MAXIMIZING APPREHENSION OF ONE STOP CRISIS CENTER: A ONE-DAY SEMINAR

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Introduction

One Stop Crisis Center (OSCC) is established since 1996 to provide assistance, assessment and support to survivors of crisis such as rape, child abuse, sodomy and domestic violence by the Emergency and Trauma Department in all Ministry of Health hospitals in Malaysia. At the time of this writing, there is no established training module in Malaysia since the introduction of OSCC.

Hospital Sipitang is a non-specialist district hospital in southern Sabah and one of the members under the Cluster Hospital Program with Hospital Queen Elizabeth as the tertiary center. We have conducted a one-day One Stop Crisis Center seminar at Hospital Sipitang while assessing the participants' knowledge on the related topics pre- and post-intervention. This program was supervised by an emergency physician.

Objectives

General objective

- To determine the effect of a one-day One Stop Crisis Center seminar on the OSCC knowledge level among the clinical staffs in Hospital Sipitang, Sabah.

Specific objectives

- To compare the pre- and post-intervention mean scores of One Stop Crisis Center knowledge on the OSCC policy among the clinical staffs in Hospital Sipitang, Sabah.
- To compare the pre- and post-intervention mean scores of One Stop Crisis Center knowledge on wound description among the clinical staffs in Hospital Sipitang, Sabah.
- To compare the pre- and post-intervention mean scores of One Stop Crisis Center knowledge on the legislative aspect of OSCC among the clinical staffs in Hospital Sipitang, Sabah.

Methodology

The study design is an interventional pilot study. Our participants were the clinical staffs from various units in Hospital Sipitang. The study population was selected according to the inclusion and exclusion criteria. The inclusion criteria were those who gave consent and the permanent clinical staffs while the exclusion criteria were those did not give consent and non-clinical staffs.

The research tool consists of set of questionnaires (Figure 1) covering the sections of OSCC policy, wound description and legislative aspect of OSCC. The questionnaires set consists of 15 questions. Component break down of the questionnaire is as shown in Figure 2. Each question contains 5 statements and the participants were required to answer true or false for each statement. The participants were instructed to answer the questionnaires before and after the OSCC seminar. The pre-intervention questionnaire was distributed at the beginning of the day whereby the participants were allocated 30 minutes to complete the questionnaire. It was used to assess the basic knowledge of the participants before the activities were carried out. The post-intervention questionnaire was distributed to the participants after the intervention program for the same allocated time. Data analysis was done with SPSS version 22.

		Correct answer		Increment in percentage (%)
		Pre-intervention	Post-intervention	
		n (%)	n (%)	
(A) OSCC policy				
1	Pesakit One stop crisis center termasuk			
	a. Mangsa yang dirogol	39 (97.5)	40 (100.0)	2.5
	b. Isteri yang dipukul suami	29 (72.5)	40 (100.0)	27.5
	c. Orang tua yang dipukul ahli keluarga	19 (47.5)	40 (100.0)	52.5
	d. Kanak-kanak yang didera ibu bapa	30 (75.0)	39 (97.5)	22.5
	e. Pekerja yang dipukul di tempat kerja	29 (72.5)	32 (80.0)	7.5
2	Fungsi One Stop Crisis Center			
	a. Mendapat maklumat dan diagnosis mangsa	27 (67.5)	40 (100.0)	32.5
	b. Membantu mangsa buat laporan polis	26 (65.0)	34 (85.0)	20.0
	c. Merawat mangsa OSCC	28 (70.0)	40 (100.0)	30.0
	d. Perkhidmatan kaunseling kepada mangsa OSCC	32 (80.0)	38 (95.0)	15.0
	e. Bantuan emosi kepada mangsa	29 (72.5)	37 (92.5)	20.0
3	Peranan pegawai triage dalam pengendalian kes OSCC			
	a. Harus peka dalam mengenalpasti pesakit yang tergolong dalam kategori OSCC	29 (72.5)	40 (100.0)	27.6
	b. Pesakit OSCC yang kritikal boleh dirawat di bilik OSCC serta merta	14 (35.0)	20 (50.0)	15.0
	c. Pesakit OSCC yang tidak kritikal ditriage ke zon hijau dan disuruh menunggu giliran seperti pesakit yang lain	37 (92.5)	39 (97.5)	5.0
	d. Gender sensitivity perlu diamalkan sepanjang masa	29 (72.5)	35 (87.5)	15.0
	e. Pesakit OSCC boleh datang ke jabatan kecemasan pada bila-bila masa	34 (85.0)	38 (95.0)	10.0
4	Peranan pegawai perubatan jabatan kecemasan dalam pengendalian kes OSCC			
	a. Segala maklumat dicatit dengan jelas	39 (97.5)	40 (100.0)	2.5
	b. Maklumat rapi mengenai tempat dan waktu kejadian harus diutamakan	6 (15.0)	13 (32.5)	17.5
	c. Pemeriksaan teliti seluruh badan termasuk bahagaian kemaluan dan dubur	9 (22.5)	13 (32.5)	10.0
	d. Chain of evidence patut dipelihara sepanjang masa	30 (75.0)	39 (97.5)	22.5
	e. Boleh menjalankan pemeriksaan terhadap mangsa rogol tanpa kehadiran polis	31 (77.5)	35 (87.5)	10.0
5	Mengenai mangsa OSCC			
	a. Consent tidak diperlukan semasa pemeriksaan pesakit OSCC	31 (77.5)	33 (82.5)	5.0
	b. Kes rogol dirujuk kepada pakar Obstetrik dan Gainekologi	33 (82.5)	40 (100.0)	17.5
	c. Kes sodomy dirujuk kepada pakar pembedahan	16 (40.0)	20 (50.0)	10.0
	d. Digalakkan untuk mendapat rawatan atau temu janji kaunseling	33 (82.5)	40 (100.0)	17.5
	e. Kes penderaan kanak-kanak dirujuk kepada SCAN team	21 (52.5)	33 (82.5)	30.0
(B) Wound description				
6	Regarding abrasion			
	a. Heals rapidly without a scar	20 (50.0)	23 (57.5)	7.5
	b. Scratches are caused by sharp tip or a needle	17 (42.5)	26 (65.0)	22.5
	c. Grazes result when the body is dragged on rough surface	29 (72.5)	32 (80.0)	7.5
	d. Abrasion is the destruction of deep dermal layer of the skin	22 (55.0)	26 (65.0)	10.0
	e. Imprint is caused by the pressure of object on body with little friction	27 (67.5)	29 (72.5)	5.0
7	Regarding bruise			
	a. There is a break in skin continuity	17 (42.5)	19 (47.5)	5.0
	b. Caused by blunt object	31 (77.5)	37 (92.5)	15.0
	c. Usually healed completely after 2 weeks	24 (60.0)	36 (90.0)	30.0
	d. Pattern can indicate the causative weapon	25 (62.5)	31 (77.5)	15.0
	e. Color may suggest the timing of injury	32 (80.0)	40 (100.0)	20.0
8	Regarding incision wound			
	a. Clean cut through the tissues	29 (72.5)	39 (97.5)	25.0
	b. Caused by a blunt object	29 (72.5)	33 (82.5)	10.0
	c. Depth of the wound is greater than its length	12 (30.0)	18 (45.0)	15.0
	d. Useful in detecting the direction of force	27 (67.5)	34 (85.0)	17.5
	e. Foreign bodies may indicate the crime scene	27 (67.5)	30 (75.0)	7.5
9	Regarding stab wound			
	a. Caused by a sharp object	28 (70.0)	37 (92.5)	22.5
	b. The weapon may enter the body cavity	30 (75.0)	37 (92.5)	17.5
	c. Exit of a penetrating wound is usually large and inverted	17 (42.5)	19 (47.5)	5.0
	d. Depth of the wound is greater than its length	31 (77.5)	36 (90.0)	12.5
	e. The margin is clear-cut without abrasion	20 (50.0)	30 (75.0)	25.0
10	Regarding laceration			
	a. The margin is irregular and ragged	30 (75.0)	38 (95.0)	20.0
	b. Foreign body may present in the wound	32 (80.0)	36 (90.0)	10.0
	c. Hair bulbs are preserved	15 (37.5)	16 (40.0)	2.5
	d. Underlying bone usually fractured	9 (22.5)	13 (32.5)	10.0
	e. Shape and size do not correspond to object	24 (60.0)	34 (85.0)	25.0
11	Regarding gunshot wound			
	a. Metal ring may be seen at the entrance wound	27 (67.5)	37 (92.5)	25.0
	b. Fibers of cloth may be found at the entrance wound	30 (75.0)	33 (82.5)	7.5
	c. Entrance wound is inverted	23 (57.5)	34 (85.0)	27.5
	d. More bleeding at the exit wound	36 (90.0)	39 (97.5)	7.5
	e. Tattooing may be seen at the exit wound	19 (47.5)	25 (62.5)	15.0
(C) Legislative aspect of OSCC				
12	Regarding rape			
	a. A sexual intercourse with an adult woman without her consent	34 (85.0)	39 (97.5)	12.5
	b. A sexual intercourse with an adult woman against her will	28 (70.0)	37 (92.5)	22.5
	c. A sexual intercourse with a girl younger than the age of sixteen with consent	32 (80.0)	39 (97.5)	17.5
	d. A sexual intercourse with his wife by a valid marriage	35 (87.5)	38 (95.0)	7.5
	e. A sexual intercourse with an adult woman with her consent made under alcoholic influence	23 (57.5)	36 (90.0)	32.5
13	Regarding evidence collection in OSCC			
	a. Evidence is best obtained from physical examination as soon as possible after the incident	31 (77.5)	39 (97.5)	20.0
	b. Persistence of DNA in a vaginal penetration may be up to 7 days	14 (35.0)	36 (90.0)	55.0
	c. Examination under anesthesia can be conducted if there is severe vaginal injury	22 (55.0)	29 (72.5)	17.5
	d. Transport and delivery of DNA specimen, drugs and alcohol to the Chemistry Laboratory is the responsibility of the attending medical officer	11 (27.5)	24 (60.0)	32.5
	e. Documentation of specimen collection is important	38 (95.0)	40 (100.0)	5.0
14	Regarding child protection			
	a. Child is a person under the age of 21	24 (60.0)	38 (95.0)	35.0
	b. Attending doctor does not have the right to inform child protector if he/she is suspecting a case of child abuse	23 (57.5)	25 (62.5)	5.0
	c. State director of social welfare can be a child protector	32 (80.0)	36 (90.0)	10.0
	d. Once reported, the temporary custody of the abused child is assumed by the protector	33 (82.5)	37 (92.5)	10.0
	e. Child protection team co-ordinates the child protection services	30 (75.0)	38 (95.0)	20.0
15	Assailant(s) of domestic violence include			
	a. His or her spouse	30 (75.0)	37 (92.5)	17.5
	b. His or her former spouse	22 (55.0)	24 (60.0)	5.0
	c. An incapacitated adult	29 (72.5)	30 (75.0)	2.5
	d. A child	26 (65.0)	35 (87.5)	22.5
	e. Any other member of the family	37 (92.5)	40 (100.0)	7.5

Figure 1. The questionnaire and scores.

	OSCC policy	Wound description	Legislative aspect of OSCC	Total
No. of questions	5	6	4	15

Figure 2. Components of questionnaire.

The intervention program includes ice breaking, interactive lectures, demonstrations and quiz. Ice breaking session was the first activity that carried out during the intervention program. This session was carried out to promote healthy and efficient communication between the facilitators and the participants to encourage better participation and teamwork amongst the participants during the activities. During this period, we also explained the outline and objectives of the program as well as the role of the participants during the intervention program.

Interactive lectures were the main intervention programs of the day, covering the important aspects of OSCC cases including case definition, survivor's age group classification, wound description and documentation, management plan and specimen collection. They were aimed to improve the knowledge on OSCC amongst the participants. The vital aspects of management and handling on each condition were highlighted and elaborated further to help the participants to consolidate their knowledge. The participants were allowed to ask question at the end of lectures to solve their burning query regarding the topics on OSCC.

Demonstrations focused on specimen collection and case simulation. We demonstrated the correct way to collect specimen from the survivors using the OSCC Forensic Examination Kit to ensure the chain of custody is observed at all time. We also emphasized on the documentation of history taking and physical examination using the Clinical Forensic Examination Form as all the information is extremely important medicolegally.

Quiz was effective in testing the participants' knowledge in a fun and rewarding way. In this activity, we focused on wound description as we came across different types of wounds while handling OSCC case. Precise and accurate description of wound is essential so that the survivors received optimal care.

Result

Sociodemographic data

A total of 40 participants were recruited as the study population according to the inclusion and exclusion criteria. 22.5% of the respondents were male and 77.5% were female. 7.5% of the participants was medical officer, 25% assistant medical officer, 7.5% matron, 45% staff nurse and 15% of them was community nurse (Figure 3). 40% of the participants was from emergency and trauma unit while 32.5% from maternal and child health clinic. The rest was from outpatient unit, operation theater, hemodialysis unit, male ward, female ward and children ward (Figure 4). 30% of the participants had experience of handling OSCC case prior to the workshop. 32.5% of the participants had read the OSCC policy before but only 15% of the participants had attended a similar OSCC course before.

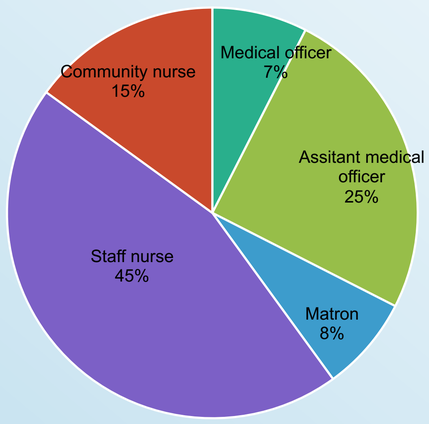

Figure 3. Percentage of participants from various positions (n=40).

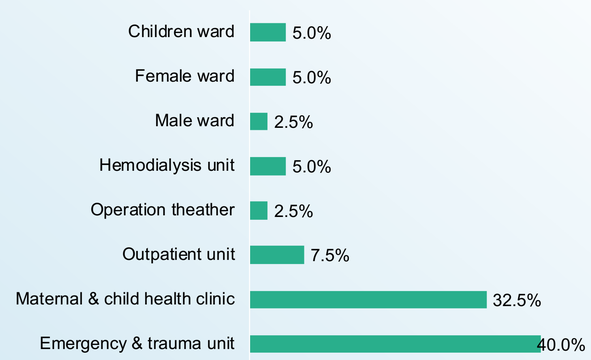

Figure 4. Percentage of participants from various units (n=40).

Knowledge on OSCC Policy							
	Total score	Min	Max	Mean	Mean difference	Standard deviation	p-value
Pre-intervention	25	10	23	17	4	3.055	<0.001
Post-intervention		18	25	21		1.633	
Knowledge on Wound Description							
	Total score	Min	Max	Mean	Mean difference	Standard deviation	p-value
Pre-intervention	30	10	25	18	4	4.326	<0.001
Post-intervention		16	29	22		3.164	
Knowledge on Legislative Aspect of OSCC							
	Total score	Min	Max	Mean	Mean difference	Standard deviation	p-value
Pre-intervention	20	7	19	14	3	3.159	<0.001
Post-intervention		13	20	17		1.805	

Figure 5. Pre- and post-intervention results on One Stop Crisis Center knowledge.

Knowledge on OSCC Policy

The total score for this section was 25. Mean scores for pre- and post-intervention were 17 and 21 respectively with a mean difference of 4. Data showed significant (p-value<0.001) increment of mean score after the one-day seminar.

Knowledge on Wound Description

With the total score of 30, the participants achieved 18 and 22 as the mean scores of pre- and post-intervention. This showed a significant (p-value<0.001) increment of 4 in the mean difference.

Knowledge on Legislative Aspect of OSCC

This section comprised a total score of 20. The mean scores pre- and post-intervention were 14 and 17 respectively. The mean difference was significant with a p-value of less than 0.001.

Discussion

Majority of the participants who attended the one-day OSCC seminar was staff nurse because they are handling OSCC cases and need more training on this subject. 40% of the participants were from emergency and trauma unit as staff in this unit should receive the training because they are the first liner who will receive, assess and manage the OSCC survivors.

Ministry of Health Malaysia developed an OSCC Policy and Guideline in 2015 emphasising a holistic approach covering the care and treatments from the acute phase until the rehabilitation phase. However, sustainable education and awareness are the keys to ensure the standard of care and to improve the quality of the OSCC service in Malaysia.

The intervention program was planned based on the OSCC policy. The effectiveness of the intervention program was proven by the significant increment of mean scores in all the sections regarding the OSCC knowledge.

Conclusion

A one-day OSCC seminar is proven effective in increasing the knowledge amongst the hospital staffs. A well-planned training module is useful in improving the OSCC knowledge. Thus, we suggest Ministry of Health Malaysia to develop an OSCC training module to ease the training of medical personnel.

References

1. One Stop Crisis Center Policy and Guidelines for Hospitals, Ministry of Health Malaysia. July 2015.
2. Clinical Management of Rape Survivor. Revised edition. World Health Organization Headquarters Departments of Reproductive Health and Research, of injury and Violence Prevention, of Gender, Women and Health. 2004.