

Clinical Audit of Sexual Abuse Referral Forms to the Sexual Assault Follow-up and Evaluation Clinic, Nassau, The Bahamas, among Females Aged 13 to 19 Years

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ABSTRACT

Objective: To evaluate the adequacy of the documentation of referral forms for sexually abused females aged 13–19 years directed to the Sexual Assault Follow-up and Evaluation (SAFE) Clinic at the Agape Family Medicine Clinic, Nassau, The Bahamas, for interim management.

Methods: An approved review was performed on 123 referral forms regarding sexually abused females aged 13–19 years who attended the SAFE Clinic from 2011 to 2015. The exercise focussed on documentation adequacy based on a scoring system developed by the researchers (> 50% was assessed to be adequate; records of the referee's disposition of the patient, the date of the incident and evidence of sexually transmitted infection (STI) screening were considered vital for adequacy). Descriptive and inferential statistics were calculated.

Results: The median age of the participants was 14 years (interquartile range: 13–15). Of the 63.4% (78) with documented nationality, 88.5% (69) were Bahamian and 11.5% (9) Haitian. Documentation status did not differ statistically significantly by nationality. Regarding documentation, 74% (91) recorded the name of the patient's school, 59.3% (73) recorded that the patient knew the assailant and 17.9% (22) indicated that the patient did not know the assailant, while 22.8% (28) did not document this latter information. Type of sexual penetration was indicated by 65.9% (81). Of the vital variables, 18.7% (23) recorded the referee's disposition of the patient, 29.8% (36) the date of the incident and 60.2% (74) evidence of STI screening; 7.3% (9) documented all three and 22.8% (28) two. The mean percentage of documentation for vital variables was 49.3% (± 3.6) for the Accident and Emergency (A&E) Department, Princess Margaret Hospital, Nassau, versus 30.5% (± 4.0) for public health clinics (PHCs) ($p = 0.001$). Overall, 69.9% (86 of 123) of the referral forms were deemed inadequate: 64.7% (33 of 51) from the A&E Department versus 73.4% (47 of 64) from PHCs among the 115 patients who provided referral information.

Conclusion: Documentation deficiencies of the sexual abuse referral forms demand reform. Complete and consistent documentation is required.

Keywords: Child sexual abuse, clinical audit, documentation, referral forms

Auditoría clínica de los formularios de remisión de abuso sexual a la Clínica de Evaluación y Seguimiento de Agresiones Sexuales, Nassau, Bahamas, entre mujeres de 13 a 19 años

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RESUMEN

Objetivo: *Evaluar la idoneidad de la documentación de los formularios de remisión para mujeres de 13 a 19 años sexualmente abusadas, dirigidas a la Clínica de Evaluación y Seguimiento de Agresiones Sexuales (ESAS) en la Clínica Ágape de Medicina Familiar, Nassau, Bahamas, para la administración interina.*

Métodos: *Se aprobó una revisión para examinar 123 formularios de remisión con respecto a las mujeres de 13 a 19 años sexualmente abusadas, que asistieron a la clínica de ESAS de 2011 a 2015. El ejercicio se centró en la idoneidad de la documentación basada en un sistema de puntuación desarrollado por los investigadores (50% fue adecuado según la valoración; los registros de la disposición de la paciente en el arbitraje, la fecha del incidente y la evidencia del tamizaje de la infección de transmisión sexual (ITS), fueron todos vitales a la hora de determinar la idoneidad). Se calcularon las estadísticas descriptivas e inferenciales.*

Resultados: *La edad promedio de las participantes fue 14 años (rango intercuartil: 13–15). De 63.4% (78) con nacionalidad documentada, el 88.5% (69) fueron bahameñas y el 11.5% (9) haitianas. El estado de la documentación en término de las estadísticas no difirió significativamente por nacionalidad. Con respecto a la documentación, el 74% (91) registró el nombre de la escuela de la paciente, 59.3% (73) registró que la paciente conocía al agresor, y el 17.9% (22) indicó que la paciente no conocía al agresor, mientras que el 22.8% (28) no documentó esta última información. El tipo de penetración sexual fue indicado por 65.9% (81). De las variables vitales, 18.7% (23) registró la disposición de la paciente en el arbitraje, 29.8% (36) la fecha del incidente, y el 60.2% (74) evidencia del tamizaje de las ITS; 7.3% (9) documentó tres de ellas y 2.8% (28) dos. El porcentaje medio de documentación de las variables vitales fue 49.3% (± 3.6) para el Departamento de Accidentes y Emergencias (A&E), Hospital Princess Margaret, Nassau, frente al 30.5% (± 4.0) de las clínicas de salud pública (CSP) ($p = 0.001$). En general, el 69.9% (86 de 123) de los formularios de referencia se consideró inadecuado: 64.7% (33 de 51) del Departamento de A&E frente al 73.4% (47 de 64) de las CSP entre las 115 pacientes que proporcionaron la información de la remisión.*

Conclusión: *Las deficiencias de la documentación de los formularios de remisión de abuso sexual exigen reformas. Se requiere una documentación completa y consistente.*

Palabras clave: Abuso sexual infantil, auditoria clínica, documentación, formularios de referencia

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INTRODUCTION

According to Bassani *et al*, the prevalence of sexual molestation continues to be poorly defined in developing countries, despite ongoing research (1). The concept of sexual abuse often invokes a sense of secrecy among lay persons and medical professionals alike. However, the issue of sexual abuse is a worldwide dilemma with dire immediate and long-term consequences and demands

competent care for patients suffering from such violence (2). Having a clear understanding of the definition of sexual abuse is a starter for all healthcare workers who serve in this capacity. The term ‘sexual abuse’ is often interchanged with ‘sexual violence’ and ‘sexual molestation’. The World Health Organization (WHO) defines ‘sexual violence’ as ‘any sexual act, attempt to obtain a sexual act, unwanted sexual comments or advances, or

acts to traffic, or otherwise directed, against a person's sexuality using coercion, by any person regardless of their relationship to the victim, in any setting, including but not limited to home and work' (3). More specifically, the WHO's Report of the Consultation on Child Abuse Prevention defines 'child sexual abuse' as 'the involvement of a child in sexual activity that he or she does not fully comprehend, is unable to give informed consent to, or for which the child is not developmentally prepared and cannot give consent, or that violate[s] the laws or social taboos of society (4).

According to Virgil, '[t]he UN Woman narrative on gender-based violence in the Caribbean cites [that] "while the worldwide average for rape was 15 per 100 000, The Bahamas has an average of 133 [per 100 000], St Vincent and the Grenadines 112, Jamaica 51, Dominica 34, Barbados 25 and Trinidad and Tobago 18"' (5). Virgil further reported that in nine Caribbean countries, 48% of adolescent girls' sexual initiation was forced or somewhat forced (5).

As healthcare providers, we are the gateway to comprehensive care after sexual assault; therefore, adequate documentation in the referral process is important for the continuity of that care (6). In an effort to manage patients presenting with sexual abuse, it is essential to have a referral system to specialist primary care physicians enabled by adequate documentation. High-quality documentation and structured communication among healthcare professionals are essential to patient safety, as it facilitates the continuity of care, coordination of treatment and evaluation of patient outcomes (7). Studies indicate that medical documentation is often fragmentary and inconsistent, which may ultimately lead to substandard care (8).

Victims of sexual abuse between the ages of 13 and 19 years seen at the Accident and Emergency (A&E) Department, Princess Margaret Hospital, Nassau, and public health clinics (PHCs) in the Commonwealth of The Bahamas are referred to the Sexual Assault Follow-up and Evaluation (SAFE) Clinic at the Agape Family Medicine Clinic. This health centre operated by the Public Hospitals Authority is in Nassau, New Providence Island. This Bahamas-based study sought to explore the adequacy of the initial referral process in the management of sexual violence/abuse. This evaluation was done in order to better facilitate the management of victims of sexual abuse, commencing with the referral process from community health as well as the A&E Department to a major PHC in The Bahamas.

SUBJECTS AND METHODS

The adequacy of the sexual abuse referral form was identified as a necessary matter for evaluation by researchers after consultation with the Head of the Family Medicine Department of the Princess Margaret Hospital, Nassau, The Bahamas. This issue of quality of care was seen as one that needs to be improved in an evidence-based manner so that as such documentation improvements are made, the foundation can be laid for improved whole person care. This should also foster better clinical research on sexual abuse occurrences and management. The review was performed on referral forms pertaining to sexually abused females aged 13–19 years who attended the SAFE Clinic. The exercise focussed on documentation adequacy based on a scoring system developed by the researchers where a score of > 50% was assessed to be adequate. Of the 141 sexual abuse referral forms reflecting all such referrals seen at the SAFE Clinic, 123 were found to be eligible for the study. This exceeded the minimum sample size of 96, estimated to be necessary for this study. Inclusion criteria were: referrals dated between 2011 and 2015, the female gender, and ages 13–19 years. In all, 10 variables were considered to be the sufficient set required to reflect meaningfully the initial physician's assessment and care plan. Of these 10, records of the referee's disposition of the patient, the date of the incident and evidence of sexually transmitted infection (STI) screening were considered to be the most vital for adequacy. The other seven were: age/date of birth, nationality, knowledge of the assailant, the assailant's gender, who referred the patient, type of sexual penetration, and date of report. Throughout, it was solely the presence or absence of this information on the referral form that was registered on the data capture sheet. Where such information was absent, it was assigned a score of 0 on the data capture sheet. The researchers' decision was to assign a score of five points each if the referee recorded how the patient was disposed of and the date of the incident. Three points were assigned if the referral form indicated that STI screening was attended to. For the remaining seven variables in the necessary set, one point each was assigned if evidence of their documentation was included in the referral form. Hence, the maximum score, reflecting the most useful referral documentation, was 20 points.

In addition to the above-mentioned necessary set, the data capture sheet also included the following demographic variables: the patient's age, address and school name. Other factors included: incident location

and assailant's age. Data were collected in the strictest confidence taking care to maintain patient anonymity. A current version of the Statistical Package for the Social Sciences (IBM SPSS, v 21) generated descriptive and inferential statistics. Descriptive statistics reflected percentages of variables and forms found to be documented. The patients' median age and nationality were reported along with their interquartile ranges (IQRs). Inferential statistics allowed for comparison of the proportions documenting variables of interest by whether the referral originated from the A&E Department or PHCs.

RESULTS

From the 123 eligible referral forms, 4.1% (5) did not include the patient's age. From the remaining 95.9% (118), the patients' median age was calculated to be 14 years (IQR: 13–15). Of the 63.4% (78) with documented nationality, 88.5% (69) were Bahamian and 11.5% (9) Haitian. Documentation status did not differ statistically significantly by nationality. Regarding address, 98.1% included the information. In this study, 74% (91) of the referral forms had the name of the patient's school recorded. Regarding the documentation of the location of the sexual abuse incident, 26% (32) contained this information. The researchers decided not to report further statistics on the occurrence of incidents by specific location to foster confidentiality on this matter. The site from which the patient was referred was indicated on 94.3% (116) of the forms.

The status of the assailant(s) (*ie* whether known or unknown to the patient) was documented in 87.2% (95) of the cases. Where documented, 76.8% (73) of the times, the assailant was recorded as known, while 23.2% (22) stated unknown. The gender of the assailant was recorded in 82.3% (100) of the instances, while the assailant's age was recorded in 16.3% (20). Examiners documented the type of sexual penetration on 65.9% (81) of the referral forms. Of these, 38.2% (47) were documented as vaginal penetration, 17.9% (22) suggested that penetration was vaginal based on other information on the referral form, 9.8% (12) were documented as oral penetration, and 7.3% (9) indicated anal penetration.

Evidence of STI screening was reflected in 60.2% (74) of the forms. No documentation of any prophylaxis administered was apparent. Physicians recorded the date of the incident on 29.8% (36) of the forms and their disposition of the patients (*eg* referral for counselling) on 18.7%. These three variables, considered to be the most useful for assessing the adequacy of documentation, were present in 7.3% (9) of the cases, while 22.8%

(28) reported two of the three. Among PHCs, 45.3% (29) did not indicate any of the three most vital variables, compared to 7.8% (4) for the A&E Department referral documentation. The mean percentage of documentation for vital variables was 49.3% (\pm 3.6) for the A&E Department *versus* 30.5% (\pm 4.0) for PHCs (p = 0.001). Overall, 69.9% (86 of 123) of the referral forms were deemed inadequate: 64.7% (33 of 51) from the A&E Department *versus* 73.4% (47 of 64) from PHCs among the 115 patients who provided referral information. The Table and the Figure provide further details of this comparison.

Table: Comparison of documentation by the Accident and Emergency Department *versus* public health clinics

Variable	Accident and Emergency Department	Public health clinics	Phi correlation coefficient (p -value)
Evidence of sexually transmitted infection screening	92.3% (58)	35.9% (23)	0.576 (< 0.001)
Date of incident	21.6% (11)	36.5% (23)	0.176 (0.173)
Referee's disposition of the patient	26.9% (14)	12.5% (8)	0.183 (0.142)
Patient's age/date of birth	98.1% (51)	93.8% (60)	-0.106 (0.254)
Patient's nationality	93.2% (41)	83.8% (31)	0.225 (0.128)
Knowledge of assailant	59.6% (31)	57.8% (37)	0.143 (0.500)
Assailant's gender	88.5% (46)	78.1% (50)	0.229 (0.048)
Report date	100% (52)	98.4% (63)	-0.084 (0.365)
Type of sexual penetration	71.2% (37)	65.6% (42)	-0.059 (0.525)
Referral site	100% (52)	100% (64)	0.000 (1.000)

DISCUSSION

Results from this study clearly demonstrated major deficiencies in the referral forms, whether the point of entry for care was one of the many PHCs or the A&E Department. The majority of the affected patients' referral forms did not meet the researchers' minimum criteria for adequacy. Approximately five times as many PHC forms lacked all three vital variables as compared to the A&E Department forms. This may be attributed to the increased frequency with which such forms are filled in the A&E Department. Further, as cases in the A&E Department are usually more acute in nature, patients are likely to have more recent memory of the events and can provide more detailed histories. It is also possible that there is a greater probability of court hearings arising from these types of cases, thus resulting in somewhat more detailed documentation.

Based on the results, many of the differences in the referral documentation status by sociodemographic information were not statistically significant. As it

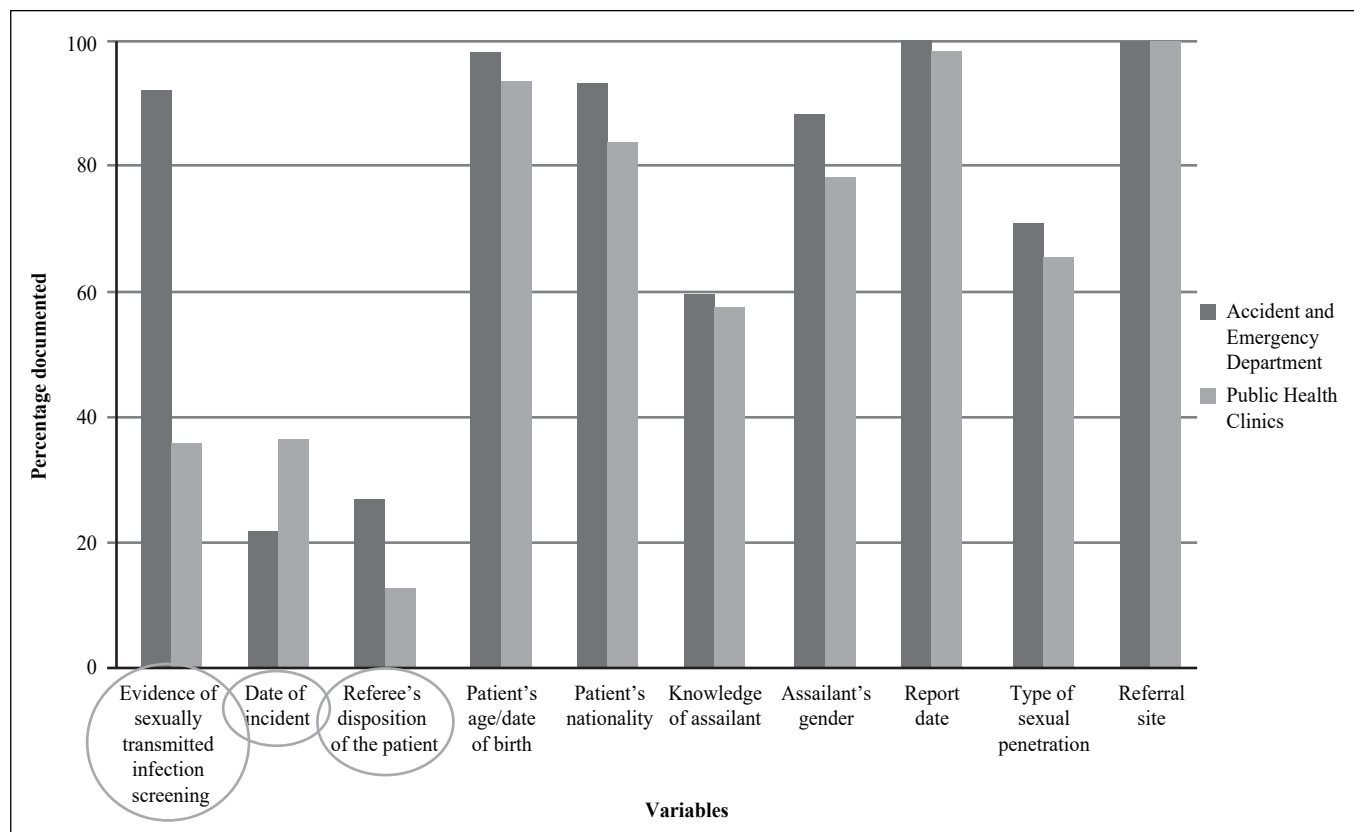


Figure: Comparison of documentation by the Accident and Emergency Department *versus* public health clinics highlighting vital variables.

relates to nationality, this study found that the ratio of Bahamian to Haitian nationals was consistent with the wider community. According to the Department of Statistics of the Government of The Bahamas, Haitian nationals accounted for 7.2% of the general population in New Providence (9). Additionally, they represented about 12.5% of the students enrolled in the government school system in New Providence (10).

The greatest incidence of reported sexual abuse was among females aged 13–15 years, which accounted for 80.5% of the referrals. Similarly, the National Center for Juvenile Justice, United States of America (USA), stated that adolescents between the ages of 12 and 17 years were the largest group of sexual assault victims (11). Another study by the Department of Justice, USA, in 2000, reported that the single age with the greatest proportion of sexual assault victims having reported to law enforcement was age 14 years (12). This is comparably supported in the present study, where the median age of the patients was also 14 years.

Deficient documentation posed difficulties in adequately analysing the management patterns of patients. Less than two-thirds of the referral forms indicated that STI screening protocols were used to make diagnoses

and provide appropriate treatment. The researchers considered this variable a crucial piece of information required for adequacy, allowing for continuity of care subsequent to the patient's referral to the SAFE Clinic. The referee's disposition of the patient, which was also a high priority variable, was not identified in the majority of the cases. This again highlights impairment in the referral system, as the follow-up of the patients and the referee's disposition of the patients were not effectively communicated to facilitate continuity of care. The date of the incident was also deemed a vital variable in assessing the adequacy of the referral forms. This information would help to stratify cases so that management could be tailored to their individual needs. The role of the physician includes not only assessing the physical, emotional and behavioural consequences of sexual abuse, but also coordinating with other professionals to provide comprehensive treatment and follow-up of children exposed to child sexual abuse (13).

The deficient documentation of the referral forms demands the need for reform. Complete and consistent documentation is required in all medical records, especially documents involving transfers of patients for continued follow-up and evaluation. The use of

structured records is likely to be beneficial, by providing a method for standardized quality assurance review and clinical data abstraction (14).

CONCLUSION

Based on this study, the researchers recommend the use of structured referral forms by physicians to better ascertain the vital information for optimal care. In The Bahamas, given the challenges of communication within an archipelago, electronic records would also facilitate improved continuity of care. A review of the literature concluded, and we concur, that a multidisciplinary approach to physician training in the management of sexual abuse cases improved documentation.

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