started in isolation, in discussion with my supervisors, as none of the eventual participants were involved in the conceptualisation of the research problem, in the development of the research proposal, and in obtaining ethical approval from the review boards of the University of Pretoria or the healthcare institutions. The thesis as a research report was also completed in the "laboratory", away from the participants, in consultation with my supervisors.

My role as facilitator was important in all the interactions with the participants, as the research was not done *on* the people involved, but *with* them, where they are situated, as suggested by Stringer (2014). Most of my interactions and most of my time was spent with the practice development facilitators to

facilitate their development to assist in the transformation of forensic care. I left the collaboration with the fundamental participants and boundary partners, as well as their inclusion and participation, mostly to the practice development facilitators.

Throughout, my role and positionality changed in accordance with the needs of the practice development facilitators. The approach that I followed during my interaction with the practice development facilitators was “high frequency, low intensity”. Practice development principles call for “high challenge, high support” (McCormack 2014; Manley, Solman & Jackson 2013; Manley & Titchen 2012); I did not follow this guideline, because healthcare providers in emergency departments are exposed to many kinds of violence in their work environment, and this can in turn cause avoidance, detachment and stress (Kennedy & Julie 2013; Sawatzky & Enns 2012; Taylor & Rew 2010). My purpose was thus to gradually facilitate the emancipatory practice development process and conduct research without possibly causing stress, or overwhelming participants with technical and academic terminology or processes.

In order to address the research question, I worked eclectically, using a variety of data generation and analysis methods. The following assumptions underpinning my research were derived directly from the paradigmatic stance I adopted (see Sections 1.7 and 4.4.2.1 for a more detailed discussion):

- reality is complex and is created by individuals and the world around them;
- to change situations for the better, emancipatory processes may be used, taking context and culture into consideration;
- interactions between human agency and social structures can activate events;
- people and teams have the ability to transform circumstances for themselves and others; and
- eclectic work may use retroduction to explain what happened, and why it happened.

At the start of the research, I was an outsider, but for most of the time during the research process, my power and positionality were “somewhere in between” (Kerstetter 2012). Some practice development facilitators required more guidance than others, and all needed to be reminded that the skills and information they gained during our interactions needed to be ploughed back into their emergency departments, as well as into the practice of the fundamental participants. I became a confidante to some of the practice development facilitators, who relied on me as a sounding board for the challenges they faced in their emergency departments, and the actualisation of the actions set out for this research. The role I played was that of guide, but I was careful never to push or coerce practice development facilitators or participants to move faster than they chose to, as I valued and appreciated

their participation and willingness to attempt to change the practice in the emergency departments. I also allowed the action research process to determine the tempo of the data generation and progress.

5.5.2 Positionality of the practice development facilitators

The positionality of the practice development facilitators developed during the research process, and they became more committed as time passed. The practice development facilitators became co-researchers who provided guidance to the fundamental participants, as recommended by Hardy et al. (2012) and McCormack and Dewing (2010). The practice development facilitators were responsible for creating opportunities for learning in and from practice, thereby providing leadership (Hardy et al. 2012). Their roles were fluid and ranged from co-option to collective action. They were influenced by the needs, familiarity with the task and confidence of the practice development facilitators, as well as negotiations and agreements between all involved. The participatory modes of practice development facilitators are presented in Table 5.2.

Table 5.2: Participatory modes of practice development facilitators

Mode of participation	Involvement of participants
Co-option	Participants are chosen, but they are not given any power or asked for input.
Compliance	Activities are assigned to participants but the researcher decides on the activities.
Consultation	Participants are asked for opinions and the researcher analyses the data and decides on the course of action.
Cooperation	Participants work with the researcher to determine priorities, the researcher keeps the responsibility for directing the process.
Co-learning	Participants and the researcher share their knowledge to create new understanding and collaboratively generate action plans under facilitation of the researcher.
Collective action	Participants set their own agenda, plan and implement actions without any motivation from outsiders.

Source: Adopted from Cornwall (1996, cited by Herr and Anderson 2014:51)

At the outset of the study, the practice development facilitators were co-opted. The practice development facilitators' mode of participation then changed to compliance, as I asked them to distribute the participant information leaflet and informed consent forms. The consultation mode was only applied once during the study for the planning of training provided by an external presenter (the DNA project). The practice development facilitators were asked to identify possible dates for the training, but due to work duties, the presenter could not provide training on the allocated days. Without further consultation, I changed the dates to suit the external presenter, and the information was communicated to the practice development facilitators and the dates for the training were changed accordingly. Most of the time, the practice development facilitators moved between the cooperation and

co-learning modes of participation. I directed the overall process of the study, and the practice development facilitators collaboratively assisted me in determining the next steps, as well as increased their understanding of the process while planning and implementing actions identified during the nominal group technique (see Section 9.2). The practice development facilitators therefore played active roles in data generation and analysis, but none of them had prior experience with research procedures and processes. I assured them that the data generation and analysis methods were new to me too, and that we were all learning together.

5.5.3 Positionality of the other participants

The positionality of the fundamental participants depended on the skills of the practice development facilitators. The fundamental participants were included in the data generation, and the findings after the analysis were posted in an allocated area referred to as the “talking wall” for comments and inputs in each of the emergency departments. The talking wall is discussed in detail in Section 6.3.

The boundary partners occupied their own power positions, so access to this group presented some challenges. Doctors initially seemed enthusiastic, but when information or their participation was requested, only a few volunteered their time and information. The SAPS was approached, but remained uninvolved. After contact with the SAPS was eventually established, the contact persons provided some direction for making contact with the boundary partners outside of the hospital environment.

5.6 Clarifying values and beliefs

In order to engage in activities that might lead to a transformation of forensic care in emergency departments, values and beliefs were clarified to create a vision statement as depicted in the conceptual framework (see Section 4.4.2). Values are the foundations that guide action, interactions and the expectations of individuals and groups (McCormack, Manley & Titchen 2013; Sayer 2011; McCormack et al. 2004). Every person holds values that are influenced by others and their values, and by social structures shaping relationships and self-understanding that can be beneficial or detrimental to any actions taken (Sayer 2011; Bhaskar 1998). People treat values and beliefs as something personal and subjective, and mostly they are only expressed when people are questioned about them, but exploring values and beliefs is important in action research (McAteer 2013; Sayer 2011).

Values were clarified in this study using the values clarification exercise of the Royal College of Nursing (2007) (see Annexure D). Each nurse in the unit received the values clarification exercise with the assurance that there are no wrong or right answers. After the nurses had completed this exercise, the

answers were handed back to the relevant practice development facilitator. The practice development facilitators also completed the document. I facilitated the process, and the practice development facilitators created the vision statements from the exercise completed by the nurses.

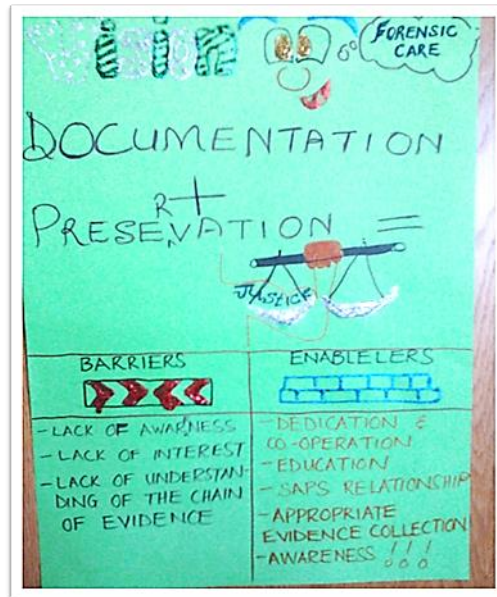
The process in accordance with the guidelines set out by the Royal College of Nursing (2007) was the following:

- All the answers to the questions posed on the hand-out were collated.
- Theming then took place by writing each theme on a different piece of paper, and a summary of the themes was reshaped into draft statements and phrases.
- Finally, draft statements and phrases were assessed for meaning and clarified until the practice development facilitators were satisfied with the content.

The expressed values assisted in creating shared visions that formed the basis for assistance and confronting problematic measures in an effort to enhance actions to be taken (McCormack, Manley & Titchen 2013). The practice development facilitators were also requested to make a poster of their values and beliefs regarding forensic care. These posters were displayed in the emergency departments, and confirmation was obtained from the nurses that they were satisfied with the vision statement, and so consensus was reached. The posters created on the vision statements are set out in Photographs 5.2 to 5.4:



Photograph 5.2: Vision statement of Emergency Department A, created on 18 August 2014



Photograph 5.3: Vision statement of Emergency Department B, created on 19 August 2014

- As a level 1 hospital, we believe that adequate forensic, education, knowledge, skills will facilitate forensic care by all stakeholders. Also involving family and friends for correct information, preserving evidence to ensure justice is ensured.

Photograph 5.4: Vision statement of Emergency Department C, created on 22 June 2014

Any differences between the expressed values and actual values can cause conflict amongst participants. This can be constructive in that it forces them to reflect critically on their vision statement and revisit their expressed values. It is thus possible to re-clarify values and revisit the vision in such cases in an attempt to explain reactions to change and the conflict experienced (McCormack et al. 2004). However, in this study, there was no need to revisit any of the values that initiated the vision statements.

5.7 Summary

In this chapter the population and sample were discussed, as well as how access was negotiated. After access was gained, a stakeholder analysis was done in order to identify the role players in forensic care. I also described my positionality and that of the practice development facilitators, the fundamental participants and the boundary partners in order to explain the relationships that were established during the study. Furthermore, the first circle on the conceptual framework, which contains shared values and vision, was addressed. Access to the emergency departments and the healthcare providers paved the way for the third cycle in the study and the first cycle of collaboration, inclusion and participation.

CHAPTER 6: FIRST GLANCE

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6.1 Introduction

In Chapter 5, the participants and their positionality were discussed. In Chapter 6, the first cycle of looking at practice was undertaken as the first step of Part II, Cycle 3, and Sub-cycle 1.

For the purposes of the first *looking* cycle to explore, describe and explain the forensic care that exists in emergency departments, the practice development facilitators and I reached consensus that we would use a data generation method with minimal impact on the care provided. The *look* phase was followed by *thinking*. That included the data generation, as participants had to think about the forensic care they were already providing. The thinking phase was then extended when the practice development facilitators and some fundamental participants assisted me with the data analysis. I engaged in my own thinking phase to ponder the data generation method and the findings. Finally, the *act* phase followed, where we identified additional information that we still needed in order to create a complete picture of the existing practice.

6.2 Looking

A first glance into the existing practices was done with the healthcare providers working in the various emergency departments for the data generation period starting on 25 February and ending on 2 April 2014. One challenge I encountered was that the size and exact composition of the sample for this cycle was unknown, as the data were generated simultaneously in all three emergency departments over a period of nine days. During this time, I facilitated three sessions for each of the emergency departments, as illustrated in Figure 6.1, and participants could contribute to the data generation at any time during the data collection period. The size of the sample, based on the different handwritings that appeared on the flipchart sheets, was approximately ten participants from Emergency Department A, seven participants from Emergency Department B and seven from Emergency Department C, an estimated total of 24 participants for Objective 1. Some practice development facilitators documented answers on behalf of participants (see Section 6.3 for a discussion of this).

6.3 Data generation

Gillberg (2014), and Bergold and Thomas (2012) urge action researchers to adapt and/or develop new data generation strategies in order to make connections between the researcher and participants possible (Gillberg 2014; Bergold & Thomas 2012). In order to actively engage the practice development facilitators, the fundamental participants and the boundary partners, a participatory approach to data

generation was necessary, as recommended by Patton (2012) and Bergold and Thomas (2012). A participatory approach to data generation assists participants to become co-researchers who have specific knowledge of the context, as well as of what events and how events transpire in their context (Flicker 2014b; Bergold & Thomas 2012). To address the first objective, the goal of the data generation in this study was to raise awareness and unlock thinking about forensic care in emergency departments, as suggested by Dlamini (2014). Thus, I selected the “talking wall” as a data generation strategy. This approach allowed the practice development facilitators to start engaging participants in an easy, non-intimidating manner.

6.3.1 The talking wall

The talking wall is a technique that is used mainly in the business environment to initiate discussion, explore issues, analyse problems and develop action plans (Fruchter & Bosch-Sijtsema 2011; Parsell, Gibbs & Bligh 1998). The process of using a talking wall, as described by Kinnison et al. (2011), entails writing a question on a sheet of flipchart paper and attaching it to a wall, and then giving participants an opportunity to provide answers by writing on the same sheet of flipchart paper. To enhance inter-professional learning, small groups made up of members of different discipline groups may discuss the answers that have been written down, and can clarify and comment on the answers while they identify the issues that emerge. The issues that are identified are then taken back to the larger group for discussion. The larger group collates the issues and discusses and explores ways to address these problems. The use of talking walls to enhance inter-professional learning amongst multi-disciplinary healthcare teams was introduced by Parsell et al. in 1998. Kinnison et al. (2011) also implemented a talking wall for inter-professional learning in veterinary science, and reported that this technique enhanced the generation of new ideas and social interaction between veterinarians and veterinary nurses.

I chose a talking wall as a data generation method in the hope that it would initiate discussions and exploration around the forensic care already provided in each of the emergency departments, as well as generate base-line data. Very little is said in the literature about the advantages and disadvantages of using a talking wall. Moreover, no evidence on the use of a talking wall for data generation in research could be identified, despite a search of the relevant electronic data bases (CINAHL, Health source: Nursing/Academic Edition, MEDLINE and Scopus). However, I decided to use a talking wall to generate data, even though there is little evidence for the use of the technique to do so, because the literature indicates that the technique is highly effective for initiating awareness and dialogue on many

different issues (Kinnison et al. 2011), and such awareness and dialogue were desirable for the study and possibility of initiating change.

6.3.2 Preparation for data generation with a talking wall

I collaborated with the unit managers and practice development facilitators to identify a space against a wall away from the public eye that could be used as a talking wall. The unit managers and the practice development facilitators suggested the tearooms of the emergency departments, because all nurses on duty reportedly spend some time in the tearoom. After identifying a wall space in the tearoom, I wrote two questions on two separate sheets of flipchart paper and pasted them on the wall. I then invited the participants to write down their perceptions, opinions, etc., on the sheets of paper provided. The two questions that I posed were the following:

- Question 1: What do you think forensic care is?
- Question 2: What forensic care does your department already provide?

At the start of the data generation process, some fundamental participants were hesitant to write on the sheets. However, the practice development facilitators reported that the nurses in the emergency departments began to engage in social conversations about the forensic care questions posted in the tearoom. Thus the intention of using a talking wall to create awareness and social interaction to generate ideas was fulfilled, as predicted by Fruchter and Bosch-Sijtsema (2011), Kinnison et al. (2011) and Parsell et al. (1998).

I realised that the nurses might need some encouragement to write their answers on the flipchart sheets, and I remained aware of the importance of facilitating the process of data generation. I therefore negotiated with the practice development facilitators to assist in the facilitation process, because when fundamental participants are involved in a process of change, it increases their level of ownership in the process and the change. The practice development facilitators told me that they were willing to help, but were not sure whether they possessed the requisite skills. I therefore offered to lead three facilitation sessions for each emergency department, while the practice development facilitators observed. Learning through observation has been found to be an effective learning technique when people need to learn or enhance specific skills (St-Onge et al. 2013; Sandt 2012; Shortland 2010). The duty rosters of the practice development facilitators were checked and data generation sessions were organised to correspond with the rosters. The most convenient times for data generation were identified by the respective practice development facilitators and I joined them accordingly. For Emergency

Departments B and C, the most convenient times for data generation were early in the morning, from 4:00 to 10:00. The early morning time provided opportunities to collect data from nurses working on both the day and the night shifts. For Emergency Department A, the early afternoon, over lunchtime, was the most convenient. Figure 6.1 provides a summary of the data generation sessions in which I was involved.

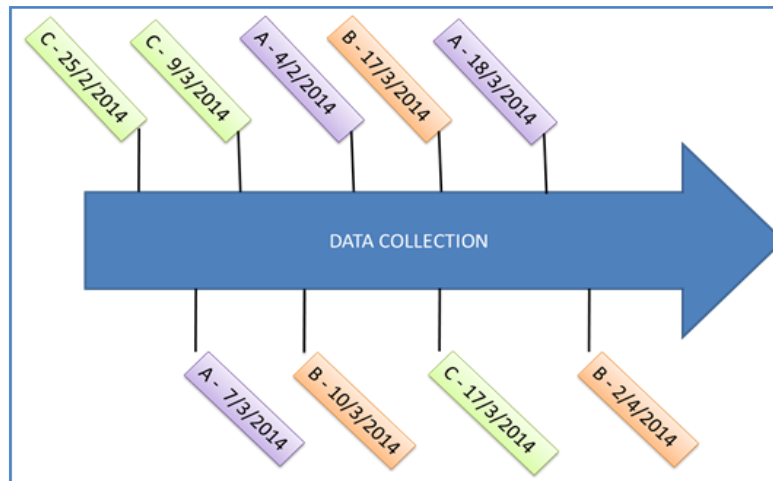


Figure 6.1: Summary of data generation sessions in Emergency Departments A, B and C

Prior to the data generation sessions, I had conversations with the practice development facilitators on research ethics, with a specific focus on autonomy. I also stressed that the working principles of collaboration, inclusion and participation were to be followed at all times to reach as many participants as possible. However, the practice development facilitators were initially not convinced that the principles of collaboration, inclusion and participation would be sufficient to encourage the participants to answer the questions that had been posed.

6.3.3 Generating the data

Data generation by means of the talking wall took place from 25 February to 2 April 2014. In each emergency department, a practice development facilitator and I would seat ourselves in the tearoom opposite the “talking wall”, but facing the nurses as they entered. Social conversation was started with the nurses in the tearoom. Interest in a high-profile case in the South African High Court involving a celebrity implicated in an intimate partner murder had piqued public interest, and conversations soon evolved to include the questions posed on the flipchart sheets on the wall. The nurses, as the fundamental participants, were invited to write their comments to the questions posed on the flipchart sheets, and if they were hesitant to put down anything in their own handwriting, we offered to write their

comments down for them. Some participants agreed that we could write down their answers, while others declined, saying that they would still think about their answers.

Some participants verbalised concern that they did not know what to write, because to their knowledge, no forensic care was provided in the unit and/or they did not know what forensic care entailed. They were assured that there were no wrong or right answers, and that answers such as “I don’t know” or “I don’t understand” were perfectly acceptable. I became aware that some participants were hesitant to respond because they did not think their comments would be worthy of being including in the data set. During and after the data generation using the talking walls at the three emergency departments, I ascribed their hesitance to participate to my being a stranger, and to the fact that the participants were not used to the collaborative, inclusive, participatory nature of action research. However, as the data generation progressed, the flipchart sheets became more densely populated with answers. Possibly writing down answers became easier, as the answers that were already written on the sheet may have assisted participants to generate more answers.

It is suggested that some additional investigation into the use of a talking wall as a method to generate data is needed. My experience of using a talking wall has highlighted some advantages and some challenges in using this data generation method. I discuss the advantages and disadvantages identified from my field notes and experience during and after the use of a talking wall below.

6.3.4 Advantages of a talking wall as a data generation technique

After the introduction of the talking wall in this study, it was evident that there was immediate awareness regarding the commencement of the research, as well as the topic of forensic care. Healthcare providers had access to the area at all times, so using a talking wall decreased the possibility that the research activities would interrupt the services provided in the emergency department and also did not impinge on the nurses’ personal time. Allowing nine days for the data generation ensured that all the nurses working in each emergency department had an opportunity to record their answers to the questions posed on the talking wall. Their written comments appeared to assist other participants to formulate and record their own comments, and therefore contributed to the data.

The use of a talking wall also assisted in preserving resources, especially time and cost. Participants did not receive surveys to complete that could be lost or misplaced, and no transcription of interviews was necessary. In addition, the use of the talking wall allowed me and the practice development facilitators to practise our facilitation skills – at the start of the research, the practice development

facilitators were concerned about how to get the participants to participate. I facilitated initial sessions using the talking walls, and during the follow-up sessions I supported the efforts of the practice development facilitators in building on the relationships that we formed during the research process.

The use of a talking wall is not complicated or technical, and can be used in various situations. For example, the unit manager in Emergency Department B later benefited from the knowledge she gained from using the talking wall. During the research period, she had to embark on a quality improvement programme. She opted to use the talking wall method to involve the personnel to decide on the focus of the quality improvement programme, and to make suggestions on possible steps that could be implemented to address the focus of the programme. She later told me that it was the first time that all the personnel in the unit had participated in the whole process, and that they had become very engaged in the quality improvement programme.

6.3.5 Challenges associated with using a talking wall

The method has some disadvantages for research purposes. For example, the fact that the talking wall was in an area accessed by all the healthcare providers, as well as by administrative and cleaning personnel, made it difficult to pinpoint the exact sample and sample size. This problem was exacerbated by the fact that some responses were recorded by me or the practice development facilitators on behalf of fundamental participants, because some participants were somewhat reserved about writing down their own opinions (they feared that their handwriting might be identified by other members in the emergency department). In the facilitation sessions, I stressed the importance of writing down exactly what a participant said and then confirming what had been written down with the participant to ensure that each idea had been captured accurately.

Even though I am not able to provide the exact sample size or a record of who the participants were, unquestionably awareness was raised about a general sense of what forensic care is, and which forensic services were already provided, and this was a starting point for actions to be taken. I later realised that not all the nurses used the tearoom, as some preferred to take their break outside the emergency department. I asked these participants whether they knew about the talking wall and told them where to find the talking wall in case they wanted to add any information.

One participant in Emergency Department A decided to use the talking wall to voice her frustration about the employer. Some participants apologised for the profanity on the paper, but I felt that other participants were partly in agreement with this expression of frustration. I did not explore the meaning or origin of the frustration, as this was not the focus of the research. Furthermore, because the

participants in the sample could not be identified, items written on the flipchart sheets could not be clarified.

6.4 Thinking about the data

In order to remain true to the collaborative, inclusive and participatory nature of this study, I used collaborative data analysis. Appointments were made with the practice development facilitators for data analysis sessions at each of the emergency departments. The collaborative data analysis was done for Emergency Department A on 3 April 2014 in the unit manager's office, for Emergency Department B on 7 April 2014 in the unit's lecture room, and for Emergency Department C on 4 April 2014 in the unit's tearoom. I facilitated the data analysis process in each of the emergency departments.

Inductive content analysis was used, because this strategy is recommended in studies using purposive sampling of participants and qualitative data (Elo et al. 2014). Furthermore, inductive content analysis allowed for the generation of new insights into the problem at hand as it involved creating codes from the data collected that enabled the creation of general statements, as described by Saldaña (2013), and Elo and Kyngäs (2008). For the purposes of this research, the aim of the content analysis of the data generated by means of the talking wall was to identify what forensic care is, and which forensic care services were already being provided in the emergency departments included in the study.

As a method, inductive content analysis can pose several challenges. One potential challenge is that inductive content analysis is flexible, and that there is no standardised manner to analyse the data. I could use this flexibility to my advantage by involving the practice development facilitators in the data analysis, to strengthen the trustworthiness of the data analysis, as recommended by Elo et al. (2014), Elo and Kyngäs (2008) and Julien (2008:121). Another potential challenge in inductive content analysis is that the starting point of the categorising and coding can seem chaotic. In an attempt to overcome this potential problem, I facilitated the activities and acted as a scribe during the data analysis process. To provide some order, I used the steps stipulated by Stringer (2014) as discussed in Section 6.4. An additional disadvantage of content analysis is that excessive interpretation of the data can pose a threat to the completion of the data analysis (Elo & Kyngäs 2008), as this part of the research process is potentially time-consuming. To counter this risk, analysis of the data collected through the talking wall entailed only one step: establishing baseline data from the data on the flipchart sheets. The steps in the data analysis are set out below.

6.4.1 Reviewing the data

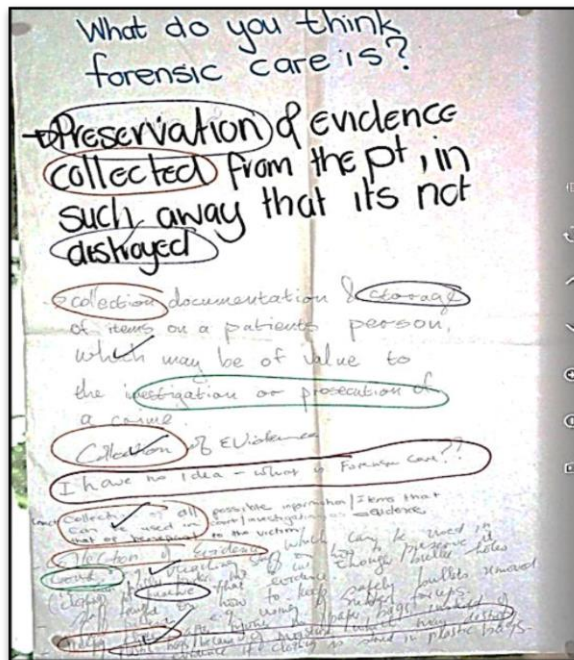
Both Stringer (2014) and Rowley (2014) recommend commencing the data review by familiarising oneself with the questions posed at the start of the data generation phase. The data available is then reviewed and read until the readers are familiar with the content of a specific data set. The questions posed during data generation by means of the talking wall were written on separate sheets of paper, ensuring that they were clearly visible to all the practice development facilitators present. The answers for each of the questions were read out loud separately, and re-read, by one of the facilitators from the flipchart sheets. The reading and re-reading of the data ensured that both the practice development facilitators and I became familiar with the content, and got a feel for the views and ideas voiced by the participants, as recommended by Maltby et al. (2010) and O'Leary (2010), as a first step of the analysis process.

6.4.2 Unitising the data

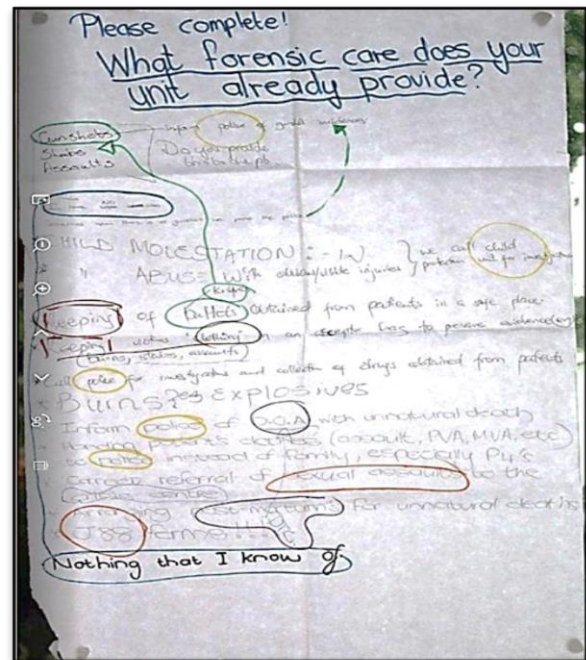
Stringer (2014) and Rowley (2014) recommend that units of meaning be identified as the next step of content analysis, by highlighting or circling meaningful words, phrases or sentences. In this study, after the practice development facilitators had familiarised themselves with the content, I asked them to circle words or phrases that stood out for them, in order to form units of meaning that could increase understanding of the existing practice.

6.4.3 Categorising, coding and identifying themes

The final step suggested by Stringer (2014) and Rowley (2014) is categorising, coding and identifying themes into units of meaning and related categories. Later, themes are recognised by identifying commonalities among the categories. Descriptive coding was used, as described by Saldaña (2013). For the first question (What do you think forensic care is?), the practice development facilitators were requested to formulate a sentence describing what forensic care is. For the second question (What forensic care does your department already provide?), I asked the practice development facilitators to check if any of the words that were circled could perhaps be grouped. I acted as scribe and wrote the findings on new sheets of paper. Photographs 6.1 and 6.2 (overleaf) demonstrate how this data analysis was conducted.



Photograph 6.1: Data analysis
(Emergency Department B)



Photograph 6.2: Data analysis
(Emergency Department C)

6.5 Thinking about the findings

After the data analysis, the practice development facilitators and I reached consensus that the findings were representative of the data collected and analysed from the talking wall. The findings of each emergency department were then put together, as similar themes were identified in all three emergency departments. The themes identified for the first question (What do you think forensic care is?) were evidence management, and working with the criminal justice system. The forensic care already provided (Question 2) was divided into forensic care provided to deceased victims of violence and crime, and forensic care given to living victims of violence and crime. Sub-themes for forensic care given to living victims of violence and crime included the collection of evidence, documentation and referral. The findings on what forensic care involves as well as the forensic care already provided in the participating emergency departments are summarised in Figure 6.2 (overleaf).

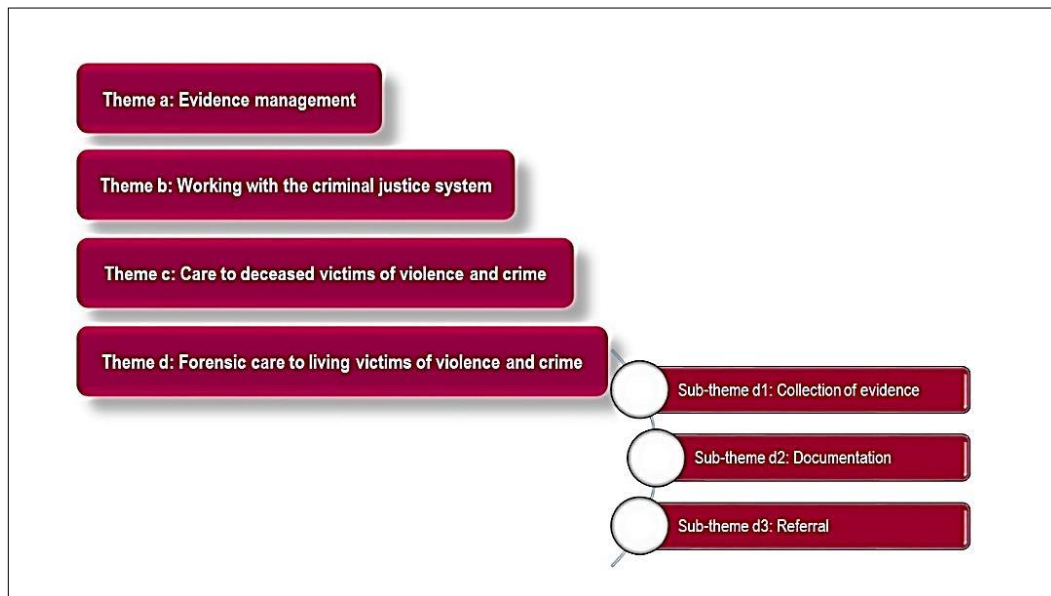


Figure 6.2: Summary of findings for the first looking cycle

6.5.1 Forensic care

Two themes were identified in the data analysis concerning the first question posed on the talking wall (What do you think forensic care is?). The first theme identified was evidence management; the second theme that emerged was working with the criminal justice system. The themes that emerged in the data generation stages of the study are designated with lower case letters, to distinguish them from the overall themes in the combined framework based on the research, which are designated with numbers (see Section 8.5).

6.5.1.1 Theme a: Evidence management

Evidence management relates to the identification, collection, preservation, documentation and storage of evidence. The theme was evident in contributions such as the following:¹

"Forensic care consists of collecting evidence or preserving it for processing." (Emergency Department A)

"Preservation of evidence collected from the patients, in such a way that it is not destroyed." (Emergency Department B)

"Collection, documentation and storage of items on a patient's person, which may be of value." (Emergency Department B)

¹ The participants' comments are printed in italics to highlight their voices and to distinguish their input from quotes from the literature. Their input is quoted verbatim, and minor grammatical changes and insertions are marked by square brackets.

“Keeping clothes after injuries in paper bags instead of plastic bags, because of moisture which may destroy evidence if clothing is sorted in plastic bags.” (Emergency Department B)

“Taking evidence of any suspicious incident[s].” (Emergency Department C)

The identification, collection and preservation of evidence, combined with detailed documentation and maintaining the chain of evidence, are essential in the actualisation of forensic care (Cabelus & Spangler 2013; Darnell 2011; Dougherty 2011; Joyner & Duma 2010). “Collection of evidence” was the phrase used most often in the data generated, and one participant mentioned identification of evidence, and documentation. One participant admitted that she had no idea. The findings suggested that most of the participants who wrote their responses on the talking wall were aware that evidence should be collected, but during observational visits to the emergency departments at the start of study, I did not observe the collection of evidence for any patients other than the sexual assault victims in the private sector emergency departments.

6.5.1.2 Theme b: Working with the criminal justice system

The criminal justice system’s multiple role players include the SAPS, the judiciary, court support services, prosecution services, legal representatives and the departments of health (Pagliaro & Bently Cewe 2013; Department of Justice and Constitutional Development 2010). The participants identified the following role players (highlighted in bold print):

*“Working together with the **police and justice system**.”* (Emergency Department A)

*“Evidence can be used in **court**.”* (Emergency Department B)

*“Evidence may be of value to the **investigation or prosecution of a crime**.”* (Emergency Department B)

Even though it was not recorded on the talking wall, the link between the healthcare and the criminal justice systems was mentioned in conversations with the participants. The participants realised that trauma patients in their care who have been exposed to violence and crime are forensic patients, who may later seek their human right to justice, and that therefore interaction with the criminal justice system is often inevitable.

6.5.2 Forensic care already provided

In response to the second question (What forensic care is already provided in the emergency department?), six participants reported that they had no knowledge of any forensic care provided in their respective emergency departments. Two main themes were identified during the data analysis of the responses to this question, namely forensic care to deceased victims of violence and crime, and

forensic care to living victims of violence and crime, where the SAPS was named as a major role player. The sub-themes identified under forensic care to living victims of violence and crime were collection of evidence, documentation and referral, as discussed below.

6.5.2.1 Theme c: Care to deceased victims of violence and crime

Victims of violence and crime often enter the emergency departments already deceased (dead on arrival), or they die within minutes of entering the emergency department. In such cases, the nurses in the emergency department contact the SAPS to report a case and the victim's body is then removed and transported to a government mortuary, where a forensic death investigation takes place. The role played by the nurses in the emergency department is captured in the following statements:

"Inform the police of a death on arrival with unnatural deaths." (Emergency Department B)

"Arranging post-mortems for unnatural deaths that occur in the ED with the police." (Emergency Department B)

"Handing patients' clothes (assault, pedestrian vehicle accidents, motor vehicle accident, etc.) to police instead of family, especially the patients that die in the ED." (Emergency Department B)

Healthcare providers are obliged to report cases of unnatural death, or death where violence and crime is suspected, to the SAPS (Department of Justice and Constitutional Development 2004; South Africa 2003).

6.5.2.2 Theme d: Forensic care to living victims of violence and crime

The specific living victims of violence and crime that were identified by the healthcare providers included victims of sexual assault, assault, gunshots and stab wounds, and children. The victims of violence and crime identified by the participants were compared to the 27 categories of forensic patients identified by Pasqualone and Michel (2015), and it was found that the participants perceived only four of the 27 categories as being in need of forensic care. The sub-themes identified under the forensic care of victims of violence and crime were the types of services provided, such as the collection of evidence, documentation and referral.

6.5.2.2.1 Sub-theme d1: The collection of evidence

The participants identified the collection of evidence as important, as can be seen from the following responses:

"Collecting bullets for police collection." (Emergency Department A)

"Keeping of bullets obtained from patients in a safe space." (Emergency Department B)

“Collecting evidence, keeping victims’ clothing in a paper bag to preserve evidence.” (Emergency Department B)

“Collecting evidence in sexual assault patients.” (Emergency Department C)

The collection of evidence is indeed an essential part of forensic care, as already indicated in Section 2.2.3.2; this is emphasised by Starr (2013), Henderson et al. (2012), Kodikara (2012), and DeVore and Sachs (2011). Collecting evidence is not a complicated task, but training on the proper procedure in evidence collection is essential to ensure that any evidence that is collected can be used in the criminal justice system (Sekula 2016). In the action phase of this study, the participants received some guidelines on evidence collection during the DNA project training (see Annexure M).

6.5.2.2.2 Sub-theme d2: Documentation

The participants recognised that it is important to document a patient's history, injuries, and the evidence collected, as is evident from the following comments:

“Documents can be used in investigations or court.” (Emergency Department A)

“Document clothing and items on a patient's person.” (Emergency Department A)

“Document any collection and storage of items.” (Emergency Department A)

Documentation is of great significance in forensic cases, as it may provide links between the crime scene, the perpetrator and the victim (Cabelus & Spangler 2013). Furthermore, accurate documentation of the victim's history of the incident, physical signs and symptoms, as well as the evidence collected, can assist with the positive outcomes of legal proceedings for victims of violence and crime (Sekula 2016; Dougherty 2011).

6.5.2.2.3 Sub-theme d3: Referral

The services and places for referral recorded on the talking wall were mentioned in the following responses:

“Child molestation or abuse with obvious/visible injuries – we call [the] child protection unit for investigation.” (Emergency Department B)

“Call police for investigations and collection of drugs obtained from patients.” (Emergency Department B)

“Contact with the FCS [Family violence, Child protection and Sexual offences Unit] within the police service.” (Emergency Department C)

The emergency departments refer cases to the SAPS, but there was no evidence of existing relationships or a specific SAPS contact person at this stage of the study. Furthermore, the public

hospital does not provide forensic services to sexual assault victims, as they are managed at the medico-legal crisis centre, as is evident from a comment about the “*correct referral*” made by a participant from Emergency Department A in the phrase below:

“...correct referral of sexual assaults to the crisis centre...” (Emergency Department A)

According to the practice development facilitators, the management of sexual assault victims in the medico-legal crisis centre is hospital policy, but the policy could not be traced. The referral only pertained to the police and another service providers. No mention was made of other services that victims of violence and crime might need, such as social services or victim empowerment organisations that form a part of the management of such victims, according to Campbell et al. (2011).

6.6 Reflections on using the talking wall

The use of the talking wall allowed data to be generated in the context of the emergency department without violating the rights of any forensic patients. I believe that the talking wall also contributed to initiating awareness regarding forensic care already provided in the emergency departments. The fact that the talking wall was open to all healthcare providers who had access to the tearoom meant that everybody working in the emergency department had an opportunity to give input. Overall, I felt that the benefits of this inclusiveness outweighed the acknowledged limitation of being unable to pinpoint the exact sample included by the talking wall (see Section 6.3.5). The eclectic nature of the study's paradigm and the core principle of inclusion were expressed, addressing Objective 1. Furthermore, the detailed discussion of how the talking wall worked, and how well it worked, may inform readers on how the process of triggering awareness was set in motion.

6.7 Trustworthiness

The trustworthiness of the data set generated and analysed using the talking wall was considered in terms of the quality criteria for qualitative data developed by Lincoln and Guba (1985:289-331) (see Section 2.6). The criteria used for Cycle 3 were credibility, transferability and dependability:

- **Credibility:**

For the purposes of the data set collected via the talking wall, credibility was ensured through member checking, because the raw data were on the wall during the data collection phase from 25 February to 2 April 2014, and the data from the analysis were displayed on the talking wall for further comments and input from 8 April to 31 December 2014. No additions were made during this

period. Furthermore, peer debriefing was done between me and the practice development facilitators to guide them through the research process, while considering the ethical considerations.

- **Transferability:**

The transferability in this study depends largely on the readers of the research, but the data generation method – the talking wall – was used to assist in creating awareness and discussions around quality improvement programmes.

- **Dependability:**

Dependability of the data was ensured by photographing all the data and keeping the original sets of data generated in a secure location so that an audit can be performed on the data. The generation and analysis of the data are discussed in the thesis to assist with the justification of the methods used.

6.8 Embracing responsibility towards forensic patients

During the study, I realised that the findings might be more theoretical than practical, as emergency practice was not systematically observed. However, the fundamental aspects of forensic care, namely evidence management and collaborating with the criminal justice system, were identified. The management of evidence was a core theme, because participants addressed this issue in the answers they provided to both the questions posed. This showed that even though the participants had limited knowledge regarding forensic care, they were already aware of the importance of the correct management of evidence. I believe that healthcare providers working in emergency departments should embrace their responsibility to care for forensic patients, just as they care for people with life-threatening conditions. However, in this context, the following question arose: What forensic roles and responsibilities did the healthcare providers in the participating emergency departments perceive themselves to have?

The literature reviewed in Chapter 2 revealed that limited time is spent on forensic aspects and that a limited scope is covered in the undergraduate curricula of both doctors and nurses. It was thus not surprising that the healthcare providers who participated in this study were unsure of what is expected of them. In order for practice to develop to provide better services to forensic patients, clarification of healthcare providers' roles and responsibilities is an obvious step. Their forensic roles and responsibilities were therefore explored in the hope of increasing awareness amongst healthcare providers and inspiring them to actively fulfil their duties regarding their forensic patients. The *act* phase

of the first cycle of looking at their practice thus provided input into the second cycle of *looking* at their practice (see Chapter 7).

6.9 Summary

In Chapter 6, the existing forensic care provided in the participating emergency departments was explored. The findings indicated that forensic care was already being provided in the participating emergency departments to some extent to deceased and living victims of violence and crime. However, the participants' uncertainty surrounding forensic care made it clear that more work needs to be done to improve the services provided. In an attempt to create a better understanding of how to improve the services provided, the healthcare providers' actual and expected forensic roles and responsibilities were determined, as discussed in the Chapters 7 and 8.

CHAPTER 7: THROUGH THE LOOKING GLASS

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7.1 Introduction

In Chapter 6, I discussed how the meaning of forensic care, as well as the forensic care provided in the participating emergency departments, was explored. The literature reviewed in Chapter 3 showed that the undergraduate curricula of doctors and nurses, especially in South Africa, devote relatively little time to forensic aspects, and that the scope of the material covered in this regard was limited. This was confirmed by the findings reported in Chapter 6 that the participating healthcare providers lacked clarity on what is expected from them. Hence, in order to gain a deeper understanding of the participants' perceptions of their actual forensic roles and responsibilities, a second cycle of looking at forensic care practice was deployed.

As discussed in this chapter, the forensic roles and responsibilities of healthcare providers were explored in this study, in the hope of increasing awareness amongst healthcare providers and inspiring them to take an active role in fulfilling their duties regarding forensic patients. The cycle started with a consideration of the participants (*looking at the participants*) and choosing a suitable data generation technique to enable the participating healthcare providers to think about their actual forensic roles and responsibilities. The nominal group technique was chosen. My intention in this consideration was twofold: finding and applying an appropriate data generation technique for this context, as well as gaining a better understanding of the actual forensic roles and responsibilities, as perceived by these participants. At the conclusion of the *act* part of this cycle, I provided an inventory of the findings of the findings in this stage to the participants, which contributed to the action of exploring the healthcare providers' expected forensic roles and responsibilities with them.

7.2 Considering the scene

This action research cycle started with my consideration of which healthcare providers could best inform me about the actual forensic roles and responsibilities of South African healthcare providers. As in the rest of this study, the targeted population was healthcare providers working in the three participating emergency departments. My specific intention was to engage doctors, using a modified nominal group technique. The selection process was dynamic and was adapted for each of the data generation sessions.

For Emergency Department A, purposive selection was used as planned (see Section 5.3), and the data generation session was organised by the practice development facilitators to coincide with the doctors' monthly meeting.

In the case of Emergency Department B, an invitation was sent to the doctors who worked in the emergency department (purposive sample), but none of the doctors confirmed their attendance, and on the day of the data generation session, none of the doctors attended. The practice development facilitators seemed anxious about this and attempted to recruit other doctors, but to no avail. A collaborative decision was made, based on the emerging design, to adapt the sampling procedure to purposive convenience sampling in order to make it possible still to generate data. We decided to purposively invite healthcare providers who were conveniently available. Nine participants were recruited, most of whom were training to specialise in emergency medicine. Of these, three were paramedic students and four were registered nurses in the process of completing their post-basic qualifications in emergency nursing. The practice development facilitators acted as the two remaining participants.

Data generation at Emergency Department C was more problematic, as none of the doctors who were invited came to the session, and no other healthcare providers were available at the time. Thirty minutes after the scheduled time, one doctor and an emergency nurse arrived for the group session. The data generation session then commenced. The doctor commented at the end: *“We forget how many forensic patients we actually see on a daily basis.”*

The demographic profiles of the sample who participated in the nominal group technique are presented in Table 7.1.

Table 7.1: Summary of the nominal group participants’ demographic information

Demographic information	
Age	
20-29 years	4
30-35 years	11
36-40 years	6
41-45 years	3
46-50 years	2
Older than 50 years	1
Sex	
Male	10
Female	17
Qualification	
Doctor	15
Registered nurse	9
Other – Paramedics	3

A total of 27 healthcare providers participated in the data generation for Objectives 2 and 3 – there were 15 medical doctors, nine registered nurses and three paramedics. The participants included ten men and 17 women, and most of the participants fell in the age category between 30 and 35 years. The findings from all three participating emergency departments have been combined for the sake of brevity.

Five of the participants were of the opinion that they had the necessary knowledge and skills to care for patients with forensic needs, while 11 were of the opinion that they did not, and ten of the participants were unsure about their knowledge and skills. Of the 27 participants, 13 reported that they had received some form of forensic training, but 14 participants had not received any training. The 13 participants who had received forensic training included ten doctors, two nurses and one paramedic.

The training received by the doctors included limited undergraduate training in medical school, as reported by 11 participants. Two had had days of forensic training, and one participant specified that it was part of that person's Master's degree. One participant indicated completing a course of 14 months on this topic, but provided no details of what the course entailed. The key information that was reportedly covered in the courses attended by those who had received some training was how to describe wounds and injuries, completing legal documentation such as the J88 form and death certificates, and some main pertinent Acts. One participant wrote that *"the use of a rape kit was demonstrated once"*. The training received by the two nurses was limited to a few days, and the key information provided was how to handle a forensic patient's clothing, any bullets retrieved and documentation. The paramedic who had received forensic training indicated that the training had lasted only one day, but gave no details on the key information provided in the training.

7.3 A modified nominal group technique as a data generation strategy

The data in this cycle were generated by using a modified nominal group technique, which is a technique generally used to explore issues and find possible solutions to complex problems (Owen et al. 2015; Bromley 2014). The nominal group technique is recognised as a data generation method that can enhance collaboration and participation by participants in a research process (Fawkes et al. 2014; McMillan et al. 2014; Harvey & Holmes 2012), which is in line with the working principles of action research and emancipatory practice development applied in this study. The original steps for conducting a nominal group were described by Van de Ven and Delbecq (1972). In this study, I used a combination of the steps adapted from Van de Ven and Delbecq (1972) by Harvey and Holmes (2012) and Roeden, Maaskant and Curfs (2012). These steps were the following:

- *Generating ideas:*
To start with generation of ideas, a question is provided in writing to the participants, and it is read out by a facilitator. Participants are then requested to write down their ideas in silence in the form of statements.
- *Recording ideas:*
The facilitator records the ideas that are generated. Ideas are recorded on a flipchart sheet visible to all participants, using a round-robin feedback session to make sure that each member responds with one idea at a time, until all the ideas of all the participants have been recorded.
- *Discussing ideas:*
Each idea that is recorded is discussed to resolve issues of clarity and importance. This step provides participants with an opportunity to express their understanding of the ideas represented on the flipchart sheet.
- *Voting on ideas:*
In order to prioritise the ideas, participants vote for at least five ideas that they regard as the most important and rank these by ascribing a number to each idea. The votes are counted and summarised by the facilitator. It is assumed that the ideas that are ranked the highest are the most important. However, it is imperative to note that consensus does not imply that everybody is in agreement – it merely indicates that all the participants present at the nominal group are willing to live with the decisions made (Wilkinson 2012).

7.3.1 Preparation for the nominal group

The date and venue for each nominal group session were organised in advance and the invitations for the nominal group technique were forwarded to the doctors in the form of an agenda. This agenda was a product of a collaborative initiative between the practice development facilitators and me (see Annexure H1). The agenda included a discussion on the purpose of the meeting, the date, venue, and approximate duration of the meeting. The agenda points were an introduction to the research, the completion of the consent form and demographic data, as well as questions that needed to be addressed in the nominal group technique session. The last part of the agenda informed the participants about the contact person, and gave details on confirmation of attendance. The dates on which these data were generated are set out in Figure 7.1.

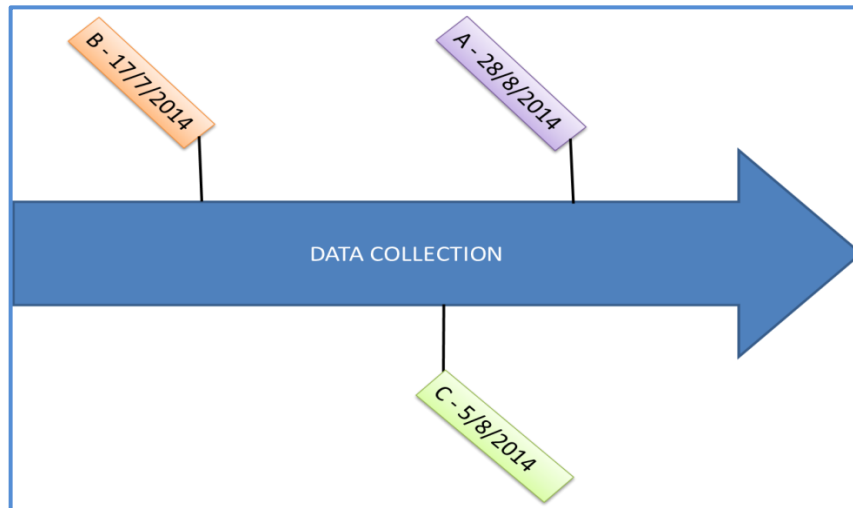


Figure 7.1: Dates of the nominal group sessions

7.3.2 Generating the data

Data were generated by employing a modified form of the nominal group technique, as follows:

- Rules of engagement were established to ensure order during the group activity. Wilkinson (2012) recommends establishing rules of engagement, because it sets the stage for the participants' behaviour and interaction during the session. The rules of engagement assisted me to facilitate the nominal group better.
- Two questions were asked in each nominal group session. These questions were related – the purpose of the first question was to elicit the forensic roles and responsibilities as voiced by the healthcare providers, because they are considered important role players in the investigation of crime by Müller and Saayman (2003). The second question was aimed at actions proposed to enhance the services provided to the victims of violence and crime, as suggested by Harvey and Holmes (2012) – see Section 9.2 for the findings.
- No ranking or voting was applied, as only general consensus was requested from the participants. The responses provided could not be prioritised, because arguably ordering the roles and responsibilities relating to victims of violence and crime could be read as implying that it is acceptable to prioritise some roles or responsibilities and neglect others. The answers assisted in clarifying learning needs. This finding supports Colón-Emeric, Bowlby and Svetkey's (2012) study, which reported that the nominal group technique is an effective method to identify learning needs.

I facilitated the nominal groups, supported by the practice development facilitators of each emergency department. Each nominal group session started by welcoming the participants, and each participant received an information leaflet and informed consent form (see Annexure H2) and a demographic information form (see Annexure H3). Participants were then given a chance to read and complete the consent form and the demographic information form. After the documents had been completed, rules of engagement were established for each group. I then asked the participants to read the questions on the information leaflet and to write down their responses on the paper provided. In addition, the questions were displayed against the wall on separate flipchart sheets:

- Question 1: What are the forensic roles and responsibilities of healthcare providers in emergency departments?
- Question 2: What are the actions that can be taken to transform forensic care in emergency departments?

The participants were given a few minutes to generate their ideas. These ideas were then recorded on the flipchart sheets in a round-robin fashion to ensure that all participants had an opportunity to voice their ideas.

7.3.3 Advantages of using the nominal group technique

The advantage of using the nominal group technique is that each participant receives an equal opportunity to voice ideas on the topic at hand, while no single member dominates the discussion (Varga-Atkins et al. 2011). The nominal group technique is time- and cost-effective as a method of data generation and analysis, and consensus is reached by the end of the group session, which implies that no transcription and further interpretation are necessary (Owen et al. 2015; Harvey & Holmes 2012; Varga-Atkins et al. 2011). Because little preparation is required for the participants (Harvey & Holmes 2012), using the nominal group technique allowed me to adapt my intended sampling method at short notice, without compromising the quality of the data.

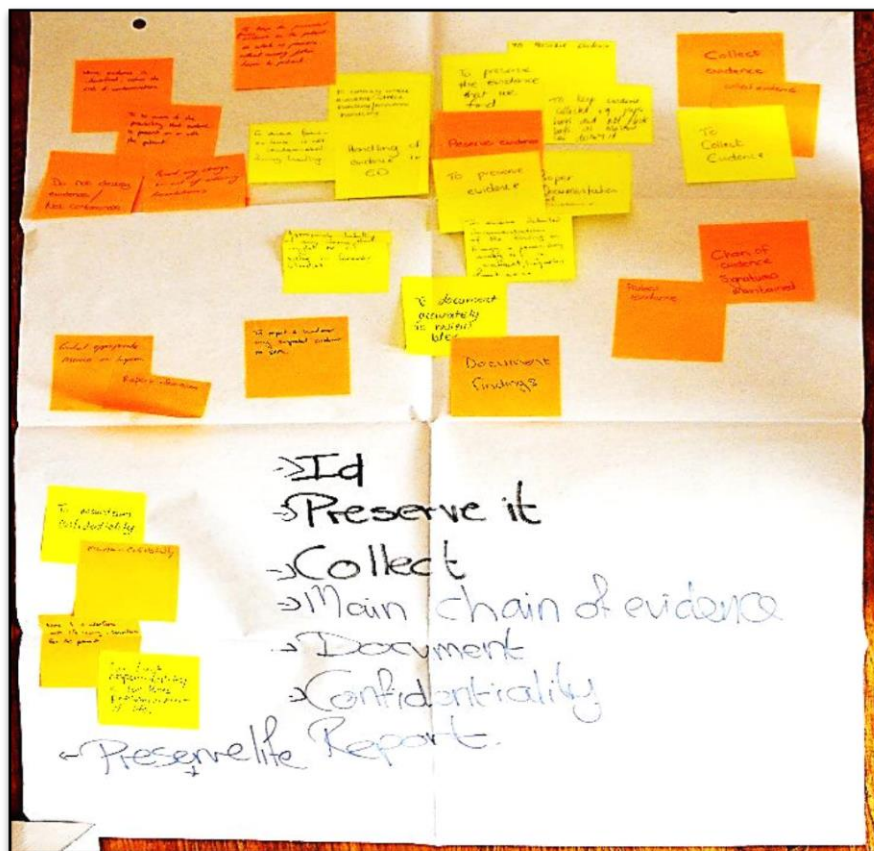
7.3.4 Challenges in using the nominal group technique

Challenges associated with using the nominal group technique include small sample sizes (Owen et al. 2015; Harvey & Holmes 2012), undesirable venue layout (Harvey & Holmes 2012), and the time and effort required to recruit participants (Fawkes et al. 2014), because the participants need to be physically present during data generation (Landeta, Barrutia & Lertxundi 2011). The challenges that I experienced were that the invited participants did not confirm attendance at the nominal group

technique session. Most did not come to the session, particularly in Emergency Departments B and C. Some practice development facilitators were able to recruit other participants, and in the case of Emergency Department B they found additional participants. One of the practice development facilitators volunteered to approach doctors working in Emergency Department C to respond to the questions posed during the nominal group technique session. I agreed, because Stewart, Shandasani and Rook (2007) affirm that the nominal group technique could be compared with doing an individual interview in a group setting. The written responses of four doctors could subsequently be included for data analysis.

7.4 Thinking about actual forensic roles and responsibilities

The data analysis for the data generated using the nominal group technique involved an interactive process that formed part of the sessions that I facilitated to elicit thinking regarding the actual forensic roles and responsibilities of healthcare providers in the participating emergency departments. Data on the flipchart paper sheets were first checked for any duplication by identifying ideas that had a similar meaning. Photograph 7.1 is an example of the raw data generated during the sessions.



Photograph 7.1: Raw data generated during the nominal group technique session

The items were then discussed to clarify the ideas and increase the understanding of the forensic roles and responsibilities of healthcare providers. The participants present at the nominal group sessions agreed that all the identified roles and responsibilities were important for healthcare providers working in emergency departments. In order to simplify the reporting of the findings of the nominal groups, the written responses were compiled and themed to identify the actual forensic roles and responsibilities as perceived by the participating healthcare providers. The data from the nominal groups revealed three main themes, namely the responsibility towards the patient, the management of evidence and reporting to authorities. Figure 7.2 provides a summary of the themes.



Figure 7.2: Summary of the findings of the second looking at practice cycle

7.4.1 Theme e: Responsibility towards patients

According to the participants, the responsibility towards a patient involves identifying a forensic patient, getting consent from the patient to collect evidence, and ensuring that confidentiality and privacy are maintained. The participants also stressed that preserving life should take precedence over collecting evidence. Furthermore, participants mentioned involving the patient's family. Items recorded included the following:

- "Identify injuries on the patient."* (Emergency Department B)
- "Identify the kind of patient that fall[s] under the forensic category."* (Emergency Department C)
- "Take adequate history."* (Emergency Department A)
- "Get consent to collect evidence."* (Emergency Department A)
- "Ensure privacy and confidentiality."* (Emergency Department C)
- "Communicate with the family."* (Emergency Department A)
- "None if it interferes with lifesaving interventions for the patient."* (Emergency Department A)
- "Our first responsibility is for the preservation of life."* (Emergency Department A)

It was evident that healthcare providers were aware of their responsibility to provide healthcare that includes forensic care to patients whom they suspect to be victims of violence and crime. Furthermore, they indicated that these patients should be cared for in the same manner as any other patient in the emergency department in terms of the necessity to preserve life. It was in line with the training and values of healthcare providers working in emergency departments that the participants strongly emphasised the need to preserve life first.

7.4.2 Theme f: Responsibility to manage the evidence

The participating healthcare providers acknowledged their responsibility to manage evidence collected from a forensic patient. The management of evidence includes aspects of collection, protecting, preserving and documenting evidence, as well as maintaining the chain of evidence, as is evident from the following comments:

“Collect, preserve and protect evidence.” (Emergency Department A)

“To keep evidence collected e.g. Paper bags not plastic bags as moisture destroys evidence.” (Emergency Department A)

“Collection method – evidence avoid contamination.” (Emergency Department A)

“Where evidence is identified, reduce risk of contamination.” (Emergency Department B)

“Correctly collect evidence: correct handling – minimal handling.” (Emergency Department C)

“Take good descriptive notes.” (Emergency Department A)

“Be artistic.” (Emergency Department A)

“Complete J88 correctly.” (Emergency Department B)

“Proper documentation of evidence.” (Emergency Department C)

“Ensure detailed documentation of the findings on primary and secondary survey of a patient’s injuries found.” (Emergency Department C)

“Chain of evidence signature maintained.” (Emergency Department C)

The responses from the participants indicated that they have some knowledge of how to handle potential evidence. For example, they know that evidence such as clothing should be stored in paper bags and that the contamination of evidence should be limited as far as possible. The importance of keeping detailed notes was acknowledged, and participants mentioned the importance of ensuring that the chain of evidence is maintained.

7.4.3 Theme g: Reporting to authorities

The participants understood that they are not alone in the management of forensic patients and that members of the criminal justice system also have an important role to play, such as the police and the courts. Under reporting to authorities, the following items were recorded:

“Contact appropriate resources on suspicion.” (Emergency Department A)

“Dispatch – where to send the evidence.” (Emergency Department A)

“Report and hand over any evidence to the SAPS.” (Emergency Department A)

“Attend court when subpoenaed.” (Emergency Department A)

The authorities included some of the stakeholders identified in Section 5.3.3. However, the participants admitted that they did not know exactly whom to contact, or how to make contact with the authorities.

7.5 Reflections on using the nominal group technique

The use of the nominal group technique to generate data from a wide variety of healthcare providers, including doctors, nurses and paramedics, assisted the participants and me to understand perceptions of the actual forensic roles and responsibilities of healthcare providers in South African emergency departments. Using the technique posed some challenges and tested my and the practice development facilitators’ flexibility, because in Emergency Departments B and C, healthcare providers who were invited to participate did not attend the nominal group technique sessions as planned, and alternative plans had to be made (see Section 7.3.4). The findings suggested that the participants were somewhat uncertain of their exact roles and responsibilities. However, the participants were certain that they are responsible for each patient, first for preserving life and then for collecting evidence and documenting the evidence and the process thoroughly. I therefore have hope that forensic care may become a natural extension of the daily practice in emergency departments that could lead to better outcomes for forensic patients.

7.6 Rigour in using the nominal group technique

Rigour in using the nominal group technique was established by applying the qualitative criterion of trustworthiness. Rigour as described in Section 2.6 applies for this section.

Credibility was ensured by providing a detailed description of the data generation and analysis used for the data by means of the nominal group technique. Ground rules were established at the start of each session, creating an atmosphere of honesty amongst the participants, as suggested by Shenton

(2004:67). Furthermore, credibility was enhanced by the fact that the participants were provided with opportunities to discuss the items identified and reach consensus. The demographic information on the participants also provided evidence that all the participants were indeed working in the emergency environment. Therefore their participation assisted in creating a “picture” of the actual forensic practices. Triangulation occurred, as the data generated from the three different sites and by the three different sets of participants were similar, providing a reflection of the practice.

7.7 Arranging action

In order to arrange actions that could follow, I compiled an inventory of the findings made in the study up to this point in the process. These findings represented the perceptions of the participants regarding forensic care, forensic care already provided and forensic roles and responsibilities. However, I remained uneasy, because the participants’ obvious uncertainty constantly reminded me of Aschman et al.’s (2012) claim that in South Africa, healthcare providers’ forensic roles and responsibilities were only implied and not clearly spelled out. In compiling the findings, I considered the findings of the first two *looking* at practice cycles and grouped the similar themes and sub-themes together (see Figure 7.3 for the matched themes).



Figure 7.3: Grouped findings of first two looking at practice cycles

I concluded that the healthcare providers working in the participating emergency departments understood and acknowledged that they had a responsibility towards forensic patients, and had to management of evidence and assist the authorities. But this was not enough. I suspected that there was a mismatch between the forensic roles and responsibilities of healthcare providers actually performed in practice and perceived as necessary by these healthcare providers, and those expected

from them. I therefore decided that the next action should be to explore the literature to establish what the elusive expectations were in terms of legislation and other literature in the public domain.

7.8 Summary

The perceptions of the actual forensic roles and responsibilities of healthcare providers working in the participating emergency departments were identified. The findings were then matched with the findings reported in Chapter 6 in order to create a more complete picture of the participating healthcare providers' actual forensic roles and responsibilities and their perceptions of these roles and responsibilities.

To supplement this picture of the situation in practice, I was compelled by Aschman et al.'s (2012) claim that South African healthcare providers' forensic roles and responsibilities were not sufficiently defined to seek more information on the forensic roles and responsibilities expected of South African healthcare providers. This was in line with the study's aim to provide a deeper understanding of the reality of forensic care in South Africa. In Chapter 8, the findings from the literature gathered and reviewed to identify expected forensic roles and responsibilities are discussed.

CHAPTER 8: UNDER THE MAGNIFYING GLASS

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8.1 Introduction

Chapter 8 (Part II, Cycle 3, Sub-cycle 1) discusses the third cycle of looking at practice. Once the participants and I had explored the existing practice, and perceptions regarding the forensic care provided, as well as the roles and responsibilities that healthcare providers were aware of, the need arose to explore what the expected roles and responsibilities of these healthcare providers are. In order to identify these expected roles and responsibilities, a realist synthesis was done. First, I *looked* at a method to explore the expected roles and responsibilities. This was followed by a *thinking* phase that included the collaborative data analysis and the merging of findings from the three *looking* at practice cycles to form the three main themes of Cycle 3, Sub-cycle 1. I then interpreted the findings and *acted* by constructing a framework for healthcare providers' forensic roles and responsibilities that guided the actions planned and implemented through this study.

8.2 Through realist synthesis glasses

Realist synthesis, which was used in the *looking* phase for this action research cycle, was developed by Pawson as an alternative to systematic and meta-analysis reviews with an explanatory rather than a judgemental focus (Reeves 2015:1; Greenhalgh et al. 2011). Realist synthesis can be applied to judge between rival programme theories, consider the same theory in comparative settings, to question programme theory integrity or a synthesis to compare official expectations with actual practice. The purpose of doing a realist synthesis for this study was to identify the expected forensic roles and responsibilities of healthcare providers explicitly or implicitly mentioned in the literature, and in legislation and policies. Realist synthesis is a theory-driven process that supports the exploration of complex interventions by eclectically applying various methods to explain the influence of the context on the implementation of complex interventions (Wong et al. 2013; Pawson et al. 2004).

A complex intervention is an intervention that has multiple purposes, involving multiple stakeholders with long implementation chains that are subject to the culture and context of the organisation where the intervention is operationalised (Pawson 2013; Rycroft-Malone et al. 2012). In order to explain a complex intervention, texts from different settings are included in the literature review. In this study, these included administrative and legislative material, grey literature and formal research literature, as recommended by Hewitt, Sims and Harris (2014) and Pawson (2006). The recommended search strategy to gather the appropriate literature, according to Pawson (2006) and Pawson et al. (2004), is snowball sampling. There is no hierarchy of evidence or strict grounds for inclusion of any particular text

in a realist synthesis; instead, the literature is reviewed for fragments of evidence and an appraisal is made on the grounds of relevance to the purpose of the review (Wong et al. 2013; Pawson 2006). A realist synthesis involves a flexible systematic gathering of information which is integrated and interpreted to inform the purpose of the synthesis, with a specific focus on the mechanisms and context of the implementation of a complex intervention (Pawson 2006). Furthermore, the integration of information is advocated to provide contributions for new interventions, programmes and policies (Tractenberg 2013). The stages for a realist synthesis, as set out by Pawson (2006), are the following:

- *Stage 1:*

The scope/question of the review should be identified with the focus on explaining and expanding the understanding of the complex intervention under review and its implementation (Rycroft-Malone et al. 2012). Pawson (2006:80) also recommends that the reviewer should engage in activities to map the territory so as to “establish what is important, get a feel for the circumstances and gather hunches on the implementation difficulties”.

- *Stage 2:*

After the scope/question of the review has been refined, a search for primary sources should commence. The first activity is to do a scoping search to identify the existing literature that deals with the scope/question (Jagosh et al. 2013). The literature that is identified is then explored to locate programme theories and empirical evidence.

- *Stage 3:*

The quality appraisal of the literature identified is then performed, with the focus on assessing how relevant the pieces of information are to the realist synthesis (Jagosh et al. 2013). Pawson (2013, 2006) emphasise that in the overall picture in a realist synthesis, the rigour of a study is secondary to relevance to the study and that it is appropriate to include various fragments of evidence as long as these contribute to the deeper understanding of the phenomenon at hand.

- *Stage 4:*

The extraction of data to build an explanation is then initiated, by reading the literature thoroughly. Coding is done with the purpose of identifying how an intervention is supposed to work, how the intervention has been reported to work, as well as rival ideas revealed in the literature (Pawson 2006). The next action involves collation, which is the organisation of data to identify connections amongst the fragments of evidence. Rycroft-Malone et al. (2012) and Pawson (2006) caution that extracting data is not a linear process, but an iterative process, and that the decision-making of the reviewer should be recorded to ensure transparency and increase the trustworthiness of the synthesis.

- *Stage 5:*

After collation, the data are synthesised by starting with a preliminary understanding of the intervention under review and answering the following questions set out by Pawson (2006:94): “What is it about this kind of intervention that works for whom, in what circumstances, in what respect and why?”. Synthesising the data should enable a reviewer to produce a theory about the optimal arrangements necessary for more positive outcomes.

- *Stage 6:*

The last step is disseminating findings in order to inform the stakeholders involved in the implementation of the intervention. It is important to note that a realist synthesis delivers a narrative of the original intention and the working mechanisms of an intervention (Lodenstein et al. 2013; Pawson 2006).

8.2.1 Applying realist synthesis

In the first two cycles that pertained to *looking* during the collaborative part of this study, the participating healthcare providers working in the emergency departments explained their perceptions of their actual forensic roles and responsibilities. The forensic roles and responsibilities of healthcare providers are a form of a complex intervention, because how forensic roles and responsibilities are operationalised depends on the culture and context of the healthcare facility concerned and of the healthcare providers working there. Moreover, the expected roles and responsibilities of healthcare providers towards victims of violence and crime are not well defined, especially in South Africa, and have been described as implied roles and responsibilities, leaving room for interpretation on what actions need to be taken (Aschman et al. 2012; Smythe et al. 2008).

In this study, the realist synthesis provided information on the expected forensic roles and responsibility of the healthcare providers. Given that forensic care pertains to medical care that is interrelated with the law and legal processes, legislation, policies and research, the data were combined by means of a realist synthesis, as suggested by Pawson, Wong and Owen (2011), to enable me and the participants as co-researchers to grasp the forensic roles and responsibilities of healthcare providers.

The legislation was interpreted in line with Botha’s (2012) advice that all laws should be interpreted in line with the *Constitution of the Republic of South Africa, Act No. 108 of 1996* (South Africa 1996), and the context for which it is interpreted. The legislation and other literature were therefore interpreted from my perspective and that of the practice development facilitators as healthcare providers focusing on the roles and responsibilities stipulated for the management of the forensic patient population, without

attending to the specific crime addressed in each Act. In Stage 4 of the synthesis, the DEPICT-model of collaborative data analysis was used to analyse the data extracted from the identified literature (see Section 8.3.2).

A two-stage literature search was done to identify the forensic roles and responsibilities of healthcare providers towards living victims of violence and crime in emergency departments. The assumption was made that some guidance must be available to healthcare providers to delineate their expected roles and responsibilities. During the first stage, the focus was on legislation, norms, standards and policies available in the public domain that describe the forensic roles and responsibilities of healthcare providers towards victims of violence and crime in the South African context. The electronic database Sabinet Net Law: SA Legislation was searched. The search revealed seven relevant documents. The search strategy used for Stage 1 was not limited to any date, and the search terms used included *Duties OR *Roles AND/OR *Responsibilities AND/OR Obligations AND *Forensic OR *Clinical forensic medicine.

Of the seven documents, only one explicitly addressed the forensic roles and responsibilities of healthcare providers. The *Regulation regarding the rendering of clinical forensic medicine services, Regulation 176* (South Africa 2012) formed the basis for snowball sampling of other documents in the search. Figure 8.1, overleaf, contains a summary of the literature identified in the scoping search.

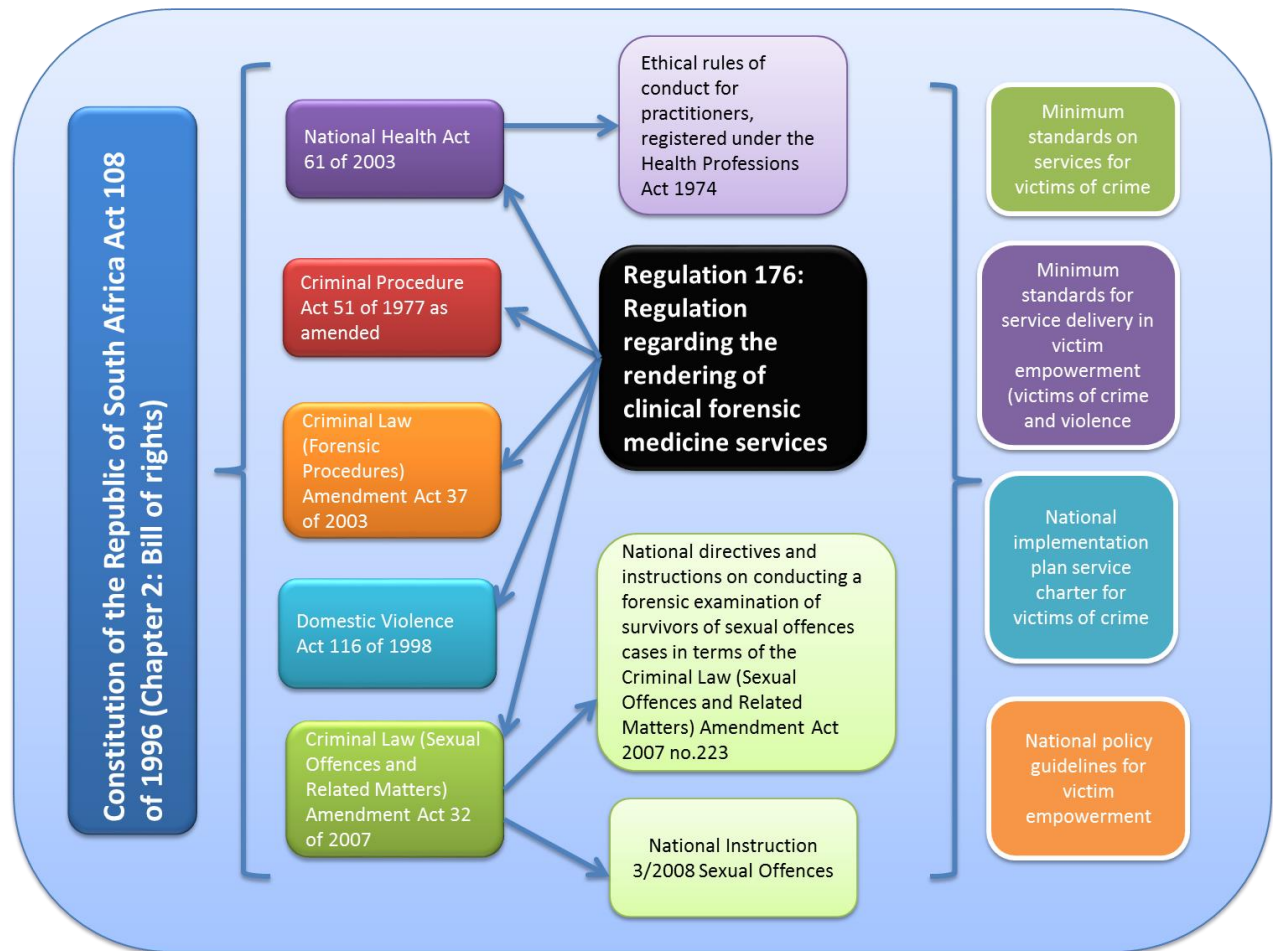


Figure 8.1: A summary of the literature identified in the scoping search

During Stage 2 of the scoping search, four electronic databases were searched (CINAHL, Criminal Justice Abstracts, Health Source: Nursing/Academic Edition and MEDLINE). The search was limited to English language and to the literature published between 2005 and 2014. The search terms used were *Healthcare OR *Health care *practitioners OR *providers OR *medical AND *Forensic OR *Forensic population OR *Clinical forensic medicine AND *Responsibilities OR *Role(s) OR *Duties OR *Legislation AND *Victims of violence and crime. The search retrieved 115 records, which I screened for evidence of the roles and responsibilities related to victims of violence and crime. Records reporting on psychiatric forensic medicine, forensic pathology, forensic microbiology and forensic death investigation were eliminated, as they did not fall into the aim of the focus of this realist synthesis. After screening, 24 records remained. Because so few applicable records mentioned the forensic roles and responsibility of healthcare providers, a quality appraisal was completed.

The 31 documents obtained from Stages 1 and 2 of the literature search were loaded into ATLAS TI 7.0. As none of the documents, with the exception of *Regulation 176*, address forensic roles

and responsibilities, only fragments of information could be extracted. Pawson (2006) refers to the process of searching for bits of evidence in whole documents as a collation with the purpose of producing an explanation and better understanding of the phenomenon under study. Each document was carefully reviewed for any evidence that addresses or suggests healthcare providers' roles and responsibilities towards victims of violence and crime. During the extraction of information following the suggested snowball sampling, an additional 17 records were identified and included in the review. Data were extracted from these records in the same fashion as from the original 31 documents. The records are identified in the final reference list with an asterisk (*).

8.2.2 Challenges of implementing realist synthesis

Realist synthesis, like other forms of review, poses a number of challenges that limit the relevance and appropriateness of its uses. Realist synthesis is not “standardisable or reproducible” (Pawson et al. 2004). Even though specific stages for performing a realist synthesis have been developed, Pawson et al. (2004) explain that these stages should be viewed as principles for undertaking a realist synthesis, and not as a standardised procedure. The lack of a standardised formula makes it impossible to reproduce exactly the same realist synthesis. Jagosh et al. (2013) and Pawson et al. (2004) argue that judgement of what to include in the review is based on the experience and understanding of the reviewer, regardless of the type of review or standardised formulas. In order to address this challenge, I have attempted to describe and discuss key decisions, and I acknowledge that it was not possible to record all the decisions in detail, as some decisions are made unconsciously, as Pawson (2006) and Pawson et al. (2004) have explained.

An additional challenge identified is that a realist synthesis “provides no easy answers” (Pawson et al. 2004). Given the explanatory nature of a realist synthesis, no definitive answers can be provided, as the findings are contextual for the participants present at the time of the realist synthesis (Hewitt et al. 2014; Pawson 2013). However, Pawson (2006) argues that the “progression made by a realist synthesis is from some knowledge to more knowledge” that can be built upon in the future.

8.3 Thinking about the data

After the data extraction, I had to think about doing data analysis in keeping with the collaborative, inclusive and participatory nature of the study. Therefore data were collaboratively analysed by the practice development facilitators and by me, adapting the DEPICT model of collaborative data analysis (Flicker & Nixon 2014). The acronym DEPICT refers to the steps followed during collaborative data

analysis set out by Flicker and Nixon (2014), namely Dynamic reading, Engaged code development, Participatory coding, Inclusive reviewing and summarising of categories, Collaborative analysis and Translation. Collaborative data analysis was chosen because it saved time and provided the practice development facilitators with an opportunity to participate further in the data analysis, as recommended by Cornish, Gillespie and Zittoun (2014) and Flicker and Nixon (2014). The collaborative approach to data analysis ensured that the practitioners' perspectives and contexts were taken into consideration.

A collaborative data analysis process poses some challenges. The participants involved in the data analysis must be provided with some kind of training or guidance on the process (Flicker 2014b). The practice development facilitators involved in this study had previously had some exposure to data analysis, as part of analysis of the talking wall (see Section 6.4). In addition to providing a systematic approach to the data analysis, the process described by the DEPICT model was followed (see below). Coghlan and Gaya (2014), and Parduhn (2011) warn that participants might be recognised while working through the data if the sample is small. This particular challenge was not relevant to this study, because the data analysed for this section involved extracts from the literature. Further challenges identified by Flicker (2014c) and Parduhn (2011) relate to the possibility of peer pressure and group thinking becoming a problem. However, I am confident that the steps followed during the data analysis prevented this problem. Prior to the data analysis session, preparation was done to ensure that the practice development facilitators would attend and that the data were presented in a suitable manner.

8.3.1 Preparation for data analysis

The preparation for data analysis involved the following:

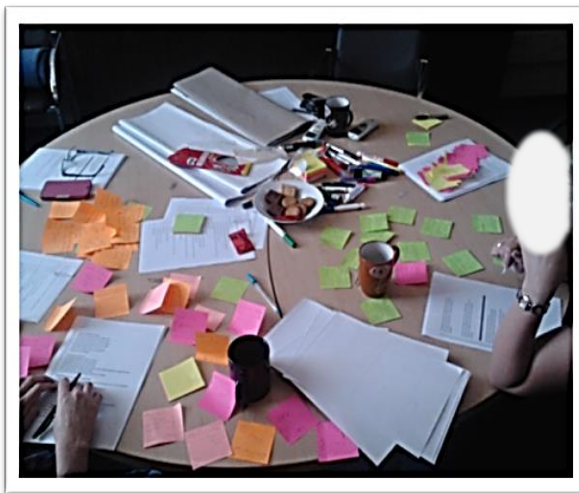
- *Negotiating participation:*

The unit managers and practice development facilitators were informed of the collaborative data analysis session in August 2014. The date was set for 29 October 2014 to ensure that planning could be done to prevent any interruption in the daily activities of the emergency departments. All the practice development facilitators from the three participating emergency departments were invited. Two practice development facilitators from Emergency Department A, and one from Emergency Department B and one from Emergency Department C attended the data analysis session.

- *Preparation of the data for analysis:*

The extracts from the literature were transferred to a Word document and formatted with line numbers, using double spacing, to ensure that the categories and codes identified during the data analysis could be traced back to the original Word document. Two copies of the document were

printed, and each document was then split in half. Each practice development facilitator was provided with a document containing data (half of the original document), sticky notes and pens. I acted as the facilitator, and after greeting and welcoming the participants, informed the practice development facilitators of the steps to be taken for the data analysis. The practice development facilitators attention was also drawn to the research question posed on the flipchart sheet on the wall (see Photographs 8.1 and 8.2 for a depiction of the activities during the data analysis): What are the forensic roles and responsibilities of healthcare providers in the emergency department regarding victims of violence and crime?



Photograph 8.1: Activities during data analysis



Photograph 8.2: Activities during data analysis

8.3.2 Data analysis steps

The steps followed in the data analysis process were the following:

- *Dynamic reading:*
During dynamic reading, pieces of data are given to the participants to read with instructions for keeping the research question in mind, as well as “asking further questions, identifying themes and linking ideas” (Flicker & Nixon 2014). The practice development facilitators were requested to read through the document they received mindfully, and to identify items, concepts or ideas that they felt were important. Each practice development facilitator received half of the document.
- *Engaged code development:*
During engaged code development, data are organised inductively or deductively, and the codes identified are then posted on a wall and clustered (Flicker & Nixon 2014). This step occurred simultaneously with the dynamic reading. The practice development facilitators documented one

concept and/or idea per sticky note that emerged during the dynamic reading. The sticky notes were not displayed at this stage of the process.

- *Participatory coding:*

In the DEPICT model, this stage involves the collation of all codes. Transcripts are read and coded by at least two participants, in pursuit of research rigour. Participatory coding assists with creating “ownership and engagement” in the research (Flicker & Nixon 2014). Two practice development facilitators read the same piece of the document, implying that the data were analysed by two independent coders. The practice development facilitators were not informed prior to the data analysis that two of them had received the same set of data. This was done to ensure that the practice development facilitators were not influenced by one another’s ideas and biases.

- *Inclusive reviewing and summarizing of categories:*

Flicker and Nixon (2014) describe this step as searching for agreeing and conflicting viewpoints and the summary of the codes and how these originate. For the purposes of the study, after the practice development facilitators had completed their dynamic reading and engaged coding, each practice development facilitator was given an opportunity to provide one code at a time, following a round-robin approach. The codes were provided on sticky notes and were stuck on a wall.

- *Collaborative analysis:*

This analytical step involves reflection on the discoveries made during the data analysis, while ensuring that the question posed was answered (Flicker & Nixon 2014). I approached the collaborative analysis step concurrently with the inclusive reviewing and summarizing of categories. During the round-robin session, similar codes were clustered together against the wall. The process was followed until no new categories emerged. The clusters of codes were then documented on the sticky notes and placed together on the wall to create themes.

- *Translating:*

Flicker and Nixon (2014) urge researchers to disseminate their findings in different ways so that relevant audiences can be provided with the findings. The findings from the data analysis of the forensic roles and responsibilities of healthcare providers were shared through a poster that was displayed on a wall space identified by the practice development facilitators to guide the proposed action plans for the third cycle of *looking* at practice of the study.

8.4 Thinking about the findings stemming from the realist synthesis

Three main themes were identified (as discussed below) during the data analysis, revealing that healthcare providers have expected forensic roles and responsibilities towards victims of violence and

crime, the authorities and themselves. According to the *Criminal Law (forensic procedures) Amendment Act, No. 37 of 2013* (South Africa 2013), the *Regulation Regarding the Rendering of Clinical Forensic Medicine Services – R176* (South Africa 2012), the *Criminal Law (Sexual Offences and Related Matters) Act, No. 32 of 2007 as amended* (South Africa 2007a), the *National Health Act, No. 61 of 2003* (South Africa 2003) and the *Criminal Procedure Act, No. 51 of 1977 as amended* (South Africa 1977) the healthcare providers identified in the legislation supposed to provide clinical forensic services are medical practitioners (doctors) and registered nurses. The findings are illustrated in Figure 8.2.

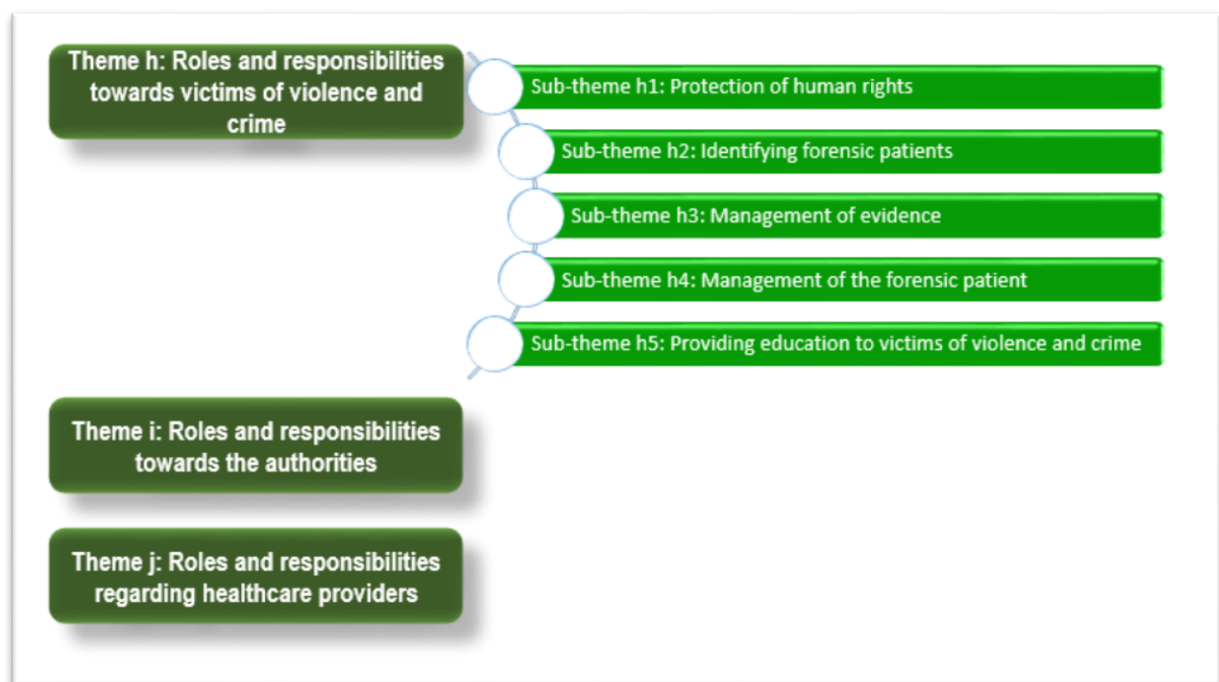


Figure 8.2: Summary of the findings of the third cycle of looking at practice

8.4.1 Theme h: Roles and responsibilities towards victims of violence and crime

The theme of roles and responsibilities towards victims of violence and crime were divided into the following sub-themes: protection of human rights, identification of forensic patients, evidence management, management of the forensic patient, and the provision of education to victims of violence and crime.

8.4.1.1 Sub-theme h1: Protection of human rights

Healthcare providers are named as custodians of human rights, with the responsibility to protect, uphold, respect and promote the human rights of the elderly, adults and children, according to the *National Health Act, No. 61 of 2003* (South Africa 2003), and the *Minimum standards on services for*

victims of crime (Department of Justice and Constitutional Development 2004), Donnelly (2012), Lukhozi (2009) and Santucci (2001). The literature indicates that to fulfil the role of human rights custodians, healthcare providers should have the following attributes: they should be fair, free from bias and prejudices, as well as accountable (Lukhozi 2009; Department of Social Development 2004; WHO 2004). Healthcare providers are also urged to maintain high ethical standards, maintain patients' dignity and privacy, and be advocates for their patients (Donnelly 2012; Lukhozi 2009; WHO 2004). However, if healthcare providers fail to identify forensic patients, they may violate the human rights of a specific patient population.

8.4.1.2 Sub-theme h2: Identification of forensic patients

The data revealed that the identification of forensic patients is an important aspect, since before care can be provided, healthcare providers should be aware of the types of patients in need of forensic care. The responsibility of healthcare providers towards especially living victims of violence and crime deduced from the literature implies that healthcare providers should address the needs of the forensic patient population (South Africa 2012; Eisert et al. 2010). The primary care and interventions called for begin with the initiation of surveillance systems to screen for victims of violence and crime in order to increase the identification of forensic patients (Ward et al. 2012). The forensic needs of such patients start with the ability of healthcare providers to be aware of and to identify forensic patients and the evidence that might be present on their bodies (Eisert et al. 2010; Wiler & Bailey 2007).

8.4.1.3 Sub-theme h3: Management of evidence

The management of evidence forms a core responsibility for healthcare providers. After informed consent is obtained, the identified evidence should then be collected, preserved and protected, while meticulously documenting injuries, from which areas evidence was collected, as well as how it was collected and stored (South Africa 2012; Eisert et al. 2010; Lukhozi 2009; Department of Justice and Constitutional Development 2004). In order to ensure that the evidence can be used in the fulfilment of the human right to justice, the chain of evidence should be maintained by documenting the handover of evidence to the police (South Africa 2009; Wiler & Bailey 2007; McGillivray 2005).

8.4.1.4 Sub-theme h4: Management of the forensic patient

When patients have been identified as forensic patients, their medical needs should be addressed. These include the assessment, treatment of injuries, testing for HIV and pregnancy, as well as the provision of post-exposure prophylaxis, where indicated (South Africa 2012, 2007b; Department of

Social Development 2004). The collection of evidence should never take preference over saving a patient's life. However, it is imperative that efforts to protect and preserve evidence should be employed to provide the criminal justice system with some evidence to use in its pursuit of justice (Sekula 2016; Eisert et al. 2010).

8.4.1.5 Sub-theme h5: Providing education to victims of violence and crime

Patients are in need of education concerning the services available in respect of rendering forensic care and referral to victim empowerment organisations, as well as education regarding their rights (Department of Social Development 2009; South Africa 2009; Smythe et al. 2008). Additional needs that should be addressed for victims of violence and crime are their advocacy, counselling and mental health support needs (South Africa 2012, 2009; Ward et al. 2012; WHO 2003).

8.4.2 Theme i: Roles and responsibilities towards authorities

Healthcare providers act as a critical link between the health system and the criminal justice system (Smythe et al. 2008; McGillivray 2005). Victims of violence and crime are likely to seek medical attention for their injuries first rather than to report the matter to the police. Healthcare providers therefore have a responsibility to report cases where crime is suspected by the police (Department of Justice and Constitutional Development 2004; South Africa 1998). Healthcare providers are also obliged to attend court proceedings to provide evidence as expert witnesses (South Africa 2012, 1977; Department of Justice and Constitutional Development 2004). In order to assist the authorities in preventing and managing crime and violence, healthcare providers are encouraged to do research regarding violence prevention, the effective management of forensic patients and victim empowerment (Henderson et al. 2012; Ward et al. 2012).

8.4.3 Theme j: Roles and responsibilities regarding healthcare providers

Primarily healthcare providers are obliged to assume their forensic roles and responsibilities (Donnelly 2012; Department of Social Development 2009; Müller & Saayman 2003). Healthcare providers assume their responsibilities by engaging in training and education to obtain forensic knowledge and skills (Henderson et al. 2012; Stark & Norfolk 2011; South Africa 2003). The training and education can be either formal or informal, and should assist healthcare providers to understand the principles, policies and protocols regarding evidence management and various forensic examinations (South Africa 2012; Sharma 2003; WHO 2003).

8.5 Reflection on the expected forensic roles and responsibilities

The use of a realist synthesis allowed me to use a wide variety of literature to identify the forensic roles and responsibilities expected from healthcare providers. I did the data extraction on my own, as I had access and time to search and read the literature. During the data extraction, I realised that healthcare providers have had limited inputs in the generation of the expected forensic roles and responsibilities, and that the Department of Social Development and the Department of Justice and Constitutional Development were the main generators of the governmental policies and procedures. Furthermore, during my review and data extraction, limited evidence was found on mechanisms put in place to inform healthcare providers of their expected roles and responsibilities. This finding supports the accusation made by Aschman et al. (2012) that forensic roles and responsibilities are merely implied in South African legislation.

The themes revealed that the victims of violence and crime are in need of medical and forensic care provided by healthcare providers. The emergency departments followed the progression to the criminal justice system in an attempt to address the victims' human right to justice. The practice development facilitators commented that they never thought the role of healthcare providers was so important.

The participation of the practice development facilitators in the data analysis, I believe, assisted in enhancing the quality of the data and resulted in an acute awareness regarding the limitations of the actual roles and responsibilities of healthcare providers. After the themes and categories were identified, we engaged in a discussion about the connections between the actual and expected roles and responsibilities. The practice development facilitators and I then reached consensus that the themes identified in the three cycles of looking at practice could be combined. For ease of reference, the merged themes were renamed with numbers so that they are not confused with the previous themes (identified by means of lower case letters) that were identified by the participants and absorbed into these three main themes. The merged themes are illustrated in Figure 8.3.

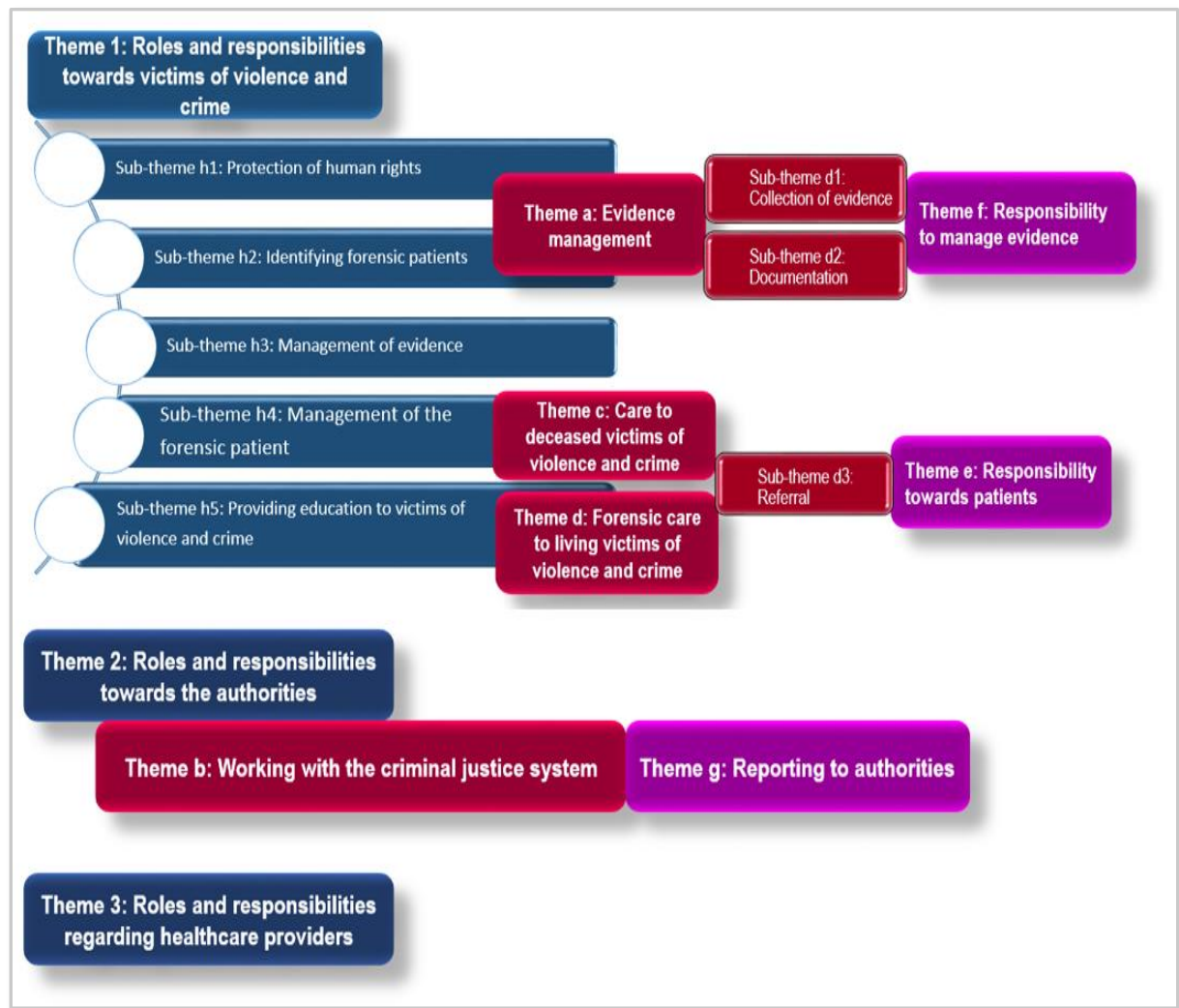


Figure 8.3: Merging the findings of the three *looking at practice* cycles

The themes and sub-themes were reorganised as can be seen in Figure 8.2. Theme 1 (the roles and responsibilities towards victims of violence) were merged with other themes from the first two cycles of *looking at practice* that pertained to forensic patients. This assisted us to grasp the healthcare providers' actual and expected roles and responsibility towards victims of violence and crime. Theme 2 (the roles and responsibilities towards the authorities) were also merged to let healthcare providers know that they should inform and assist stakeholders in the criminal justice system regarding medical aspects. Theme 3 (the roles and responsibilities regarding the healthcare providers) were not identified in any of the preceding cycles, but emerged during the realist synthesis as an important aspect of forensic care.

Taking into consideration the findings of the look phase in the collaborative part of the study and in order to enlighten myself, the participants and the readers, I interpreted the forensic roles and

responsibilities. As already mentioned, healthcare providers understand that they have duties towards forensic patients, but the fact that the actual roles and responsibilities are based mainly on experience and knowledge from healthcare providers' own (usually limited) practice can be detrimental to a patient's human right to justice. The expected roles and responsibilities are scattered *ad hoc* throughout the literature and have been prescribed by third parties without consultation with healthcare providers. After interpreting the roles and responsibilities, I constructed a framework, the *act* phase of the second cycle of looking at practice, to guide healthcare providers regarding their forensic roles and responsibilities (see Section 8.7).

8.6 Interpreting forensic roles and responsibilities

The care of living victims of violence and crime, which is referred to as clinical forensic medicine, is a new and emerging clinical discipline that probably has its origin in the fact that violence and crime are escalating in society at alarming rates (Odell 2015). Clinical forensic medicine has not yet been recognised as a formal speciality, and calls have been made to formalise the education and training provided to healthcare providers in this regard (Odell 2015; Simmons 2014). Taking into consideration that clinical forensic medicine integrates aspects of medicine and the law, healthcare providers should also be aware of the relevant legislation that directs their expected roles and responsibilities (Sekula 2016).

A review of the existing legislation showed that the expected forensic roles and responsibilities of healthcare providers in South Africa are presented in fragmented ways, and are scattered throughout the various Acts in the form of single sentences and paragraphs. Only one relevant regulation, *Regulation 176*, is available in South Africa to provide explicit guidance. The stipulations made in the legislation places the onus on healthcare providers who work in the public health sector to provide forensic care to victims of violence and crime (South Africa 2012, 2007b). The legislation is silent on the obligations of healthcare providers in the private sector towards victims of violence and crime. It would seem that the South African context of two parallel healthcare sectors (Rowe & Moodley 2013) has been overlooked by legislators. However, victims of violence and crime are privileged in that they have a right to select a healthcare provider of their choice (Department of Justice and Constitutional Development 2004; South Africa 1996), and therefore healthcare providers in the private sector are not exempted from providing forensic care to this patient population.

The forensic roles and responsibilities of healthcare providers are shared by both the public and private healthcare sectors, as is evident from the ability of the healthcare providers in emergency departments

in both these settings to provide definitions for forensic care. These definitions identified the connection between the patient, the healthcare provider and the legal system, and were consistent with the definitions provided by Lynch (2013:6), Darnell (2011) and Wyatt et al. (2011:2). Identification of the forensic patient population is thus central to the rendering of forensic care.

8.6.1 The forensic patient population

The identified victims of violence and crime who are reportedly receiving forensic care include victims of sexual assault, assault, abuse, and gunshots, as well as of incidents involving substance abuse, in accordance with some of the categories of forensic patients (Pasqualone 2015:40; Eisert et al. 2010). Even though the categories of assault and abuse were not specified during the data generation on the talking wall, it links to the patients in need of forensic care, as specified in *Regulation 176* (South Africa 2012). Internationally, the forensic population has been divided into 27 categories (see Table 3.1), more than the number of eight categories identified in *Regulation 176*.

Applying the broad categories, it seems that forensic care is in fact provided to at least 12 of the international categories of forensic patients. When victims of violence and crime seek medical attention, healthcare providers should address medical, forensic, psychological and educational needs. As healthcare providers in emergency departments, the management focuses mostly on providing lifesaving interventions, and this can have unfortunate repercussions for the victims of violence and crime who seek justice later (Çalışkan & Özden 2012; Dougherty 2011). Therefore healthcare providers should be aware of potential evidence present on a patient's body, and where possible should preserve evidence while performing lifesaving interventions.

8.6.2 Services to the forensic population

Victims of violence and crime may present to emergency departments with various injuries, and healthcare providers should be able to prioritise medical and forensic care. Medical care takes preference over forensic care in cases of life-threatening injuries, but care should be taken to contain the destruction and contamination of evidence. The five components of forensic care (identification, collection, preservation and documentation of evidence, and maintaining the chain of evidence) listed by Cabelus and Spangler (2013), Darnell (2011), Dougherty (2011), and Joyner and Duma (2010) were mentioned and identified during all three data generation sessions. When the five identified components are performed, the forensic needs of victims of violence and crime are assumed to be met.

Psychological needs are also mentioned in the literature (South Africa 2012, 2009; Ward et al. 2012; WHO 2003), but the exact needs of the patient should be individually assessed. Cornaglia, Feldman and Leigh (2013) found that violence and crime have mental health consequences that could lead to post-traumatic stress in victims, as well as in the people involved in the situation. As the participating healthcare providers rightly pointed out in the nominal group sessions, they too may need mental healthcare support.

Protecting the forensic patients' human rights is another service that healthcare providers are expected to provide, and this need can be fulfilled if healthcare providers meet high ethical standards, maintain the dignity of patients and act as advocates for the patients (Donnelly 2012; Lukhozi 2009; WHO 2004). The participants were also of the opinion that a victim's family should be informed and communicated with as part of forensic care. The inclusion of forensic patients' families could assist in ensuring that human rights recommendations are adhered to. The protection of human rights forms the basis for delivering forensic care to victims of violence and crime (Stark & Payne-James 2014; Donnelly 2012; Payne-James 2005:7). Nevertheless, victims of violence and crime, and healthcare providers need the assistance of the police and prosecutors to protect the human right to justice.

8.6.3 Collaboration with role players in the criminal justice system

Healthcare providers are responsible for reporting incidents of violence and crime to the police so that a case can be opened (Department of Justice and Constitutional Development 2004; South Africa 1998). However, the response and willingness of the police working in complaints offices have been described as problematic, due to a lack of discipline among and high rates of misconduct by police officers (Sauerman & Ivkovic 2015; Bradford et al. 2014). In the cases that do reach the courts, a healthcare provider may be subpoenaed to act as an expert witness. The healthcare providers named in the legislation are nurses and doctors, but the testimony of nurses as expert witnesses in court is only recognised by some courts in the Western Cape and Gauteng (Shukumisa 2011). A likely reason for the courts' refusal of nurses' testimony as expert witnesses is that doctors have statistically significantly higher knowledge levels regarding forensic care than nurses (Jina et al. 2013; Çalışkan & Özden 2012)

8.6.4 Roles and responsibilities in relation to healthcare providers

The healthcare providers who participated in the study had some knowledge of aspects of managing forensic patients, but the actual clinical practice of forensic management was not observed directly during the study. Jina et al. (2013) demonstrated in their study about sexual assault victims that

healthcare providers have contradictory knowledge and limited confidence levels about providing forensic care. As sexual assault victims are one of the categories of victims of violence and crime, it is possible that the findings of Jina et al. (2013) may also apply to other categories of forensic patients, as listed in Table 3.1. It was reported in Turkey that the forensic knowledge levels of emergency healthcare providers were inadequate (Çalışkan & Özden 2012). Based on the actions recommended by the participants using the nominal group technique (as discussed in Section 9.2), it seems that the participating healthcare providers in South Africa were aware of their limited training and of their education needs.

Educating healthcare providers regarding their forensic roles, responsibilities, knowledge and skills requires greater attention and action. Medical doctors receive some forensic education in their undergraduate degree, and if they specialise in clinical pathology. However, little time in training is spent on living victims of violence and crime, as is evident from the regulations set out by the regulations for the Diploma in Forensic Medicine (Colleges of Medicine of South Africa 2015). The South African Nursing Council has only begun on the process of recognising forensic nursing. Nursing students are not yet exposed to forensic nursing during their undergraduate training. Regardless of the lack of recognition of such training, some training has been initiated by the Department of Health and other healthcare institutions, but the content and practical work have not been standardised (Jina et al. 2013). Given that doctors and nurses are designated as the healthcare providers who need to provide forensic care to victims of violence and crime, they need the requisite knowledge and skills.

8.7 Deductions on the forensic roles and responsibilities of healthcare providers

References to necessary skills are dispersed throughout the legislation and other literature. I realised that busy healthcare providers would not have the time to do a comprehensive literature review or collect data on the subject of forensic roles and responsibilities. Hence, in an attempt to create a better understanding of what forensic roles and responsibilities entail, I constructed a framework based on the findings from the talking wall, the nominal group technique sessions and the realist synthesis (see Figure 8.2). The data were sorted, refined, synthesised and discussed with the practice development facilitators and my supervisors. Even though the focus of my study was not person-centredness, I used the person-centred framework of McCormack and McCance (2010) (see Figure 4.1) as a guide for the construction of the framework for the forensic roles and responsibilities. Additional data that the practice development facilitators and I deemed important and therefore included in the framework relate to the

need mentioned by a participant in response to the second question posed during the nominal group. The need was for mental healthcare support to healthcare providers. The participant noted: *“Debriefing is important, there must be employment wellness programmes”* (Emergency Department A). The framework as presented in Figure 8.4 is aimed at informing healthcare providers of their forensic roles and responsibilities in a compact visual representation. The colours used in the framework have no intrinsic significance and were used for visual effect only.

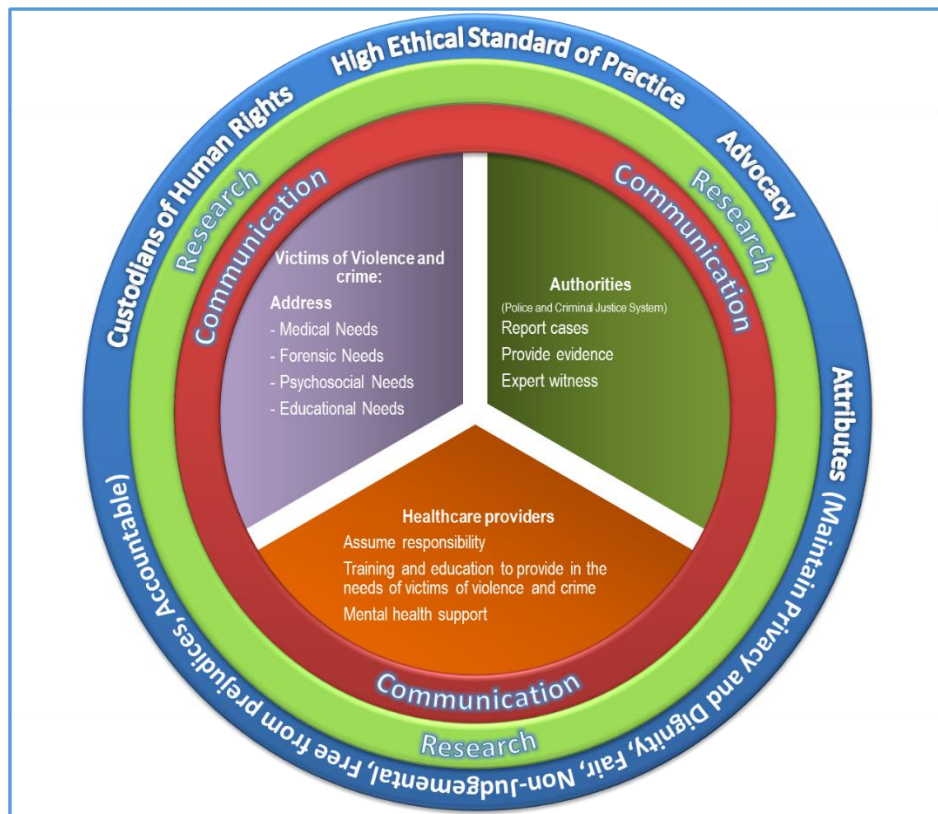


Figure 8.4: Framework for forensic roles and responsibilities towards victims of violence and crime

The framework is depicted in circles, which represent a continuous process. The three outer circles are a representation of the conditions necessary to provide forensic care in the ever-changing clinical, social and political environment, in keeping with the attempt required by critical realism to emancipate people. The area in centre circle is divided into three equal parts that represent the main role players involved in and with forensic care. To clarify the framework in detail, I explain it from the centre outward.

At the centre of the framework are the entities which are at the core of the roles and responsibilities towards victims of violence and crime, namely the victims themselves, the authorities and healthcare providers. The healthcare providers are responsible for offering care that meets the medical, forensic, psychosocial and educational needs of victims of violence and crime. Healthcare providers are also

responsible for reporting cases where violence and crime are suspected to the police, so that a case can be opened and processed through the criminal justice system. During the progression of a case, the healthcare providers may be obligated to appear in court to provide testimony as expert witnesses when this is required by the role players in the criminal justice system. To ensure that healthcare providers can fulfil their roles and responsibilities towards victims of violence and crime, as well as towards the authorities, healthcare providers must assume their responsibility. In order to do so, they should engage in training and education to ensure that their expected obligations are honoured, and suitable training should be provided. Furthermore, the violence that healthcare providers are exposed to can have detrimental effects on their own health and mental wellbeing. Therefore services are required that provide mental health support to healthcare providers caring for victims of violence and crime.

The centre is enfolded by a red circle, reminding healthcare providers of their role and responsibility to communicate with other healthcare providers, victims of violence and crime, and the authorities. Healthcare providers need to communicate with victims of violence and crime, ensuring that they are aware of their rights and the services available. Communication with the authorities is important to build helpful relationships, especially with the police, as they are the entry point to the criminal justice system. Experience shows that role players from the criminal justice system are more accommodating towards healthcare providers as expert witnesses when there is open and honest communication between them. The communication between healthcare providers themselves should, according to the data, be educational in nature and should provide mental health support.

Furthermore, research to improve the collaboration with and quality of care provided to forensic patients is important. Therefore the next circle (the yellow circle) represents research. Victims of violence and crime, the authorities, and healthcare providers all form part of their own complex systems, and the relationships between the three entities depicted in the centre require ongoing exploration. Research is necessary to ensure that the core of the framework continues to develop and possibly expand in terms of the entities described.

The blue circle on the outside indicates that healthcare providers can only fully embrace their roles and responsibilities when healthcare providers acknowledge that they are custodians of human rights who have to maintain high standards of ethical practice. As healthcare providers are sometimes the first people that a victim of violence and crime comes into contact with, they must act as advocates for the human right to justice. The following attributes are important: maintaining privacy and dignity, being fair, non-judgemental, free from prejudices, and accountable.

8.8 Summary

In this chapter, I have described the expected forensic roles and responsibilities as uncovered in the realist synthesis. The findings were then merged with the findings made in the three cycles of looking at practice, after which the data were interpreted. The *act* phase concluded with the construction of a framework for healthcare providers' forensic roles and responsibilities based on their actual and expected practices. The framework assisted us to identify actions that could be integrated into existing practice. The planned and actual actions implemented in the study are discussed in Chapter 9.

CHAPTER 9: PUTTING PLANS INTO ACTION

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9.1 Introduction

In Chapter 8, the healthcare providers' actual and expected forensic roles and responsibilities were explored. In this chapter, the participants and I looked at these actual and expected roles and responsibilities and had to think through the actions that were proposed and what actions could actually be implemented without interrupting the daily routine in emergency departments. Three smaller action research cycles were engaged in (identified using lower case letters) to implement the planned actions. These cycles are considered in line with reflective questions posed by Rolfe, Freshwater and Jasper (2001): *What? So what? and Now what?* The action plans, as well as the review and implementation of actions, are presented in this chapter to reveal the realities that the practice development facilitators and I faced.

The aim of this chapter is to address the third objective of the study (collaboratively recommend actions to transform forensic care) and the fourth objective (facilitate, evaluate and refine collective actions). Transformation denotes purposeful changes to enhance the practice capacity of practitioners through participatory and collaborative action (see Section 1.8.1). This implies that transformation cannot happen without actions. During the data generation to establish the baseline for forensic care in the three participating emergency departments, a second question was posed, namely: What are the actions that can be taken to transform forensic care in emergency departments?

The population and selection of participants have already been discussed in Section 5.3, and the nominal group technique as a data generation strategy was looked at in Section 7.3. The data analysis (see Section 7.4) and rigour (see Section 7.6) of the nominal group technique have also been considered in Chapter 7. In this chapter, the actions required to transform forensic care as proposed by the participants of the nominal group techniques are identified and discussed.

9.2 Theme 4: Raising awareness

Theme 4 of the study, namely raising awareness, identified the proposed actions of needed to transform forensic care. The sub-themes identified under raising awareness included the following: providing additional training and education, establishing clear guidelines, ensuring that sufficient resources are available, and establishing a multi-disciplinary approach for the provision of forensic care.

Participants agreed that there was not enough awareness amongst healthcare providers and the community regarding patients who require forensic care. They suggested awareness campaigns for

healthcare providers, as well as for the community, in an attempt to raise awareness. The following comments were collected:

“Create awareness by training.” (Emergency Department A)

“Have more talks in the hospital to create awareness.” (Emergency Department B)

“Raise awareness of what the responsibilities are.” (Emergency Department C)

In the next sub-section, the theme of raising awareness is discussed in relation to the sub-themes that were identified.

9.2.1 Sub-theme 4.1: Providing training and education

The training and education of healthcare providers were discussed extensively. The need to formalise, access and receive additional formal and informal courses was constantly emphasised, specifically focusing on the needs of healthcare providers in emergency departments. Suggested topics for training included evidence collection and documentation. The following contributions provide evidence of the need for training and education that the participants indicated:

“Formal training.” (Emergency Department A)

“Formulate a formal course for medical practitioner[s].” (Emergency Department B)

“Teaching methods of collecting evidence without compromising patient care.” (Emergency Department B)

“Education of staff.” (Emergency Department B)

“Continued education on forensics and how it benefits to the patient and the nursing profession.” (Emergency Department C)

“In-service training.” (Emergency Department C)

The need for ongoing training and education as identified by the participants as a potential area for action confirms the existing literature, which indicates that practitioners, professional councils, organisations and governments generally acknowledge the need for continued and additional training (Putre 2013; Henderson et al. 2012). However, limited information is available on specific requirements, so this study adds to the existing body of knowledge concerning the specific training needs of healthcare providers. In addition, this study provides insight into the need for such training and education.

9.2.2 Sub-theme 4.2: Establishing clear guidelines

The establishment of guidelines for the provision of forensic care was discussed at length by the participants. The debate centred mainly on the types of guidelines that should be designed, and

whether a guideline, checklist, protocol, algorithm or policy would be best. At the end of the discussions, participants reached consensus that an algorithm would suit their environment and needs best, as algorithms are commonly used to guide the management of patients in emergency departments. Advanced cardiac life support algorithms (ACLS) were mentioned as an example of a kind of algorithm that was developed and published by the American Heart Association, and that is used successfully in the emergency departments. Participants commented as follows:

“Protocols guiding chain of evidence.” (Emergency Department A)

“Protocol, guideline – Algorithm.” (Emergency Department B)

“Create flow charts in emergency departments to create awareness.” (Emergency Department B)

“Develop standard operating procedure and on-going practice.” (Emergency Department C)

Guidelines are generally developed to ensure that safe, effective and standardised care is delivered to patients (Abrahamson, Fox & Doebbeling 2012; Mickan, Burls & Glaziou 2011). The existing literature in this regard correlates with the participants’ views. However, for the practitioners to take ownership of the implementation of guidelines, the involvement of healthcare providers in the development of guidelines is essential (Abrahamson et al. 2012; Lugtenberg et al. 2011). Furthermore, the implementation of guidelines implies a number of hurdles, such as practitioners’ not agreeing with the content of the guidelines, a lack of applicability, inadequate time and a shortage of staff in the work environment (Abrahamson et al. 2012; Lugtenberg et al. 2011; Mickan et al. 2011). The development of such suggested guidelines was never implemented during this study, although the practice development facilitators planned a collaborative session with the identified stakeholders to start with the development of an algorithm. Thus the practice development facilitators displayed the intention to take action in this area subsequent to the study.

9.2.3 Sub-theme 4.3: Ensuring that sufficient resources are available

The resources required to transform forensic care that were identified by the participants relate to equipment and human resources. Participants mentioned equipment, but did not elaborate on the specifications during the discussion in the second cycle of looking at practice. Equipment for collecting evidence may include evidence collection kits, but the stock and equipment available to perform daily activities in an emergency department can also be used, as long as the evidence is not contaminated with DNA (deoxyribonucleic acid) or micro-fibres (Eisert et al. 2010). The need for sufficient human resources depends on having dedicated people in an emergency department who can take responsibility for forensic patients and maintain the chain of evidence. In addition, it seems important to allocate a person to deal with forensic patients on a daily basis, as is evident from the comments below:

“Dedicated staff member for collecting, documenting securing and hand[ing] over of evidence.”
(Emergency Department B)

“Allocate a responsible staff member to preserve evidence every shift.” (Emergency Department C)

However, task allocation is not regarded as an ideal option, as it may lead to increased stress when a practitioner is not adequately equipped with the knowledge and skills required to perform a task, according to Edwards et al. (2015) and Kessler, Heron and Dopson (2013). These authors also emphasise that tasks and responsibilities must be shared to ensure that all practitioners are optimally used. The idea of allocating a practitioner to manage evidence collection was not implemented during the action phase of the study, possibly due to the limited existing knowledge and skills regarding forensic care in the three participating emergency departments.

9.2.4 Sub-theme 4.4: Establishing a multi-disciplinary approach

To transform forensic care in an emergency department, a multi-disciplinary approach was proposed by the participants. Healthcare providers seemed aware that they would not be able to transform forensic care on their own. They suggested contact with the authorities in order to gain support, with access to services available outside the hospital. The creation of collaborative relationships with the SAPS, the community, lawyers and paramedics was highlighted as important to ensure better communication and awareness, as is apparent from the following contributions:

“Work on relationships between staff and police.” (Emergency Department A)

“Increased communication between road and emergency department staff – give pre-warning.”
(Emergency Department A)

“Communicating any positive results from appropriate evidence collection to motivate the staff.”
(Police and prosecutors) (Emergency Department B)

“Relationships with police, community, lawyers, paramedics.” (Emergency Department C)

The multi-disciplinary and multi-sectorial collaboration that was suggested by the participants is consistent with the recommendations of Amar and Sekula (2016), as well as Pagliaro and Bently Cewe (2013). However, limited information is available on how to go about establishing contact with role players in other sectors. The uncertainty about establishing contact seemed to cause some challenges, especially with regard to the criminal justice system – the SAPS was apparently not ready for the outreach from the emergency departments.

9.3 The journey to taking action

Taking action is a fundamental aspect of action research, and the intention is that participants should fulfil an active role in making collaborative changes (Ospina & Anderson 2014). The activities in this study followed a systematic approach, as presented in the conceptual framework (see Section 4.2). The systematic approach for taking action started with the distribution of baseline data during the first week of February 2015 in the form of posters that were placed on the talking wall spaces (see Annexure I). The practice development facilitators were then requested to develop action plans based on the baseline findings for transforming forensic care in the participating emergency departments. They were also requested to keep in mind that the actions should, where possible, blend with the everyday activities in the emergency departments.

The practice development facilitators requested me to provide some structure on what the action plans should consist of, so I provided them with an action plan template (see Annexure J1) to guide them in formulating planned activities and target dates, designating the person(s) responsible, and defining outcomes, as well as how actions would be monitored. The action plans were completed within four to nine weeks after the findings were distributed and the proposed actions were provided. Appointments were made to discuss the action plans developed by the practice development facilitators. The action phase of the research ran from March 2015 to September 2015, as is evident from the dates of the meetings set out in Figure 9.1.

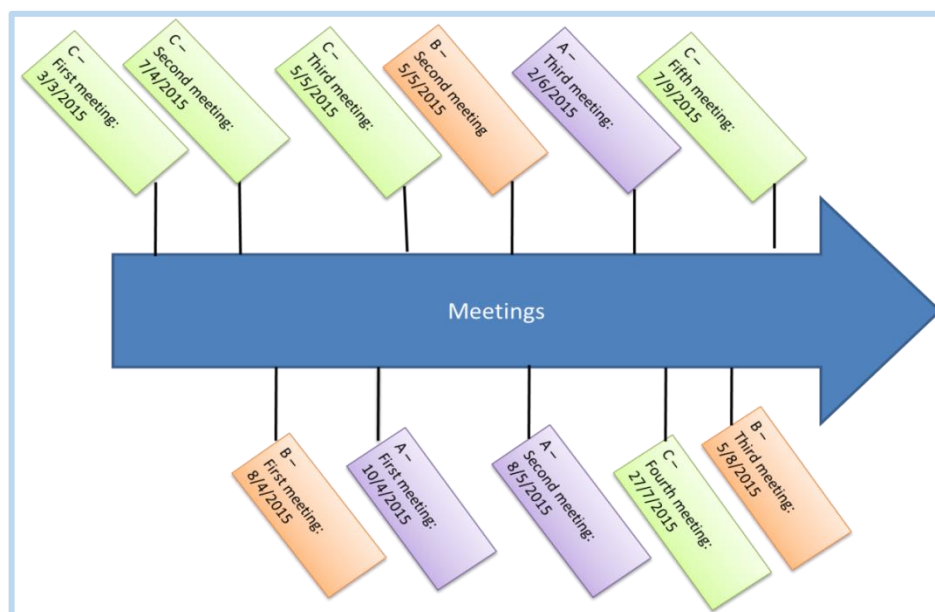


Figure 9.1: Meeting dates in the action phase of the study

The actions that practice development facilitators implemented in their practice were recorded in my reflective diary (see Annexure K). These actions are described below, according to the reflection cycle of Rolfe et al. (2001). The cycle covers the following questions: *What?* (for the purposes of this study, describing the situation), *So what?* (for the purposes of this study, exploring and explaining meaning to create deeper understanding), and *Now what?* (for the purposes of this study, indicating the next step(s) to be taken).

9.3.1 Cycle a: Planning action

In respect of the *What?* question, the practice development facilitators in Emergency Department A and Emergency Department B developed action plans according to the template provided to them (Annexure J1). The practice development facilitators from Emergency Department C were unsure of how to go about creating an action plan, so I assisted them with the first item on their action plan. However, the action plan developed by the practice development facilitators at Emergency Department C after the first visit was misplaced and had to be re-developed. The action plans were all in line with the identified roles and responsibilities and the proposed actions provided in the baseline data.

The action plan of Emergency Department A complied with most of the criteria set out for an action plan, but the persons responsible for actions included me and other boundary partners (doctors, unit managers). In addition, not all of the actions that were planned had monitoring strategies. The action plan of Emergency Department B allocated the action to be taken to one practice development facilitator and me, with very specific target dates and no outcomes or stipulation of how the progress would be monitored. When asked why only one practice development facilitator's name appeared on the action plan, the practice development facilitators indicated that this specific practice development facilitator works office hours and is in the emergency department every day, so this person was to ensure that forensic care awareness was implemented over weekends and night duty. The action plan of Emergency Department C was handwritten, with vague target dates. The persons responsible included boundary partners such as law enforcement and management. For examples of the action plans developed by the participating emergency departments, see Photographs 9.1 to 9.3 for the first action(s) pages; for the complete action plans see Annexures J2 to J4.

Action Plan Template: Practice Development Project

Instructions: Use this template to develop your action plan regarding forensic care. You will need to complete the columns and identify specific activities under each of the major activities identified in the template.

Nr.	Activity	Target date	Responsible person(s)	Outcome	How will it be monitored?
1	<u>Raise Awareness</u> <ul style="list-style-type: none"> Notice board Posters Morning rounds - Random - Awareness Academic day Responsible person - delegation → In the book 	<ul style="list-style-type: none"> Mid. April Each month with education Daily 	L (L) (R) (K), L, R G /M.	Placing notice board where it is visible to all staff. Continuous reminder on different days to reach all staff.	When students Attendance Register Back!
2	<u>Training and education</u> <ul style="list-style-type: none"> PRN Books Education topics <ul style="list-style-type: none"> Identification of forensic patients How and when to report forensic patients Wound identification and recording General recording of forensic notes Handling of evidence 	<ul style="list-style-type: none"> April May June July August 	L, R, K, / L, R, K M ??	Handouts will ensure everyone gets the same information Continuous education and reminders	Sign for PRN handouts Attendance register for in-service training
3	<u>Establish guidelines</u> <ul style="list-style-type: none"> Develop a tick list for nursing Develop a step by step guideline for doctors Consent form - taking photos Establish protocols <p>What's add</p> <p>Complications</p> <p>Assessment</p> <p>Ngobane</p>	<ul style="list-style-type: none"> End July 	L, R, K, & other hospitals Or Prof unit managers, L, R, K	To ensure a standard approach & accurate record keeping. To ensure compliance	Random audit Q1 of 24 Morning

Photograph 9.1: Action plan Emergency Department A

Action Plan Template: Practice Development Project

Instructions: Use this template to develop your action plan regarding forensic care. You will need to complete the columns and identify specific activities under each of the major activities identified in the template.

Nr.	Activity	Target date	Responsible person(s)	Outcome	How will it be monitored?
1	Wound Description Audits to be completed to obtain baseline data for the unit with regard to wound description competency. (See attached audit form) January, February and March 2015 Priority One PRF's to be audited.	30 April 2015	S. R.	Base of possible actions	
2	Meeting to be arranged with the SAPS sector of the region to establish communication lines and build relations. (See attached agenda)	30 April 2015	F. R.	Will there be a follow-up?	
3	On completion of baseline data collection and meeting with SAPS an algorithm should be developed for treatment and support of the following patients: <ul style="list-style-type: none"> Sexual assaults Physical assaults Domestic violence Substance, drugs and alcohol related injuries and violence Drunk driving Child abuse <p>What should be included here?</p>	14 May 2015	S. R.	Should we not also involve the staff in the creation of the algorithm. Or get a team to help you	How will we know if this works? This The creation of the algorithm might take a while longer.

Step 1 - After Police - Then we will complete the outcome and monitoring process!!

Photograph 9.2: Action plan Emergency Department B

Activity	Date	Responsible Person	Outcome	How will it be Monitored
1. Wound Classification ↳ Types of Wounds ↳ Documentation	Continuous <i>at Training Session long, middle training session</i>	* All Staff * H... * K...	Ensure staff Training Set Standard for Wound Explanation	* Document Audit * Review Meetings * Register Monitoring
1. Sexual Assault Patients ↳ Evidence Collection ↳ Patient Support	Continuous <i>SA Reps</i>	* All Staff * P... * C... * Law Enforcement * Victim Empowerment	* In Service Training * ICAS → Debriefing (Staff) * Good Relations % SAP	* Document Audit * Review Meetings % SA * In Service * Register Monitoring
1. Evidence Collection on P1 pts en... 3SW, Stabs, ↳ Storing & Preservation ↳ Maintain Chain of Evidence	Continuous <i>Not the Police DNA 3SW Stabs K... K...</i>	* All Staff in Unit * H... * K... * Law Enforcement * Legal Prosecutors	* Inservice Training * Literature Support 25/26 July out ACS	* Documentation Audits * Review Meetings
1. Correct Identifying of Forensic Patient <i>Disinfect every before & leave</i>	Continuous <i>End of Shift</i>	* All Staff in Unit * Mortuary Referrals * Post Mortem Reports	* Inservice Training * Literature Support <i>25/26 July Aug</i>	* Statistic Reports * M+M Meetings * Post Mortem Reports
1. Supporting Policies & Procedures Support structure & guidelines	Continuous Update With Literat and Laws	* RNM * Management <i>Richter C... M...</i>	* Staff awareness * Read & Sign Register	* Read & Sign Register * Updated Policies in the Unit

Photograph 9.3: Action plan Emergency Department C

Concerning the So what? question, the development of action plans by the practice development facilitators was important for participants to take ownership of the proposed actions, as recommended by Townsend (2014) and Popplewell and Hayman (2012). The action plans were tailored for each emergency department by the practice development facilitators who understood the context and dynamics of their work environment, and who assisted with the mobilisation of collective action (Guhathakurta 2014; Townsend 2014; Rycroft-Malone 2013).

A number of challenges were identified regarding the planned actions. The practice development facilitators assigned activities to boundary partners, so I inquired whether these boundary partners were aware of their assigned activities and how the practice development facilitators would approach the boundary partners to gain collaboration and participation. I also stressed that boundary partners could not be held responsible or accountable for activities they had not agreed too. The practice development facilitators acknowledged that boundary partners had not been informed, but committed themselves to informing the boundary partners within their reach. My inclusion as a person responsible for action made me feel part of the team, "an outsider action researcher who had lost some of their outsider status" (Kerstetter 2012:120). However, after some reflection, I had to ask myself whether my inclusion perhaps implied that the practice development facilitators did not take full ownership and perceived the

project to belong to me. I did not explore these concerns with the practice development facilitators at the time, as my first priority was to foster good relationships that remained constructive, as Bellman (2012a) advises.

Regarding the *Now what?* question, the action plans for each emergency department were discussed, and the challenges were identified. The practice development facilitators were asked to think about ways to engage the boundary partners to whom they had assigned activities. Furthermore, they were requested to think about the feasibility of the proposed timelines, as well as the outcomes that they set out to achieve. Practice development facilitators were also requested to start with the implementation of the actions, and follow-up meetings were scheduled.

9.3.2 Cycle b: Taking action

For the *What?* question, initial action planning meetings and follow-up contact sessions were arranged to support, guide and monitor the progress of the emergency departments, as Kemmis et al. (2014) suggest. During the follow-up meetings with the emergency departments, achievements were celebrated and challenges were identified.

The practice development facilitators from Emergency Department A approached their administration officer and received two registers – one for entering forensic patients and another for maintaining the chain of evidence. Lockable cupboards were ordered for the safe-keeping of evidence until it is handed over to the SAPS. Concerning other proposed actions, the practice development facilitators reported that the department was very busy, and that there was little time available to initiate training and communicate effectively with the fundamental participants about forensic care. However, they initiated a form of in-service training by providing each registered nurse with written information on the topics they identified, and making sure that each nurse acknowledged receipt. The practice development facilitators also informed me that the SAPS did not seem to know under which police station's jurisdiction Emergency Department A fell. The emergency department is surrounded by three police stations, and none of them offered any help. One of the practice development facilitators had a meeting with the unit manager of the Medico-Legal Crisis Centre. She reported that it was fruitful and that the Centre had provided contact numbers of all the police stations in the area, as well as written information regarding the care of sexual assault victims.

Two of the practice development facilitators from Emergency Department B resigned from the emergency department, and only one practice development facilitator was left as the study progressed. This practice development facilitator developed an audit tool for wound descriptions, based on a poster

that I had developed for forensic wound classification and description (see Annexure L1). This audit tool (see Annexure L2) was shared with the other emergency departments. The practice development facilitator audited seven files for wound descriptions and the scores ranged between 0% and 33%. The practice development facilitator insisted that a meeting with the SAPS should take place first, before any of the planned actions could be performed, resulting in a delay in taking action.

The practice development facilitators in Emergency Department C reported that in-service training had started, as indicated in the action plan regarding the documentation of the wound characteristics. The initial audit scores on wound descriptions in Emergency Department C ranged from 0% to 17%.

For the *So what?* question, the implementation of the actions started slowly, even though there was some change. Kemmis et al. (2014) and Stringer (2007) caution that the realities of the practice, culture and context may cause challenges in implementing planned actions. The practice development facilitators of Emergency Department A were asked to think about ways to reach the participants and to look at their original plan for creating awareness. The other two emergency departments established baselines for wound documentation, so that improvement could be measured. The fact that there was only one practice development facilitator left in Emergency Department B posed a challenge, as this meant that there was only one person driving the process, and it implied that limited attention may have been given to forensic care. However, as her name was the only one that appeared on the action plan originally, her commitment was evident. During the meetings, all the practice development facilitators asked for training on evidence collection.

For the *Now what?* question, the practice development facilitators were encouraged to work with what they had and ensured that every small achievement would contribute to the transformation of forensic care in their emergency departments. The practice development facilitator in Emergency Department B was asked to recruit at least one more practice development facilitator. I informed the practice development facilitators of the DNA Project, which is offered by a non-profit organisation that provides training on crime scene awareness (more information on the DNA Project is available on the organisation's website). After deliberation, the practice development facilitators requested me to organise the training. Then dates for training regarding evidence collection were requested from both the practice development facilitators and the DNA Project.

9.3.3 Cycle c: Wrapping up

In line with the *What?* question, the DNA Project agreed to provide training (see Annexure M for the information provided during the training) to the emergency departments, and the practice development

facilitators were informed. The unit managers were also informed to ensure that duty schedules would allow for some of the staff in the unit to attend. There was one problem, in that the DNA Project requires 25 people per session to run a training session. The practice development facilitators and I recruited as many people as we could. The training provided for Emergency Department A was attended by four doctors, the three practice development facilitators and 21 other healthcare providers who did not work in the emergency department. Emergency Department B requested two training sessions and divided the staff into two groups and organised on-duty training hours. Half of the staff attended the first session and the other half the second session. The practice development facilitators of Emergency Department C did their own recruitment for the DNA Project training, and the session was attended by five staff members of the emergency department, ten nurses working in the hospital and 13 paramedics.

After the training sessions, the practice development facilitators were informed that the research project was drawing to a close and that evidence would be collected of the actions taken, so that evaluation of changes that had occurred could begin. The training provided by the DNA Project seemed to enthuse and invigorate the practice development facilitators, and the practice development facilitators at Emergency Departments B and C asked me to attend meetings they had organised. The practice development facilitator at Emergency Department B organised a meeting with the local police station to discuss strategies for collaboration, and received a positive response from the station commander. The practice development facilitators at Emergency Department C also had a meeting with the SAPS and collected their first evidence from a gunshot victim – the evidence was successfully handed over to the police, maintaining the chain of evidence. The practice development facilitators also reported that the wound documentation audit had been repeated, and that the scores had increased to 67%.

At that stage, the practice development facilitators in Emergency Department A seemed disengaged and did not respond to any of my efforts at communication. Numerous attempts to communicate were extended via e-mail and text messaging and telephone calls, but to no avail. I assume that the workplace culture and context may have been a contributing factor – an investigation into the cultural and contextual factors that caused this disengagement was beyond the scope of this thesis, but it is recommended that further research into the cultural and contextual factors that cause disengagement be conducted.

Concerning the *So what?* question, it seems clear from this study that the time for forensic care has arrived in South Africa, as it has in the rest of the world (Lynch 2013). The DNA Project was launched to lobby for the preservation and collection of DNA evidence. The Project's efforts have ensured that

new legislation regarding DNA collection was signed into law in the form of the *Criminal Law (Forensic Procedures) Amendment Act, No. 37 of 2013* (South Africa 2013). The DNA Project training seemed to add momentum to the actions of the practice development facilitators in Emergency Departments B and C, and they approached the planned activities with renewed energy.

For the *Now what?* stage, the practice development facilitators and I decided to have an evaluation session on 28 September 2015. The information was communicated via text-message, e-mail and telephone calls to all the practice development facilitators and respective unit managers. They were requested to gather evidence of the actions they had implemented during the course of the study (see Annexures N1 to N3 for the evidence provided). A summary of the action plans and their implementation is provided in Table 9.1.

Table 9.1: Summary of the action plans and implemented actions

Proposed actions	Emergency Department A	Emergency Department B	Emergency Department C
Raise awareness	Awareness achieved through: <ul style="list-style-type: none"> • Notice board • Posters • Morning rounds • Academic day • Responsible person allocated for forensic duties 	Not addressed in action plan.	Not addressed as an activity, but as an outcome.
Target dates	Target dates inserted (months).		
Responsible persons	Practice development facilitators.		
Planned outcome	Placing notice board where it is visible to all staff. Continuous reminders on different days to reach all staff.		
Monitoring	Attendance registers. Allocation book.		
Actual output	Notice board and information available in the units (see Photograph 5.4). I addressed the doctors regarding the identified forensic roles and responsibilities during their academic meeting.		
Provide training and education	Professional Registered Nurse (RN) Booklets that contain education topics: <ul style="list-style-type: none"> • Identification of forensic patients • How and when to report forensic patients • Wound identification and recording • General recoding of forensic notes • Handling evidence. 	Documentation and wound description. Create algorithm for forensic patients.	<ul style="list-style-type: none"> • Correct identification of patients • Wound classification • Sexual assault patients • Evidence collection on P1 patients (Evidence collection, storing, preservation, maintaining chain of evidence, patient support).
Target dates	Target dates in the form of months.	Specific dates.	Continuous.
Responsible person(s)	Practice development facilitators. Me (Researcher). Other staff.	Practice development facilitator.	All staff. Practice development facilitators. Law enforcement officials.



Proposed actions	Emergency Department A	Emergency Department B	Emergency Department C
Outcomes	Handouts to ensure that everyone gets the same information. Continuous education and reminders.	Not completed.	Ensure staff are trained.
Monitoring	Sign for handouts. Attendance register for in-service training.	Not completed.	Document audit. Review meetings. Attendance register.
Actual output	Poster of wound classification and description developed based on literature and distributed to all emergency departments.		
	Information handouts to the registered nurses included all except one of the planned topics. DNA awareness training provided by facilitator from the DNA project (15 July 2015).	Practice development facilitator – created Audit tool based on the poster on documentation of Audit tool. DNA awareness training provided by facilitator from the DNA Project (15 & 22 July 2015).	Poster of wound classification and description developed based on the literature and distributed to all emergency departments. DNA awareness training provided by facilitator from the DNA Project (14 July 2015).
Establish clear guidelines	Develop a checklist for nursing. Develop step-by-step guideline for doctors. Consent form – taking photos. Establish protocols.	Develop algorithm for treatment and support for the following patients: <ul style="list-style-type: none"> • Sexual assault • Physical assault • Domestic violence • Substance-, drug- and alcohol-related injuries • Violence • Child abuse. 	Supporting policies and procedures.
Target dates	Target dates in the form of months.	Specific date.	Continuous.
Responsible person(s)	Practice development facilitator's and me (Researcher). Doctors.	Practice development facilitator. Me (Researcher).	Practice development facilitators. Management.
Outcomes	To ensure a standard approach and accurate record keeping. To ensure compliance.	Not defined.	Have updated policy in the unit.
Monitoring	Random audit.	Not completed.	Staff to sign and read.
Actual output	This action was not yet implemented.	The algorithm was not yet developed.	Still awaiting policy from SAPS to develop emergency department policy in line with the SAPS.
Ensuring that sufficient resources are available	Evidence cupboard and record book (including SAPS to sign). File with patient list and duplicates of doctor's notes and check list. Administration Officer to explain J88 system. Items needed: <ul style="list-style-type: none"> • Evidence bags • Evidence collection kits • Camera • Two-way radio • Documentation. 	Not addressed in action plan.	Assemble a generic evidence collation kit. Develop a standard working procedure.
Target dates	Target dates in the form of months.		Continuous.
Responsible person(s)	Practice development facilitators. Admin officer.		Practice development facilitators.
Outcomes	Easy access to all staff in a safe place.		Have a generic pack to collect evidence. Provide a written document to guide staff members.
Monitoring	Locked cupboard in pharmacy with checklist of what to order. Random checks – correlation between file and patient list.		
Actual output	An initiative was started to collect the paper bags that are used for		Paper bags are available for evidence collection and contact

Proposed actions	Emergency Department A	Emergency Department B	Emergency Department C
	sterile equipment. The administration officer formalised the system regarding the handling of the J88 forms. A lockable cupboard was received for the storage of forensic evidence.		details of the SAPS contact person are in the forensic patient register.
Proposed Actions	Emergency Department A	Emergency Department B	Emergency Department C
Establishing a multi-disciplinary approach	Educate doctors on completion of J88. Ways to inform allied healthcare workers of forensic patients – e.g. blue stickers. Specialists – education on how to preserve evidence. Record keeping. Available counsellor and social workers call list.	Not addressed in action plan.	
Target dates	Target dates in the form of months.		
Responsible person(s)	Me (Researcher). Doctors.		
Outcomes	Ensure a uniform approach and ensure better overall management of forensic cases.		
Monitoring	Target dates in the form of months.		
Actual output	The unit received a dedicated counsellor from Hospi-vision (in-house counselling services) Recent articles regarding the completion of the J88 provided to all practice development facilitators to distribute amongst the doctors.		
Communication and relationships with law enforcement, local prosecutors and paramedics	Contact with crisis centre. Contact with SAPS. Contact with Criminal Lawyer. Contact with paramedics.	Meeting to be arranged with the SAPS sector of the region to establish communication lines and build relationships.	Make contact with SAPS to create a working relationship.
Target dates	Target dates (months).	Specific target date.	Target date set (month).
Responsible person(s)	All.	Practice development facilitators and me (researcher).	Practice development facilitators.
Outcomes	Cases get reported early. Correct handling of case. Collection and preservation of evidence. Ensure legality of processes followed and medical records.	Not completed	Working relationship.
Monitoring	Minutes of meeting held.	Not completed.	Minutes of the meeting.
Actual output	Multiple attempts were made to make contact with police at all three of the surrounding police stations, but communication was unsuccessful.	Meeting with commanding officer of the police station nearest to the emergency department was held and contact numbers were exchanged.	Meeting with the SAPS was successful, see minutes of the meeting in Annexure N4 (Emergency Department B) and N4 (Emergency Department C).

An example of the actions taken included the display of forensic information on a notice board as shown in Photograph 9.4, overleaf.



Photograph 9.4: Notice board in Emergency Department A

9.4 Trustworthiness of actions taken

The aspects of trustworthiness applicable to the actions taken by the participants are transferability and dependability. Transferability depends on the reader, but the actions taken, target dates and actual outputs can provide some guidance on the implementation of actions or similar outcomes. It became clear during the study that the target dates had been underestimated, and the outcomes had been overestimated. The estimation errors confirm the usefulness of Bellman's (2012b) suggestion to possibly transfer planned action into other settings, and provide ample time for the implementation of planned actions. Dependability was ensured by compiling evidence for the actions implemented by each emergency department (see Annexure N).

9.5 Summary

The actions taken in the seven months of Phase 2 of the study were explained in this chapter, because action research involves the dimension of taking action, and the process followed should be reported (Ospina & Anderson 2014; Bellman 2012a). In this study, the action plans included aspects that were identified when the baseline data were generated, and the framework for the forensic roles and responsibilities (see Figure 8.4) of healthcare providers was compiled.

During the action phase of the study, I become conscious of the fact that although forensic care might result in extra work, it can be absorbed into everyday practice. However, the practice development facilitators had limited capacity to incorporate and enforce the actions planned, which led them to

experience frustration. Moreover, we realised that some of the action plans were very ambitious, softening our own criticism of what we had achieved. The practice development facilitators were able to address some of their own problems, but mainly on an individual level. This indicated that “human agency” still needed to be established.

In Chapter 10, the outcomes of the emancipatory practice development process on transforming forensic care are discussed to deepen the understanding of the process, and of how the practice development facilitators experienced their participation. Furthermore, the chapter also reflects on the transformation of forensic care as it manifested in practice.

CHAPTER 10: PROCESSING THE EVIDENCE

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10.1 Introduction

In Chapter 9, the implementation of actions taken by the practice development facilitators in support of transforming forensic care in three emergency departments in Gauteng was discussed. The purpose of Chapter 10 (Cycle 3, Sub-cycle 3) pertains to the evaluation of the outcomes of the emancipatory practice development process on the transformation of forensic care. Evaluation is an important aspect of both action research and emancipatory practice development. Patton (2012:2) refers to evaluation as the activities employed to “determine the merit, value or significance” of a process that has been used. By contrast, Shaw (2013) describes evaluation as a part of reflective practice. In this study, the evaluation focused on both the outcomes (the transformation of forensic care) and the emancipatory practice development process followed during the study, as recommended by Hardy, Wilson and McCance (2013) and Bellman (2012a). I looked for a method that could be used that would contribute to collaboration, inclusion and participation, and decided on a focus group. The practice development facilitators and I then engaged in thinking together about what had happened, what it meant and the way forward. Chapter 10 is also the end of the collaborative part of the study.

10.2 Exploring the outcomes with the practice development facilitators

The practice development facilitators played an integral part in the research process from the start of the study and could therefore share in-depth insights into the realities experienced during the research process. The intimate involvement of the practice development facilitators may have motivated them to express their experiences freely, as suggested by Liamputtong (2011). In exploring the outcomes, all three participating emergency departments’ practice development facilitators came together, including the unit manager of Emergency Department B. In Table 10.1, I provide an overview of the collaborative research activities that the practice development facilitators engaged in.

Table 10.1: Collaborative research activities of practice development facilitators

Part II of the study	Positionality of practice development facilitators (See Table 5.2)	Data generation technique	Themes identified
Looking at practice (Cycle 3, Sub-cycle 1)	Compliance Cooperation Co-learning	Talking wall (first cycle of looking at practice)	Theme 1 Roles and responsibilities towards victims of violence and crime
		Nominal group technique (second cycle of looking at practice)	Theme 2 Roles and responsibilities towards the authorities
		Realist synthesis (third cycle of looking at practice)	Theme 3 Roles and responsibilities toward healthcare providers
Action planned (Cycle 3, Sub-cycle 2)		Nominal group technique	Theme 4 Raising awareness

10.3 Looking at a focus groups as a data generation strategy

The outcomes derived were explored by means of focus groups. The use of focus groups to generate qualitative data is well documented in several disciplines (Liamputtong 2011; Stewart et al. 2007). Focus groups can assist participants to discover and voice their understanding(s) of a phenomenon, allowing a researcher to gather different insights and perspectives at the same time (Liamputtong 2011; Fern 2001). In this study, a combined focus group of the participating practice development facilitators from all three emergency departments was used. The purpose was to evaluate the insights and perspectives of the practice development facilitators on the outcomes of the emancipatory practice development process relating to transforming forensic care. The process involved high levels of ownership and participation from me, and from the practice development facilitators, as suggested by Olsen (2012) and Stewart et al. (2007). The use of a focus group enabled the practice development facilitators to reflect collectively on the outcomes of their planned and actual activities, as well as on the emancipatory practice development process followed during the study.

Focus group procedures and characteristics can be adapted to the discipline concerned and purpose of a study, allowing art-based activities to be incorporated in the discussion (Stewart et al. 2007). Art-based activities and research have become increasingly popular, as they can encourage collaboration and transformation endeavours (George 2014; Rydzik et al. 2012). When the practice development facilitators had to evaluate the process, the art-based activities seemed to encourage them to think beyond the tangible evidence generated during the collaboration phase of the study. Rydzik et al. (2012) suggest that art-based activities inspire collaborative and participatory reflection, causing a more balanced power relationship between a researcher and participants. More balanced power relationship

levels allow each member involved in the activities to use art to articulate self-expression, self-development and ownership (Rydzik et al. 2012).

The focus group discussion allowed for active interaction amongst the practice development facilitators and invited them to express their views on the outcomes of the research process followed in this study, as suggested by Koshy, Koshy and Waterman (2011), and Goodman and Evans (2010). The use of art-based activities during the focus group session engaged the participants and contributed to a deep understanding of the changes that had occurred during the research process, as suggested by Daykin (2015), as well as Rydzik et al. (2012).

10.3.1 Preparation for the focus group

The practice development facilitators and unit managers of all three emergency departments were informed of the date and venue for the focus group data generation session at the beginning of August 2015. The date was set for 28 September 2015. The information was shared well in advance so that arrangements could be made for the practice development facilitators to attend, and ensure minimal disruption in the services provided. The venue, a training room at one of the participating emergency departments, was booked by one of the practice development facilitators.

As the purpose of the focus group was to evaluate the outcomes of the study, an independent moderator was involved to facilitate the discussion to overcome potential bias, given that I had worked closely with the practice development facilitators during the research process. Furthermore, Stewart et al. (2007) and Schade (2007) consider the use of an independent moderator beneficial to the research process. The advantages of an independent moderator include that moderators are usually experienced in managing group dynamics, are not afraid of questioning assumptions, are objective and increase the possibility of credible findings.

Once the independent moderator had agreed to facilitate the focus group, a preparation meeting was held between the moderator and me. The moderator was informed of the purpose of the study, the research objectives and aim of the study, the types of participants expected to attend and the purpose of the focus group discussion, as suggested by Guest, Namey and Mitchell (2013). The process that was to be followed was discussed, as well as the proposed introduction. The focus group's actions were also discussed, capturing the questions to be posed during the discussion.

10.3.2 Conducting the focus group discussion

The practice development facilitators greeted each other when they arrived, as they had met during the collaborative data analysis session that had been conducted (see Section 8.3.2). They were welcomed. As the participants had already provided informed consent when they volunteered for the study, only verbal consent was needed for conducting the focus group discussion and recording the session. The practice development facilitators were asked if they would be comfortable if I attended the focus group discussion, to which they responded positively. I acted as the assistant moderator and field worker, taking notes of the setting and non-verbal communication, operating the recording equipment and facilitating the introduction to the session (opening move).

In order to focus the session, an opening move was thus used, in the form of word association as described by Mindtool (n.d.). For the purposes of the opening move, I pre-chose terms and wrote them on otherwise blank pieces of paper that were then populated further by the participants with words and phrases that the participants associated with the pre-decided terms. The opening move was used to introduce the topic and encourage active participation during the focus group discussion, as recommended by Wilkinson (2012) and Liamputtong (2011). The terms that were used were “forensic care”, because the aim of the study was to transform forensic care in level-one emergency departments, “research”, because the activities performed were for the purposes of research, and “evaluation”, because the practice development facilitators had to reflect on the outcomes of the processes followed during the study. The three words were written on separate sheets of blank flipchart paper, and each practice development facilitator received sticky notes to write down related words or phrases and stick them on the sheet with one of the provided words. The terms were then read out by the moderator and some items were clarified.

Next, the moderator stated the purpose of the focus group and explained that the evaluation would be done in the form of a reflection using the model of Rolfe et al. (2001), as well as guidance provided by Patton (2012). The session was divided into three sections to answer the *What? So what? and Now what?* questions. The practice development facilitators were also asked to write down ideas before the discussion, to assist the practice development facilitators to structure their own thoughts and ideas, as well as to minimise the “me too” effect, as described by Guest, MacQueen and Namey (2012). The questions and results are discussed below:

- In chronological order, think about *what* happened in this year while working on the project.

The practice development facilitators were allowed time to write down their thoughts and when they stopped writing, the moderator commenced with the discussion. The moderator asked someone to start. As the practice development facilitators were familiar with each other, the discussion commenced

immediately, and each practice development facilitator had an opportunity to respond. After all the practice development facilitators had shared their views, they were requested to work in small groups with practice development facilitators from the same emergency department. The session then moved to the next question.

- *So what?* Use words, phrases or pictures to explain your outcomes.

The use of art to collect data can take various forms, for example, drawings, poems or performance (McNiff 2008). Art-based activities can assist participants to view their problems and experiences from different angles and even to learn how to work better with others (Wilson & Flicker 2014; McNiff 2008). When art is used to evaluate a project, it may reveal hidden perspectives and empower participants (Daykin 2015; Wilson & Flicker 2014). However, some resistance may arise and can be expected, as some participants may perceive art as marginalising (Wilson & Flicker 2014; McNiff 2008). An analysis of art-based data may also pose challenges, because there are no specific guidelines in this regard. In an attempt to overcome the challenge of data analysis, the focus group discussion was recorded and transcribed, so that the exact phrases and words used by the participants could be matched with the art during data analysis.

The groups decided to use a combination of words, phrases and pictures to explain the meaning(s) they attached to specific items to the rest of the group. The group, moderator and I gave feedback using terms such as “I see...”, “I hear...”, “I feel...”, “I imagine...”. After the feedback was completed the moderator moved to the final part of the focus group, asking a last question: *Now what?*

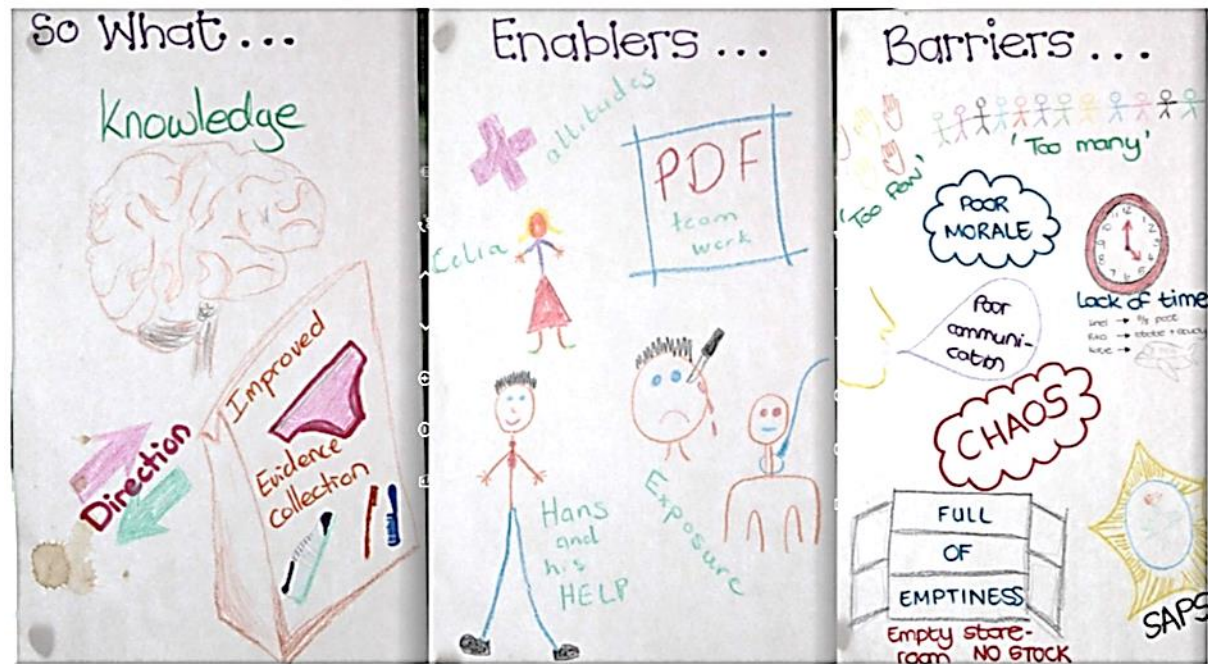
- *Now what?* Collaboratively draw a picture on the way forward.

The atmosphere stayed relaxed and the practice development facilitators completed the task with full participation. After they had completed the tasks, the practice development facilitators explained the meaning of their responses and their future plans for forensic care by referring to the picture which they had all collaboratively created (see Photograph 10.1). Feedback was provided by the moderator and me, using the same terms mentioned in the discussion of the *So what?* question. The focus group was closed by all participants verbalising what they liked least and most about the session. They were thanked for their time, effort and commitment on the day and throughout the study.

10.4 Thinking about the evaluation findings

The data analysis commenced by transcribing the recordings made during the focus group discussion, as specified by Liamputtong (2011). The data that were analysed included transcriptions (see Annexure N), field notes and the drawings made during the focus group session (Photograph 10.1). The data were

analysed through inductive content analysis and followed the same steps as those described in Section 8.3.2.



Photograph 10.1: Drawings made in response to the *So what?* question

The findings from the focus group discussion provided an overview of what happened and the consequences that followed, therefore looking at the causes and causalities. The two themes (Themes 5 and 6) identified in the focus group were transformation in practice and experiencing the emancipatory practice development process. Each theme with its related identified sub-themes is discussed below.

10.4.1 Theme 5: Transformation in practice

Theme 5 of the study relates to transforming forensic care in terms of the changes observed, reflection on the practice and the activities achieved. Four sub-themes emerged, namely increased awareness, acquired knowledge and resources, groundwork for collaboration with the SAPS, and unplanned and unintended actions.

10.4.1.1 Sub-theme 5.1: Increased awareness

The practice development facilitators reported that at the start of the study it seemed that the fundamental participants did not realise that forensic care formed part of their roles and responsibilities. The practice development facilitators commented as follows:

"They felt it is not their job."

"They didn't think it was their job and now we have made it their jobs."

“Nobody realised what we can actually do and what we should be doing.”

Assuming responsibility to provide forensic care to victims of violence and crime is an important step in changing the status quo (Henderson et al. 2012; Stark & Norfolk 2011). However, for nurses and doctors to embrace their forensic roles and responsibility, further research and awareness campaigns are necessary. Furthermore, at the start of the study, the healthcare providers were under the impression that the forensic patient population in need of forensic care was limited to sexual assault, gunshot and stab victims. When the list of forensic patients (Pasqualone 2015; Pasqualone & Michel 2015; [see Table 2.1]) was placed on the talking wall spaces, the healthcare providers were surprised at the size of the forensic patient population to whom they had a role and responsibility to provide forensic care. The practice development facilitators made the following comments regarding exposure to the different types of patients:

“When you said forensic they were just thinking gunshot victim and not just...I mean if you look on the list we see a lot of forensic patients on a daily basis.”

“Our constant exposure to forensic patients in our unit...it makes it easier to explain to other staff because we see forensic patients the whole time.”

Healthcare providers in the participating emergency departments appeared to have consequently started engaging with their forensic roles and responsibilities, as the practice development facilitators reported that increased awareness was observed. They shared their perceptions as follows:

“A lot more questions came from the staff like... what do we need to do with clothes, what do we need to do with especially gunshots...so more awareness was created amongst the staff.”

“Mind change is slowly but surely happening and there is more awareness.”

“With sexual assaults they know ...but gunshots is more for them...and they will not cut through the holes (bullet holes) anymore, they will go around it.”

“The guys would not just put it (clothes) in plastic bags any longer; it will go into brown paper bags.”

“It’s like they want a better outcome for their patient.”

These contributions indicated a change in practice, even though the progress appeared to be slow, with only a few small changes occurring during the study pertaining to how to collect and preserve evidence. Darnell (2011) advocates that the development of a healthcare providers’ “forensic antenna” is vital for forensic care and can only develop once awareness has been raised. Signs of raised awareness could therefore indicate that participating healthcare providers have started noticing that they indeed have forensic roles and responsibilities. Awareness that leads to actions implies a form of the critical consciousness required for emancipation (Freire 2000, cited by Diemer et al. 2015). Raising awareness is fundamental to identifying forensic patients and guides the care needed to meet these patients’ medical, forensic, and psychosocial and education needs, as affirmed by Sekula (2016) and Henderson

et al. (2012). Furthermore, raising awareness is essential for emancipation, as it may (and did in the case of this study) lead to the initiation of actions (West 2013; Wilson & McCormack 2006).

10.4.1.2 Sub-theme 5.2: Acquired knowledge and resources

The increased awareness could have been triggered by the knowledge and resources acquired during the activities of the study. The practice development facilitators reported that they personally gained knowledge regarding forensic care, especially around the collection of evidence, as supported by the following comments:

"I have learned a lot about the actual collection of evidence."

"...the knowledge we gained gave us some direction of what we need and do to provide forensic care...like evidence collection."

The practice development facilitators reportedly relied on the knowledge that they and the fundamental participants gained to provide better care for victims of violence and crime. They explained:

"From where we came from we had an idea that evidence must be collected but ...what to do with the evidence we had no idea...so we had bullets lying in the drug cupboard for years."

"The documentation of wounds is still a struggle...they are not very descriptive on what the wounds look like."

"We now have a process in place, it [evidence] is documented on the nursing notes, documented in the register that we have created."

The resources and equipment that they organised and implemented are captured in the following statements:

"We assembled our own generic evidence collection kit and have a register to document the movement of the evidence."

"We now have lockable cupboards for storing our forensic stuff in."

The literature review (see Section 3.6) revealed that appeals for increasing the forensic knowledge and skills of healthcare providers have been made worldwide. The increase in awareness and knowledge acquired during the study could enable the participating healthcare providers and their emergency departments to care appropriately for victims of violence and crime, as suggested by Cho et al. (2015), Cucu et al. (2014), and Çalışkan and Özden (2012). In order to assist victims of violence and crime further than their health needs, relationships also need to be established by the healthcare providers with the SAPS as the entry point into the criminal justice system.

10.4.1.3 Sub-theme 5.3: Groundwork for collaboration with the SAPS

The SAPS was identified as an important stakeholder during the stakeholder analysis, as discussed in Section 5.3.3. Establishing relationships for collaboration and referral was part of the action plans put forward by all the practice development facilitators. In this regard, the practice development facilitators reported the following progress:

"We now have a liaison with the SAPS who is dedicated to collect the evidence from us."

"We had a big problem from bodies to bullets... if it wasn't from their area they didn't want to know about it... we now have from high-up in the SAPS from what they actually needs to do..."

When the SAPS were mentioned during the discussion, the practice development facilitators reported that the main challenge they faced was gaining access to a specific contact person. During the meetings with the practice development facilitators, their reaching out to the SAPS was always a point of discussion. Only two of the emergency departments eventually managed to get hold of the SAPS, but only during Part II, Cycle 3, Sub-cycle 3, Cycle c. The struggle to get hold of the SAPS is evident from the following quotes:

"It was a battle to get the meeting... You know it took us almost four to five months to a confirmed meeting."

"There was a constant struggle and still is to get hold of the police to identify a liaison for the hospital... we now have a list of telephone numbers of all the police stations around the hospital."

The prospective assistance identified by the practice development facilitators was in the form of collaboration for training, as well as assisting the SAPS with information and evidence. The following remarks by practice development facilitators were recorded:

"The police offered to come and speak to the staff about procedures."

"...awaiting the policy from the SAPS on forensic procedures so that the policy we will write [will be] in line with the policy from SAPS..."

"We can help the police with evidence and good history you know... because they only start the investigation after the fact... like after the crime has taken place and the patient is admitted into the hospital."

10.4.1.4 Sub-theme 5.4: Unplanned and unintended actions

The participants confirmed the actions taken as planned for and reported on in Chapter 9. In addition, participants also revealed some unplanned and unintended actions that occurred in each of the emergency departments. The practice development facilitators of Emergency Department A reported the following unplanned and unintended actions that occurred during the time period of the study:

"Some doctors and nurses have improved their wound descriptions but... we have not collected any audit information on it..."

"We have started collecting paper bags...you know the ones we use for sterile equipment...to have paper bags for evidence collection."

The practice development facilitators also did a site visit to a forensic biological laboratory where information on the process of DNA testing and replication was explained. Here the practice development facilitators discovered that evidence from gunshot victims should go to the ballistics laboratory for further investigation, and not necessarily to the biological laboratory. In addition, a doctor working in Emergency Department A has undertaken to attempt to make existing documentation more appropriate for forensic patients by doing collaborative and participatory research. The practice development facilitator of Emergency Department B reported the following:

"All the staff have gone for retraining on the management of sexual assault patients...and the cupboard where we store the evidence collection kits was reorganised."

"Also we have decided to have six hours of training every second month because of the training needs that we picked up during the course of the year."

"Another thing is that the staff are now putting the patient's clothes into paper bags"

"...we have been receiving more enquiries regarding the handling of potential evidence and how and where to refer forensic patients."

The practice development facilitators of Emergency Department C developed a generic power point presentation for forensic evidence collection and documentation that was presented to the nursing staff in the unit, as well as to nurses doing the trauma course at a local university.

When reflecting on the actions that had been implemented, the participants started relaxing and the general atmosphere in the group seemed to lighten when they realised that more things had happened than they initially thought or imagined. The fact that the practice development facilitators were invited to name their actions and evaluate the outcomes and process in which they were intimately involved could have resulted in uncomfortable feelings of guilt, as anticipated by Rosenstein (2014), and Bellman (2012b). However, actions had indeed been taken to transform the practice, even though the sustainability of the actions in practice remains to be seen. Some participants revealed that they felt guilty because they assumed that some actions could have been implemented better, as is evident from the following comments:

"I feel we could have done more, it is just with the time..."

"I just feel guilty because we did a lot in a short time and then in the last two months we didn't do that much because it was just hectic."

"It was difficult to stick to the target dates that we set."

According to Klocker (2015), feelings of guilt can surface when participants are intimately involved in the research process, as they may have a high degree of ownership and expectations. The practice

development facilitators had to share my research responsibility, and thus felt that they had to cope with the fact that some changes were made and some were not.

10.4.2 Theme 6: Experiencing the emancipatory practice development process

The emancipatory practice development process was implemented as the change process for this study, using “local knowledge” and “ideas” specific to the participants’ context, as recommended by Shaw (2013). I divided the perspectives of the practice development facilitators on the emancipatory practice development process into four sub-themes, namely an outsider as initiator, sustained support, fostering relationships and connecting research to practice. The practice development facilitators started their recollection of the process by voicing their initial feelings about the research:

“In the beginning the staff was actually...they had an idea that there is forensic evidence but they felt it was not ... really anything to do with them...”

“In the beginning it was difficult to encourage people to participate because they saw it as extra work...they didn’t think they had to pay attention to it.”

“There was a lot of scepticism because we are already overloaded with work...people were not getting interested although it is an interesting topic...they want to know what is going on but they don’t want to be part of it.”

“It was a vague topic for us... there was almost this fear that it is going to take up a lot of your time.”

“Before that [the action plan] it was a bit hanging in the air and no set point to go for.”

The initial disengagement and uninterested behaviour reported by the practice development facilitators could be due to moderate to high levels of burnout. In studies conducted in the United States of America, the United Kingdom and Iran, 31% to 46% of healthcare providers working in emergency departments were found to have moderate to high levels of burnout (Rezaei et al. 2015; Howlett et al. 2014). Further research is required in the South African context on this problem. Another possibility for the initial response is that the nurses did not understand their forensic roles and responsibility, or did not know that they are legally obligated to provide forensic care, as discussed in Section 8.6.

Despite the initial apparent lack of interest, some of the participants were indeed interested, and volunteered to be practice development facilitators. The “CSI effect”, as reported by Jermyn (2013), Wyatt et al. (2011) and Schweitzer and Saks (2006), may have sparked the interest of some of the participants – television programmes on crime scene investigation (CSI) have created acute public awareness of forensic science, even though the results of these fictional investigations are sometimes improbable, and only achievable in the imaginary world of television. Furthermore, I was identified as an initiator of the research in each of the participating emergency departments.

10.4.2.1 Sub-theme 6.1: Outsider as initiator

Participants explained that they had a vague idea of forensic care, as well as of the related training needs in emergency departments, but kept their concerns and discomfort at bay by concentrating on the job at hand. They admitted that if it were not for the external initiation, they would probably not have attended to forensic care and other training needs that exist. The participants remarked:

“Celia came to give us extra work [laughs]... she was the instigator for the whole process...”

“You [Celia] brought one thing into the unit to be focused on but in that...it has created a whole global change of mind-set regarding all kinds of training. It’s kind of woken the beast...hmmm...That it’s not just forensics that needs attention...”

“It [the initiation of the research project] created kind of a ripple effect.”

“We started with Celia; she brought more awareness and the staff actually realised they did have a role to play... brought focus and awareness...”

“The forensic training is what sparked our separate training sessions which I think is going to have huge spin-offs.”

“We realised the relevance of this [forensic care] in our lives and in our unit... we need to change... our mind sets...it highlighted the need for change and the lack of support that we’ve had... from... not from everybody, but there has been resistance to change and lack of support...”

I was an outsider who initiated the research process with the intention of collaborating with the practice development facilitators while learning together, to transform forensic care. I preferred to collaborate with the practice development facilitators to generate change collectively and to gather context-specific knowledge relevant to their context by creating an acute awareness, as recommended by Titchen (2015).

The emancipatory practice development process involved three phases, namely enlightenment, empowerment and emancipation. The initiation of the study is similar to the enlightenment phase, which entails increasing the healthcare providers’ awareness and sensitivity of situations and issues regarding existing practice, and the needs of the patients they serve, as proposed by Martin et al. (2014), Snoeren, Niessen and Abma (2011). Although I was an outside initiator, a change in the practice that could have otherwise remained dormant was set in motion.

10.4.2.2 Sub-theme 6.2: Sustained support

In practice development, the support provided to practice development facilitators is recommended to take a “high-challenge/high support” form (Titchen, Dewing & Manley 2013). As the practice development facilitators had clinical posts in the emergency departments involved in the study, and had limited to no exposure to practice development, facilitation and forensic care, I decided to provide high

frequency/low intensity support, to ensure that the practice development facilitators were not inundated or overwhelmed by the tasks associated with the study. Participants' perceptions of the way they received support are captured in comments such as the following:

"...then Celia and her encouragement and enthusiasm and passion was definitely an enabler..."

"I think a lot of the time... in the unit we don't always have that...that somebody that keeps reminding you that this is important ... so for me it was a matter of discernment where I have to focus my attentions to get the biggest results at the end of the day."

"We looked and ok, so we didn't achieve that right now but what have we done....like nothing was made insignificant...I didn't get to what was on paper but there was some progress in a different areas and that was the fuel to keep on going."

"Something that Celia said to me that stuck was...work with what you have, don't try and reach far off."

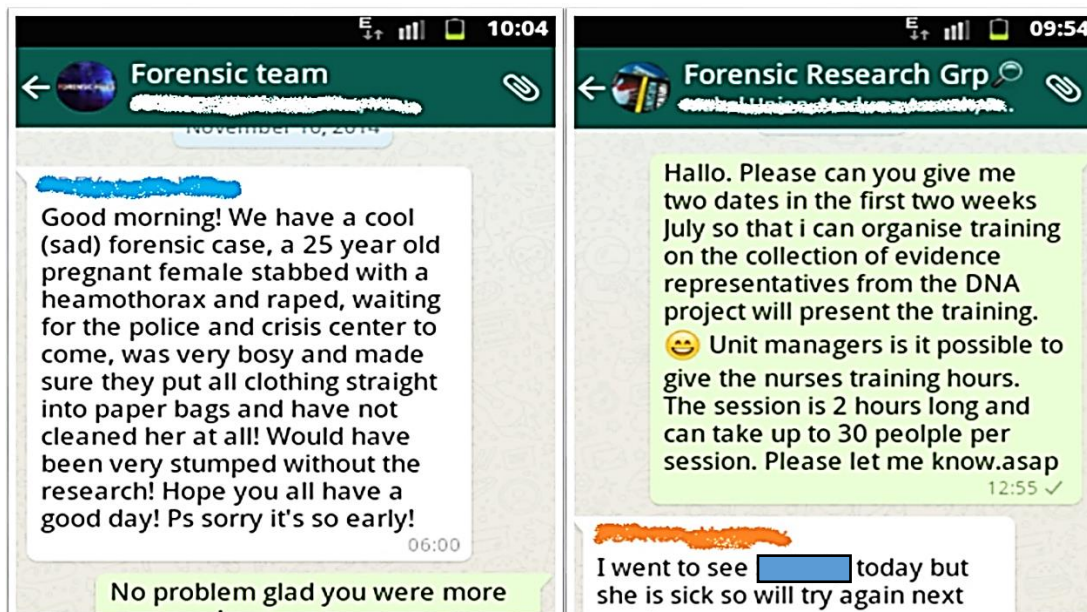
The high frequency of visits I made to the emergency departments and other forms of communication mostly assisted the practice development facilitators to stay focused on the commitments they made during each meeting session:

"There was constant contact...the fact that you say to me ok I'll see you next week... make me make a priority."

"...and I like the regrouping... like with the visits we had every time I was taken back to what we discussed the last time."

"We tried to have monthly meetings so that Celia could give us some guidance... but it was difficult to balance this [the project] work and life."

The sustained support I offered was my commitment towards working with and learning from the practice development facilitators and fundamental participants about the emancipatory practice development process and forensic care in the participating emergency departments. In addition to visits, I also kept contact by means of text-messaging and e-mails regarding information and requests between me and the practice development facilitators. Communication is an important aspect during any study, because it is the foundation of collaboration and participation, and can thus contribute to successful outcomes (Levin 2014; Bellman 2012a). Examples of screen shots of text messaging conversations are included in Photograph 10.2, overleaf (identifying information has been obscured).



Photograph 10.2: Example of text messages used for contact

In addition to high-frequency contact and support, proposed activities were limited enough (low intensity) so that healthcare providers could manage the research and their work responsibilities. In response to the way in which activities were dealt with, the participants commented as follows:

"I liked the way everything was broken down [into] small edible little pieces."

"Everything was in small little pieces that you actually felt you could achieve."

"You [looks at Celia]...you make it applicable, you make it something... it doesn't matter what the challenge is... if you just go about it slowly and you direct your steps then it is achievable."

"At the end of the day you don't feel as overwhelmed."

However, the practice development facilitators from Emergency Department A said the following:

"It is very difficult for us to change anything or to introduce anything new...because the morale is not there...and it is getting worse."

"The workload increase[s] but the staff is decreasing."

The practice development facilitators of Emergency Department A faced unique challenges, as there was no time for meetings in on-duty time, one of them was always "jet-setting", one only had a part-time post and the other practice development facilitator was rotating through the hospital. Most of the meetings held with them were in their off-time and the implementation of actions was a challenge because of the "chaos that is forever present in our unit".

10.4.2.3 Sub-theme 6.3: Fostering relationships

During the data analysis, it was identified that the practice development facilitators realised that they had to build relationships with a variety of people in order to create change. Change is a social process, and for this study required multiple stakeholders; hence, it can be important to foster new relationships and rekindle old ones (Stringer 2014). The relationships implied by the emancipatory practice development process included boundary partners and fundamental participants.

In terms of boundary partners, the focus group discussion did not reveal change in any relationships with doctors in the respective emergency departments, nor did participants provide information about the involvement of a doctor/doctors in the study.¹ The practice development facilitators commented as follows:

"Increasing the multi-disciplinary team that does not just include doctors and nurses but getting in the resources...like you said identifying the stakeholders and being able to pull them in."

"The multi-disciplinary team...from doctors to paramedics to cleaners need to be trained and are involved in forensic care."

"...but it just it will not go away...We still have to target the doctors and trauma surgeons..."

Participants therefore realised the importance of relationships and the involvement of others, such as doctors, despite their not being involved in the study. It was evident that the emancipatory practice development process had assisted the practice development facilitators to expand their view on role players who needed to be involved to change the practice. They shared ideas on how to get doctors more involved in forensic care:

"By setting examples..."

"Once it is there and they (doctors and trauma surgeons) see it being practised continuously, then... then we will start to see change...'cause I mean we own (nurses) resus [the area], they just come and assess the patient two seconds and then they are out."

"If they (doctors) see us practising it more often they will eventually also do it."

These findings correlate with the work of Walker et al. (2013) and Lee (2011). Propp et al. (2010) suggest that when nurses implement new practices, other healthcare providers (including doctors) can make it part of their practice and it can become embedded in existing practices.

In addition to boundary partners, nurses as the fundamental participants had to be prepared for their forensic roles and responsibilities. The practice development facilitators were responsible for

¹ There was one doctor who was very interested in the study, and she has undertaken to engage in further research regarding forensic aspects in emergency medicine.

communication with the fundamental participants regarding feedback and activities. To this end, I continuously reminded and encouraged the practice development facilitators to involve the fundamental participants in all the planned activities. When reflecting on this, the practice development facilitators commented as follows:

"The nursing crew were involved initially...when we went through what it is that we are going, we got ideas from them, we had posters up, they drew the whole tutti-frutti and that was really nice...we had some of them losing interest along the way."

"Process put in place but I found a lot of resistance from the staff... resistance to change...but we are getting there slowly, slowly."

"They are kind of thinking that this is a project done by us and when we are not there it doesn't get done."

"Some don't understand that it (forensic care) does exist... it is a real thing."

"In general there is a very negative morale in our unit... people in general are not interested... we come to work, do what we have to and go home...enough is enough..."

It follows that the practice development facilitators experienced some collaboration, but also some resistance, and a lack of involvement from some nurses. When practitioners work in highly demanding and stressful environments such as emergency departments, it may lead them to feel over-worked and even burnt out. In such cases, multiple levels of challenges are faced when individual, cultural and practice changes are required (Howlett et al. 2014), as already discussed in Section 10.4.2.

The practice development facilitators also reported that positive changes had been made, especially regarding the way that fundamental participants were approached. The following comments provide supportive evidence of this outcome:

"I found that personally for me dealing with the staff...I needed to realise that you can't just force people to do something, you need to go into it slowly and as they see you are doing it then slowly you will get their buy-in."

"My relationship with the staff has improved tremendously."

"They [fundamental participants] were always saying to me...your documents are not up to scratch... and when I was at home I was like ja...your documentation is poor...I needed to make sure that my documentation is up to scratch even if they pull it and audit it you...I know I will get into the nineties so it gives you pressure."

"This exercise of having to go back to them and saying but well hmm... I think my relationship with them has grown...I have learned that there is not just one way of doing stuff and you need to be open to that possibility."

"Communication between the PDF [practice development facilitator] and other people in the unit is definitely better."

It seems that the practice development facilitators learned first-hand that for change to take place in practice, all the participants should be involved in the process and communicated with in order to ensure collaboration and participation. The way the practice development facilitators approached people and reflected on their own needs either to lead by example or to learn new attributes may indicate that personal growth has taken place, as suggested by Martin et al. (2014) and Shaw (2013). The realisations from the practice development facilitators are also in line with the outcome of “improved collaborative and interpersonal relationships” identified by McCormack et al. (2006:118).

10.4.2.4 Sub-theme 6.4: Connecting research to practice

The methodology followed in this study was action research. According to Zuber-Skerritt and Fletcher (2007), the topic of such research should be a real-world problem, in this case, the provision of forensic care by healthcare providers working in emergency departments. As the study progressed, the participants assisted in defining the problem and demarcating the boundaries of forensic care through collaboration, inclusion and participation with the practice development facilitators as the main role players. The practice development facilitators were part of the development of a definition of the problem and of creating context-specific solutions, thereby increasing their commitment and buy-in, as predicted by Guta and Roche (2014) and Rigg (2014). Their appreciation of and experience of their inclusion and participation in the project are captured in the following comment:

“What she [Celia] did – she came and introduced the topic and then we actually spoke about it and she gave us ideas as to what it is and where she wanted to go but it wasn’t just a matter of this is what I want you to achieve. It was more like this is what is out there, this is what I am hoping to achieve, but what are your thoughts on it... how are we going to be able to take it through to the next level, which for me was very important because it makes one take accountability and encourages interest at the end of the day.”

During the discussions, the following comments were made regarding research:

“For me this research was actually not so much about research...[laughs]... Sorry Celia...”

“About research you thinking... yo...I don’t have [a] PhD so I can’t be doing research, I’m in a lower class of research, but the minute she broke it down and you see the cleared picture...Ok I can fit in here.”

It seems that the practice development facilitators generally saw themselves as nursing practitioners and not as co-researchers. To them, it was about improving practice, and not about research, which they viewed as something that is remote from them and mysterious. McBeath and Austin (2014), as well as Austin, Dal Santo and Lee (2012), reported a similar trend among social workers in their studies. Possible reasons for practice development facilitators to steer away from research may be found in the

possibility that practice development facilitators have not been adequately prepared to do and implement research, as Williams and Kilgour (2014) suggest.

Action research and the emancipatory practice development process followed in this study provided sufficient common ground for creating a partnership between the practice development facilitators and me, which could in turn influence some of the behaviour of the practice development facilitators and their views on research, as Barkham (2014) advises. Practice development facilitators generally experienced their involvement in a research project in a positive manner, as is captured in the following comments:

"I liked it because it make it feel relevant; I have always thought of research as something that is there far away...other people's stuff, clever people... but this make[s] me think that I can actually do research... it make[s] it daily like you do it all the time, which is cool."

"I have actually used a lot of things that Celia has done in different way in the unit such as quality improvement projects...which actually had good effects."

Such responses suggest that the study provided a way for me, an academic from the outside, and the practice development facilitators, who are involved in the practice, to learn collaboratively in and from the practice, while participating in research. During the course of the study, the practice development facilitators and some of the fundamental participants realised the relevance of the study. This could bring about increased uptake of the knowledge created during the study, similar to the findings reported by Rubin (2014). In addition, the practice development facilitators have been involved in a research process – according to McBeath and Austin (2014), as well as Williams and Kilgour (2014) such exposure could contribute to increased uptake of research into practice.

The involvement of the practice development facilitators in the research process from the start made them imagine their future and consider the skills they gained. The systematic approach and learning in and from the practice, engaged the practice development facilitators to produce results that are tangible and directly linked to their practice, as suggested by Barkham (2014). The participation of the practice development facilitators may also have inspired them to engage in further academic advancement, as Adegbola (2011) advocates. The participants had the following to say in support of this possibility:

"For me this was really an eye-opening experience...of where I want to go academically and making that seem actually reachable and possible."

"I have learnt how to put a programme together."

"I have learnt how to facilitate teaching... and get people on board."

"The action plan helps us to...ok this is something we can focus on....this is our aim..."

long-term goals for training. This includes the training of paramedics and other first responders to preserve evidence.

In order to secure participation in forensic care, the practice development facilitators suggested open communication with all involved to share ideas, as the practice development facilitators believed that this would ensure better attitudes towards forensic care. One group of professionals that was emphasised was the SAPS. The practice development facilitators argued that if open communication with the SAPS existed, then better feedback amongst emergency departments and the SAPS would take place, thereby helping to change the attitudes of the SAPS, as well as the medical staff's attitude towards forensic care.

10.5.2 Maintaining balance

The practice development facilitators pointed out that nurses must be consistently reminded of their forensic roles and responsibilities to ensure that they fulfil their role of advocacy and role modelling. The practice development facilitators also reminded themselves that even though training will be provided, they should allow time, understanding and patience for the implementation of the training in practice. Additional forensic tasks have to be combined with already existing tasks to ensure that the nurses do not feel overloaded. The practice development facilitators were in agreement that the nurses should also be sufficiently challenged to facilitate a drive for further enrichment. The practice development facilitators were of the opinion that two-way feedback should be implemented. Importantly, it was noted regarding feedback that *"sometimes we need to stop, look how far we have come and celebrate"*.

10.5.3 Expansion of forensic care

The practice development facilitators had a vision of expanding forensic care to a national level by first ensuring that it is realised in their units, then expanding to their hospitals, and then to the wider emergency medicine community. The emergency departments from the two private hospitals also discussed the possibility and desirability of collaborating with each other to ensure better care for forensic patients. The practice development facilitators from the public hospital envisioned that forensic care could become standardised practice, with continuous and consistent efforts.

10.6 Interpreting the findings from the evaluation

In order to generate a deeper understanding of the transformation of forensic care and of the emancipatory practice development process, the findings from the evaluation are explained below in

relation to the frameworks constructed and adapted in this study. Theme 5, which relates to the transformation of practice, is discussed considering the forensic roles and responsibilities framework; adaptations made to the framework based on the findings are discussed. Theme 6, which pertains to the emancipatory practice development process, is discussed in relation to the conceptual framework of this study, as well as to changes made to this framework.

10.6.1 Findings relating to the transformation of practice

Transforming forensic care as it transpired in practice was identified as Theme 5, and captured in the sub-themes, namely increased awareness, acquired knowledge and resources, groundwork for collaboration with the SAPS, and unplanned and unintended actions. In Cycle 3, Sub-cycle 1 of the study, the participants indicated that the forensic care already provided included the collection of evidence, documentation and referral (see Section 6.5.2). However, contradictory reports were made during the evaluation, in that nurses did not think that forensic care was their responsibility or stated that they did not have any real role to fulfil. The lack of role clarification and knowledge regarding South African legislation in this regard may contribute to the fact that nurses believe that the care of forensic patients is the sole responsibility of the doctors. Furthermore, in the hierarchical health system in South Africa, where doctors are in the “power seats”, nurses may feel they do not have the authority or knowledge to meet the forensic needs of patients. However, from the literature reviewed in Chapter 3 (Section 3.6), it is clear that all healthcare providers are in need of additional knowledge and skills to care for forensic patients. The participants also came to understand that the forensic population is much larger than they initially thought, raising their awareness of potential forensic patients in their care.

On reflection, the fact that providing information on wound classification and descriptions were included into the action plans gave me hope that nurses realised that they had a responsibility to observe wounds and classify them before any treatment is provided. A wound in its original state could provide valuable information to corroborate or disprove the history provided by the patient. In addition, when wound classification is done and good descriptions are provided, it is also easier to evaluate treatment and wound healing, indicating that all patients with wounds could benefit from the implementation of this plan. However, to evaluate the progression and quality of wound classification and descriptions, continuous monitoring should be put in place.

The practice implemented to preserve evidence such as placing clothes into paper bags and not cutting through bullet holes might be viewed as small and insignificant changes. However, large amounts of evidence can be preserved by employing just these two practices. Even though healthcare providers

are aware that they are responsible for evidence collection, the evidence must be handed to the police for the progression of the case. Therefore, the initiation of relationships with the police is important and should also be expanded to the forensic analysis units so that a feedback system can be set up to inform healthcare providers regarding the quality of the evidence collected. However, I acknowledge that this is an ambitious goal that will take years of collaboration and education to establish.

Unintended and unplanned actions revealed to the practice development facilitators and to me that forensic care is complex, and that high levels of flexibility are required. The actions planned and undertaken were contextual responses to the needs of each of the emergency departments. At the end of the focus group session, the practice development facilitators reported feelings of guilt about not doing more. As practitioners they have not been accustomed to the role of researcher, and I suspect it could have overwhelmed them, as I certainly was. The feelings of guilt could also have originated from their responsibility of being change agents, but with very little knowledge or exposure to facilitating changes with their associated causes and the causalities that transpired. Practice development facilitators could make changes in their own practice and with the people with whom they had direct relationships; however, wider engagement with most other participants in the emergency departments was not achieved. As the external practice development facilitator, researcher and confidante, I too had doubts about whether or not changes happened, and about whether or not I had succeeded in developing practice. I held onto the words of Klocker (2015), who reminds action researchers that “complex emotions are involved in making change”. I furthermore only now fully appreciate the need for celebrating the small changes, as advised by McCormack (2013). In retrospect, I also understand the reason for really investigating and exploring existing practices, as it is hard to celebrate change if we do not actually know what changed. However, I also gained a sense of what has been achieved from the evaluation by the practice development facilitators – we realised that there had been some changes in practice that have now been implemented and feel as if things have never been different, making me hope that these changes will be sustained.

After the transformation of practice had been evaluated, I revisited the forensic roles and responsibilities framework (see Figure 8.4). The framework was also discussed in detail in Section 8.7.

The evaluation of the study indicated that the healthcare providers who participated have, to some extent, assumed responsibility and have engaged in some training and education to address aspects in the healthcare providers’ triangle. However, taking into consideration the findings as a whole, the training and education that the healthcare providers engaged in was mainly regarding evidence management in order to meet the forensic needs of the victims of violence and crime. Therefore an

aspect in the triangle for victims of violence and crime has been indirectly addressed. More research is still needed regarding the other needs that appear in the triangle (medical, psychosocial and educational needs findings).

Looking at the forensic roles and responsibilities framework presented in Figure 8.4, I realised that I have allocated victims of violence and crime, healthcare providers and the authorities equal parts. However, I started this study with the intent to enlighten, empower and emancipate healthcare providers to deliver better forensic care to victims of violence and crime, so I adapted the roles and responsibilities framework (see Figure 10.1) and put the victims of violence and crime at the centre. This reminded me that anybody and everybody is a potential forensic patient who has the human right to justice.

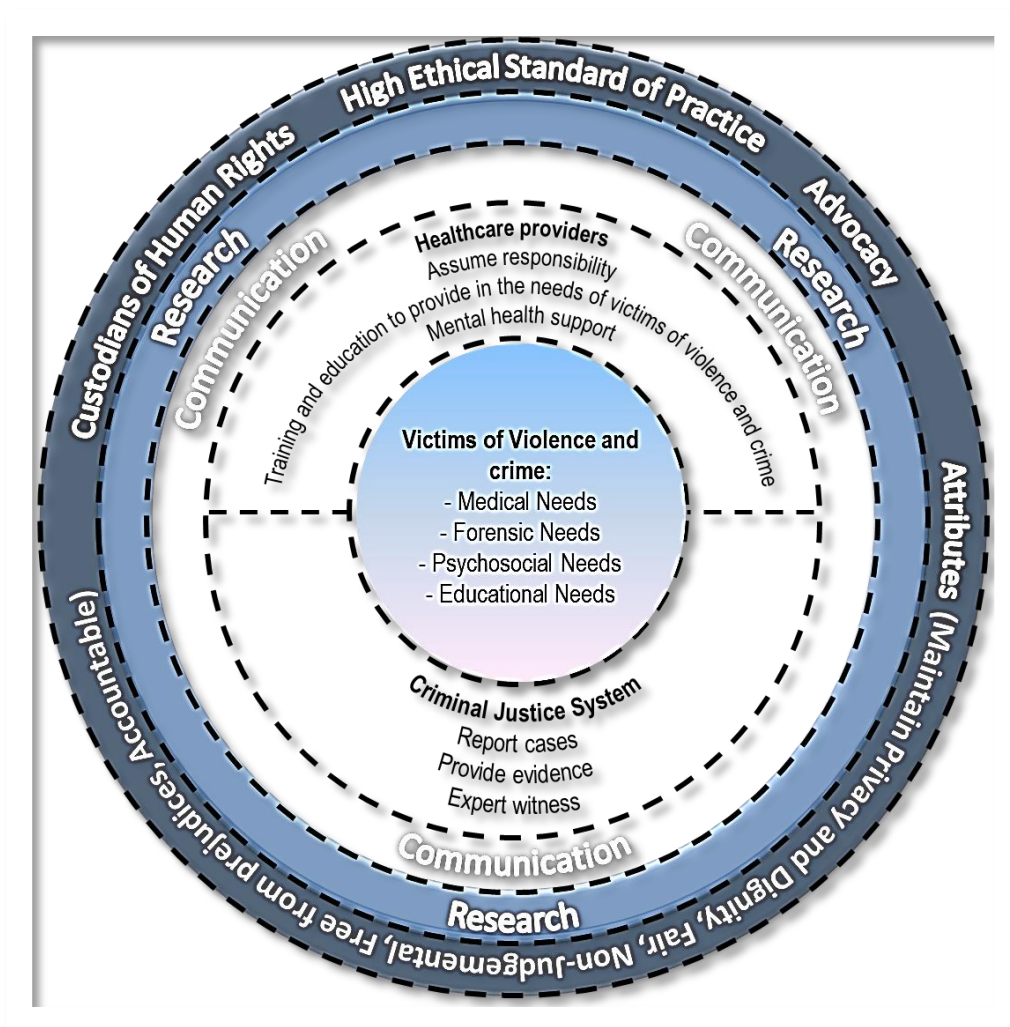


Figure 10.1: Adapted forensic roles and responsibilities framework for healthcare providers

The responsibility that healthcare providers have towards themselves and the criminal justice system was divided into equal parts, as both are needed to provide the needs for the victims of violence and crime. Furthermore, the solid lines between the circles have been changed to interrupted lines, because I feel that there is a lot of fluidity between the components. Although I view the victims of violence and crime as the most important entities in the framework, healthcare providers must practice in the ways prescribed by the outside circle, do research regarding all the components in the framework, communicate research findings, experience and lessons learnt from practice, to ensure better forensic care. In addition, the colours have been toned down using shades of blue to allow readers to interpret the content of the framework without analysing the colours assigned to each of the circles. I hope that this framework will assist healthcare providers at least to find a starting point for forensic care to be provided to victims of violence and crime. When taking the conceptual framework that guided the research activities into consideration, the roles and responsibilities framework is at the centre of transforming forensic care and is needed to direct the desired practice changes.

10.6.2 Experiencing the emancipatory practice development process in relation to the conceptual framework

Theme 6 pertains to how the practice development facilitators experienced the emancipatory practice development process and the related sub-themes that were identified, namely being an outsider as initiator, sustained support, fostering relationships and connecting research to the practice. In the conceptual framework guiding the research in Figure 10.2 (overleaf), no indication of an initiator was provided, but the participants reported that it was important for them to have somebody, in the case of this study, an outsider, to initiate change, as discussed in Section 10.4.2.1. Sustained support, fostering relationships and connecting the research to the practice are situated in the circle, transforming individuals and the context of care.

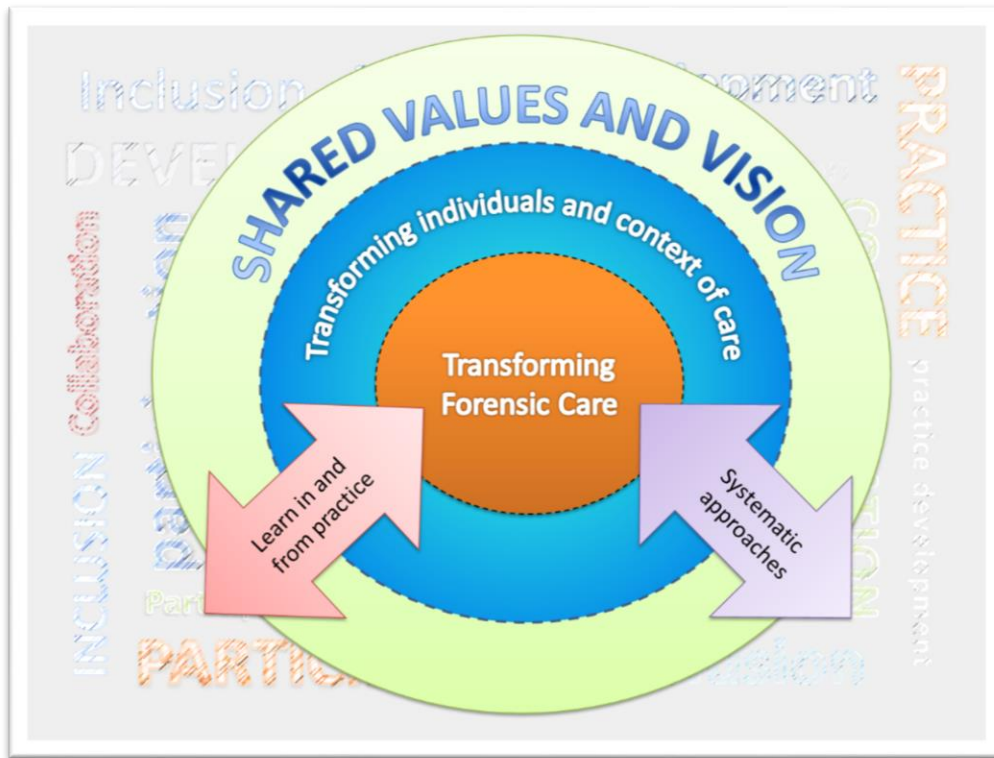


Figure 10.2: Conceptual framework guiding the research process
 (adapted from Garbett & McCormack 2002)

The sustained support provided seemed important, as practice development facilitators commented that it assisted them in focusing on forensic care and kept them motivated throughout the study. Furthermore, the practice development facilitators realised that change cannot be forced onto people and that relationships must be fostered with all parties involved in order to improve ownership and collaboration, as discussed in Section 10.4.2.2. A shift in the practice development facilitators' perceptions on research as being part of the practice was evident and may become part of the culture in the participating emergency departments as the practice development facilitators and fundamental participants were involved in demarcating the research problem, data collection, data analysis and the planning and implementation of actions. Learning in and from the practice could therefore be interpreted as practitioners doing research about their own practice, following a systematic approach.

In the literature, a systematic approach to practice development activities is similarly mentioned and called for (Martin et al. 2014; McCormack, Manley & Titchen 2013; McCormack et al. 2010; Garbett & McCormack 2002), but the details of the *what* and *how* of the systematic approaches are vague. Dewing (2014) and McCormack et al. (2013) mention key steps in the practice development journey, as mentioned in Section 4.2.1.1, and remark that the steps emphasise the meaning of each stage and the relationship between

each to form a systematic approach. The systematic approaches I used in this study are depicted in Figure 10.3 and represent a DNA chain. DNA forms the building blocks of our cells and makes us who we are. In the same way, the systematic approach used in the study forms the building blocks or DNA needed to change practice in this particular study.

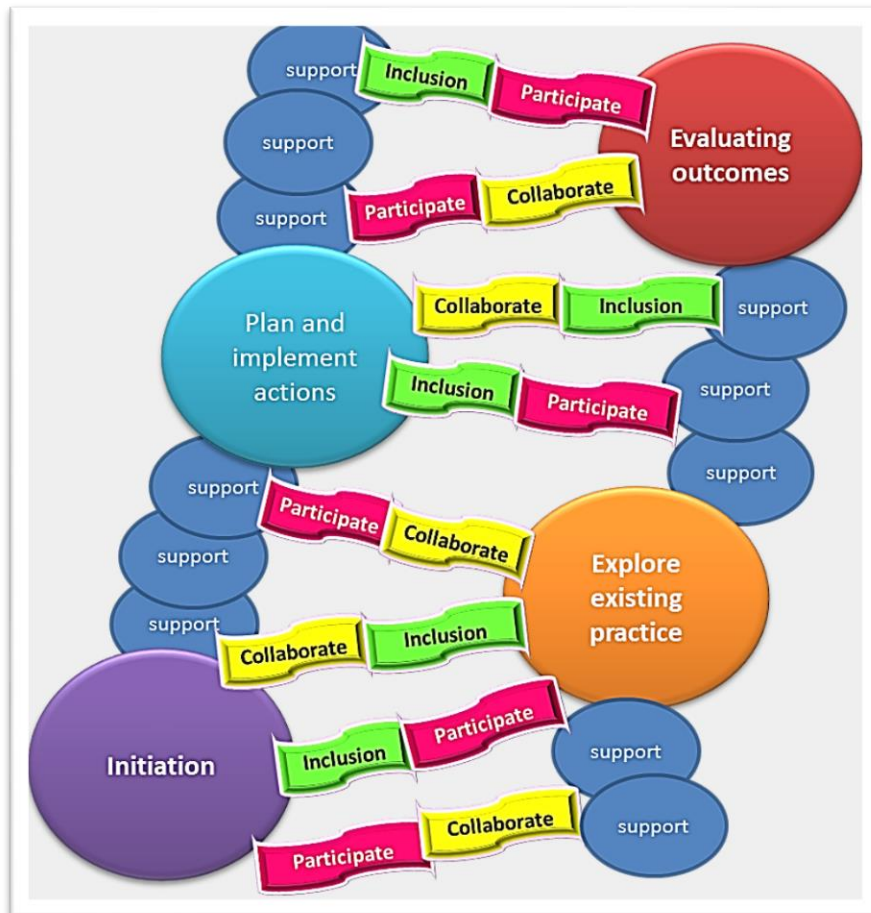


Figure 10.3: The systematic approach used in the study

The systematic approach started with the initiation of the study. The practice development facilitators stated that I initiated the research, and referred to me as the instigator. As an outsider initiating research in these three emergency departments, I had to negotiate access with the ethical review boards, hospitals and unit management before access was granted to the fundamental participants, from among whom the practice development facilitators volunteered (see Section 5.3.1). In the elements of practice development in the literature, no mention was made of initiating the process, and the reports accessible in the public domain also seldom mention the initiation of practice development endeavours. I would argue that for the purposes of research it is important to explore and explain the negotiating process, and to maintain access to the specific context and population as discussed in Section 5.2. Such an explanation could allow readers to have an idea of the time, effort and energy required to establish collaborative, inclusive and participatory

engagements amongst all involved. During the initiation phase, values and beliefs regarding forensic care were clarified, and a shared vision was created for each emergency department, as reported in Section 5.6.

The practice development facilitators were also recruited during the initiation phase. Collaboration and participation between them and me had already commenced, as discussed in Section 5.5. In the practice development steps in prior studies, no mention is made of the volunteering and recruitment of practice development facilitators. In this study, they played an essential part in the study and provided a great deal of support, and what we accomplished could not have been done without them.

Relationships were created and maintained through constant contact with the practice development facilitators, and with sustained support from my side. During the evaluation stage of the study, practice development facilitators seemed very comfortable with my presence, even though I had been a stranger just a few months ago, and there was a sense of familiarity.

The next step in the systematic approach was exploring the existing practice, in line with the practice development step of getting started together. The existing practice for forensic care was measured and evaluated by the practice development facilitators and the fundamental participants and doctors as boundary partners. Next, collaborative plans were proposed and some were implemented to address the challenges identified in Cycle 3, Sub-cycle 2. Although some of the actions planned were not implemented, progress was made, as can be seen from the evidence provided in Section 9.3.

The implementation of the action plans was followed by evaluating the outcomes, as discussed in Sections 10.4.1 and 10.4.2. The future plans proposed by the practice development facilitators (see Section 10.5) may lead to the start of new cycles of research regarding the practice in these emergency departments. The healthcare providers involved learned in and from the practice, as well as from each other. In this process, existing relationships improved, due to the participants' and my commitment to collaboration, inclusion and participation (Dewing et al. 2014; McCormack, McCance & Maben 2013). This too is in line with the steps of practice development. The collaboration, inclusion and participating principles form the connections between the DNA strings that bind the activities of the research together. None of the progress made would have been possible without staying true to the principles of collaboration, inclusion and participation.

10.7 Summary

The evaluation of the action implemented as part of the emancipatory practice development process in this chapter revealed that changes occurred in the practice and in the practice development facilitators

as individuals. From the actions planned for future implementation by the practice development facilitators, it is apparent that the work to be done around forensic care in emergency departments is far from complete. However, there has been some movement in the right direction, as the existing forensic practices have been revisited, restructured and updated, and some new practices have been instituted.

In Chapter 11, a realist evaluation of the outcomes of the study is presented, followed by conclusions based on the findings. The thesis concludes in Chapter 12, with recommendations for future research and practice.

PART III (CHAPTERS 11 AND 12): BACK TO THE LABORATORY

After the collaborative part of the study was done in the field with the participants and concluded, I engaged in a realist evaluation. Part III of the study is highlighted in Figure 11.1. It contains Chapter 11 – Considering the processed evidence, and Chapter 12 - Adjournment.

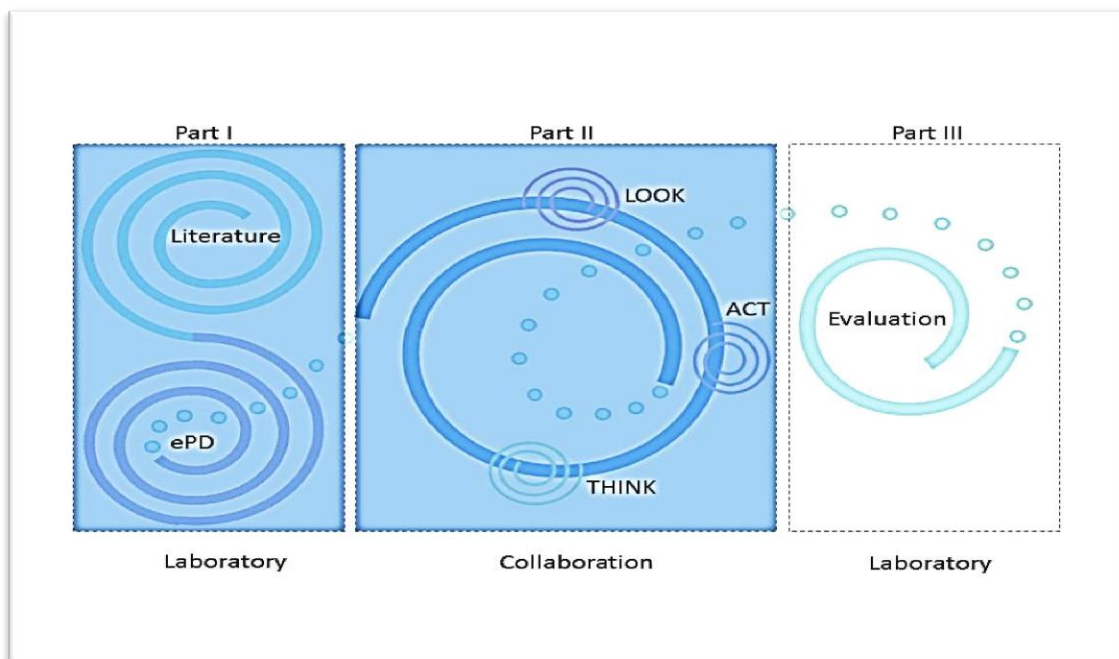


Figure 11.1: Overview of Part III

I did a realist evaluation to identify the outcomes of the study. The outcomes were improved awareness and improved ways of working. Furthermore the mechanisms triggered to achieve these outcomes are also revealed. In addition, the application of action research and emancipatory practice development as the change process has demystified research for many of the practice development facilitators, possibly helping practitioners to be more open to research and research findings in future.

The final chapter (Chapter 12) holds my potential contributions to the body of knowledge and practice. Recommendations and suggestions for further research are listed in the hope of inspiring other academics, services and practitioners to search further and to provide better care to the forensic population in need of their assistance.

CHAPTER 11: CONSIDERING THE PROCESSED EVIDENCE

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11.1 Introduction

In Chapter 10, I presented and discussed the collaborative evaluation done with the practice development facilitators. This marked the end of the collaborative part of the study (the work “in the field”). For the final part of the study, I moved back into the “laboratory”, away from the participants, and undertook an evaluation to probe the transformation (if any) that had occurred. Evaluation is an important aspect in both action research (Stinger 2014; McNiff & Whitehead 2006), and practice development (Hardy, Wilson & McCance 2013).

The evaluation method I opted for was a realist evaluation that was developed by Pawson and Tilley (1997), who used critical realism as their paradigm. The realist evaluation assisted me in identifying and explaining possible solutions for improving forensic care in emergency departments.

11.2 Looking at realist evaluation

A realist evaluation is traditionally used by policy-makers to explain what worked for whom, and in what circumstances. A realist evaluation does not provide a comprehensive account of the research process and findings; rather, the focus of the evaluation is to explain outcomes in relation to context and to the mechanisms that have been triggered (Slater & Kothari 2014, Parlour & McCormack 2012). Therefore the findings of the study will not be discussed in this chapter.

The outcomes of the study resulted from the mechanisms triggered in a specific context. Mechanisms are located in the stratified reality, of the actual, the real and the empirical, as discussed in Section 1.7.1, and they refer to the causal processes triggered to generate outcomes (Dalkin et al. 2015). Taking into consideration the stratified reality of critical realism, it is necessary to remember that not all mechanisms are directly observable. Mechanisms are resources, opportunities or constraints that influence people’s decision-making and actions (Wand et al. 2010). Researchers undertaking a realist evaluation are prompted by Slater and Kothari (2014) to monitor actions, as such an evaluation provides information about the resources made available, and who responded in what ways, and why.

Mechanisms are mostly hidden and sensitive to the context where outcomes are generated. According to Pawson (2013), the context includes the individuals involved, interpersonal relations, the institutional setting and infrastructure. The context influences whether and how programmes are implemented and to what extent, as all endeavours for change are introduced into existing social structures (Pawson 2013). Therefore Wand et al. (2010) point out that people are the reason programmes work or not, rather than the programme itself.

In order to conduct the realist evaluation, I constructed a context-mechanisms-outcomes configuration (see Figure 11.1) in an attempt to provide explanations about the mechanisms that were triggered, as well as the causes and causalities of the triggered mechanisms, as recommended by Wand et al. (2010). Marchal et al. (2012) and Wand et al. (2010) warn that undertaking a realist evaluation is a complex and time-consuming activity. The complexity stems from the multifaceted nature of social structures present in the context, and the observed and dormant mechanisms that exist in reality. Both Marchal et al. (2012) and Wand et al. (2010) acknowledge that the literature is vague on how to differentiate between context and mechanisms. Despite the difficulties mentioned, Marchal et al. (2012) state that doing a realist synthesis contributes to a better and deeper understanding of how practice can be developed with practitioners in their own context.

11.3 The Process followed

The process started with my looking at what a realist evaluation is and how it can be used, followed by thinking about how to apply it. Traditionally, a realist evaluation starts off with a programme theory, also referred to as the perceived outcomes of a programme (Pawson 2013). However, as the evaluation in this study is part of the study, and action research was used as the methodology, uncertainty about the direction the participants would take prevented me from coming up with a preconceived programme theory. Before the evaluation could start, I had to generate outcomes statements. I revisited the conceptual definition of transformation used in this study (see Section 1.8.1) and reflected on what transformation of forensic care would mean.

After *thinking* about the six themes identified in this study, namely:

- Theme 1: Roles and responsibilities towards victims of violence and crime
- Theme 2: Roles and responsibilities towards the authorities
- Theme 3: Roles and responsibilities regarding healthcare providers
- Theme 4: Raising awareness
- Theme 5: Transformation in practice
- Theme 6: Experiencing the emancipatory practice development process

I reached the conclusion that the outcomes statements of transforming forensic care in this study were an increased awareness of the forensic population and of healthcare providers' roles and responsibilities towards victims of violence and crime, as well as improved ways of working. I then *acted* by assembling the context, mechanisms and outcomes configuration for this study, as illustrated in

Figure 11.2. The aim of the configuration is to explain the mechanisms triggered to reach the identified outcomes.

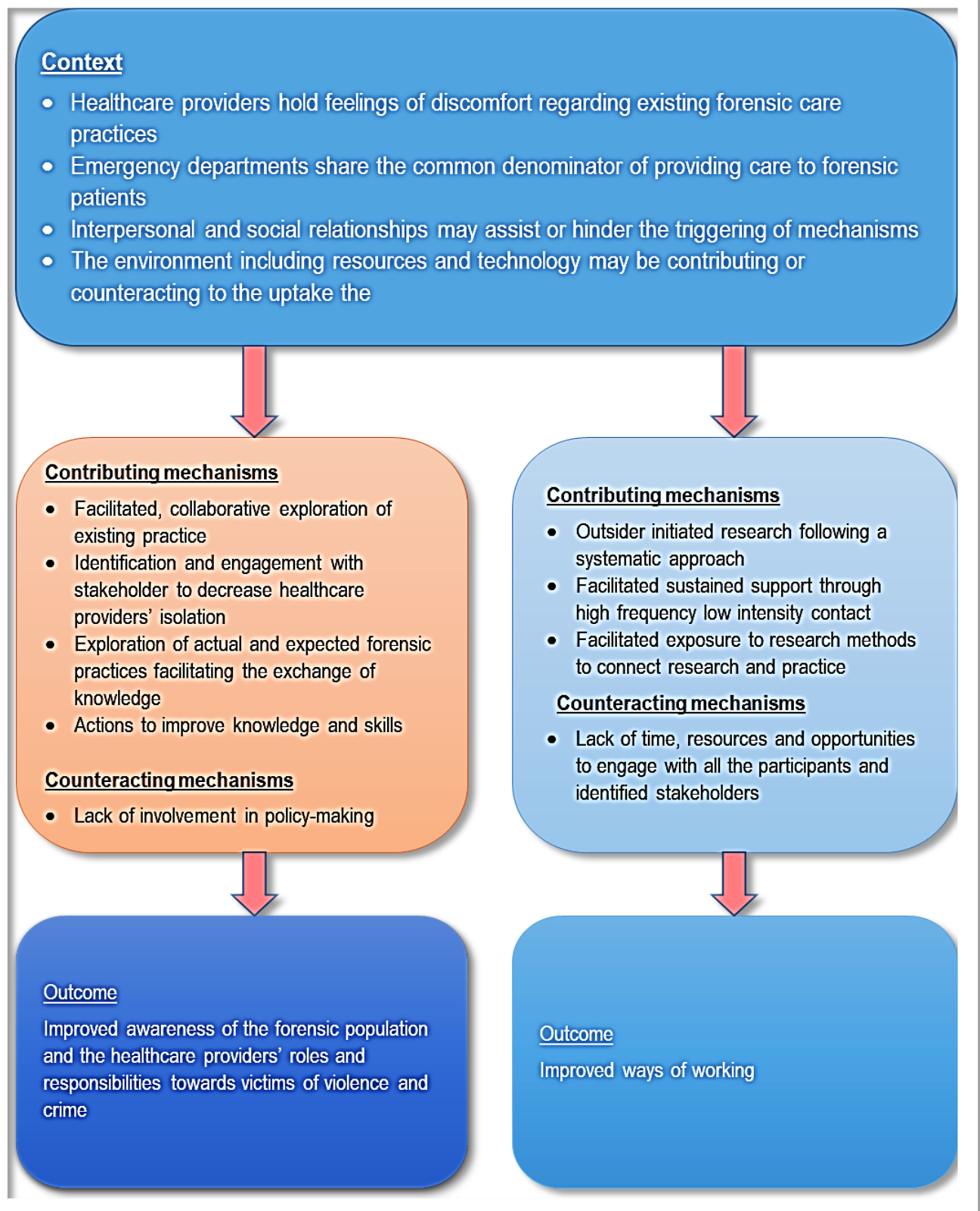


Figure 11.2: Context- mechanisms-outcomes configuration

11.4 Specifying the context

The outcomes were attained in the context of the level-one emergency departments where, through the research, the healthcare providers became aware of the lack of desirable forensic care practices in the departments (and by implication in healthcare in South Africa in general). The healthcare providers acknowledged that forensic care should be provided to victims of violence and crime, but indicated that the exact procedures that they were to follow were, to some extent, a mystery. Despite this acknowledgement that forensic care should be provided, the timing and the existing interpersonal and social relationships in the three participating emergency departments influenced the mechanisms (constructive or obstructive) that were triggered.

In Emergency Department A, the working environment is characterised by individual groups that do not engage with each other, and there is a culture of hierarchical and specialist silos. The extent to which forensic care was transformed in Emergency Department A was therefore limited to the groups to which the practice development facilitators belonged. Despite the problem of divergent groups, Emergency Department A was the only place where some doctors participated in the study. This was possibly due to their awareness of the importance of research in a level-one emergency department, given that some of the doctors are associated with the university in some capacity and the hospital is a teaching hospital. In Emergency Departments B and C, most doctors were passive onlookers, while nurses as the fundamental participants collaborated and participated in the study.

The resources available to the participants also influenced how the mechanisms that were triggered by the research process were acted upon. Emergency Department A, for instance, began recycling practices to ensure that paper bags were available for evidence collection, whereas Emergency Departments B and C could simply order paper bags from their hospital suppliers.

I am convinced that all the participants involved in the study are more aware of the forensic patients in their care and that this awareness will be carried with them, even if they were to change their place of employment. The findings also indicated that forensic care can be provided in a variety of healthcare settings, regardless of the resources, equipment and technology available. The starting point is that some healthcare providers embrace their forensic roles and responsibilities towards victims of violence and crime. This confirms that changes are not specific to a single context, but depends on the people involved, as it is the people in a programme that make it work, not just the programme itself (Wand et al. 2010).

The literature emphasises the context and workplace culture during the initiation of a practice development endeavour (Shaw 2013; Snoeren & Frost 2011). However, during a scoping review of the relevant literature, specifically pertaining to practice development regarding the context in the outcomes and restricted to electronic sources available in the public and scientific domain, I found limited information on the role of the context towards the end of a study. The literature reviewed mentions context-specific outcomes (Bläuer, Frei, Schnepf & Spirig 2015; Watling 2015; Read & Palmer 2013), context-based solutions (Van der Donk & Kuijer-Siebelink 2015), but little information is available on how to address the questions of whether or not, and how, the context has changed after practice development endeavours. Similarly, the literature on action research is also silent on the influence that research has on the context within which the research took place. Where context is mentioned at all, the discussions pertain to the transferability of context-bound findings to other settings (Stringer 2014).

11.5 Thinking about the mechanisms in relation to the outcomes

The two outcomes that were identified, were improved awareness of the forensic population and the healthcare providers' role and responsibilities towards victims of violence and crime, and improved ways of working. These outcomes were achieved through triggering mechanisms that led to the manifestation of the outcomes in the empirical realm of reality. The purpose of providing an explanation of what mechanisms were triggered, and a discussion relating to how the mechanisms triggered each outcome is presented below.

11.5.1 Improved awareness

Improved awareness was caused by contributing mechanisms such as the facilitated, collaborative exploration of existing practice, using the talking wall (see Section 6.3) as a data generation method to include as many healthcare providers in the emergency departments as possible. Even though the broad topic for the study was preconceived, the participants were given the opportunity to explore existing practice and provide direction regarding forensic care in their context. In both practice development and action research, practice is often observed with the purpose of creating awareness of the existing situation. However, due to the vulnerability of forensic patients and the limited knowledge relating to their exact management, I opted not to observe practice. I am of the opinion that the use of the talking wall initiated awareness more efficiently and more collaboratively, by drawing on the participants' own existing knowledge. I acknowledge that I may have been fortunate in that an unplanned and unrelated factor, a highly publicised murder trial that was in the news at the time, might have aided my attempt to improve awareness.

The exploration of exiting practice triggered the participants to want to identify stakeholders. The stakeholder analysis (see Section 5.3.3) allowed the participants to identify the stakeholders that they must collaborate with in order to provide better care to victims of violence and crime, as well as to understand the vast number of stakeholders involved. The identification of stakeholders is a principle of practice development (see Section 4.2.1.1) and of action research (Stringer 2014) that contributes to the understanding of how complex the development of practice is. The identification of stakeholders then elicited questions relating to who must do what this lead to the exploration of the roles and responsibilities of healthcare providers , as it was an aspect on which healthcare providers have a high level of influence (see Section 10.5.1). In this study, the exploration of actual and expected forensic roles and responsibilities concluded with the creation of a framework (see Figure 10.2) to guide healthcare providers in their care of forensic patients. The framework could be used to inform healthcare providers of their forensic roles and responsibilities in the wider context of healthcare.

The identification of the actual and expected roles and responsibilities of healthcare providers in forensic care provided opportunities for actions to improve knowledge and skills of the participants involved. The direct actions taken to improve the knowledge and skills included learning in the workplace and training by the DNA Project (see Table 9.1 for a summary of the planned and implemented actions). The importance of action learning has been highlighted by Janes et al. (2015), McCance and Wilson (2015), Odelius et al. (2015), and Watling (2015) in their practice development research, where they refer to the improvement of knowledge and skills. The improved knowledge and skills contributed to creating an improved awareness amongst healthcare providers relating to the forensic population requiring care from emergency departments.

In addition to the contributing mechanisms, one counteracting mechanism was identified, namely a lack of involvement with policy-making regarding the care of forensic patients. Access to the stakeholders from the criminal justice system was difficult to navigate. However, I am hopeful that with an increased uptake of forensic roles and responsibilities by healthcare providers, they will get to know the landscape of the criminal justice system better, and will be able to pursue their stated intent of making contact with the relevant stakeholders.

11.5.2 Improved ways of working

According to the literature, action research ventures are often initiated by insiders who identify a problem within their organisation (Coghlan & Brannick 2010), but this did not apply in this study. A contributing mechanism was that the participants indicated that in their context, in order to improve

awareness relating to the forensic population, an outsider (myself) had to initiate the research. Healthcare providers are often overwhelmed by the vast number of patients and amount of work they face, which may lead to disengagement (Rezaei et al. 2015). The healthcare providers had a vague sense of their forensic roles and responsibilities, but did not engage in any action to transform their situation and level of knowledge. The practice development literature I reviewed provided no explicit descriptions of *how* studies were initiated in the clinical setting, although a few mention that practice development initiatives were commissioned by the National Health Services (Rodgers 2016; McCormack & Dewing 2013; Miller, Corbett & Lightbody, 2012).

The practice development literature advocates a systematic process. In the study, to assist in improving ways of working in the three participating emergency departments, I adapted the systematic approach (see Section 10.6.2). The adapted version provides information on the details of the systematic approach I followed, and provides more structure than the key steps for a practice development journey (see Section 4.2.1.1).

The type of support advocated by most practice developers are “high challenge, high support” (Hardiman & Dewing 2014; Manley et al. 2014; Titchen, Dewing & Manley 2013). Watling (2015) and Shaw (2012) have reported that participants have described an increase in workload and responsibility during practice development activities, and experienced a high challenge, high support approach as frustrating, albeit encouraging. However, due to the highly stressful work environment that exists in the emergency departments, I opted for high frequency, low intensity support. The high frequency, low intensity support I provided (see Section 10.4.2.2) was a contributing mechanism as the practice development facilitators did not become too overwhelmed by extra responsibilities and took ownership of any change. The practice development facilitators appreciated the support and this contributed to collaboration, inclusion and participation. The participants also lost some of the fear of research that they felt before their participation in the study (see Section 10.4.2.2).

The research was taken to the healthcare providers caring for patients at the bedside, as proposed by the principles of practice development (McCormack et al. 2013) providing resources and opportunities for future research. The practice development facilitators were involved in organising sessions, as well as in generating, collecting and analysing data, exposing them to scientific methods of problem-solving. This involvement by the practice development facilitators narrowed the gap between the academics and the practitioners.

The counteracting mechanisms that were identified were a lack of time, resources and opportunities to engage with all the participants and identified stakeholders. Lack of time is an acknowledged limitation

of action research. The lack of engagement between me and the fundamental participants made me realise that I still need to develop my facilitation skills and seek more effective ways to prepare practice development facilitators for their roles and responsibilities.

11.6 A mirror has two faces

The realist evaluation allowed me to explain the mechanisms that were triggered and that led to the outcomes of the study (See 11.5.1 and 11.5.2). The transformation of forensic care might not be complete but the foundations have been put in place, as some participants, especially the practice development facilitators, are more aware of their forensic roles and responsibilities. Furthermore, the theory of the methods used to generate data has been provided to the practice development facilitators, and they were actively involved in the data generation and analysis during the collaborative part of the study, capacitating them to pursue similar research in future. Before the study was completed, one unit manager had already applied a method used in the research for a quality improvement project.

I learned that healthcare providers in practice have not been exposed to collaborative, inclusive and participatory research, and that the use of action research as a methodology still makes some researchers highly uncomfortable. The participants were always surprised when I gave them feedback, put up new posters on the talking wall, and engaged in conversations about forensic care and research. I believe that social interaction of this nature with the participants contributed to the increased awareness of forensic care achieved in the study. The application of action research following emancipatory practice development as a change process required energy and commitment towards the process and the participants, to ensure that the participants realised that the change was in their hands, and I was merely the initiator and facilitator of the process. It was also confirmed (see Section 10.4.2.2) that there is still a lot of mystery around research in and on practice, but the way in which I conducted the research with the participants in practice demystified research to some extent for the practice development facilitators. In addition, the choice of critical realism as my paradigm allowed me to work eclectically, allowing me to respond to the context and culture of the emergency departments and transform forensic care to improve the management of victims of violence and crime in ways that might lead to the realisation of the human right for justice.

11.7 Summary

In this chapter, I have discussed the realist evaluation I conducted to identify the outcomes of the study as well as the mechanisms triggered to reach the outcomes. In Chapter 12, I discuss the conclusion of

the study by considering its potential contributions, followed by recommendations to legislators, for practice and education, and some suggestions for future research.

CHAPTER 12: ADJOURNMENT

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12.1 Introduction

In Chapter 11, I discussed the realist evaluation done for the study. In this final chapter, I conclude the study by indicating its potential contributions. I make recommendations to legislators, for practice, regarding education and for some novice researchers, based on my experience in this study and my findings. Finally, I provide some suggestions for future research to take forward the work in this study.

12.2 Potential contributions of the study

The potential contributions of the study are fourfold. It has enhanced knowledge in four areas, namely theory, methodology, methods and the healthcare profession. The main theoretical contribution of this study is that it adds to and strengthens the growing body of literature on emancipatory practice development to initiate changes in practice that serve both healthcare providers and patients. The emancipatory practice development process advocates for systematic approaches to change practice. The exact components of such a systematic approach that I assumed for this study are contained in the key elements of practice development (see Section 4.2.1.1). In order to provide a clearer picture of the systematic approach used, I constructed a DNA chain (see Figure 10.3) of the systematic approach and placed it within the conceptual framework of the study (see Figure 12.1).

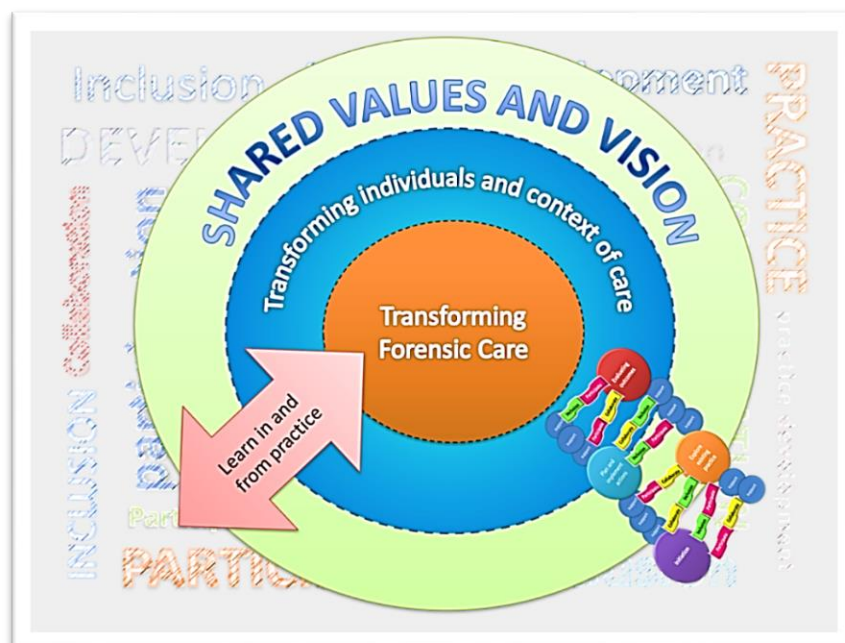


Figure 12.1: Adapted conceptual framework (compare to Figure 4.2)

The systematic approach started with initiating a change process. Then the existing practice was explored, followed by planning and implementing actions. The process concluded with an evaluation of the outcomes in terms of the changes achieved. In order to ensure that the systematic approach is not disrupted, it is essential to ensure collaboration, inclusion and participation by the participants whose practices are to be developed. The clarification of the components of a systematic approach can thus provide guidance to researchers who want to use emancipatory practice development as a change process, or to refine the identified components of the systematic approach. Furthermore, fellow researchers who wish to bring about change in practice may follow similar steps to address other challenges. A successful outcome seems possible if researchers stay flexible and if interactions are based on authentic collaboration, participation and inclusion. Neither action research nor emancipatory practice development is a process that can be rushed or imposed on people. The processes should follow the direction and pace set by the people in practice so that it is applicable to their practice, so it may cause stress and anxiety when research is done with one eye constantly on the clock.

The methodological contribution of this study relates to negotiating access to the healthcare providers in the identified emergency departments, especially if the research is initiated by an outsider. Such access is necessary when an action research approach is followed, as this approach may not be familiar to all (if any) of the selected participants. The description of how the process unfolded may assist other researchers to realise the importance of negotiating access and spending sufficient time on discussing how they gained access. The negotiation of access is often taken for granted in studies, but if research is to be conducted *with* practitioners and not *on* them, the participants' buy-in and continuous participation is crucial. Access must be negotiated and maintained to break down perceived power relationships and to ensure equal participation and valuable inputs.

This study makes a contribution to the development of methods in its use of a talking wall as both a data generation method, and a place where findings of the study were shared with the participants in the emergency departments. The talking wall was originally used to foster inter-professional communication. In this study, a talking wall initiated conversations about forensic care, and became a central area to communicate findings, actions and information. Furthermore, the nominal group technique was modified by including rules of engagement, as recommended for facilitating group interactions. Two questions were posed to ensure that participants could voice their opinions and provide input on the actions planned to bring about change. The nominal group technique did not include any ranking or voting activity to prioritise the findings, as is usually included, because I hoped that practical implications would be determined by the practice development facilitators, who knew the

context and practice of their respective emergency departments and to avoid a false hierarchy of forensic care needs and activities. Another possible method contribution relates to the emerging body of knowledge on the use of art-based activities during focus group discussions, and how this strategy can support active engagement and focus participants' activities.

The profession-related contribution of this study relates to the participating healthcare providers' increased awareness of the existing forensic population, how they should be managed, and their right to justice. The expanded understanding of who the forensic population in South Africa may be can assist healthcare providers. The identification of the forensic roles and responsibilities of healthcare providers were presented in the form of a framework (see Figure 10.1) that may serve as a guide for personal and institutional educational endeavours. This framework was based on the findings of the nominal group and the realist synthesis done in this study. It might be highly context-bound and may require adaptations, but I am convinced that it sheds some light on the topic and helps to overcome the finding of prior studies which suggest that in South Africa forensic roles and responsibilities are only implied.

12.3 Recommendations

The recommendations made relating to the study are based on the evaluations in collaboration with the practice development facilitators in Chapter 10, the realist evaluation discussed in Chapter 11 and the potential contributions (see Section 12.2). The recommendations relate to legislators, the practice, education and novice researchers.

12.3.1 Recommendations to legislators

I recommend that the existing *Regulation 176* (South Africa 2012) be amended to incorporate the forensic roles and responsibilities of healthcare providers more explicitly, as captured in the framework (see Figure 12.2).

Furthermore, government departments that develop documents and policies, such as victims' rights charters and minimum standards of care for victims of violence, should consult with healthcare providers who deliver care to these patients to ensure that more stakeholders are included. If healthcare providers are consulted, the services promised and orders promulgated may be achievable and realistic, in line with the services that can actually be rendered. This could potentially ensure that regulatory documentation is all-encompassing and implementable.

It also remains important to define healthcare providers' expected roles and to inform them of these roles to avoid ambiguities that could potentially lead to inadequate care provision to the forensic population or increase litigation against healthcare providers.

12.3.2 Recommendations for practice

Healthcare providers working in emergency departments are in an ideal position to provide forensic care to more both victims of sexual assault and other categories of forensic patients. They should therefore engage in learning activities to enhance their knowledge and skills regarding forensic care. In order for healthcare practitioners to assist with victims' right to justice and increase their own awareness, statistical recording of the forensic population should be expanded to cover the 27 categories of forensic patients recognized in some other countries.

In order to provide care to forensic patients, healthcare providers should meet the medical, forensic, psychosocial and educational needs of patients by ensuring that a multi-disciplinary team from different sectors is available. The onus of the responsibility to reach out and identify a liaison from associated services, including representatives from social development, the police, prosecutors, victim empowerment organisations, etc., lies with healthcare providers, who deliver care to the forensic patient population. Each emergency department is responsible to reach out to available service providers in the area so that collaborative relationships can be established that may in turn result in good forensic care to victims of violence and crime.

12.3.3 Recommendations for education

Some prior studies have made some recommendations for education and training (see Sections 3.5.5 and 3.6) similar to those made in this study, but it takes time for recommendations such as introducing forensic aspects into the education and training of healthcare providers to be implemented in practice. Healthcare providers who undertake undergraduate and postgraduate studies should be made aware of forensic patients and their needs – unless there is sufficient awareness, no actions can be initiated. For healthcare providers already in practice who are inadequately prepared to provide forensic care, short courses need to be developed that include special consideration of 27 categories of forensic patients, and not just victims of sexual assault. Extended knowledge of healthcare providers regarding forensic patients can potentially improve opportunities for victims of violence and crime to seek justice. The physical evidence that would be collected and detailed documentation of injuries sustained could assist with the progression of cases in the criminal justice system.

12.3.4 Recommendations to novice researchers

Novice researchers wishing to undertake action research should be warned that even though this type of research is recognised by some disciplines and research scholars, there is still strong criticism of the approach from many parts of the scientific community. Action research scholars such as Titchen (2015), Coghlan and Brydon-Miller (2014), Stinger (2014), Williamson, Bellman and Webster (2012) and McNiff and Whitehead (2006) advocate innovation, individuality and creativity, but caution that research must still be scientific. Action researchers must be explicit in their explanations and descriptions in all aspects of the study to enable readers to make judgements regarding the science and contribution of a study.

To do the research with practitioners, a researcher needs to be highly committed and flexible as the possibility always exists that the practitioners may take a different direction than the initial intention of the researcher. If the researcher is not flexible and able to embrace chaos, I recommend the use of more traditional research methodologies.

12.4 Suggestions for further research

Future research possibilities, as identified from the findings and insights gained during the study, include future research on forensic care, and also on participatory methodology and applications of the emancipatory practice development process.

Future research in forensic care may include the following:

- a comparison between the reported and actual practice of healthcare providers in a specific focus area, such as the identification and management of forensic patients;
- a descriptive study explaining the collection of evidence in emergency departments and the influence this has on the case progression of victims of violence and crime;
- an explanatory study on the forensic population's perceptions of the forensic care they receive in emergency departments in order to implement actions that could enhance the care that is delivered;
- a follow-up participatory study on refining and further developing a framework for forensic roles and responsibilities for healthcare providers;
- explanatory studies on the barriers and enablers of multi-disciplinary and multi-sectorial collaboration for better outcomes for the victims of violence and crime, in terms of management and follow-up of forensic patients;
- a comparative case study on the burnout levels of healthcare providers working in private and public emergency departments; and/or

- explanatory studies on the barriers to and enablers of the transfer of knowledge and skills between practice development facilitators and fundamental participants.

Future research on participatory methodology and the application of emancipatory practice development may include:

- explanatory studies regarding the perceptions and awareness of power relationships in the emancipatory practice development process and how these power relationships evolve during the implementation of an emancipatory practice development process;
- a case study on the significance of values and beliefs when working towards changed practice; and/or
- applied research regarding the potential value of a talking wall as a data generation method in participatory studies.

12.5 Conclusion

Healthcare providers working in emergency departments are responsible for providing medical care to all who seek care. Given that forensic patients are amongst the people seeking medical care in emergency departments, their forensic needs must be taken into consideration. If a forensic patient is overlooked, evidence present on the patient's body may become contaminated and/or be destroyed by healthcare providers, making it impossible to use such evidence in the possible pursuit of justice later.

Forensic care, which forms part of clinical forensic medicine, is still developing, and few South African healthcare providers are adequately prepared to fulfil their expected roles and responsibilities towards victims of violence and crime. One of the current challenges is that perpetrators can often safely rely on the fact that many healthcare providers are ill-equipped to care for the forensic population.

In an attempt to assist healthcare providers in three South African level-one emergency departments to transform their forensic practice I employed action research and emancipatory practice development as a change process. In South Africa, level-one emergency departments must provide leadership to other levels of emergency departments in both the public and private sectors, as victims of violence and crime may seek medical attention in any level emergency department. In this study, the participating healthcare providers gained knowledge and skills regarding forensic care, as well as knowledge on processes to be followed to solve practice problems, based on scientific methods. The process of doing research with practitioners is riddled with obstacles and uncertainties, but the outcomes are rewarding, because such research leads to personal and professional growth in all parties involved.

REFERENCES

- Abdool, N.N.T. & Brysiewicz, P. 2009. A description of the forensic nursing role in emergency departments in Durban, South Africa. *Journal of Emergency Nursing*, 35(1), 16-21.
- Abrahams, N., Mathews, S., Jewkes, R., Martin, L.J. & Lombard, C. 2012. Every eight hours: Intimate femicide in South Africa 10 years later! *South African Medical Research Council*, August, 1-4.
- Abrahamson, K.A., Fox, R.L. & Doebbeling, B.N. 2012. Facilitators and barriers to clinical practice guideline use among nurses. *American Journal of Nursing*, 112(7), 26-35. [<http://dx.doi.org/10.1097/01.NAJ.0000415957.46932.bfj>]
- Adams, J.A., Starling, S.P., Frasier, L.D., Palusci, V.J., Shapiro, R.A., Finkel, M.A. & Botash, A.S. 2012. Diagnostic accuracy in child sexual abuse medical evaluation: Role of experience, training and expert case review. *Child Abuse and Neglect*, 36, 383-92. [<http://dx.doi.org/10.1016/j.chiabu.2012.01.004>]
- Adams, P. 2010. Action research. In Salkind, N.J. ed. *Encyclopaedia of research design*. London: Sage, 5-10.
- Adegbola, M. 2011. Soar like geese: Building developmental network relationships for scholarship. *Nursing Education Perspectives*, 3(1), 51-3.
- Alsaif, D.M., Alfaraidy, M., Alsowayigh, K., Alhusain, A. & Almadani, O.M. 2014. Forensic experience of Saudi nurses; an emerging need for forensic qualification. *Journal of Forensic and Legal Medicine*, 27, 13-6.
- Amar, A.F. 2016. Response to victimization. In Amar, A.F. & Sekula, L.K. eds. 2016. *A practical guide to forensic nursing*. Indianapolis, IN: Sigma Theta Tau International, 55-75.
- American Academy of Forensic Sciences. 2010. *History of forensic science*. [Online] Available from <http://www.aafs.org/about/history-aafs> [Accessed 11 April 2015].
- Angus, J.E. & Clark, A.M. 2012. Using critical realism in nursing and health research: Promise and challenges. *Nursing Inquiry*, 19(1), 1-3.
- Aragón, O. & Macedo, G. 2010. A "Systemic Theories of Change" approach for purposeful capacity development. *Institute of Development Studies Bulletin*, 41(3), 87-99.

- Archer, M.S. 2000. *Being human: The problem of agency*. Cambridge: Cambridge University Press.
- Archer, M.S., Bhaskar, R., Collier, A., Lawson, T. & Norrie, A. eds. 1998. *Critical realism: Essential readings*. London: Routledge.
- Aschman, G., Meer, T. & Artz, L. 2012. Behind the screens: Domestic violence and health care practices. *Agenda: Empowering Women for Gender Equity*, 26(2), 51-64. [<http://dx.doi.org/10.1080/10130950.2012.700221>].
- Assid, P.A. 2011. Transforming an emergency department: From crisis to excellence. *Journal of Emergency Nursing*, 37(6), 537-40.
- Austin, M.J., Dal Santo, T.S. & Lee, C. 2012. Building organisational support for research-minded practitioners. *Journal of Evidence-Based Social Work*, 9(1-2), 174-211.
- Bargal, D. 2014. Lewin, Kurt. In Coghlan, D. & Brydon-Miller C. eds. *The SAGE encyclopaedia of action research*. London: Sage, 500-3.
- Barkham, M. 2014. Practice-based research network: Origins, overview, obstacles, and opportunities. *Counselling and Psychotherapy Research*, 14(3), 167-73.
- Baskerville, B. 2014. Rigour. In Coghlan, D. & Brydon-Miller C. eds. *The SAGE encyclopaedia of action research*. London: Sage, 690-92.
- Breier, M., Wildschut, A. and Mqolozana, T., 2015. Nursing in a new era. [Online] Available <http://ecommons.hsrc.ac.za/bitstream/handle/123456789/6610/4030.pdf?sequence=1&isAllowed=y> [26 October 2016].
- Bellman, L. 2012a. Clinical action research to advance patient care. In Williamson, G.R., Bellman, L. & Webster, J. eds. *Action research in nursing and healthcare*. London: Sage, 66-93.
- Bellman, L. 2012b. Ethical considerations. In Williamson, G.R., Bellman, L. & Webster, J. eds. *Action research in nursing and healthcare*. London: Sage, 147-66.
- Bergold, J. & Thomas, S. 2012. Participatory research methods: A methodological approach in motion. *Forum: Qualitative Social Research*, 13(1), Art 30. [Online] Available from <http://nbn-resolving.de/urn:nbn:de:0114-fgs1201304> [Accessed 23 April 2015].

Bhaskar, R. 1998. Facts and values: Theory and practice. In Archer, M.S., Bhaskar, R., Collier, A., Lawson, T. & Norrie, A. eds. *Critical realism: Essential readings*. London: Routledge, 409-43.

Bhaskar, R. & Lawson, A. 1998. Introduction: Basic texts and development. In Archer, M.S., Bhaskar, R., Collier, A., Lawson, T. & Norrie, A. eds. *Critical realism: Essential readings*. London: Routledge, 3-15.

Bläuer, C., Frei, I.A., Schnepf, W. & Spirig, R., 2015. Implementation of a nurse-led education programme for chronic heart failure patients during hospitalisation, and strategies supporting their self-management at home: a practice development project in the context of the Swiss healthcare system. *International Practice Development Journal*, 5(1), 1-15. [Online] Available from <http://www.fons.org/library/journal.aspx> [Accessed 5 October 2015].

Boomer, C.A. & McCormack, B. 2010. Creating the conditions of growth: A collaborative practice development programme for clinical nurse leaders. *Journal of Nursing Management*, 18, 633-44.

Borg, S., Young, L. and Munksgaard, K., 2013. A Critical Realism Methodological Framework for Undertaking Conceptual and/or Empirical Research: The CER-model. In *The 29th annual IMP conference*. [Online] Available from <http://impgroup.org/uploads/papers/7998.pdf> [Accessed 1 November 2016]

Bornman, S., Budlender, D., Clarke, Y., Manook, S.L., Van der Westhuizen, C. & Watson, J., with Antunes, S. & Iqbal, N. 2013. *The state of the nation, government priorities and women in South Africa*. Women's Legal Centre. Cape Town: Women's Legal Centre.

Botha, C. 2012. *Wetsuitleg: 'n Inleiding vir studente*. 5de uitg. Kaapstad: Juta.

Boydell, K.M., Gladstone, B.M., Volpe, T., Allemang, B. and Stasiulis, E., 2012, January. The production and dissemination of knowledge: A scoping review of arts-based health research. In *Forum Qualitative Sozialforschung/Forum: Qualitative Social Research*, 13(1). [Online] Available from <http://www.qualitative-research.net/index.php/fqs/article/view/1711/3328>

Bradbury, R. & Reason, P. 2006. Broadening the bandwidth of validity: Issues and choice-points for improving the quality of action research. In Reason, P. & Bradbury, H. eds. *Handbook of action research*. 2nd ed. London: Sage, 343-51.

- Bradford, B., Huq, A., Jackson, J. & Roberts, B. 2014. What price fairness when security is at stake? Police legitimacy in South Africa. *Regulation and Governance*, 8, 246-68.
- Bromley, P. 2014. Using nominal group technique (NGT) to reach consensus on graduate attributes for nurses undertaking postgraduate certification in neonatal intensive care in Australia. *Journal of Neonatal Nursing*, 20, 246-52.
- Brugha, R. & Varvasovszky, Z. 2000a. Stakeholder analysis: A review. *Health Policy and Planning*, 15(3), 239-46.
- Brydon-Miller, M., Greenwood, D. & Maguire, P. 2003. Why action research? *Action Research*, 1(1), 9-28.
- Bryson, J.M. 2004. What to do when stakeholders matter. *Public Management Review*, 6(1), 21-53.
- Bunniss, S. & Kelly, D.R. 2010. Research paradigms in medical education research. *Medical Education*, 44, 358-66.
- Burgoyne, J.G. 2010. Evaluating action learning: A critical realist complex network theory approach. *Action Learning: Research and Practice*, 7(3), 239-51.
- Busch-Armendariz NB & Vohra-Gupta S. 2011. Sexual assault needs assessment in Texas: Documenting existing conditions and striving toward preferred outcomes. Institute on Domestic Violence and Sexual Assault. Center for Social Work Research. *School of Social Work*. The University of Texas at Austin.
- Cabelus, N.B. & Spangler, K. 2013. Evidence collection and documentation. In Hammer, R.M., Moynihan, B. & Pagliaro, E.M. eds. *Forensic nursing: A handbook for practice*. 2nd ed. Burlington, MA: Jones & Bartlett Learning, 261-84.
- Çalışkan, N. & Özden, D. 2012. The knowledge levels of health personnel in Turkey regarding forensic evidence. *Journal of Forensic Sciences*, 57(5), 1217-21. [<http://dx.doi.org/10.1111/j.1556-4029.2012.02148.x>]
- Campbell R, Greeson MA, Bybee DI, Kennedy A & Patterson D. 2011. *Adolescent sexual assault victims' experiences with SANE-SARTs and the criminal justice system*. United States: U.S. Department of Justice.

Canterbury Christ Church University. 2016. *What is practice development?* [Online] Available from <https://www.canterbury.ac.uk/health-and-wellbeing/england-centre-for-practice-development/what-is-practice-development.aspx> [Accessed 10 October 2016].

Carter, S., Daniel, S. & Place, B. 2011. Reducing healthcare associated infections in critical care. [Online] Available from <http://www.fons.org/Resources/Documents/Project%20Reports/LSHA BartsNov2011.pdf> [Accessed 7 December 2015].

Chase, S.M., Crabtree, B.F., Stewart, E.E., Nutting, P.A., Miller, W.L., Stange, K.C. & Jaén, R.J. 2015. Coaching strategies for enhancing practice transformation. *Family Practice*, 32(1), 75-81.

Cho, O., Cha, K. & Yoo, Y. 2015. Awareness and attitudes towards violence and abuse among emergency nurses. *Asian Nursing Research*, 9, 213-8.

Clark, A.M. 2008. Critical realism. In Given, L.M. ed. *The SAGE encyclopaedia of qualitative research methods*. London: Sage, 167-9.

Coghlan, D. 2014a. Authenticity. In Coghlan, D. & Brydon-Miller, C. eds. *The SAGE encyclopaedia of action research*. London: Sage, 68-9.

Coghlan, D. & Brannick, T. 2013. *Doing action research in your own organization*. 3rd ed. London: Sage.

Coghlan, D. & Gaya, P. Flicker, S. 2014c. Dissertation writing. In Coghlan, D. & Brydon-Miller, C. eds. *The SAGE encyclopaedia of action research*. London: Sage, 280-283.

Coghlan, D. & Shani, A.B. 2005. Roles, politics, and ethics in action research design. *Systemic Practice and Action Research*, 18(6), 533-46.

Colleges of Medicine of South Africa. 2015. *Regulations for admission to the Diploma in Forensic Medicine of the College of Forensic Pathologists of South Africa*. [Online] Available from http://www.collegemedsa.ac.za/Documents%5Cdoc_194.pdf [Accessed 5 December 2015].

Colón-Emeric, C.S., Bowlby, L. & Svetkey, L. 2012. Establishing faculty needs and priorities for peer-mentoring groups using a nominal group technique. *Medical Teacher*, 34, 631-4.

Convery, A. 2014. Classroom-based action research. In Coghlan, D. & Brydon-Miller, C. eds. *The SAGE encyclopaedia of action research*. London: Sage, 103-7.

- Conway, J.C. & Fitzgerald, M. 2004. Processes, outcomes and evaluation: Challenges to practice development in gerontological nursing. *Journal of Clinical Nursing*, 13(6b), 121-7.
- Cornaglia, F., Feldman, N.E. & Leigh, A. 2013. Crime and mental well-being. *Journal of Human Resources*, 49(10), 110-40.
- Cornish, F., Gillespie, A. & Zittoun, T. 2014. Collaborative analysis of qualitative data. In Flick, U. ed. *The SAGE handbook of qualitative data*. London: Sage, 79-93.
- Costello, P.J.M. 2011. *Effective action research*. 2nd ed. New York, NY: Continuum.
- Cowley, R., Walsh, E. & Horrocks, J. 2014. The role of the sexual assault nurse examiner in England: Nurse experience and perspectives. *Journal of Forensic Nursing*, 10(2), 77-83.
- Creswell, J.W. 2010. Mapping the developing landscape of mixed methods research. In Tashakkori, A. & Teddlie, C. eds. 2010. *SAGE handbook of mixed methods in social & behavioural research*. London: Sage, 45-68.
- Cucu, A., Daniel, I., Paduraru, D. & Galan, A. 2014. Forensic nursing emergency care. *Romanian Journal of Legal Medicine*, 22, 133-6.
- Dalkin, S.M., Greenhalgh, J., Jones, D., Cunningham, B. and Lhussier, M., 2015. What's in a mechanism? Development of a key concept in realist evaluation. *Implementation Science*, 10(1), 1-7.
- Darnell, C. 2011. *Forensic science in healthcare: Caring for patients, preserving the evidence*. Boca Raton, FL: CRC Press.
- Daszko, M. & Sheinberg S. 2005. Survival is optional: Only leaders with new knowledge can lead transformation. *Theory of Transformation final to short article*. [Online] Available from http://www.sheila-clfcs.com/docs/Survival%20is%20Optional_Daszko_Sheinber.pdf [Accessed 28 February 2016].
- Daykin, N. 2015. *Creative and arts-based evaluation methods*. [Online] Available from <http://www.creativeandcredible.co.uk> [Accessed 12 September 2015].
- De Kock, C., Kriegler, A. & Shaw, M. 2015. *A citizen's guide to SAPS crime statistics 1994-2015*. [Online] Available from https://webcms.uct.ac.za/sites/default/files/image_tool/images/225/PDFs_CRI/CITIZENGUIDE/CRI_doc_protected_CrimCitGuideSAPS.pdf [Accessed 4 December 2015].

De Leeuw, M. & Jacobs, W. 2010. Forensic emergency medicine: Old wine in new barrels. *European Journal of Emergency Medicine*, 17(4), 186-91.

Deforge, R. & Shaw, J. 2012. Back- and fore-grounding ontology: Exploring the linkages between critical realism, pragmatism, and methodologies in health & rehabilitation sciences. *Nursing Inquiry*, 19(1), 83-95.

Degutis, L.C. 2013. Epidemiology of violence. In Hammer, R.M., Moynihan, B. & Pagliaro, E.M. eds. *Forensic nursing: A handbook for practice*. 2nd ed. Burlington, MA: Jones & Bartlett Learning, 31-44.

Department of Justice and Constitutional Development. 2004. *Minimum standards on services for victims of crime*. Pretoria: Government Printer.

Department of Justice and Constitutional Development. 2010. *A practical guide: Court and case flow management for regional and district criminal courts*. Pretoria: Government Printer.

Department of Social Development. 2004. *Minimum standards for service delivery in victim empowerment*. Pretoria: Government Printer.

Department of Social Development. 2009. *National policy guidelines for victim empowerment*. Pretoria: Government Printer.

DeVore, H.K. & Sachs, C.J. 2011. Sexual assault. *Emergency Medicine Clinics of North America*, 29, 605-20.

Dewing, J., Harmon, A. & Nolan, J. 2014. The aspire to inspire programme in aged care: The final chapter, one year on. *International Practice Development Journal*, 4(1), 1-9. [Online] Available from <http://www.fons.org/library/journal.aspx> [Accessed 14 September 2015].

Dewing, J., McCormack, B. & Titchen, A. 2014. *Practice development workbook for nursing, health and social care teams*. Oxford: Wiley-Blackwell.

Dewing, J. & Traynor, V. 2005. Admiral nursing competency project: practice development and action research. *Journal of Clinical Nursing*, 14, 695-703.

Dick, B. 2014. Validity. In Coghlan, D. & Brydon-Miller C. eds. *The SAGE encyclopaedia of action research*. London: Sage. 803-805.

- Diemer, M.A., McWhirter, E.H., Ozer, E.J. & Rapa, L.J. 2015. Advances in the conceptualizations and measurement of critical consciousness. *Urban Review*, 47(5), 809-23.
- Dlamini, N. Coghlan, D. 2014b. Organizational culture. In Coghlan, D. & Brydon-Miller, C. eds. *The SAGE encyclopaedia of action research*. London: Sage, 578-80.
- Donnelly, S. 2012. Forensic science in a human rights framework. *Australian Journal of Forensic Sciences*, 44(1), 93-103.
- Dougherty, C.M. 2011. Evidence collection in the emergency department. In Lynch, V.A. & Duval J.B. eds. *Forensic Nursing Science*. 2nd ed. St. Louis, MO: Elsevier, 155-67.
- Douglas, K. 2014. Spotlight on forensic nursing. *Australian Nursing & Midwifery Journal*, 21(10), 21-4.
- Du Rand, P. & Viljoen, M.J. 2002. Assessment of a post-basic nursing education programme. *Curationis*, May, 14-21.
- Dwyer, S.C. & Buckle, J.L. 2009. The space between: On being an insider-outsider in qualitative research. *International Journal of Qualitative Methods*, 8(1), 54-63.
- Earl, S., Carden, F. & Smutylo, T. 2001. *Outcome mapping – building learning and reflection into development programs*. Ottawa: International Development Research Centre.
- Easton, G. 2010. Critical realism in case study research. *Industrial Marketing Management*, 39, 118-28.
- Eckert, W.G. 1990. Forensic sciences and medicine: The clinical or living aspects. *American Journal of Forensic Medicine and Pathology*, 11(4), 336-41.
- Edwards, S.T., Rubenstein, LV., Meredith, L.S., Schmidt Hackbarth, N., Stockdale, S.E., Cordasco, K.M., Lant, A.B., Roos, P.J. & Yano, E.M. 2015. Who is responsible for what tasks within primary care: Perceived task allocation among primary care providers and inter disciplinary team members. *Healthcare*, 3, 142-9.
- Eikeland, O. 2006. Condescending ethics and action research. *Action Research*, 4(1), 37-47.
- Eisert, P.J., Eldredge, K., Hartlaub, T., Huggins, E., Keirn, G., O'Brien, P., Rozzi, H.V., Linda, C.P. & March, K.S. 2010. CSI: New York: Development of forensic evidence collection guidelines for the emergency department. *Critical Care Nurse Quarterly*, 33(2), 190-9.

Eldredge, K. 2010. *Forensics in the trauma setting. On the edge*. [Online] Available from <http://iafn.org/displaycommon.cfm?an=1&subarticlenbr=436&printpage=true> [Accessed 27 September 2012].

Elo, S., Kääräinen, M., Kantse, O., Pölkki, T., Utriainen, K. & Kyngäs, H. 2014. Qualitative content analysis: A focus on trustworthiness. *SAGE OPEN*, January-March, 1-10. [<http://dx.doi.org/10.1177/2158244014522633>]

Elo, S. & Kyngäs, H. 2008. The qualitative content analysis process. *Journal of Advanced Nursing*, 62(1), 107-15.

Ennals, R. 2014. Development coalitions. In Coghlan, D. & Brydon-Miller, C. eds. *The SAGE encyclopaedia of action research*. London: Sage. 205-252.

Fairbrother, G., Cashin, A., Mekki, T.E., Graham, I. & McCormack, B. 2015. Is it possible to bring the emancipatory practice and evidence-based practice agendas together in nursing and midwifery? *International Practice Development Journal*, 5(1), 1-4. [Online] Available from <http://www.fons.org/library/journal.aspx> [Accessed July 2016].

Fawkes, C.A., Leach, C.M.J., Mathias, S. & Moore, A.P. 2014. Development of a data collection tool to profile osteopathic practice: Use of a nominal group technique to enhance clinician involvement. *Manual Therapy*, 19, 119-24.

Fehler-Cabral G, Campbell R & Patterson D. 2011. Adult sexual assault survivors' experiences with sexual assault nurse examiners (SANEs). *Journal of Interpersonal Violence*, 26(18), 3618-3639.

Fern, E.F. 2001. *Advanced focus group research*. London: Sage.

Fernandes, A. 2011. *Guidance for commissioning integrated urgent and emergency care: A "whole system" approach*. [Online] Available from http://www.rcgp.org.uk/policy/~media/Files/CIRC/Audit/Urgent_emergency_care_whole_system_approach.ashx [Accessed 9 October 2015].

Finley, S. 2008. Community-based research. In Given, L.M. ed. *The SAGE encyclopaedia of qualitative research methods*. London: Sage, 97-101.

Flicker, S. & Nixon, S.A. 2014. The DEPICT model for participatory qualitative health promotion research analysis piloted in Canada, Zambia and South Africa. *Health Promotion International*. [Online] Available from https://www.researchgate.net/profile/Sarah_Flicker/publication/259720229_The_DEPICT_model_for_participatory_qualitative_health_promotion_research_analysis_piloted_in_

Canada_Zambia_and_South_Africa/links/0a85e5304c4226f3c5000000.pdf [Accessed 6 December 2015].

Flicker, S. 2014a. Collaborative data analysis. In Coghlan, D. & Brydon-Miller, C. eds. *The SAGE encyclopaedia of action research*. London: Sage, 121-124.

Fourie, J. 2014. *Violence and unintentional injury one of SA's four major health burdens*. [Online] Available from <http://www.unisa.ac.za/news/index.php/2014/07/violence-and-unintentional-injury-one-of-sas-four-major-health-burdens/> [Accessed 8 May 2015].

Fox, K.A. & Cook, C.L. 2011. Is knowledge power? The effect of a victimology course on victim blaming. *Journal of Interpersonal Violence*, 26(17), 3407-27.

Foster, P. 2014. Collaborative developmental action inquiry. In Coghlan, D. & Brydon-Miller, C. eds. *The SAGE encyclopaedia of action research*. London: Sage, 124-128

Friedman, V.J. & Putnam, R.W. 2014. Action science. In Coghlan, D. & Brydon-Miller, C. eds. *The SAGE encyclopaedia of action research*. London: Sage, 15-8.

Fruchter, R. & Bosch-Sitjsema, P. 2011. The wall: Participatory design workspace in support of creativity, collaboration, and socialization. *AI and Society*, 26, 221-232.

Garbett, R. & McCormack, B. 2002. A concept analysis of practice development. *Nursing Times Research*, 7(2), 87-100.

Gelling, L. 2010. Gaining access to the research site. In Gerrish, K. & Lacy, A. eds. *The research process in nursing*. Oxford: Wiley-Blackwell, 114-26.

George, A. 2014. Aesthetics. In Coghlan, D. & Brydon-Miller, C. eds. *The SAGE encyclopaedia of action research*. London: Sage, 29-31.

Geventa, J. & Cornwall, A. 2008. Power and knowledge. In Reason, P. & Bradbury, H. eds. *The SAGE handbook of action research*. London: Sage. 172-89.

Gillberg, C. 2014. Feminism. In Coghlan, D. & Brydon-Miller C. eds. *The SAGE encyclopedia of action research*. London: Sage, 337-40.

- Gilson, L., Elloker, S., Olckers, P. & Lehmann, U., 2014. Advancing the application of systems thinking in health: South African examples of a leadership of sensemaking for primary health care. *Health Research Policy and Systems*, 12(1), 1-13.
- Glittenberg, J., Lynch, V.A. & Sievers, V. 2007. Forensic nursing: A healthcare response to the epidemic of violence. *Colorado Nurse*, 107(1), 3-5.
- Gomm, R., Needham, G. & Bullan, A. 2000. *Evaluating research in health and social care*. London: Sage.
- Goodman, C. & Evans, C. 2010. Focus groups. In Gerrish, K. & Lacy, A. eds. *The research process in nursing*. Oxford: Wiley-Blackwell, 359-68.
- Gorski, P.S. 2013. What is critical realism? And why should you care? *Contemporary Sociology: A Journal of Reviews*, 42, 658-70.
- Grant, G. & Ramcharan, P. 2010. User involvement in research. In Gerrish, K. & Lacy, A. eds. *The research process in nursing*. Oxford: Wiley-Blackwell, 36-48.
- Grant, J., Nelson, G. & Mitchell, T. 2008. Negotiating the challenges of participatory action research: Relationships, power, participation, change and credibility. In Reason, P. & Bradbury, H. eds. *The SAGE handbook of action research*. London: Sage, 588-602.
- Gray, D.E. 2009. *Doing research in the real world*. Los Angeles, CA: Sage.
- Greene, M.J. 2014. On the inside looking in: Methodological insights and challenges in conducting qualitative insider research. *Qualitative Report*, 19(15), 1-13.
- Greenhalgh, T., Wong, G., Westhorp, G. & Pawson, R. 2011. Protocol – Realist and Meta-Narrative Evidence Synthesis: Evolving Standards (RAMESES). *BioMed Central Methodology*, 11, 115 [n.p.]. [Online] Available from <http://www.biomedcentral.com/1471-2288/11/115> [Accessed 3 December 2015].
- Greeson MR & Campbell R. 2012. Sexual assault response teams (SARTs): An Empirical Review of their effectiveness and challenges to successful implementation. *Trauma, Violence, & Abuse* 14(2); 83-95.
- Guest, G., MacQueen, K.M. & Namey, E.E. 2012. *Applied thematic analysis*. London: Sage.

- Guest, G., Namey, E.E. & Mitchell, M.L. 2013. *Collecting qualitative data a field manual for applied research*. London: Sage.
- Guhathakurta, M. 2014. Development action research. In Coghlan, D. & Brydon-Miller C. eds. *The SAGE encyclopaedia of action research*. London: Sage. 248-250.
- Guta, A. & Roche, B. 2014. Community-based participatory research. In Coghlan, D. & Brydon-Miller, C. eds. 2014. *The SAGE encyclopaedia of action research*. London: Sage. 156-159.
- Hardcastle, T.C., Steyn, E., Boffard, K., Goosen, J., Toubkin, M., Loubser, A., Allard, D., Moeng, S., Muckart, D. & Brysiewicz, P. 2011. Guideline for the assessment of trauma centres for South Africa. *South African Medical Journal*, 101(3), 189-94.
- Hardiman, M. & Dewing, J., 2014. Critical Ally and Critical Friend: stepping stones to facilitating practice development. *International Practice Development Journal*, 4(1), 1-19. [Online] Available from <http://www.fons.org/library/journal.aspx> [Accessed 21 October 2015].
- Hardy, S., Bolster, D., Kelly, T. & Yalden, J. 2012. Enhancing facilitation skills through a practice development masterclass: The other side of the rainbow. *Australian Journal of Advanced Nursing*, 29(2), 37-47.
- Hardy, S., Wilson, V. & McCance, T. 2013. Evaluation approached for practice development: Contemporary perspectives. In McCormack, B., Manley, K. & Titchen, A. eds. *Practice development in nursing and healthcare*. Oxford: Wiley-Blackwell, 169-89.
- Harrendorf, S., Heiskanen, M. & Malby, S. eds. 2010. *International statistics on crime and justice. For the European Institute for Crime Prevention and Control*. Vienna: United Nations Office on Drugs and Crime.
- Harvey, N. & Holmes, C.A. 2012. Nominal group technique: An effective method for obtaining group consensus. *International Journal of Nursing Practice*, 18, 188-94.
- Henderson, E., Harada, N. & Amar, A. 2012. Caring for the forensic population: Recognizing the educational needs of emergency department nurses and physicians. *Journal of Forensic Nursing*, 8(4), 170-7.
- Herr, K. & Anderson, G.L. 2005. *The action research dissertation: A guide for students and faculty*. London: Sage.

- Herr, K. & Anderson, G.L. 2014. *The action research dissertation: A guide for students and faculty*. 2nd ed. London: Sage.
- Hewitt, G., Sims, S. & Harris, R. 2014. Using realist synthesis to understand the mechanism of interprofessional teamwork in health and social care. *Journal of Interprofessional Care*, 28(6), 501-6.
- Hill, G. 2014. Cycles of action and reflection. In Coghlan, D. & Brydon-Miller, C. eds. *The SAGE encyclopaedia of action research*. London: Sage, 233-73.
- Houmes, B.V., Fegan, M.M. & Quintana, N.M. 2003. Establishing a sexual nurse examiner (SANE) program in the emergency department. *Journal of Emergency Medicine*, 25(1), 111-21.
- Houston, S. 2001. Beyond social constructionism: Critical realism and social work. *British Journal of Social Work*, 31, 845-61.
- Houston, S. 2010. Prising open the black box: Critical realism, action research and social work. *Qualitative Social Work*, 9(1), 73-91.
- Howlett, M., Doody, K., Murry, J., LeBlanc-Duchin, D., Fraser, J. & Atkinson, PR. 2014. Burnout in emergency department healthcare professional is associated with coping style: A cross-sectional survey. *Emergency Medicine Journal*, 32, 722-7. [<http://dx.doi.org/10.1136/emmermed-2014-203750>]
- Huzzard, T. & Johansson, Y. 2014. Critical action research. In Jeanes, E. & Huzzard, T. eds. *Critical management research: Reflections from the field*. London: Sage, 81-101.
- Hynes, G., Coghlan, D. & McCarron, M. 2012. Developing practice in healthcare: The contribution of building to negotiating the tensions among practice, professional and organisational knowing. *International Journal of Action Research*, 8(2), 159-84.
- Institute for Security Studies. 2015. *Assault and sexual offences: Overview of the official statistics: 2014/15*. Fact Sheet, September 2015. [Online] Available from www.issafrica.org/crimehub [Accessed 20 October 2015].
- Jagosh, J., Pluye, P., Wong, G., Cargo, M., Salsberg, J., Bush, P.L., Herbert, C.P., Green, L.W., Greenhalgh, T. & Macaulay, A.C. 2013. Critical reflections on realist review: Insights from customizing the methodology to the needs of participatory research assessment. *Research Synthesis Methods*, 5(2), 131-41.

- James, N. 2008. Authenticity. In Given, L.M. ed. *The SAGE encyclopaedia of qualitative research methods*. London: Sage, 44-5.
- Jancey, J.J., Meuleners, L. & Philips, M. 2011. Health professionals' perceptions of sexual assault management: A Delphi study. *Health Education Journal*, 70(3), 249-59.
- Janes, N., Cowie, B., Bell, K., Deratnay, P. & Fourie, C. 2015. Revealing and acting on patient care experiences: exploring the use of photovoice in practice development work through case study methodology. *International Practice Development Journal*, 5(11), 1-12. [Online]Available from <http://www.fons.org/library/journal.aspx> [Accessed 5 October 2016].
- Jensen, D. 2008. Credibility. In Given, L.M. ed. *The SAGE encyclopaedia of qualitative research methods*. London: Sage, 138-9.
- Jermyn, D. 2013. Labs and slabs: Television crime drama and the quest for forensic realism. *Studies in History and Philosophy of Biological and Biomedical Sciences*, 44(1), 103-9.
- Jina, R., Jewkes, R., Christofides, N. & Loots, L. 2013. Knowledge and confidence of South African health care providers regarding post-rape care: A cross-sectional study. *Bio Med Central Health Services Research*, 13, 257. [<http://www.biomedcentral.com/1472-6963/13/257>].
- Johnstone, M.J. 2011. Nursing and justice as a basic human need. *Nursing Philosophy*, 12(1), 34-44.
- Joyner, K. & Duma, S. 2010. Introducing forensic healthcare in contemporary South Africa. In Joyner, K. ed. *Aspects of forensic medicine: An introduction for healthcare professionals*. Cape Town: Juta. xiv-xx.
- Julien, H. 2008. Content analysis. In Given, L.M. ed. *The SAGE encyclopaedia of qualitative research methods*. London: Sage, 120-121.
- Kagan, P.N., Smith, M.C., Cowling, W.R. & Chinn, P.L. 2009. A nursing manifesto: An emancipatory call for knowledge development, conscience, and praxis. *Nursing Philosophy*, 11, 67-84.
- Kelleher, C. & McGilloway, S. 2009. "Nobody ever chooses this...": A qualitative study of service providers working in sexual violence sector – key issues and challenges. *Health and Social Care in the Community*, 17(3), 295-303.

- Kelley, K.D. & Campbell, R. 2013. Moving on or dropping out: Police processing of adult sexual assault cases. *Women & Criminal Justice*, 23(1), 1-18.
- Kemmis, S. & McTaggart, R. 2014. Critical participatory action research. In Coghlan D. & Brydon-Miller C. ed. *The SAGE encyclopaedia of action research*. London: Sage, 208-11.
- Kemmis, S., McTaggart, R. & Nixon, R. 2014. *The action research planner: Doing critical participatory action research*. Singapore: Springer.
- Kennedy, M. & Julie, H. 2013. Nurses' experiences and understanding of workplace violence in a trauma and emergency department in South Africa. *Health SA Gesondheid*, 18(1), 1-9.
- Kent-Wilkinson, A. 2010. Forensic nursing educational development: An integrated review of the literature. *Journal of Psychiatric and Mental Health Nursing*, 18, 236-46.
- Kerstetter, K. 2012. Insider, outsider, or somewhere in between: The impact of researchers' identities on the community-based research process. *Journal of Rural Social Sciences*, 27(2), 99-117.
- Kessler, I., Heron, P. & Dopson, S. 2013. Indeterminacy and the regulation of task allocation: The shape of support roles in healthcare. *British Journal of Industrial Relations*, 50(2), 310-32.
- Kinnison, T., Lumbis, R., Orpet, H., Welsh, P., Gregory, S. & Baillie, S. 2011. Piloting interprofessional education interventions with veterinary and veterinary nursing students. *Journal of Veterinary Medicine*, 38(3), 311-8.
- Kobernick, M.E., Seifert, S. & Sanders, A.B. 1985. Emergency department management of the sexual assault victim. *Journal of Emergency Medicine*, 2, 205-14.
- Koch, T. & Kralik, D. 2006. *Participatory action research in healthcare*. Oxford: Blackwell.
- Kodikara, S. 2012. Practice of clinical forensic medicine in Sri Lanka: Does it need a new era? *Legal Medicine*, 4, 167-71.
- Koshy, E., Koshy, V. & Waterman, H. 2011. *Action research in healthcare*. London: Sage.
- Krug, E.G., Mercy, J.A., Dahlberg, L.L. & Zwi, A.B. 2002. The world report on violence and health. *Lancet*, 360, 1083-8.

- Landeta, J., Barrutia, J. & Lertxundi, A. 2011. Hybrid Delphi: A methodology to facilitate contribution from experts in professional context. *Technological Forecasting & Social Change*, 78, 1629-41.
- Lawson, A. 1998. Economic science without experimentation. In Archer, M.S., Bhaskar, R., Collier, A., Lawson, T. & Norrie, A. eds. *Critical realism: Essential readings*. London: Routledge, 144-86.
- Ledray, L. 2010. Expanding evidence collection time: Is it time to move beyond the 72-hour rule? How do we decide? *Journal of Forensic Nursing*, 6, 47-50.
- Lee, N. 2011. An evaluation of CPD learning and impact upon positive practice change. *Nurse Education Today*, 31, 390-5.
- Levin, M. 2012. Academic integrity in action research. *Action Research*, 10(2), 133-49.
- Levin, M. 2014. Co-generative learning. In Coghlan, D. & Brydon-Miller, C. eds. *The SAGE encyclopaedia of action research*. London: Sage. 109-12.
- Liamputtong, P. 2011. *Focus group methodology principles and practice*. London: Sage.
- Lincoln, S.L. & Guba, E.G. 1985. *Naturalistic inquiry*. London: Sage.
- Linnarsson, J.R., Benzien, E. & Årestedt, K. 2014. Nurses' views of forensic care in emergency departments and their attitudes, and involvement of family members. *Journal of Clinical Nursing*, 24, 266-74.
- Linnarsson, J.R., Benzien, E. & Årestedt, K. & Erlingsson, C. 2012. Preparedness to care for victims of violence and their families in emergency departments. *Emergency Medicine Journal*, 30, 198-201.
- Lodenstein, E., Dieleman, M., Gerretsen, B. & Broerse, J.E.W. 2013. A realist synthesis of the effect of social accountability interventions on health service providers' and policymakers' responsiveness. *Systematic Reviews*, 2:98. [Online] Available from <http://www.systematicreviewsjournal.com/content/2/1/98> [Accessed 5 December 2015].
- Lugtenberg, M., Burgers, J.S., Besters, C.F., Han, D. & Westert, G.P. 2011. Perceived barriers to guideline adherence: A survey among general practitioners. *BioMed Central Family Practice*, 12, 98 [n.p.]. [Online] Available from <http://www.biomedcentral.com/1471-12296/12/98> [Accessed 18 December 2015].

Lukhozi, S.M. 2009. Clinical forensic medicine and human rights – doctors as human rights defenders. *South African Journal of Bioethics and Law*, 2(2), 67-9.

Lynch, V.A. 2011. Forensic nursing science: Global strategies in health and justice. *Egyptian Journal of Forensic Sciences*, 1, 69-76.

Lynch, V.A. 2013. Forensic nursing science. In: Hammer, R.M., Moynihan, B. & Pagliaro, E.M. eds. *Forensic nursing: A handbook for practice*. 2nd ed. Burlington, MA: Jones & Bartlett Learning. 1-14.

Maier, S. L. 2011. Sexual assault nurse examiners' perceptions of funding challenges faced by SANE programmes: "It stinks". *Journal of Forensic nursing*, 8, 81-93.

Maltby, J., Williams, G., McGarry, J. & Day, L. 2010. *Research methods for nursing and healthcare*. Harlow, UK: Pearson.

Manley, K. & McCormack, B. 2003. Practice development: Purpose, methodology, facilitation and evaluation. *Nursing in Critical Care*, 8(1), 22-9.

Manley, K., McCormack, B. & Wilson, V. 2008. *International practice development in nursing and healthcare*. Oxford: Blackwell.

Manley, K., O'Keefe, H., Jackson, C., Pearce, J. & Smith, S. 2014. A shared purpose framework to deliver person-centred, safe and effective care: organisational transformation using practice development methodology. *International Practice Development Journal*, 4(1), 1-31. [Online] Available from <http://www.fons.org/library/journal.aspx> [Accessed 28 October 2016].

Manley, K., Solman, A. & Jackson, C. 2013. Working towards a culture of effectiveness in the workplace. In McCormack, B., Manley, K. & Titchen, A. eds. *Practice development in nursing and health care*. 2nd ed. Oxford: Wiley-Blackwell, 146-68.

Manley, K. & Titchen, A. 2012. *Being and becoming a consultant nurse: Towards greater effectiveness through a programme of support*. [Online] Available from http://www.rcn.org.uk/_data/assets/pdf_file/0005/444299/003574.pdf [Accessed 9 April 2014].

Manley, K., Titchen, A. & Hardy, S. 2009. Work-based learning in the context of contemporary health care education and practice: A concept analysis. *Practice Development in Health Care*, 8(2), 87-127.

Manley, K., Titchen, A. & McCormack, B. 2013. What is practice development and what are the starting points? In McCormack, B., Manley, K. & Titchen, A. eds. *Practice development in nursing and health care*. 2nd ed. Oxford: Wiley-Blackwell, 45-65.

Marchal, B., Van Belle, S., Van Olmen, J., Hoérée, T. & Kegels, G. 2012. Is realist evaluation keeping its promise? A review of published empirical studies in the field of health systems research. *Evaluation*, 18(2), 192-212.

Markowitz, J. 2007. *The role of the sexual assault nurse examiner in the prosecution of domestic violence cases*. Alexandria, VA: National District Attorneys Association.

Martin, J., McCormack, B., Fitzsimons, D. & Spirig, R. 2014. The importance of inspiring a shared vision. *International Practice Development Journal*, 4(2), 1-15. [Online] Available from <http://www.fons.org/library/journal.aspx> [Accessed 6 May 2015].

Maxwell, J.A. & Mittapalli, K. 2010. Realism as a stance for mixed methods research. In Tashakkori, A. & Teddlie, C. eds. 2010. *SAGE handbook of mixed methods in social & behavioural research*. London: Sage. 145-68.

McAteer, M. 2013. *Action research in education*. London: Sage.

McBeath, B. & Austin, M.J. 2015. The organizational context of research-minded practitioners: Challenges and opportunities. *Research on Social Work Practice*, 25(4), 446-59.

McBrearty, P. 2011. The lived experience of victims of crime. *International Emergency Nursing*, 19, 20-6.

McCabe, J.L. & Holmes, D. 2009. Reflexivity, critical qualitative research and emancipation: A Foucauldian perspective. *Journal of Advanced Nursing, Journal compilation 2009*:1518-26.

McCance, T. and Wilson, V., 2015. Using person-centred key performance indicators to improve paediatric services: an international venture. *International Practice Development Journal*, 5(8), 1-7. [Online] Available from <http://www.fons.org/library/journal.aspx> [Accessed 5 October 2015].

McCormack, B. 2010. *A review of practice development in nursing and midwifery in the Republic Ireland and the development of strategic framework*. [Online] Available from http://health.gov.ie/wp-content/uploads/2014/03/review_practice-development_nursing_midwifery.pdf [Accessed 10 December 2015].

McCormack, B. 2014. Practice development. In Coghlan, D. & Brydon-Miller, C. eds. *The SAGE encyclopaedia of action research*. London: Sage, 637-40.

McCormack, B., Dewar, J., Wright, J., Garbett, R., Harvey, G. & Ballantine, K. 2006. *A realist synthesis of evidence relating to practice development: Final report to NHS Education for Scotland NHS Quality Improvement Scotland*. [Online] Available from http://www.healthcareimprovementscotland.org/previous_resources/policy_and_strategy/a_realist_synthesis_of_evidence.aspx [Accessed 19 October 2015].

McCormack, B. & Dewing, J. 2010. *The implementation of a model of person-centred practice¹ in older person settings in Ireland*. [Online] Available from <http://www.britishgerontology.org/DB/gr-editions-2/generations-review/the-implementation-of-a-model-of-person-centred-pr.html> [Accessed 22 December 2015].

McCormack, B. & Dewing, J. 2013. A Case study of practice development 'The practice development journey'. In In: McCormack, B., Manley, K. & Titchen, A. eds. *Practice development in nursing and healthcare*. Oxford: Wiley-Blackwell, 88-108.

McCormack, B., Dewing, J., Breslin, L., Coyne-Nevin, A., Kennedy, K., Manning, M., Peelo-Kilroe, L. & Tobin C. 2009. Practice development: Realising active learning for sustainable change. *Contemporary Nurse*, 32(1-2), 92-104.

McCormack, B., Dewing, J., Breslin, L., Coyne-Nevin, A., Kennedy, K., Manning, M., Peelo-Kilroe, L., Tobin, C. & Slater, P. 2010. Developing person-centred practice: Nursing outcomes arising from changes to the care environment in residential settings for older people. *International Journal of Older People Nursing*, 5, 93-107.

McCormack, B., Henderson, E., Wilson, V. & Wright, J. 2009. Making practice visible: the Workplace culture critical analysis tool (WCCAT). *Practice Development in Health Care*, 8(1):28-43.

McCormack, B., Manley, K. & Garbett, R. 2004. *Practice development in nursing*. Oxford: Blackwell.

McCormack, B., Manley, K. & Titchen, A. eds. 2013. Introduction. In In: McCormack, B., Manley, K. & Titchen, A. eds. *Practice development in nursing and healthcare*. Oxford: Wiley-Blackwell, 1-17.

¹ Typing error in the original title of the article as on this website.

- McCormack, B., McCance, T. & Maben, J. 2013. Outcome evaluation in the development of person-centred practice. In: McCormack, B., Manley, K. & Titchen, A. eds. *Practice development in nursing and healthcare*. Oxford: Wiley-Blackwell, 190-211.
- McGillivray, B. 2005. The role of Victorian emergency nurses in the collection and preservation of forensic evidence: A review of the literature. *Accident and Emergency Nursing*, 13, 95-100.
- McIntosh, P. 2010. *Action research and reflective practice*. London: Routledge.
- McMillan, S.S., Kelley, F., Sav, A., Kendall, E., King, M.A., Whitty, J. & Wheeler, A.J. 2014. Using the nominal group technique: How to analyse across multiple groups. *Health Services Outcomes Research Methods*, 14, 92-108.
- McNiff, J. & Whitehead, J. 2006. *All you need to know about action research*. London: Sage.
- McNiff, S. 2008. *Handbook of the arts in qualitative research: Perspectives, methodologies, examples, and issues*. Thousand Oaks, CA: Sage.
- Meisel, Z.F., Carr, B.G. & Conway, P.H. 2012. From comparative effectiveness research to patient-centered outcomes research: Integrating emergency care goals, methods, and priorities. *Annals of Emergency Medicine*, 60, 309-16.
- Melrose, M.J. 2001. Maximizing the rigor in action research: Why would you want to? How could you? *Field Methods*, 13(2), 160-80.
- Merriam, S.B., Johnson-Bailey, J., Lee, M., Kee, Y., Ntseane, G. & Muhamad, M. 2001. Power and positionality: Negotiating insider/outsider status within and across cultures. *International Journal of Lifelong Education*, 20(5), 405-16.
- Mickan, S., Burls, A. & Glaziou, P. 2011. Patterns of "leakage" in the utilisation of clinical guidelines: A systematic review. *Postgraduate Medical Journal*, 87, 670-9.
- Miller, J., Corbett, G. & Lightbody, C. 2012. Improving the Patient Journey in a Minor Injuries Area. [Online] Available from <http://www.fons.org/Resources/Documents/Project%20Reports/PFHairyresMay2012.pdf> [Accessed 28 October 2016]
- Mindtool. n.d. Word association. [Online] Available from https://www.mindtool.com/pages/articles/newLDR_76htm [Accessed 8 September 2015).

- Mitchell, G. 2013. Selecting the best theory to implement planned change. *Nursing Management*, 20(1), 32-7.
- Mollen, C.J., Goyal, M.K. & Frioux, S.M. 2012. Acute sexual assault: A review. *Paediatric Emergency Care*, 28(6), 548-90.
- Moyakhe, N.P. 2011. Justice in health care – the role of health care workers in advocacy. *South African Journal of Bioethics and Law*, 4(1), 9-12.
- Moynihan, B. 2013. Vulnerable populations. In Hammer, R.M., Moynihan, B. & Pagliaro, E.M. eds. *Forensic nursing: A handbook for practice*. 2nd ed. Burlington, MA: Jones & Bartlett Learning, 101-12.
- Müller, K. & Saayman, G. 2003. Clinical forensic medicine: Completing the form J88 – what to do and what not to do. *South African Family Practice*, 45(8), 39-43.
- Mustafa, R.F. 2011. The P.O.E. Ms of educational research: A beginners' concise guide. *International Education Studies*, 4(3), 23-30.
- Neuman, J.E. 2014. Tavistock Institute. In Coghlan, D. & Brydon-Miller, C. eds. *The SAGE encyclopaedia of action research*. London: Sage. 758-762.
- Newton, A.W. & Vandeven, A.M. 2010. Child abuse and neglect: A worldwide concern. *Current Opinion in Paediatrics*, 22, 226-33.
- Odell, M. 2015. Faculty of Clinical Forensic Medicine: A major development in clinical forensic medicine. *Emergency Medicine Australasia*, 27, 369-71.
- Odelius, A., Allan, H., Hunter, B., Bryan, K., Knibb, W. & Shawe, J. 2015. From transformative learning to social change? Using action research to explore and improve informal complaints management in an NHS trust. *International Practice Development Journal*, 5(1). [Online] Available from <http://www.fons.org/library/journal.aspx> [Accessed 5 October 2015].
- O'Leary, Z. 2010. *The essential guide to doing your research project*. London: Sage.
- Olivari, D.R. & Hearn, S. 2013. What is a boundary partner? [Online] Available from <http://www.outcomemapping.ca/download/BP%20discussion%202013.pdf> [Accessed 12 December 2015].
- Olsen, W. 2012. *Key debates and methods in social research*. London: Sage.

- Oppong, S.H. 2013. The problem of sampling in qualitative research. *Asian Journal of Management Sciences and Education*, 2(2), 202-10.
- Ospina, S.M. & Anderson, G. 2014. The action turn. In Coghlan, D. & Brydon-Miller, C. eds). *The SAGE encyclopaedia of action research*. London: Sage, 18-21.
- Owen, A., Arnold, K., Friedman, C. & Sandman, L. 2015. Nominal group technique: An accessible and interactive method for conceptualising the self-advocacy of adults with intellectual and developmental disabilities. *Qualitative Social Work*, 0(00):1-15. [[http://dx.doi.org/ 0.1177/1473325015589803](http://dx.doi.org/0.1177/1473325015589803)]
- Pagliaro, E.M. & Bentley Cewe, B.R. 2013. The forensic nurse witness in the American justice system. In Hammer, R.M., Moynihan, B. & Pagliaro, E.M. eds. *Forensic nursing: A handbook for practice*. 2nd ed. Burlington, MA: Jones & Bartlett Learning, 401-20.
- Pan, Y., Tang, Y. & Gulliver, S. 2012. A component-based method for stakeholder analysis. In *Proceedings of the International Conference on Knowledge Management and Information Sharing*, 290-3.
- Pant, M. 2014a. Empowerment. In Coghlan, D. & Brydon-Miller, C. eds. *The SAGE encyclopaedia of action research*. London: Sage. 290-292.
- Pant, M. 2014b. Participatory action research. In Coghlan, D. & Brydon-Miller, C. eds. *The SAGE encyclopaedia of action research*. London: Sage. 583-587.
- Parduhn, D. 2011. "Everyone is doing something and calling it PRA": A critical reflection on participatory methods in development. [Online] Available from: <http://www.hiidunia.com/wp-content/uploads/downloads/2011/10/%E2%80%98Everyone-is-doing-something-and-calling-it-PRA%E2%80%99-A-Critical-Reflection-on-Participatory-Methods-in-Development.pdf> [Accessed 18 December 2015].
- Parlour, R. & McCormack, B. 2012. Blending critical realist and emancipatory practice development methodologies: Making critical realism work in nursing research. *Nursing Inquiry*, 19(4), 308-21.
- Parsell, G., Gibbs, T. & Bligh, J. 1998. Three visual techniques to enhance interprofessional learning. *Postgraduate Medical Journal*, 74, 387-90.
- Pasqualone, G.A. 2015. The relationship between the forensic nurse in the emergency department and law enforcement officials. *Critical Care Nurse Quarterly*, 38(1), 36-48.

- Pasqualone, G. & Michel, C. 2015. Forensic patient hiding in full view. *Critical Care Nursing Quarterly*, 38(1), 3-16.
- Patel, A., Roston, A., Tilmon, S., Stern, L., Roston, A., Patel, D. & Keith, L. 2013. Assessing the extent of provision of comprehensive medical care management for female sexual assault patients in US hospital emergency departments. *International Journal of Gynaecology and Obstetrics*, 123, 24-8.
- Patomäki, H. & Wight, C. 2000. After post positivism? The promises of critical realism. *International Studies Quarterly*, 44, 212-37.
- Patton, M.Q. 2002. *Qualitative research and evaluation methods*. Thousand Oaks, CA: Sage.
- Patton, M.Q. 2012. *Essentials of utilization-focused evaluation*. Thousand Oaks, CA: Sage.
- Pawson, R. 2006. Digging for nuggets: How “bad” research can yield “good” evidence. *International Journal of Social Research Methodology*, 9(2), 127-42.
- Pawson, R. 2013. *The science of evaluation: A realist manifesto*. London: Sage.
- Pawson, R., Greenhalgh, T., Harvey, G. & Walshe, K. 2004. Realist synthesis: An introduction. ESRC Research Methods Programme, University of Manchester. [Online] Available from <http://betterevaluation.org/sites/default/files/RMPmethods2.pdf> [Accessed 5 December 2015].
- Pawson, R., Wong, G. & Owen, L. 2011. Known knowns, known unknowns, unknown unknowns: The predicament of evidence-based policy. *American Journal of Evaluation*, 32, 518-46.
- Pawson, R. & Tilley, N. 1997. An introduction to scientific realist evaluation. In Chelimsky, E. & Shadish, W. R. eds. *Evaluation for the 21st century: A handbook*. Thousand Oaks, CA: SAGE, 405-418.
- Payne-James, J. 2005. History and development of clinical forensic medicine. In Stark, M.M. ed. *Clinical forensic medicine: A physician's guide*. 2nd ed. Secaucus, NJ: Humana Press.
- Phelan, A. 2012. Elder abuse in the emergency department. *International Emergency Nursing*, 20, 214-20.
- Popplewell, R. & Hayman, R. 2012. Where, how, and why are action research approaches used by international development non-governmental organisations? International NGO training and research centre. Briefing paper, 32. [Online] Available from <http://www.intrac> [Accessed 26 May 2014].

- Prasad, B.D. 2014. Social justice. In Coghlan D. & Brydon-Miller C. eds. *The SAGE encyclopaedia of action research*. London: Sage. 707-711.
- Propp, K.M., Apker, J., Ford, W.S.Z., Wallace, N., Serbenski, M. & Hofmeister, N. 2010. Meeting the complex needs of the health care team: Identification of nurse-team communication practices perceived to enhance patient outcomes. *Qualitative Health Research*, 20(1), 15-28.
- Putre, L. 2013. CSI in the ED: Emergency department clinicians learn forensic skills to help crack crime cases. *Hospitals and Health Networks*. [Online] Available from www.hhnmag.com [Accessed 11 May 2015].
- Ravitch, S.M. & Wirth, K. 2007. Developing a pedagogy of opportunity for students and their teachers. *Action Research*, 5(1), 75-91.
- Read J. & Palmer R. 2013. A stroke staff training programme involving expert patients: a case study of its impact on staff and service development. *International Practice Development Journal*. 1 (3), 1-16. [Online]. Available from <http://www.fons.org/library/journal.aspx> [Accessed 5 October 2016].
- Reed, M.S., Graves, A., Dandy, N., Posthumus, H., Habacek, K., Morris, J., Prell, C., Quinn, C.H. & Stringer, L.C. 2009. Who's in and why? A typology of stakeholder analysis methods for natural resource management. *Journal of Environmental Management*, 90, 1933-49.
- Reeves, S. 2015. The importance of realist synthesis for the interprofessional field. *Journal of Interprofessional Care*, 29(1), 1-2.
- Rege, S. 2011. Medico-legal cases across various hospitals – a review & understanding of procedures. *Medico-Legal Update*, 11(2), 67-69.
- Registered Nurses Association of Ontario. 2002. *Toolkit implementation of clinical practice guidelines*. Canada: Registered Nurses Association of Ontario.
- Reijnders, U.J.L., Giannakopoulos, G.F. & De Bruin, K.H. 2008. Assessment of abuse-related injuries: A comparative study of forensic physicians, emergency room physicians, emergency room nurses and medical students. *Journal of Forensic and Legal Medicine*, 15, 15-9.
- Rezaei, J., Naderi, S., Mahmoudi, E., Rezaei, S. & Hashemian, A.H. 2015. Job burnout rate and related demographic factors in nursing personnel employed in emergency departments of chosen educational

hospitals by Kermanshah University of Medical Science in 2012. *Advances in Biological Research*, 9(2), 117-27.

Rigg, C. 2014. Action learning. In Coghlan, D. & Brydon-Miller, C. eds. 2014. *The SAGE encyclopaedia of action research*. London: Sage. 9-14.

Roeden, J.M., Maaskant, M.A. & Curfs, L.M.G. 2012. The nominal group technique as an evaluation tool for solution-focused coaching. *Journal of Applied Research in Intellectual Disabilities*, 25, 588-93.

Rodgers, P. 2016. An Exploration of the Patient's Experience Following an Acute Myocardial Infarction and Participation in a Clinical Research Study. [Online] Available from <http://www.fons.org/Resources/Documents/Project%20Reports/An-Exploration-of-the-Patient%E2%80%99s-Experience-Following-an-Acute-Myocardial-Infarction-and-Participation-in-a-Clinical-Research.pdf> [Accessed 28 October 2016].

Rolfe, G., Freshwater, D. & Jasper, M. 2001. *Critical reflection in nursing and the helping professions: A user's guide*. Basingstoke, UK: Palgrave MacMillan.

Rose, J. & Glass, N. 2008. The importance of emancipatory research to contemporary nursing practice. *Contemporary Nurse*, 29, 8-22.

Rosenstein, B. 2014. Evaluation. In Coghlan, D. & Brydon-Miller, C. eds. *The SAGE encyclopaedia of action research*. London: Sage. 314-7.

Rowe, K. & Moodley, K. 2013. Patients as consumers of health care in South Africa: The ethical and legal implications. *Biomed Central Medical Ethics*, 15, 15. [Online] Available from <http://www.biomedcentral.com/1472-6939/14/15> [Accessed 2 September 2014].

Rowe, W.E. 2014. Positionality. In Coghlan, D. & Brydon-Miller, C. eds. *The SAGE encyclopaedia of action research*. London: Sage. 627-8.

Rowley, J. 2014. Data analysis. In Coghlan, D. & Brydon-Miller, C. eds. *The SAGE encyclopaedia of action research*. London: Sage. 239-42.

Royal College of Nursing. 2007. *Section 3: Resources for clarifying values and beliefs*. Royal College of Nursing Resource File. London: Royal College of Nursing. [Online]. Available from www.rcn.org.co.uk [Accessed 6 February 2014].

- Rubin, A. 2014. Bridging the gap between research-supported interventions and everyday social work practice: A new approach. *Social Work*, 59(3), 223-30.
- Rudge, T., Holmes, D. & Perron, A. 2011. The rise of practice development with/in reformed bureaucracy: Discourse, power and the government of nursing. *Journal of Nursing Management*, 19, 837-44.
- Rutty, J.E. 2006. Does England need a new genesis of forensic nursing? *Forensic Science, Medicine, and Pathology*, 2(3), 149-55.
- Ryan, M.T. 2000. Clinical forensic medicine. *Annals of Emergency Medicine*, 36(3), 271-3.
- Rycroft-Malone, J. 2013. How you must use PARIHS to deliver safe and effective care. In McCormack, B., Manley, K. & Titchen, A. eds. *Practice development in nursing and healthcare*. Oxford: Wiley-Blackwell, 130-45.
- Rycroft-Malone, J., McCormack, B., Hutchinson, A.M., DeCorby, K., Bucknall, T.K., Kent, B., Schultz, A., Snelgrove-Clarke, E., Stetler, C.B., Titler, M. & Wallin, L. 2012. Realist synthesis: Illustrating the method for implementation research. *Implementation Science*, 7, 33. [Online] Available from <http://www.implementationscience.com/content/7/1/33> [Accessed 24 May 2014].
- Rydzik, A., Pritchard, A., Morgan, N. & Sedgley, D. 2012. The potential of arts-based transformative research. *Annals of Tourism Research*, 40, 283-305.
- Saferstein, R. 2007. *Criminalistics: An introduction to forensic science*. 9th ed. Upper Saddle River, NJ: Pearson.
- Saija, L. 2014. Writing about engaged scholarship: Misunderstanding and the meaning of “quality” in action research publications. *Planning Theory & Practice*, 15(2), 187-201.
- Saldaña, J. 2013. *The coding manual for qualitative researchers*. London: Sage.
- Sampsel K, Szobota L, Joyce D, Graham K & Pickett W. 2009. The impact of a sexual assault/domestic violence program on ED care. *Journal of Emergency Nursing* 35(4), 282-9.
- San Diego County Board of Supervisors. 2001. San Diego County sexual assault response team (SART): Standards of practice - for members of the interdisciplinary SART.

- Sandt, F. 2012. Peer observation action research project. *School Leadership & Management*, 32(4), 355-73.
- Santucci, K.A. 2001. Clinical forensic medicine: An unexplored frontier. *Clinical Paediatric Emergency Medicine*, 2, 229-98.
- Sapford, R. 2006. Methodology. In Jupp, V. ed. *The SAGE dictionary of social research methods*. London: Sage, 176-8.
- SAPS – see South African Police Service
- Sarvestani, R.S., Moattari, M., Nasrabadi, A.N., Momennasab, M., Yektatalab, S. and Jafari, A., 2016. Empowering nurses through action research for developing a new nursing handover program in a pediatric ward in Iran. *Action Research*, p.1476750316636667.
- Sauerman, A. & Ivkovic, S.K. 2015. Police integrity in South Africa. In Ivkovic, S.K. & Haberfeld, M.R. eds. *Measuring police integrity across the world*. New York, NY: Springer, 213-239.
- Saumure, K. & Given, L.M. 2008. Nonprobability sampling. In Given, L.M. ed. *The SAGE encyclopaedia of qualitative research methods*. London: Sage, 562.
- Sawatzky, J.V. & Enns, C.L. 2012. Exploring the key predictors of retention in emergency nurses. *Journal of Nursing Management*, 20, 696-707.
- Sayer, A. 2011. *Why things matter to people: Social science, values and ethical life*. New York, NY: Cambridge University Press.
- Schade, J. 2007. *Ten reasons you should hire a professional moderator to conduct focus groups*. [Online] Available from http://www.jrsconsulting.net/freearticles_16.html [Accessed 14 October 2015].
- Schiller, C.J. 2016. Critical realism in nursing: an emerging approach. *Nursing Philosophy*, 17, 88-102.
- Schmeer, K. 2001. *Stakeholder analysis guidelines*. [Online] Available from <http://0-www.who.int.innopac.up.ac.za/workforcealliance/knowledge/toolkit/33.pdf> [Accessed 20 November 2013].
- Schweitzer, N.J. & Saks, M.J. 2006. CSI effect: Popular fiction about forensic science affects the public's expectations about real forensic science. *Jurimetrics*, 47, 357-64.

- Sekula, L.K. 2016. What is forensic nursing? In Amar, A.F. & Sekula, L.K. eds. *A practical guide to forensic nursing*. Indianapolis, IN: Sigma Theta Tau International, 1-18.
- Seng, J.S., Sanubol, M., County, J. & Arbor, A. 2004. The first year as sexual assault nurse examiner: Role transition and role-related stress within a new SANE team. *Journal of Emergency Nursing*, 30(2), 126-133.
- Sharma, B.R. 2003. Clinical forensic medicine – management of crime victims from trauma to trial. *Journal of Clinical Forensic Medicine*, 10, 267-73.
- Sharma, B.R. 2006. Clinical forensic medicine in the present day trauma-care system – an overview. *Injury: International Journal of the Care of the Injured*, 37, 595-601.
- Shaw, T. 2013. Approaches to practice development. In McCormack, B., Manley, K. & Titchen, A. eds. *Practice development in nursing and healthcare*. Oxford: Wiley-Blackwell, 66-87.
- Shaw, T., 2012. Unravelling the consequence of practice development: an exploration of the experiences of healthcare practitioners. *International Practice Development Journal*, 2(2), 1-29. [Online] Available from <http://www.fons.org/library/journal.aspx> [Accessed 28 October 2016].
- Shenton, A.K. 2004. Strategies for ensuring trustworthiness in qualitative research projects. *Education for Information*, 22, 63-75.
- Sherry, M. 2008. Insider/outsider status. In Given L.M. ed. *The SAGE encyclopaedia of qualitative research methods*. London: Sage, 147-69.
- Shortland, S. 2010. Feedback within peer observation: Continuing professional development and unexpected consequences. *Innovations in Education and Teaching International*, 47(3), 295-304.
- Shukumisa. 2011. *Formal recognition of forensic nursing in South Africa*. [Online] Available from <http://www.shukumisa.org.za/?s=Formal+recognition+of+forensic+nursing+in+South+Africa&submit=Go> [Accessed 22 May 2012].
- Simmons, B. 2014. Graduate forensic nursing education: How to better educate nurses to care for this patient population. *Nurse Educator*, 39(4), 184-7.
- Singh, S.K. 2012. Crime, society and role of forensic medicine. *Indian Journal of Forensic Medicine & Toxicology*, 6(2), 184-7.

- Salter, K.L. and Kothari, A., 2014. Using realist evaluation to open the black box of knowledge translation: a state-of-the-art review. *Implementation Science*, 9(1), 1-14.
- Smith, E. 2012. Getting in through the front door: The first hurdle of researching in companies. *International Journal of Training Research*, 10(3), 153-63.
- Smith, L., Bratini, L., Chambers, D., Jensen, R.V. & Romero, L. 2010. Between idealist and reality: Meeting the challenges of participatory action research. *Action Research*, 8(4), 407-25.
- Smith, S. 1951. The history and development of forensic medicine. *British Medical Journal*, March 24, 599-607.
- Smythe, D., Artz, L., Combrinck, H., Doolan, K. & Martin, L.J. 2008. Caught between policy and practice: Health and justice responses to gender-based violence. Crime, violence and injury prevention in South Africa: Data to action. *Tygerberg: Medical Research Council-University of South Africa Crime Violence and Injury Lead Programme*, 150-172.
- Snoeren, M. and Frost, D., 2011. Realising participation within an action research project on two care innovation units providing care for older people. *International Practice Development Journal*, 1(2), 1-18. [Online] Available from <http://www.fons.org/library/journal.aspx> [Accessed 5 October 2016].
- Snoeren, M.M.W.C., Niessen, T.J.H. & Abma, T.A. 2011. Engagement enacted: Essentials of initiating an action research project. *Action Research*, 10(2), 189-204. [<http://dx.doi.org/10.1177/1476750311426620>]
- South Africa. 1959. *Inquest Act, No 58 of 1959 as Amended*. Pretoria: Government Printer.
- South Africa. 1977. *Criminal Procedure Act, No. 51 of 1977*. Pretoria: Government Printer.
- South Africa. 1978. *Nursing Act, No. 50 of 1978*. Pretoria: Government Printer.
- South Africa. 1996. *Constitution of the Republic of South Africa, No. 108 of 1996*. Pretoria: Government Printer.
- South Africa. 1998. *Domestic violence Act, No. 116 of 1998*. Pretoria: Government Printer.
- South Africa. 2003. *National Health Act, No. 61 of 2003*. Pretoria: Government Printer.

South Africa. 2003. National Health Act, No 61 of 2003. Regulations regarding the rendering of pathology service

South Africa. 2005. *Nursing Act, No. 33 of 2005*. Pretoria: Government Printer.

South Africa. 2007a. *Criminal Law (Sexual Offences and Related Matters) Amendment Act, No. 32 of 2007*. Pretoria: Government Printer.

South Africa. 2007b. *Health Professions Amendment Act, No. 59 of 2007*. Pretoria: Government Printer.

South Africa. 2009. *National directives and instructions on conducting a forensic examination on survivors of sexual offence cases in terms of the Criminal Law (Sexual Offences and Related Matters) Amended Act, No. 223 of 2007*. Pretoria: Government Printer.

South Africa. 2012. *Regulations regarding the rendering of clinical forensic medicine services. Regulation 176*. Pretoria: Government Printer.

South Africa. 2013. *Criminal Law (Forensic Procedures) Amendment Act, No.37 of 2013*. Pretoria: Government Printer.

South African Nursing Council (SANC). 2014. Competencies for forensic nurse. [Online] Available from <http://www.sanc.co.za/pdf/Competencies/SANC%20Competencies-Forensic%20Nurse%202014-05.pdf> [Accessed 8 December 2015].

South African Police Service (SAPS). 2015. *Crime situation in South Africa*. [Online] Available from: www.saps.gov.za/resource_centre/publication/statistics/crimestats/2015/crime_stats.php [Accessed 1 December 2015].

Stakeholder Participation Working Group of the 2010 HIA in the Americas Workshop. 2011. *Best Practices for stakeholder participation in Health Impact Assessment*. Oakland, CA, October 2011. [Online] Available from <http://www.healthimpactproject.org/resources/document/Guide-for-Stakeholder-Participation.pdf> [Accessed 20 November 2013].

Stark, M.M. & Norfolk, G.A. 2011. Training in clinical forensic medicine in the UK – Perceptions of current regulatory standards. *Journal of Forensic and Legal Medicine*, 18, 264-275.

- Stark, M.M. & Payne-James, J.J. 2014. Provision of clinical forensic medical services in Australia: A qualitative survey 2011/2. *Journal of Forensic and Legal Medicine*, 21, 31-7.
- Starr, L. 2013. Assisting victims of crime – bridging the gap from trauma to trial. *Australian Nursing Journal*, 13(9), 29.
- Steinfort, P. 2014. Soft systems methodology. In Coghlan, D. & Brydon-Miller, C. eds. *The SAGE encyclopaedia of action research*. London: Sage. 721-7.
- Stewart, D.W., Shamdasani, P.N. & Rook, W. 2007. *Focus groups*. Thousand Oaks, CA: Sage.
- St-Onge, S., Martineau, B., Harvey, A., Bergeron, L., Mamede, S. & Rikers, R. 2013. From see one do one, to see a good one do a better one: Learning physical examination skills through peer observation. *Teaching and Learning in Medicine: An International Journal*, 25(3), 195-200.
- Stoudt, B.G. 2014. Quantitative methods. In: Coghlan, D. & Brydon-Miller C. eds. *The SAGE encyclopaedia of action research*. London: Sage. 669-73.
- Streck, D.R. 2012. Editorial – Action research. *International Journal of Action Research*, 8(2), 139-41.
- Stringer, E.T. 2007. *Action research*. Thousand Oaks, CA: Sage.
- Stringer, E.T. 2014. *Action research*. 4th ed. Thousand Oaks, CA: Sage.
- Sullivan, E., Hegney, D. & Francis, K. 2013. An action research approach to practice, service and legislative change. *Nurse Researcher*, 21(2), 8-13.
- Tashakkori, A. & Teddlie, C. 2010. *SAGE handbook of mixed methods in social & behavioural research*. London: Sage.
- Taylor, J.L. & Rew, L. 2010. A systematic review of the literature: Workplace violence in the emergency department. *Journal of Clinical Nursing*, 20, 1072-85.
- Tisdell, E.J. 2008. Feminist epistemology. In Given, L.M. ed. *The SAGE encyclopaedia of qualitative research methods*. London: Sage, 331-5.
- Titchen, A. 2015. Action research: Genesis, evolution and orientations. *International Practice Development Journal*, 5(1), 1-16. [Online] Available from <http://www.fons.org/library/journal.aspx> [Accessed 19 October 2015].

Titchen, A., Dewing, J. & Manley, K. 2013. Getting going with facilitation skills in practice development. In McCormack, B., Manley, K. & Titchen, A. eds. *Practice development in nursing and healthcare*. Oxford: Wiley-Blackwell, 109-29.

Tomal, D.R. 2010. *Action research for educators*. Plymouth, UK: Rowman & Littlefield.

Tongco, D.C. 2007. Purposive sampling as a tool for informant selection. *Ethnobotany Research & Applications*, 5, 147-58.

Townsend, A. 2014. Collaborative action research. In Coghlan, D. & Brydon-Miller, C. eds. *The SAGE encyclopaedia of action research*. London: Sage. 116-9.

Tractenberg, L. 2013. Applying knowledge cartography techniques and tools to facilitate the process of realist synthesis. *Electronic Journal of Business Research Methods*, 11(2), 105-15. [Online] Available from www.ejbrn.com [Accessed 6 December 2015].

United Nations. 1985. *Declaration of basic principles of justice for victims of crime and abuse of power adopted by general assembly resolution 40/34 of 29 November 1985*. [Online] Available from <http://www2.ohchr.org/english/law/pdf/victims.pdf> [Accessed 14 October 2012].

Uva, J.L. 1995. Clinical forensic medicine. *Academic Emergency Medicine*, 2(8), 757-8.

Van de Ven, A.H. & Delbecq, A.L. 1972. The nominal group as a research instruments for exploring health studies. *American Journal of Public Health*, 62(3), 337-42.

Van Der Donk, C. & Kuijer-Siebelink, W. 2015. Practitioner research to promote practice development: the continued development by means of practitioner research of a multidisciplinary learning environment within neurorehabilitation care for older persons. *International Practice Development Journal*, 5(2), 1-14. [Online] Available from <http://www.fons.org/library/journal.aspx> [Accessed 16 October 2016].

Van Hooft, S. 2011. Caring, objectivity and justice: An integrative view. *Nursing Ethics*, 18(2), 149-160.

Varga-Atkins, T., Bunyan, N., Fewtrell, R. & McIsaac, J. 2011. *The nominal group technique – a practical guide for facilitators. Written for the ELESIG Small Grants Scheme*. Liverpool, UK: University of Liverpool.

Varvasovzky, Z. & Brugha, R. 2000. How to do (or not to do)...a stakeholder analysis. *Health Policy and Planning*, 15(3), 338-45.

Vetten, L., Le, T., Leisegang, A. & Haken, S. 2010. *The right and the real: A shadow report analysing selected government departments' implementation of the 1998 Domestic Violence Act and 2007 Sexual Offences Act*. Johannesburg: Tshwaranang Legal Advocacy Centre.

Voigt, J.R., Hansen, U.M., Glindorf, M., Poulsen, R. and Willaing, I., 2014. Action research as a method for changing patient education practice in a clinical diabetes setting. *Action Research*, p.1476750314534453.

Walker, K. 2009. Editorial: Practice development: Who cares and so what? *Journal of Clinical Nursing*, 18:157-59.

Walker, R., Cooke, M., Henderson, A. & Creedy, D.K. 2013. Using a critical reflection process to create an effective learning community in the workplace. *Nurse Education Today*, 33, 504-11.

Wand, T., White, K. & Patching, J., 2010. Applying a realist (ic) framework to the evaluation of a new model of emergency department based mental health nursing practice. *Nursing inquiry*, 17(3), 231-9.

Wang, J., Ge, J., Lu, Q. 2012. A review of stakeholder analysis. *System Science, Engineering Design and Manufacturing Information. (ICSEM) 3rd International Conference*, 2, 40-3.

Ward, C.L., Artz, J., Berg, J., Boonzaier, F., Crawford-Browne, S., Dawes, A., Foster, D., Matzopoulos, R., Nicol, A., Seekings, J., Van As, A.B. & Van der Spuy, E. 2012. Violence, violence prevention, and safety: A research agenda for South Africa. *South African Medical Journal*, 102, 218-24.

Waterman, H., Tillen, D., Dickson, R. & De Koning, K. 2001. Action research: A systematic review and guidance for assessment. *Health Technology Assessment (Winchester, England)*, 5, 23(iii).

Watling, T. 2015. Factors enabling and inhibiting facilitator development: lessons learned from Essentials of Care in South Eastern Sydney Local Health District. *International Practice Development Journal*, 5(2), 1-16. [Online] Available from <http://www.fons.org/library/journal.aspx> [Accessed 5 October 2016].

Wecht, C.H. 2005. The history of legal medicine. *Journal of American Academy of Psychiatry and the Law*, 33(2), 245-51.

West, J. 2013. From being to becoming: The journey of becoming and organisational practice development facilitator through the stages of enlightenment, empowerment and emancipation. *International Practice Development Journal*, 3(3), 1-16. [Online] Available from <http://www.fons.org/library/journal.aspx> [Accessed 20 October 2015].

WHO – see World Health Organization

Wight, R.A. 2014. Agriculture and ecological integrity. In Coghlan, D. & Brydon-Miller, C. eds. *The SAGE encyclopaedia of action research*. London: Sage, 32-5.

Wiler, J.L. & Bailey, H. 2007. The need for emergency medicine resident training in forensic medicine. *Annals of Emergency Medicine*, 50(6), 733-8.

Wilkinson, A.K. 2011. Forensic nursing educational development: An integrated review of the literature. *Journal of Psychiatric and Mental Health Nursing*, 18, 236-46.

Wilkinson, M. 2012. *The secrets of facilitation*. San Francisco, CA: Jossey-Bass.

Williams, A. & Kilgour, P. 2014. Research: What potential does it hold for teacher practitioners? *TEACH Journal of Christian Education*, 8(1), 38-41.

Williamson, G.R. 2012a. Foundations of action research. In: Williamson, G.R., Bellman, L. & Webster, J. eds. *Action research in nursing and healthcare*. London: Sage, 7-30.

Williamson, G.R. 2012b. Action research, nursing and healthcare. In Williamson, G.R., Bellman, L. & Webster, J. eds. *Action research in nursing and healthcare*. London: Sage, 51-65.

Williamson, G.R. & Prosser, S. 2002. Action research: Politics, ethics and participation. *Journal of Advanced Nursing*, 40(5), 587-93.

Wilson, C. & Flicker, S. 2014. Arts-based action research. In Coghlan, D. & Brydon-Miller, C. eds. *The SAGE encyclopaedia of action research*. London: Sage, 58-61.

Wilson, V. & McCormack, B. 2006. Critical realism as emancipatory action: The care for realistic evaluation in practice development. *Nursing Philosophy*, 7, 45-57.

Wittmann-Price, R.A. 2004. Emancipation in decision-making in women's health care. *Journal of Advanced Nursing*, 47(4), 437-45.

Wong, G., Greenhalgh, T., Westhorp, G., Buckingham, J. & Pawson, R. 2013. Rameses publication standards: Realist syntheses. *BioMed Central Medicine*, 11, 21. [Online] Available from <http://www.biomedcentral.com/1741-7015/11/21> [Accessed 23 April 2014].

Woodhams, C. & Lupton, B. 2014. Transformative and emancipatory potential of intersectionality research. *Gender in Management: An International Journal*, 29(5), 301-7.

World Health Organization (WHO). 2002. *World report on violence and health: Summary*. Geneva: WHO.

World Health Organization (WHO). 2003. *Guidelines for medico-legal care of victim's sexual violence*. Geneva: WHO.

World Health Organization (WHO). 2004. *Preventing violence: A guide to implementing the recommendations of the World report on violence and health*. Geneva: WHO.

World Health Organisation (WHO). 2009. *Violence prevention: The evidence*. Geneva: WHO.

World Health Organisation (WHO). 2014. *Global status report on violence prevention 2014*. Geneva: WHO.

Wyatt, J.P., Squires, T., Norfolk, G. & Payne-James, J. 2011. *Oxford Handbook of Forensic Medicine*. Oxford: Oxford University Press.

Yildiz, T., Selimen, D. & Dogan, D. 2014. A study comparing the pre- and post-training knowledge of emergency department nurses in Turkey for the diagnosis of physically abused women. *Journal of Family Violence*, 29, 519-25.

Young S, Wells D & Summers I. 2004. Specific training in clinical forensic medicine is useful to ACEM trainees. *Emergency Medicine Australasia*, 16, 441-445.

Zuber-Skerritt, O. & Fletcher, M. 2007. The quality of an action research thesis in the social sciences. *Quality Assurance in Education*, 15(4), 413-36.

Zuber-skerritt, O. & Perrey, C. 2002. Action research within organisations and university thesis writing. *Learning Organization, The*, 9, 171-179.

Annexure A

Permission from internal review boards.



The Research Ethics Committee, Faculty Health Sciences, University of Pretoria complies with ICH-GCP guidelines and has US Federal wide Assurance.

- FWA 00002567, Approved dd 22 May 2002 and Expires 20 Oct 2016.
- IRB 0000 2235 IORG0001762 Approved dd 13/04/2011 and Expires 13/04/2014.



UNIVERSITEIT VAN PRETORIA
UNIVERSITY OF PRETORIA
YUNIBESITHI YA PRETORIA

Faculty of Health Sciences Research Ethics Committee

25/11/2013

Approval Certificate
New Application

Ethics Reference No.: 364/2013

Title: Transforming forensic care in level-one emergency departments in Gauteng through emancipatory practice development **Dept :** Nursing Sciences **Institution:** University of Pretoria **Cell:** 0829575458

E-Mail: celia.filmalter@up.ac.za

Dear Ms. Cecilia Jacoba Filmalter

The **New Application** as supported by documents specified in your cover letter for your research received on the 28/08/2013, was finally approved by the Faculty of Health Sciences Research Ethics Committee on the 18/09/2013 .

Please note the following about your ethics approval:

- Ethics Approval is valid for End date: December 2015 Total Duration: 3 Years
- Please remember to use your protocol number (**364/2013**) on any documents or correspondence with the Research Ethics Committee regarding your research.
- Please note that the Research Ethics Committee may ask further questions, seek additional information, require further modification, or monitor the conduct of your research.

Ethics approval is subject to the following:

- The ethics approval is conditional on the receipt of 6 monthly written Progress Reports, and
- The ethics approval is conditional on the research being conducted as stipulated by the details of all documents submitted to the Committee. In the event that a further need arises to change who the investigators are, the methods or any other aspect, such changes must be submitted as an Amendment for approval by the Committee.

We wish you the best with your research.

Yours sincerely

Dr R Sommers; MBChB; MMed (Int); MPharmD.

Deputy Chairperson of the Faculty of Health Sciences Research Ethics Committee, University of Pretoria

The Faculty of Health Sciences Research Ethics Committee complies with the SA National Act 61 of 2003 as it pertains to health research and the United States Code of Federal Regulations Title 45 and 46. This committee abides by the ethical norms and principles for research, established by the Declaration of Helsinki, the South African Medical Research Council Guidelines as well as the Guidelines for Ethical Research: Principles Structures and Processes 2004 (Department of Health).

♦ Tel: 012-3541330

♦ Web: www.healthethics-up.co.za

♦ Fax: 012-3541367 Fax2Email: 0866515924

♦ H W Snyman Bld (South) Level 2-34

♦ E-Mail: manda@med.up.ac.za

♦ Private Bag x 323, Arcadia, Pta, S.A., 0007



**RESEARCH OPERATIONAL COMMITTEE FINAL APPROVAL OF
RESEARCH**

Approval number: UNIV-2013-0035

Ms C Filmatter

E mail: celia.filmalter@up.ac.za

Dear Ms Filmatter

**RE: TRANSFORMING FORENSIC CARE IN LEVEL-ONE EMERGENCY
DEPARTMENTS IN GAUTENG THROUGH EMANCIPATORY PRACTICE
DEVELOPMENT**

The above-mentioned research was reviewed by the Research Operational Committee's delegated members and it is with pleasure that we inform you that your application to conduct this research at Private Hospital, has been approved, subject to the following:

- i) Research may now commence with this FINAL APPROVAL from the Committee.
- ii) All information with regards to Company will be treated as confidential.
- iii) Company's name will not be mentioned without written consent from the Committee.
- iv) All legal requirements with regards to patient rights and confidentiality will be complied with.
- v) Insurance will be provided and maintained for the duration of the research. This cover provided to the researcher must also protect both the staff and the hospital facility from potential liability
- vi) In accordance with MCC approval, that medicine will be administered by or under direction of the authorised Trialist
- vii) The research will be conducted in compliance with the GUIDELINES FOR GOOD PRACTICE IN THE CONDUCT OF CLINICAL TRIALS IN HUMAN PARTICIPANTS IN SOUTH AFRICA (2000)
- viii) Company must be furnished with a STATUS REPORT on the progress of the study at least annually on 30th September irrespective of the date of approval from as well as a FINAL REPORT with



reference to intention to publish and probable journals for publication, on completion of the study.

- ix) A copy of the research report will be provided to Company once it is finally approved by the tertiary institution, or once complete.
- x) Company has the right to implement any Best Practice recommendations from the research.
- xi) Company reserves the right to withdraw the approval for research at any time during the process, should the research prove to be detrimental to the subjects/Netcare or should the researcher not comply with the conditions of approval.
- xii) APPROVAL IS VALID FOR A PERIOD OF 36 MONTHS FROM DATE OF THIS LETTER.

We wish you success in your research.

Yours faithfully

Prof Dion du Plessis

Full member, Research Operational Committee & Medical Practitioner evaluating research applications as per Company Policy

Shannon Nell
Chairperson: Research Operational Committee

Date: 21/11/2013

This letter has been anonymised to ensure confidentiality in the research report.
The original letter is available with author of research



Protocol title: Transforming forensic care in level-one emergency departments in Gauteng through emancipatory practice development by CJ Filmlalter

Summary of review:

This is a PhD protocol. The aim is to transform forensic care in emergency departments. There will be 2 supervisors and, appropriately, they both have a PhD degree. The protocol deals in depth with what will be done. Relevant concepts are extensively dealt with and well referenced. The methodology includes mostly quantitative and one qualitative arm. Overall, I have no problems with the methodology and I think this is a promising undertaking that will result in valuable publications and presentations. As appropriate, only one question will be asked for the qualitative study. It may be useful to add some prompts here.

Points that require clarification:

Whereas it is in the interest of patients, the involved hospitals, the investigators and the participants that the study be performed, I have 4 concerns that should be easy to deal with.

1. I could not find information on costs and funding to be used. The cited annexure was missing.
2. Many participants will be involved including nurses and doctors and the various arms of the study will be time consuming. Please clarify how you will prevent this from interfering with the running of the emergency departments. This may need to be discussed with the Hospital Manager.
3. Are you planning to provide any remuneration to the participants?
4. Please prepare participant information sheets and consent forms and provide these for perusal by our Ethics Committee prior to initiating the study.

I recommend that the protocol be approved subject to clarification of the above.

Yours faithfully,

DATE: 27th November 2013

Tel: 011 726 6990
Fax: 011 726 6835
Email: lindadesseins1@telkomsa.net



**Permission to do Research and access Records / Files / Data base at the
Healthcare service**

To: Chief Executive Officer/Information Officer

From: CJ Filmatter (The Investigator)
University of Pretoria

Dr E Kenoshi

Re: Permission to do the following research at

I am a researcher working at the University of Pretoria faculty of Healthcare science department of nursing. I am requesting permission to conduct a study in the Emergency department of the that involves access to patient records.

The title of the study is: **Transforming forensic care in level-one emergency departments in Gauteng through emancipatory practice development.**

I intend to publish the findings of the study - with the healthcare providers in the Healthcare Services in professional journals and/ or at professional meetings like symposia, congresses, or other meetings of such a nature.

I furthermore request in terms of the requirements of the Promotion of Access to Information Act. No. 2 of 2000 that we be granted access to clinical records, files and databases.

I undertake not to proceed with the study until we have received approval from the Faculty of Health Sciences Research Ethics Committee, University of Pretoria.

Yours sincerely

Signature of the Principle Investigator

Permission to do the research study at this hospital and to access the information as requested is hereby approved.

Chief Executive Officer

Dr M.E. Kenoshi

Signature of the CEO



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47 Clinton Road, New Redruth, Alberton, South Africa
PO Box 1002, Alberton, 1450, South Africa
www.netcare.co.za

LETTER CONFIRMING KNOWLEDGE OF NON-TRIAL RESEARCH TO BE CONDUCTED IN THIS NETCARE FACILITY

Dear Celia Filmalter

Re Transforming forensic care in level-one emergency departments in Gauteng through emancipatory practice development

We hereby confirm knowledge of the above named research application to be made to the Netcare Research Operational Committee and in principle agree to the research application for Netcare Union Hospital/site/division, subject to the following:

1. That the data collection may not commence prior to receipt of FINAL APPROVAL from the Sustainability Committee of Netcare (Research Operational Committee).
2. A copy of the research report will be provided to Netcare Research Operational Committee once it is finally approved by the tertiary institution, or once complete.
3. Netcare has the right to implement any Best Practice recommendations from the research.
4. That the Hospital/Site/Division Management reserves the right to withdraw the approval for research at any time during the process, should the research prove to be detrimental to the subjects / Netcare or should the researcher not comply with the conditions of approval.

We wish you success in your research.

Yours faithfully



Signed by Hospital/Site/Division Management

9-10-2013

Date

Hospital General Manager

(Specify designation)