Medical and Forensic Clinical Placement and Support Program Evaluation

Acknowledgement of Country

NSW Health Education Centre Against Violence acknowledges the Traditional Custodians of the lands where we work and live. We celebrate the diversity of Aboriginal peoples and their ongoing cultures and connections to the lands and waters of NSW.

We pay our respects to Elders past, present and emerging and acknowledge the Aboriginal and Torres Strait Islander people that contributed to the development of this resource.

Medical and Forensic Clinical Placement and Support Program Evaluation

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Nicholas Comninos and Natalie Edmiston were employed by Western Sydney Local Health District in NSW Health Education Centre Against Violence to develop the Medical and Forensic Clinical Placement and Support Program.

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Executive Summary

I couldn't have done it without that placement…. I came away from that placement having a much bigger understanding of how smooth the process can be and how it should work.

Jo, learner, describing her first examination back in her regional LHD after placement

Background

The Medical and Forensic Clinical Placement Program

The NSW Medical and Forensic Clinical Placement and Support Program (MFCPSP) was developed to support the sexual assault medical and forensic workforce with training and professional development.

NSW Health has funded a large expansion of the workforce in 2023-2024 and the nascent nature of the workforce has resulted in the need to rapidly train a large number of examiners Successful completion of NSW Health Education Centre Against Violence's Graduate Certificate in the Medical and Forensic Management of Adult Sexual Assault requires the opportunity to observe a medical and forensic examination. During or following completion of the Graduate Certificate, credentialling requires the opportunity to conduct supervised examinations. However, there can be challenges with providing access to observation and supervised examinations in sexual assault medical and forensic examinations, particularly in regional and rural areas where there may be infrequent examinations. The MFCPSP provides opportunities for examiners from non- metropolitan Local Health Districts to attend placement at a busy metropolitan service as a "learner".

The MFCPSP is a partnership between Sydney LHD, Northern Sydney LHD, the NSW Health Education Centre Against Violence (ECAV) based at Western Sydney LHD and the Ministry of Health. The Program was funded under the National Partnerships Agreement on Family, Domestic and Sexual Violence, 2023-24. The three LHDs received dedicated funding for the program from 2023-24 to 2024-25.

The Evaluation

The evaluation of the program consisted of both internal quality assurance activities and a formal mixed – method evaluation. Data was collected through online surveys, semi-structured interviews, focus groups and forms used in internal quality assurance. Perspectives were obtained from MFCPSP learners, MFCPSP supervisors and staff from regional LHDs who nominated participants for placements.

From February 2024 to end April 2025, 41 placements took place. Evaluation data is available for 39 placements, representing 37 individual learners as two people had two placements. Of the 37 learners, 31 were currently enrolled in the Graduate Certificate, 11 were currently working as an examiner, two were doctors and the remainder were nurses. All but one learner were female. The primary placement site was Northern Sydney LHD for nine, and Sydney LHD for 30 learners.

Findings

The learner experience integrated knowledge, providing understanding of a trauma informed and patient centred response to sexual assault

I think it's really helped shape me into the type of clinician that I want to be. Laura, learner

Clinical placements were an opportunity for learners to see what it is to "be" a medical and forensic examiner. The key experiences desired were opportunities to become familiar with and use the tools of examiners eg examination kit, examination record. Almost all learners observed a case and on most placements (25/39) were able to perform at least one case under supervision. Considerable teaching was delivered to learners and simulation of an entire case and attendance at the sexual health clinic were highly valued.

Placement was a supportive environment that valued the learner alongside service delivery for patients. By seeing all the parts of the examination together, learners were able to look from a distance and reflect on ensuring the service provision is trauma informed. By being present at multiple examinations, learners overcame anxiety about the specific steps and processes required for an examination, and the novel nature of the work.

I am in a rural environment and I went nearly a whole year without a call-out. You lose your confidence when you're not called out for a very long period of time, so I put my hand up to do this one week placement. It's enabled me to get some cases and to see some contemporary work being done. You don't know what you don't know when you're out there, so it's been really good for me to observe other practitioners, to observe their dialogue, how they tackle trauma-informed care. Kate, learner

The experience of placement enabled learners to see themselves as examiners, not just in relation to what activities they might do, but in terms of the type of professional they might be. The learners described becoming energised by exposure to the values and mission of the supervisors.

It made me actually want to do this even more, if anything. I didn't find anything was overwhelming or anything. I actually found that that's what I wanted to do. I found I was more passionate about doing this after being there. Amy, learner

From anonymous surveys, overall satisfaction with the placement was high amongst both learners (n=21, mean 9.48/10) and supervisors (n=12, mean 8.83/10). All supervisor respondents and 95% of learner respondents either agreed or strongly agreed that placement site staff 'were willing to work with others', 'were positive role models', 'were ethical and professional' and 'demonstrated respect and empathy toward patients'.

Confidence changes as a result of placement were attributed to the supportive environment and exposure to cases

But I also see the change in confidence and, you know, and see them grow with their skills or just see them, you know, doing it and say, "Yes, you can actually do that." And so they feel better from what I've seen, if they've had enough cases and practice. Camilla, supervisor

Overall confidence improved from pre-placement to post-placement, and each skill also showed improved mean confidence. Confidence increases were most common for technical skills of decontamination (87.2% placements showed increased confidence), chain of evidence (76.9%) and specimen collection (71.8%). Learners on approximately two thirds of placements showed increased confidence in history taking (66.7%), consent (62.5%), examination (69.2%) and documentation (69.2%). Learners on about half of placements reported improved confidence in medical care and follow up (51.3%) and less than half reported improved confidence in using a vaginal speculum or anoscope (38.5% for both). These increases in confidence were similar regardless of whether learners had performed an examination, or had only observed cases.

Confidence in medical and forensic examination skills was described as important for a successful placement experience and as an outcome of the placement, with specific benefits for the workforce. Confidence changes as a result of placement were attributed to the supportive environment and exposure to cases.

I think it was probably a combination of my foundation knowledge, the new knowledge that I learned through the course, and then the support from the team on the placement. I think altogether – if you took any of that out, maybe I would have had a different experience. But I think altogether, those things is what really solidified it and made me feel confident. Laura, learner

Impact on placement sites was largely positive, despite the considerable demands of the program

So it is very collaborative between the patient and I, and it just was that one more in-depth collaborative in terms of, I would be explaining why I would be asking certain questions and then ask the patient the question. That was a really positive experience for all three of us. Briony, Supervisor

All involved in the program and the evaluation expressed the value of the placements continuing and even expanding to include second placements and placement opportunities for metropolitan examiners as well as regional examiners. Challenges to maintaining capacity are presented due to the reliance in the program, so far, on a site lead. More support and training for supervisors alongside additional administrative support were possible solutions to the workload on site leads. Learners being better supported by their Local Health District (LHD) and by NSW Health ECAV faculty, could result in better prepared learners on placement.

Supervisors described having the learners as enjoyable, because of their enthusiasm for the work, but adding slightly to the time for the examination. Supervisors also described the benefits of self-reflection and reviewing practice which was brought about by having learners present.

Benefits for service delivery within regional Violence Abuse and Neglect services were considerable

I wouldn't be doing the work if I hadn't had the placement because it would take me months, months, months to get the amount of exposure to that clinical call-out because you have to supervise three witnessed. I wouldn't have that here. Julia, learner

Benefits to the regional LHD that had supported learners to attend placement were directly related to delivery of Violence Abuse and Neglect (VAN) services. The placement enabled some examiners to start to conduct examination under indirect supervision, which was particularly beneficial for LHDs with limited existing examiners. Faster progress along the supervision continuum in a week, rather than many months, was transformative and maintained motivation for the work. Besides the opportunity to have supervised examinations, the LHDs benefited from learners being exposed to different ways of working.

Absolutely spending that money is worth it in terms of making sure we can maintain the SANE workforce and deliver the service that we have to ....., you know, we need to find a way to quickly get people on board and we need to not sit with the risk of not being able to provide a service. And this is one way to be able to do that. Regional LHD staff

The Entrustable Professional Activity (EPA) feedback form was useful for feedback and for ongoing professional development back in the regional LHD.

I think the introduction of the EPAs has been quite useful there as well. I feel as though we've got much better feedback from the placement as to how our candidate is and how they've gone and what we need to work with them on. Regional LHD staff

To sustain program delivery, logistical support and adaptability is required

So, you know, I would say it actually works really well, but it is just to acknowledge the complexity, I guess, of our approval systems and arrangements. Regional LHD staff

Placement organisation took time but was generally considered to be a streamlined and relatively low burden activity for the learners, as their managers organised their rostering and NSW Health ECAV organised their travel. The process of going on placement remained stressful due to the unfamiliarity of the environment and fatigue. Learners will continue to require administrative support to participate in placements.

The experiences during early placements differed from those during later placements due to the evolving nature of the program. Feedback forms and Advisory Group meetings enabled continual adaption the placement experience. Flexibility of duration of placement and in components delivered on placement is desired.

Key recommendations

1. NSW Statewide Medical and Forensic Leadership Group should prioritise the continuation of the MFCPSP.
2. High caseload services are preferred host sites, maximising opportunities to observe and participate in medical and forensic examinations, as these are what enables learners to see what it is to “be” an examiner. Placements should be entirely at one site, increasing trust, opportunities for active involvement with cases, and appropriate rest breaks. The maximum number of placements at a site per should be less than half of the year eg 26 and is probably best capped at around 14-20, to ensure sustainability by avoiding supervisor burnout.

3. Eligibility for placement should include learners other than current Graduate Certificate students and second placements for very small regional sites.
4. NSW Statewide Medical and Forensic Leadership Group should continue to evolve the MFCPSP, including obtaining feedback from learners and host sites and exploring the possibility of placements at other high case load sites.
5. Host sites require direct funding for administrative support from NSW Health Medical Forensic Enhancement Funding.
6. NSW Health ECAV Graduate Certificate, alongside home LHDs, can contribute to successful placements by preparing learners with a minimum skill set, emotional preparation, orientation and simulation opportunities.

Workforce development recommendations

1. NSW Heath needs to invest in supervisors broadly- both placement site supervisors, medical leads and all examiners who may have a preceptor role particularly during a period of workforce expansion. Preceptorship within the home LHD is likely to play an important role in maintenance of confidence gains from placement. Training in supervising others in the workplace, particularly in a trauma informed approach, is recommended.
2. The NSW Statewide VAN workforce, including the psychosocial workforce, needs to support the professional identity of medical and forensic examiners, particularly as practitioners of trauma informed care. This connects work to values, validates diversity in practice based on patient context and should lead to more confidence to be a supervisor both on placements and in LHDs.
3. NSW Health must invest in an ongoing community of practice eg SANE network and professional development groups.
4. LHD VAN services should build relationship with publicly funded sexual health clinics, as they are an excellent place for experiential learning of sexual history taking and genital examinations. NSW Ministry of Health PARVAN should communicate with NSW Centre for Population Health regarding the value of this collaboration.
5. NSW LHDs should support sharing of practices and values between LHDs including fundings site visits to other services.

6. NSW Health should continue to prioritise support for regional areas as significant differences and resource limitations make it challenging to develop and maintain workforce.
7. NSW Health should support medical leads and senior nurses to understand and utilise EPAs as part of credentialing within the LHDs.

Glossary

Abbreviation/Term	Definition
Activity Theory	A sociological framework that describes units of activity and the tools, rules, community and division of labour that impact on the activity system obtaining its objective.
EPAs	Entrustable Professional Activities. EPAs are an established tool used in both undergraduate and post-graduate medical and nursing education. EPAs describe the work that examiners do and the behaviours that demonstrate that the learner can be entrusted at a given level of supervision.
Graduate Certificate	A graduate certificate is a higher degree, also known as a postgraduate qualification. In this report we predominantly refer to the NSW Health ECAV Graduate Certificate in the Medical and Forensic Management of Adult Sexual Assault
Learners	People attending a clinical placement are referred to as "learners".
LHD	Local Health District
MFCPSP	Medical and Forensic Clinical Placement and Support Program
MFE	Medical and Forensic Examiners
MFER	Medical and Forensic Examination Record
NSW Health ECAV	NSW Health Education Centre Against Violence;
PARVAN	Prevention and Response to Violence Abuse and Neglect. PARVAN is a unit of NSW Health which develops policy and supports services for children, young people and adults who are victims of violence, abuse or neglect.
Preceptor/ship	A preceptor is an experienced practitioner who provides supervision during clinical practice and facilitates the application of theory to practice. Preceptorship is a period of time when a preceptor supports transition to practice.
PSR	Placement Summary Report
SAIK	Sexual Assault Examination Kit

SANE	Sexual Assault Nurse Examiner
Students	A person undertaking a course of study; predominantly Graduate Certificate students.
VAN Services	Violence, Abuse and Neglect Services

Background

NSW Health is the main provider of sexual assault services in NSW, with services delivered in every Local Health District (LHD). Doctors and nurses work alongside counsellors to provide integrated psychosocial, medical and forensic crisis responses and examinations across the districts (NSW Health, 2020). Increased demand for expert medical and forensic examiners (MFEs) in these services requires a significant expansion of the workforce, including increased participation of nurses in the workforce. In the United States nurses working in this area are referred to as sexual assault nurse examiners (SANEs), and this term is also sometimes used in Australia.

In order to practice as an MFE, nurses need to complete specialist training, most commonly a year-long graduate certificate provided by NSW Education Centre Against Violence (ECAV) (NSW Government). The process of qualifying and credentialing nurses to conduct medical and forensic examinations can be lengthy and challenging, particularly for regional NSW. A key aspect of training is practical skill development which can occur via simulation of skills or via conducting activities under supervision. This supervised practice can occur in a workplace as part of professional development or can occur at a separate facility, where the term clinical placement is most used. Clinical placement may be paid or unpaid and the primary purpose is developing and/or maintaining the required competencies for practice. Clinical placements facilitate nurses' transfer of theory to practice, provide opportunities to upskill, access support, and develop the confidence and experience to remain in the role. Despite its acknowledged importance, there is a paucity of literature on clinical placements for SANEs.

The purpose of this literature review is to (a) provide an overview of the training programs including simulation and any placement programs available to support sexual assault nurse examiners (SANEs), both internationally and in Australia. It will also (b) include a brief review of clinical placements features that *support* successful placements, with a focus on Australian undergraduate nursing literature. This literature is reviewed in lieu of Australian placements for postgraduate health professionals, for which there was very little data. Whilst we know postgraduate visits to other facilities occur, these are not necessarily reported and tend to be singular, informal experiences; they are often not part of an organised program but focused on increasing the individual's skill set. We aim to identify the key organisational and interpersonal factors involved in successful clinical placements as well as provide context for the evaluation of the newly established NSW Health Medical and Forensic Clinical Placement and Support Program (MFCPSP).

Part A: MFE Programs

There is a small but developing body of knowledge examining clinical training for MFEs providing care to sexual assault survivors. Part A of the literature search focused on 11 articles describing practical skill training for nurses or doctors via workplace-based learning or simulation (Appendix 1). No papers discussed clinical placement independent of other training. Six programs included practical placements either without simulation (Parekh et al., 2005); or in combination with simulation (Morris et al., 2022; Burton et al., 2022; Sekula et al., 2022; Thomas et al., 2022 and Thomas et al., 2020 [one program, 2 papers]; Torregosa et al., 2023), and 3 were purely simulation-based (Baker et al., 2016 and Witt et al. 2015 [one program, 2 papers]; Mackler et al., 2023; Marks et al., 2017). Barriers to training were also reviewed (Gary et al., 2023). All of the reports are from the United States, except for Parekh et al. (2005), which took place in Australia.

Programs with practical components

Parekh et al (Parekh et al., 2005) discuss the development, implementation and evaluation of a sexual assault medical education program based in the Australian Capital Territory. Whilst the program was oriented towards doctors, it serves as a useful template for the requirements of a successful sexual assault examiner program.

The service, Forensic and Medical Sexual Assault Care (FAMSAC), consisted of in-house education and an external university course and incorporated team building, networking activities and protocol development. The core elements of the program included: forensic evidence collection, assessment and management of injuries, prevention of sexually transmissible infections and pregnancy, counselling and emotional support. Participant satisfaction and knowledge acquisition were evaluated using a semi-structured interview and a questionnaire. Parekh (2005) and colleagues found that FAMSAC's provision of team building, clinical support, contribution from experts in the field, practical experience, and university credit proved successful amongst doctors. Program completion meant doctors now fulfilled the requirements of the university to be awarded the Graduate Certificate in Forensic Medicine. Participants reported improved knowledge of core elements of sexual assault medicine, intention to remain working in the service, and growing confidence attributable to both education and practical experience. Practical experience occurred at the site of current or future employment

and was aided by a preceptor. This is also the only published report of training programs in Australia.

The Indiana SANE Training Project was established to evaluate the existing forensic nursing workforce throughout Indiana and work to expand access to qualified SANEs through training and collaboration with stakeholders, with a focus on rural and underserved areas of the state (Morris et al., 2022). Noting Indiana's high rates of child abuse and neglect reports, the authors designated the most immediate need as access to paediatric medical forensic providers. Indeed, 137 (86%) nurse participants reported that their hospital did not provide paediatric SANE services. With feedback from nurses who participated in activities during the first project year, Morris et al. (2022) aimed to evaluate service gaps and training needs.

Between September 2018 to December 2019,160 nurses were trained by the project both on-line and in-person. The training was established in order to "create, facilitate, and support educational and clinical experiences to achieve and sustain competency and establish quality forensic nursing services statewide" (Morris et al., 2022, p.147). The projects activities included a range of didactive SANE trainings, as well as clinical observations, in-person clinical immersion for adult and adolescents, clinical skills lab, professional development support, courtroom training, medical forensic services training, and mock examinations. Clinical immersion elements were found to be especially successful component of SANE education.

Burton et al. (Burton et al., 2022) detail a "holistic" approach to training sexual assault nurse examiners wherein attention is given to multidimensional perspectives on trauma, diversifying trainee experiences with special populations and situations, and both clinical and practice-based learning is incorporated. Preparation for preceptorship is a focus of the paper, whereas actual experiences during preceptorship or clinical placement is not described. Adequate preparation and a positive experience when practising is reported to enhance SANE training and reduce turnover. Emphasis was also placed on peer support, and community engagement and outreach made more urgent with the emergence of the COVID-19 pandemic. Building peer connections and attending conferences online facilitated trainees' transition from learner to educator – an important step in developing expertise in practice. Burton et al. found that a holistic approach to SANE training encouraged trainees to address concerns and identify personal needs for improved skill or facility in certain areas before engaging in patient care and evidence collection. Moreover, for SANEs practicing in locales with large populations of vulnerable

individuals, having a strong sense of self-efficacy in the SANE practice with diverse patient populations and effective self-care may reduce overall stress and alleviate moral distress.

The Duquesne University School of Nursing developed a hands-on and online clinical preceptor course to supplement the existing SANE didactic course training (Sekula et al., 2022). The aim was to create a comprehensive model that took students from initial SANE training through to certification. 36 nurses achieved certification, and another 116 completed a didactic course and initial hands-on skills training in preparation for certification. The on- on-one preceptorship was costly to deliver, requiring a dedicated SANE for the 300 hours of clinical experience required. Challenges to the program included the adaptations required by the COVID-19 pandemic and engagement of nurses once they returned to their home institution to complete additional hours. Elements supporting the program's success included access to feedback from all participants of full mock sexual assault examinations on live standardized patients. This involved feedback from patient advocates, standardized patients, and written feedback utilizing a detailed skills checklist by the precepting SANE. In addition, trainees had access to one-to-one mentoring program, including access to a team of SANEs who returned individual SANE-related questions and requests as quickly as possible and between 12–24 hours. Monthly educational sessions and quarterly case review sessions were held live on videoconference and recorded so as to be revisited. Lastly, incentives to remain active in the online group were given through access to a funded spot in the program. Overall, the course provided a successful pathway for nurses wanting to become SANEs. The structure of the program was especially conducive for training nurses in rural and under- served areas.

Thomas et al (2022; 2020) report on a didactic and clinical program for SANEs, discussing the unique challenges and collaborations undertaken in their rural communities and during the COVID-19 pandemic. The clinical component of the program involved supervision of SANEs conducting examinations for the purpose of support, identification of training needs and evaluation. The supervision was primarily a structured case review following examinations. Key challenges were the elevated risk of domestic violence, geography forcing patients and providers to travel multiple hours for services, and lack of availability of SANE trainees. In contrast, contributing process model, community collaboration, and commitment to rural counties were the keys to success both before and during the COVID-19 pandemic. In addition, monthly Zoom meetings and one-on-one trainee meetings allowed SANE trainees to vent their feelings and frustrations in addition to their standard case and content review. Collaboration with local

partners such as the city police, county sheriff's office, state attorney's office, and emergency medical services also aided in overcoming the challenges surrounding COVID-19.

Torregosa et al. (2023) examined the long-term impact of SANE programming on the confidence of SANE trainees and on their attitudes toward the SANE role after obtaining SANE certification. The TAMIU-SANE program was established with the aim of addressing the shortage of SANEs in the "medically underserved United States– Mexico border region" Here, human trafficking is seen as a threat and sexual assaults may be less likely to be reported (Boyce et al., 2018; Torregosa et al., 2023, p.1). Training components included didactic or basic SANE training (BST) and clinical or advanced SANE training (AST). The program coordinator facilitated the clinical placement of trainees in AST in facilities to conduct a supervised forensic medical examination on real victims of sexual assault. Mental health support and debriefing to counteract vicarious trauma were available, including a support group with a clinical psychologist. Trainees were also supplied with tuition and travel reimbursement and stipends during training to facilitate involvement.

The 27 nurses included in the study completed a questionnaire at 3 points: (Time 1) baseline, (Time 2) 6 months after SANE certification, and at (Time 3) 12 months after SANE certification. At first, an increased sense of self-confidence was identified amongst trainees at least six months after completing SANE certification. This was identified as a direct outcome of the support of the SANE program personnel in facilitating the clinical training and placements of the SANE participants. Confidence in the SANE role slowly decreased six months after obtaining SANE certification as SANE trainees were now on their own to maintain their SANE skills. Increased support and infrastructure to integrate SANE into the wider medico-legal community is needed to maintain enhance recruitment of SANEs in the workforce, to maintain retention in the role and sustain SANE programs in underserved communities.

Of the articles reviewed in this section, the most commonly reported outcomes of clinical placements reported by nurse trainees included: increased skills, knowledge and comfort in the role, and greater confidence and competence in caring for sexual assault survivors. However, as Torregosa (2023) noted, confidence towards the SANE role may deteriorate over time. As such, regularity of practice is an important component of both confidence building and retention. The most commonly reported elements supporting success during placements included the active provision of clinical and peer support; team and community building and collaboration; the availability of feedback from supervisors; and didactic and practical training that is immersive and hands-on.

Simulated Training

Simulation programs can serve as a substitute for clinical experience. The infrequency of actual SANE examinations impacts both the ability of SANEs to develop initial skills, and their ability to maintain clinical competency (Marks et al., 2017). Due to the logistics, time, cost and emotional demands associated with qualification as a SANE, simulation-based training models provide opportunities to streamline the educational process, while preserving the quality of education (Marks et al., 2017).

SANE-A-PALOOZA is an ongoing education program utilizing hands-on practice with standardized patients and human simulators. By providing concentrated clinical skill application, SANE-A-PALOOZA aimed to decrease the amount of time between initial training and independent practice as a SANE, as well as function as a skill refresher for SANEs with low caseload. Whilst on the one hand, practice with standardized patients may serve as a valuable bridge between classroom learning and applying clinical knowledge with patients, on the other, their use is expensive, and physically and emotionally demanding on the patient. There are also logistical challenges associated with training and scheduling availability. Baker et al., (2016) and Witt et al (2015) provide an overview of the program's logistics with the aim of aiding other organizations in developing skill-building experiences for new or less-experienced sexual assault nurse examiners.

Transgender and non-binary (trans*) individuals face disproportionately higher rates of sexual violence yet experience discrimination at rape crisis centers (RCCs). Through the creation and implementation of a virtual continuing education course, Mackler et al.'s (2023) quality improvement project aimed to increase SANEs' self-perceived competence in caring for trans* assault survivors. Moreover, the project aimed to promote a trans*-inclusive environment at an RCC based on an environmental assessment. Results indicated that trans*-specific training can significantly impact SANEs' self-perceived competency in caring for trans* assault survivors. Participants reported feeling more confident in their ability to provide an initial assessment, medical care, forensic examination, and discharge and referral information to trans* clients after participating in the training. Results from the organizational environment assessment showed that areas in which the RCC was not ready to serve trans* clients included forms and paperwork, office records, non-discrimination policies, bathrooms, advertising, outreach, staff training, and environment (Mackler et al., 2023).

Marks et al., (2017) describe a program based in experiential learning (Kolb, 2014) incorporating human manikin-based simulation and specially trained actors designed to "decrease total training time, decrease training costs, increase confidence of SANEs, increase availability of SANEs, and create a positive learner experience" (Marks et al., 2017, p.596). The 19 SANEs to complete the program reported training with the actors, or "SimVics" as either "beneficial" or "very beneficial". The trainees additionally reported that feedback from the SimVics and instructors contributed to their self-confidence generally, in relation to conducting a speculum examination, and in receiving emotional support. Proceeding the training, 90% of trainees reported they were "confident" or "very confident" in conducting forensic examination. Overall, predicted benefits of the pilot training were confirmed.

There is a broader body of literature regarding SANE training in the United States. Gary et al. (Gary et al., 2023) reported on 40 registered nurse stakeholder responses to a SANE education program at The Center of Excellence in Forensic Nursing (CEFN) at Texas Agricultural and Mechanical (A&M) Health. This consisted of an adult/adolescent SANE course, a paediatric SANE course that followed the International Association of Forensic Nurses (IAFN) SANE education guidelines, as well as other continuing education courses. They offer considerations for future educational offerings and reflect on areas for improvement to the CEFN program.

Responses to SANE needs and/or barriers to service area revealed overlapping themes. Participants remarked on barriers such as SANE shortage, large service areas and long trips for patients to obtain care, a desire for resources and support related to starting or expanding SANE programs, and a lack of education regarding the SANE role from other healthcare providers. Participants articulated barriers to training such as pandemic interruptions and access due to travel, and employment barriers linked to call hours and limited employment opportunities with full-time positions. The barrier of limited employment opportunities has also been reported previously (Witt et al., 2015). Stakeholders requested further education and training, interprofessional teams, and a course on self-care for SANEs.

Australian SANE Programs

In Australia, the requirements for being credentialed to work as a sexual assault nurse examiner (SANE) are not uniform between states.

NSW Health Policy 2020_006 states that a SANE must have obtained, or be working towards, the NSW Health ECAV Graduate Certificate in the Medical and Forensic Management of Adult Sexual Assault or equivalent. Before they can work independently, a SANE must have:

1. been awarded one of the graduate certificates identified above (or equivalent)
2. provided a minimum of three crisis responses where their clinical practice is directly supervised (or shadowed) by an experienced medical and forensic examiner
3. indirect supervision for each and every case when deemed appropriate by their supervisor to practice without direct supervision, until credentialed.

NSW Health ECAV Graduate Certificate in the Medical and Forensic Management of Adult Sexual Assault is a free course for people working or anticipating working as examiners in NSW. This course has also been available for nurses working in Tasmania as sexual assault forensic examiners (SAFEs).

It is available to both doctors and nurses and is completed over 12 months part time. The course is delivered on-line and has two compulsory face-to-face teaching sessions which include simulation training. The learning outcomes include being able to respond to the immediate and ongoing health needs of an adult male or female patient following a sexual assault and to be able to perform a forensic medical examination and specimen collection and document the findings and procedures (Education Centre Against Violence, n.d.)

To ensure that graduands have clinical experience, a pre-requisite of course enrolment is working in or observing at a clinical service providing medical and forensic care to people experiencing sexual assault. Despite this, limited opportunities to work in or observe clinical services, particularly in regional areas of NSW, has impacted on progression to independent practice. The MFCPSP, the subject of this evaluation, aims to ensure adequate clinical experience to facilitate progression by providing a one-week clinical placement in a busy metropolitan sexual assault service.

There are a variety of other courses in Australia designed to meet training needs across the states and territories (Appendix 2). Many of these are short in duration and whilst practical in nature, do not necessarily provide for clinical experience.

The Graduate Certificate in Forensic Medicine offered by Monash University was unavailable to nurses for several years but is now available as the Graduate Certificate of Forensic Nursing and Midwifery (Monash University, n.d.).

This certificate equips nurses with advanced expertise and specialised knowledge in forensic nursing and midwifery. Content includes knowledge of the Australian legal system, laws of evidence, the classification of injuries and forensic responsibilities arising from physical injury and sexual assault. Skills are developed in the preparation of a medico-legal report and giving evidence in court proceedings, documentation of injuries and collection of forensic evidence. An expectation of completion of the course is the ability to perform adult clinical forensic examinations to detect, assess, interpret and document evidence of physical and/or sexual assault and collect evidence during examinations. The certificate is completed over one year part time and is delivered as a combination of on-line and in person block teaching. No clinical placement opportunities are described on the course website.

Forensic Medicine Queensland (Queensland Health, n.d.) overseeing the tertiary qualification process of sexual assault nurse examiners (SANEs) state-wide, currently offers a course consisting of six on-line modules and a two day workshop, including a half day practical assessment. This course is not currently affiliated with a registered training organisation, meaning no postgraduate qualification is awarded, however there are plans for this to occur (Samantha Granato, Educator, Forensic Medicine Queensland, personal communication 1 October 2024). Following successful completion of the course, nurses commence simulation activities and mentored work within their local health service district.

Central Queensland University reports also delivering on-line modules without a formal post graduate qualification (Central Queensland University, 2021).

The in-house program described in Australian Capital Territory (Parekh et al., 2005) has likely adapted over time. The component of practical experience is still available as week-long clinical placements are available at the Forensic and Medical Sexual Assault Care service in the ACT. A unique feature of this service is the dual attendance of two clinicians, one leading and the other assisting. This allows for supervised progression from an observing to a leading clinician. (Cassandra Noble, CNC forensic services, ACT Health, personal communication 19 March 2024) In the Northern Territory a two day course in the Forensic Medical Management of Adult Sexual Assault / Abuse was offered in 2023 (Central Queensland University, 2021). After completion of the course, both doctors and nurses could apply to work at an on-call service where practical experience would be gained.

In Western Australia, the Sexual Assault Resource Centre (SARC) provides a three day in person course delivered by SARC medical forensic doctors. On-line learning is required prior to the course and following completion of the course, and passing written and practical assessments, nurses and doctors are qualified to collect forensic specimens from patients who have been sexually assaulted. Supervised practice is implied, as a learning outcome is the ability to perform a sexual assault examination with guidance from SARC doctors (Sexual Assault Research Centre, n.d.).

Yarrow Place in South Australia provides a two day practical training program in Clinical Forensic Medicine for doctors. The one day training for nurses is not directed at developing practical skills for providing medical and forensic examinations (Women and Children's Health Network, n.d.)

Clinical experience in supervised practice is an important component of workforce development. The absence of clinical experience components in courses does not necessarily mean that supervised practice is not occurring. It is likely that a variety of systems and procedures are in place across Australia to support supervised practice. However, the absence of definite access to supervised practice, such as formal clinical placements as part of formal training, is a likely barrier to progression to ongoing work as a sexual assault examiner.

Part B: Clinical placements and experiential learning features that support successful placements

Part B of the literature search focused on 5 articles regarding the clinical placements and experiential learning features that support successful placements. Three of these programs took place in Australia (Doyle et al., 2017; Luders et al., 2021; Sweet & Broadbent, 2017), while the remaining two were based in Canada (Nagel et al., 2024) and the United Kingdom (Rowland & Trueman, 2024).

Doyle et al. (2017) examined the perceptions of 150 final-year undergraduate student nurses at a university in Australia regarding their learning environment during clinical placements, focusing on factors such as the pedagogical atmosphere, the leadership style of the ward manager, and the nursing practices on the unit. The study found no significant differences in student satisfaction or in what students deemed "successful" placements based on the specialty of the placement.

The research indicated that the most significant predictor of students' perceived success during clinical placements was the culture within the clinical workplace. Specifically, the internal culture of a ward—how staff interact with each other—was identified as the key factor, followed by the external culture—how staff engage with those outside the team, including undergraduate students. The primary element that made students feel welcomed was the staff's willingness to assist them during their placements.

These findings align with Lamont et al. (Lamont et al., 2015), which revealed that a lack of support from staff correlated with perceived negative attitudes towards students. The study highlighted that a welcoming and supportive unit culture was crucial for determining the success of students' placements and enhancing learning in clinical settings. Elements contributing to a "Happy to Help" environment included consistent friendliness from staff and positive feedback from both peers and ward personnel. Additionally, various communication methods were utilized, such as team meetings and communication boards, and opportunities for organizational learning were regularly available and encouraged. Students noted positive cultural aspects, including uplifting posters displayed throughout the unit, with an overall absence of sarcasm or negativity in the workplace (Doyle et al., 2017).

Luders et al. (2021) sought to assess the perceptions of Australian nursing students regarding their placements across seven tertiary education institutions, utilizing the Placement Evaluation Tool (PET). The majority of students reported a positive experience during their placements. Overall feedback highlighted staff interactions with students, factors affecting placement arrangements, and the implications for students' personal lives. This resulted in the identification of three key themes that influence the placement experience: staff attitudes toward students, environment, and lifestyle.

Staff attitudes were the most mentioned issue, accounting for 37% of responses. Feedback included both positive (63%) and negative comments (36%). As expected, supportive staff attitudes significantly enhanced students' experiences. Conversely, those who encountered negative attitudes reported a generally unfavourable placement, which adversely affected their learning and made them hesitant to ask questions.

The second main theme focused on the placement environment, which generated 40% of responses and encompassed subthemes such as placement relevance, safety, supervision, assessment, and professional culture.

A total of 22 participants noted how placements impacted their lifestyles, citing factors like travel requirements, academic workload, and the challenges of shift work on family life and

paid employment. Financial concerns also emerged, particularly regarding the loss of income, local accommodation costs, and transportation expenses.

While most Australian students have positive experiences in various clinical settings, a minority face negative staff attitudes, unsafe environments, and lifestyle challenges. Further research is needed to gain a deeper understanding of the experiences of students, supervisors, and educators to establish quality standards for nursing placements in Australia, along with resources to support this process (Luders et al., 2021).

Nagel at al.'s (2024) scoping review sought to map peer-reviewed literature describing interprofessional practice education initiatives involving experiential learning for pre-licensure students in healthcare disciplines.

Interprofessional practice describes the process wherein health providers from various disciplines work together to provide high quality care to clients (Lutfiyya et al., 2019). Experiential learning is an educational approach focused on combining theoretical and practical aspects of learning. It highlights the significance of "hands-on" experience in the learning process, to facilitate a more holistic education (Murray, 2018). In this sense, learning is not merely an outcome but is ongoing and grounded in experience, or "cycle" (Kolb, 2014).

The 100 articles reviewed by Nagel et al (2024) represented 12 countries, with interprofessional practice education initiatives categorized into three key types of literature: primary research, program descriptions, and program evaluations. Among these, 43 articles incorporated a theory, framework, or model in designing their initiatives, but only eight were specifically related to experiential learning. Various teaching and learning strategies were utilized, including small interprofessional student groups, team huddles, direct care provision, and reflective activities; however, few initiatives followed a complete experiential learning cycle. (Nagel et al., 2024).

Rowland and Trueman (2024)'s quality improvement report provides a comprehensive understanding of the experiences and challenges faced by healthcare students during clinical placements. Interviews were conducted with both students and staff, complemented by a literature review. This investigation identified six key themes related to student placement experiences: belonging and acceptance, familiarity and continuity, confidence and competence, preparation and readiness, supervision and support, and feelings of being overwhelmed, stress, and their impact on social and emotional well-being. These themes informed the development

of a student experience survey, designed to establish baseline measurements and track subsequent changes.

In response to the baseline data on student satisfaction gathered from the initial survey, several initiatives were implemented to enhance student satisfaction with clinical placements. These initiatives included the introduction of monthly student inductions, improved access to information technology, the provision of student induction packs, and the issuing of newsletters. While quantitative assessments from the student experience survey indicated positive outcomes, qualitative or non-measured feedback highlighted the significant impact of these changes. These included improved relationships, communication and processes between the teams in Berkshire Healthcare around student placements. The enhanced communication and collaboration across teams underscored the necessity for clear and streamlined administrative processes.

Sweet and Broadbent (2017) investigated the perceptions of undergraduate nursing students at an Australian university regarding the attributes of clinical facilitators that enhance their educational experiences. The research employed a cross-sectional survey design, targeting a cohort of 452 third-year nursing students from a single Australian university. Out of this group, 43 students completed the survey, returning a response rate of 9.7%. The findings reveal that nursing students regard the availability, approachability, and provision of feedback by clinical facilitators as significantly influential on their learning within the clinical environment. These qualities were evident as both barriers and enablers of learning, depending on the way in which they were enacted. For example, whilst the presence and engagement of the clinical facilitator in the student's learning was an enabler, poor availability or lack of engagement was a barrier to student learning. At large the study demonstrates that the role of clinical facilitators is crucial to student learning, and these insights may be useful to inform the development of clinical facilitator models, guidelines, and continuing education initiatives.

The studies above indicate some of the most successful elements contributing to learning on clinical placement to be staff and educator attitudes; the availability, approachability, and provision of feedback of clinical facilitators was seen as important and allowed trainees to feel confident, encouraged to ask questions, and like their presence was not a burden. Learning was maximised when facilitators were flexible with their time and availability, leading to “teachable moments” for trainees (Sweet & Broadbent, 2017). Trainees valued feedback from peers and

educators highly, and a culture of positivity and an absence of sarcasm or negativity were seen to increase work satisfaction.

The culture of a work environment is crucial to the success of students on clinical placements. We aim to identify some of the key organisational and interpersonal factors involved in successful clinical placements through our evaluation of the newly established NSW MFCPSP.

NSW Medical and Forensic Clinical Placement and Support Program

The NSW Medical and Forensic Clinical Placement and Support Program (MFCPSP) was developed to support the sexual assault medical and forensic workforce with training and professional development. NSW Health previously funded a qualitative research project to investigate the motivations and barriers to participation for the sexual assault medical and forensic workforce. The report makes five recommendations in response to the findings. These include increased daytime staffing throughout all of NSW LHDs and a review of current approaches to recruitment and training (Edmiston et al., 2024).

NSW Health has funded a large expansion of the workforce in 2024-25 (NSW Health, 2023) and the nascent nature of the workforce has resulted in the need to rapidly train a large number of examiners. As a result, NSW Health ECAV doubled the intake into the Graduate Certificate in 2024 by having two intakes throughout the year.

Local Health Districts (LHD) are responsible for supporting people undertaking the Graduate Certificate, credentialling their workforces, and ensuring that they have appropriate training and supervision. Successful completion of the Graduate Certificate requires the opportunity to observe a medical and forensic examination. During or following completion of the Graduate Certificate, credentialling requires the opportunity to conduct supervised examinations. However, there can be challenges with providing access to observation and participation in sexual assault medical and forensic examinations, particularly in regional and rural areas where there may be infrequent examinations.

The MFCPSP is a partnership between Sydney LHD, Northern Sydney LHD, the NSW Health ECAV based at Western Sydney LHD and the Ministry of Health. The three LHDs received dedicated funding for the program from 1 January 2024 to 30 June 2025.

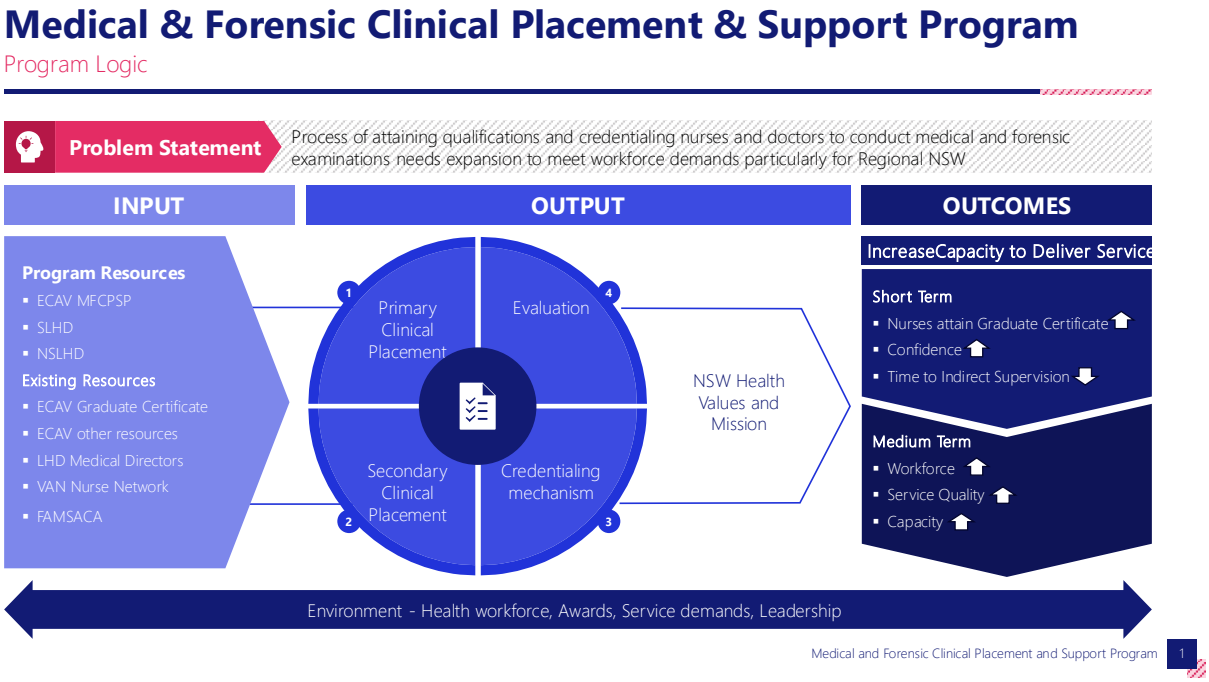
Advisory Group

An Advisory Group was established in late 2023 to support the development of the program. The Advisory Group membership primarily consisted of representatives from the partner LHDs, Ministry of Health and regional LHD representation. Meetings were held monthly.

Program Logic

A common understanding of the program purpose and aims was facilitated by the development of a program logic (Figure 1). A program logic model is a visual representation that shows how a program is intended to work by connecting activities with outputs and outcomes (Centre for Epidemiology and Evidence, 2023). The overall outcome of the program is to increase the capacity of LHDs to be able to deliver services to people throughout NSW.

Figure 1. MFCPSP Program Logic



The key outputs of the MFCPSP were the establishment of clinical placements, the development of a credentialing or assessment mechanism and an evaluation process.

Placements were offered at Sexual Assault Services in Sydney Local Health District (at Royal Prince Alfred Hospital) or Northern Sydney Local Health District (at Royal North Shore Hospital). **Primary clinical placements** are offered to students in NSW Health ECAV's Graduate Certificate in the Medical and Forensic Management of Adult Sexual Assault. Participants are provided with work-based learning where they can observe and participate in medical and

forensic examinations and other activities of a Sexual Assault Service. Participants can use observed cases for case reports, which are a mandatory component of the Graduate Certificate. Some participants may also conduct supervised examinations during their placement, however for most participants directly supervised examinations will be conducted in their own Local Health District (LHD) as part of credentialling.

Some LHDs have limited capacity to directly observe a sexual assault medical and forensic examiner conducting an examination. To meet this need, the Program offers **secondary clinical placements** where doctors or nurses can undertake a directly supervised medical and forensic examination at a Sexual Assault Service. Clinicians attending a secondary clinical placement do not necessarily need to have attended a primary clinical placement or be enrolled in the Graduate Certificate, if previous training and observations have been completed.

Placements were made available to NSW Health staff members working as or anticipating working as a medical and forensic examiner in an NSW Health VAN Service or Sexual Assault Service. Individuals were nominated by the service where they worked or intended to work, and were paid to attend the placements.

An assessment mechanism was developed by the NSW Assessment Working Group: Sexual Assault Medical Examiners 2024-2025, an activity of the Medical and Forensic Clinical Placement and Support Program. The working group included experienced medical and forensic examiners and SANEs. A framework of Entrustable Professional Activities (EPAs) was chosen to describe the essential activities conducted by a medical and forensic examiner. EPAs are an established tool used in both undergraduate and post-graduate medical and nursing education.

The EPA description provides a shared mental model regarding standards and scope of practice for supervisors and learners. EPAs describe the work that examiners do and the behaviours that demonstrate that the learner can be entrusted at a given level of supervision. The EPA descriptors include methods for assessing the learner. EPAs are not a qualification or an accreditation but can be used to support credentialing.

The evaluation of the program consisted of both internal quality assurance activities and the evaluation as presented in this report. Internal quality assurance processes are included within the evaluation but were also used throughout the program to guide program development and refinement.

Evaluation Aims

The aim of this evaluation was to comprehensively evaluate the MFCPSP, including placement processes and outcomes, to inform ongoing delivery of the program and workforce development strategies more broadly.

The research questions for this study were as follows:

RQ1: What happens on placement? What activities, including teaching activities and observing and conducting examinations, do learners participate in during their placement? What meaning do they ascribe to the experience of placement?

RQ2: What are the outcomes of placement? How does the placement impact learners' confidence? What factors are associated with placement outcomes?

RQ3: What are the broader impacts of the placement program on placement sites (RQ3a) and regional LHDs (RQ3b)?

RQ4: What sustainability factors need to be addressed in order to support learners undergoing placement and inform program delivery?

The research questions are findings are reported in line with the above questions.

Methods

Study design

This study utilised a mixed-method approach, collecting data through online surveys, semi-structured interviews, focus groups, pre- and post-placement activity forms and placement summary reports (routine parts of the clinical placement process) (Table 1). These methods collected a combination of qualitative and quantitative data from a number of stakeholder perspectives:

- MFCPSP learners: nurses and doctors from regional LHDs who attended placements at Royal North Shore Hospital and/or Royal Prince Alfred Hospital
- MFCPSP supervisors: medical professionals supervising these placements
- Staff from regional LHDs who nominated participants for placements.

Table 1: Data Collection Methods

Method	Participants	Timing	Recruitment	Medium	Data collected
Activity forms	All MFCPSP learners	Pre-placement 2 weeks before placement	Compulsory part of program	Online (MS Forms)	Previous MFE experiences, confidence in medical and forensic procedures, hopes for placement
		Post placement Within 2 weeks post-placement	Compulsory part of program	Online (MS Forms)	Cases attended, confidence in medical and forensic procedures, acceptability of placement
Placement summary reports	MFCPSP supervisors	Within 4 weeks post-placement	Completed as part of supervision responsibilities	Online (MS Forms)	Teaching activities, facilitators, feedback provision
Surveys	MFCPSP learners	Approximately 3 months following placement completion	Direct email invitation, SMS follow-up	Online survey (REDCap)	Placement experiences and impact
	MFCPSP supervisors	3 months before end of study period	Direct email invitation	Online survey (REDCap)	Placement experiences and impact

Interviews	MFCPSP learners	Approximately 3 months following placement completion	Direct email invitation SMS follow-up	Video conferencing (Zoom)	Placement experiences and impact
	MFCPSP supervisors	3 months before end of study period	Direct email invitation	Video conferencing (Zoom)	Supervision experiences and impact
Focus groups	Staff from regional LHDs	March 2025	Direct email invitation	Video conferencing (Zoom)	Impact on regional LHDs

Routine data collection

Recruitment

All learners were required to complete pre- and post-placement activity forms as part of the placement process. Likewise, supervisors were required to complete placement summary forms for each learner at the end of the placement. Data from these three activities formed the basis of a separate MFCPSP Quality Assurance (QA) activity (WSLHD RGO QA Approval 2404/06); data used for this QA activity were also approved for use in the MFCPSP Evaluation Study. As activity forms and placement summary reports constituted routine data collection, no additional consent was sought from participants for the use of their deidentified data in this evaluation.

Activity forms

The activity forms were developed to monitor placement outcomes and provide feedback to enable improvements.

Functions also included facilitating the placement process by:

- letting the site know the learner's experience and learning needs.
- giving the learner the opportunity to reflect on their own learning needs and progress during placement.
- ensuring the home LHD medical lead has information about the learner's progress so they can support ongoing learning.

Information that would be useful for placement sites was discussed at Advisory Group meetings. The confidence components on the activity forms were based on the activities that examiners need to do, and these activities were subsequently described as EPAs.

The pre-placement form assesses learners' previous experience of MFEs, their pre-placement confidence, and training needs. Closed- and open-ended questions asked about:

- Previous experience in the field: current or previous employment as an MFE, number of examinations observed, number of examinations performed under direct and indirect supervision
- If they are a current or past student of the NSW Health ECAV Graduate Certificate
- Confidence in medical and forensic procedures: obtaining consent, taking patient history, examinations, using a speculum, using an anoscope/proctoscope, using Sexual Assault Investigation Kit (SAIK) to collect forensic specimens, documenting response using Medical Forensic Examination Record (MFER), using photography as part of the examination, decontamination, chain of evidence, providing or advising on medical care and follow up
- Training needs: top 2-3 areas where further experience/training is wanted, and what they hope to get out of placement

The post-placement form collects data on learners' experiences while on placement, their post-placement confidence, and overall impressions of the placement. Questions included closed- and open-ended items asking:

- Details of the placement: how many they had completed, site/s attended
- Number and details of cases attended (or reasons if no cases attended):
    - Date/time, observed or performed examination, medical and forensic procedures involved in case
- If time was spent not on site and not on call
- Confidence in medical and forensic procedures (as detailed above)
- Acceptability of placement: overall satisfaction, most valuable aspects, areas for improvement, other comments/feedback

Placement summary reports

Learner-reported activity form data was supplemented by supervisor-reported placement summary reports. These were completed for each learner, typically by their primary supervisor on the placement. A series of mostly closed-ended questions asked if learners attended cases,

if they were taught each of the medical and forensic procedures detailed above (during case attendance, through simulations/direct teaching, both, or neither), who was the primary facilitator of this teaching, if any other teaching/training activities were conducted, and if feedback was provided to the learner.

Surveys and interviews

Recruitment

Learners were invited to participate in the survey and interview via email approximately 3 months following the completion of placement, with these emails sent in cohorts. The invitation email included a RedCap survey link and a reply email to express interest in participating in an interview. A minimum of 3 emails were sent to each learner over a 4 week period (Table 2). As recruitment was slower than anticipated, an ethics amendment was sought to allow SMS reminders to be sent. A link to the survey was also displayed to all learners at the Graduate Certificate face to face educational days in May 2025, including the final cohort who were not invited to interview.

Table 2: Timing of Learner Recruitment Contacts

Cohort	First contact	SMS reminder	Final reminder
Feb – Jun 2024	Aug 2024	Dec 2024	Feb 2025
Aug – Sep 2024	Nov 2024	Dec 2024	Feb 2025
Nov 2024 – Jan 2025	Feb 2025	Feb 2025	Feb 2025
Feb – Apr 2025	Not directly invited – insufficient time from placement to potential interview, however were able to respond to survey if desired		

All placement site staff who had supervised one or more participants were also invited to participate. A key contact from each of the placement sites circulated an email invitation to supervisors, containing a RedCap survey link and reply email to express interest in participating in an interview. Invitations were sent to placement site staff approximately 3 months prior to the end of the study period, to allow for the maximum accrual of experience as a supervisor.

Survey design and materials

Parallel online surveys explored learners' and supervisors' experiences of the MFCPSP. These were based on the National Placement Evaluation Centre (NPEC)'s Nursing Student Placement

Evaluation Tool (PET – Nursing) for learners, and the NPEC's Supervisor Evaluation Tool (PET – Supervisor) for supervisors (Cooper et al., 2020). Both surveys comprised 20 closed-ended items assessing different aspects of the placement experience, including the supervisory and team relationships (e.g. if learners were supported, safe and valued), impressions of placement staff (i.e. as clinical role models), educational value and impact of the placement for learnings, and overall satisfaction. These surveys were hosted online on RedCap. Survey participants were provided a copy of the PIS at the beginning of the survey, and their consent was considered implicit in survey completion.

Interview procedure

Semi-structured interviews were conducted one-on-one with MFCPSP learners and supervisors using videoconferencing software (Zoom). Interviews lasted approximately 45-60 minutes, and were audio-recorded and transcribed for analysis. Placement participants were asked about their motivations for participation; experiences on placement (including observing and conducting examinations, and when not attending examinations); supervisor and team dynamics; assessments and feedback; logistics of organising placement; and impact of the placement on their confidence, preparedness, and work since attending. Supervisors were asked about their experiences of supervision (including being observed, supervising examinations, and direct teaching); team dynamics; assessing competence and giving feedback; logistics of organising placement; and impacts of the placement on participants, the clinical team, and service provision. All interview participants provided written informed consent for participation.

Focus Groups

Recruitment

Two regional LHDs (Hunter New England, Western NSW) were purposively recruited to be sites based on expression of interest, willingness to participate, and to maximise diversity of experience. Focus groups consisted of two or more people from the regional LHD, aiming to represent a variety of roles and perspectives (e.g. VAN managers, medical and psychosocial leads, other doctors and nurses from the LHD). All participants were invited to participate through email invitation from the research team.

Focus group procedure

Focus groups were conducted by two members of the research team using videoconferencing software (Zoom). They were audio-recorded and transcribed for subsequent analysis. The focus group schedule prompted participants to talk about their LHD's experiences with the MFCPSP, motivations for sending staff on placement, challenges and benefits of placements for learners and for the broader LHD, impacts of the MFCPSP on the training and credentialling of MFEs, and suggestions for improvement of the placement program. Facilitators aimed to elicit perspectives and discussion on these prompts from and between participants in different roles within the LHD, in order to generate a more comprehensive understanding of LHDs' experiences of the placement program. All focus group participants provided written informed consent for participation.

Data analysis

The following describes the data analysis of the three types of data. While the data sources were analysed separately the results are integrated and presented by research question within the results section.

Routine data analysis

Completed pre-placement activity forms, post placement activity forms and placement summary reports were matched by placement week and de-identified prior to analysis. Learners who completed two placements were identified, enabling reporting of learner characteristics, with all other analysis conducted on placement weeks.

Descriptive statistics described learners' pre-placement background and levels of experience (including previous experience observing and/or performing cases under direct supervision). Means and frequencies were calculated to describe the details of cases attended during placements including site, case observed/performed under direct supervision, and procedures involved. The teaching and training modalities used to delivery education across key domains were described alongside any supplementary teaching and overall satisfaction.

For overall confidence, individual skill confidence scores were summed. Repeated measures ANOVAs were used to explore changes in confidence levels from pre- to post-placement for both individual skills and overall (RQ2), and to determine if this varied significantly depending on if learners had completed a case simulation (yes/no) or performed cases under supervision (yes/no; RQ3).

Free-text responses were invited of learners with respect to what they themselves most wanted 'to get out of placements', the 'most valuable aspect of the placement' and 'areas for improvement'. Thematic analysis was used to group free-text response fields into themes and consensus among researchers was reached at two research meetings as to key illustrative responses. Illustrative quotes were identified by learner number as all data was de-identified before analysis. Content analysis was conducted to identify frequency that specific activities were mentioned in free text responses.

Data from these placement activity forms were analysed using MS Excel and SPSS

Survey data

Descriptive statistics described anonymous Placement Evaluation Tool (PET) survey findings for participants and supervisors separately but comparatively, to explore the alignment/divergence of participant and supervisor perspectives. Reponses were grouped under the following 5 categories: 1) the Learning environment, 2) the Team, 3) Supervision, 4) Learner Safety/Support and 5) Value to the Learner.

Interview and focus group data

Thematic analysis of the data was conducted using NVivo as a data analysis tool. The research team familiarized themselves with the data and then transcripts were coded following an initial reading of the transcript, as recommended. Transcripts were then re-read line-by-line, in close detail, to capture relevant concepts or 'codes' coming from the data. Known as semantic codes, these first order codes were mostly descriptive and reflected the semantic content of the data. A preliminary codebook was then developed and trialled by the research team. Researchers then met to discuss the initial coding and refined the codebook. Themes were generated from reading and discussing the coded data. Initial themes were refined by discussion and comparison to survey and routine data. Representative quotes were included. Learners and supervisors were given a pseudonym and identified by role. Focus groups were identified by group.

Ethical considerations

The study received ethics approval from Western Sydney University Human Research Ethics Committee (ref. no. 2024/ETH01402). It was a low/negligible risk project. Interviewers were trained in sensitively asking questions in relation to these experiences, and had access to the

principal investigator should a participant have been distressed. Access to counselling was also available. Focus group participants were all involved in service management level work and therefore there were not significant power differentials within focus groups. There was support and counselling available for the interviewers by the supervisor and external support if needed.

Confidentiality and data security were ensured by secure storage of consent forms separate from any interview data. Audio recordings were destroyed by deleting any copies from computers and/or servers, once transcription had occurred. The transcripts had any identifiable information removed and were stored on a password protected Western Sydney University OneDrive.

Results

Participant Characteristics

Learner and supervisor characteristics are summarised in Tables 3 and 4, respectively, and are detailed for each of the methods below.

Routine data participants

Pre-placement activity forms, post-placement activity forms and placement summary reports could be matched for 39 placements but representing 37 unique learners. From February 2024 to end April 2025, 41 placements took place; 2 of these were excluded as they were placements for March 2025 Graduate Certificate intake and outside the evaluation parameters. Two learners completed forms for first and second placements. The other two learners who completed a second placement attended the first before the commencement of the use of the forms.

Of 37 learners, the majority (31) were currently completing the Graduate Certificate; the remaining six had previously completed this qualification. A total of 11 were working as MFEs at the time of one of their placement; five of these had been working for more than 12 months. Both of the learners who completed two sets of forms were not working as examiners at first placement but were working as examiners at second placement; both were current Graduate Certificate students.

For the 37 learners, 12 had observed SA crisis response cases before first placement. Only three learners had a performed examinations under direct supervision before the first placement and, and six learners had performed examinations under indirect supervision before attending first placement. Both of the learners who completed two sets of forms had performed examinations under direct supervision before the second placement and one had completed examinations under indirect supervision. It is noteworthy that four learners reported having completed examinations under indirect supervision but not under direct supervision before first placements.

All but one were female, two were doctors and the remainder were nurses.

Nine placements had RNSH as the primary site, the 30 remainder had RPAH as the primary site. During the RNSH placements, 5/9 also attended RPAH. During the RPAH placements 3/30 also attended RNSH. As a result RNSH had contact with learners over 12 weeks; RPAH had contact with learners over 35 weeks.

Survey participants

Surveys were completed by 21 learners and 12 placement supervisors.

All learner survey respondents were female, 20/21 (95%) were nursing professionals (Table 3). The most common age group was 40-49 years (9/21; 43%) and 17/21 (81%) were aged 40 years or over. 13/21 (62%) had attended placements at Royal Prince Alfred Hospital (RPAH) as a primary site (which commenced placements under the formalised MFCPSP in February 2024), with the remainder at Royal North Shore Hospital as a primary site (RNSH, which commenced placements in August 2024). 18/21 (86%) of learner respondents attended cases at RPAH whereas 11/21 (54%) attended RNSH, as opportunistic 'cross attendance' at the non-primary site was possible to maximise caseload exposure.

Among supervisor respondents, 10/12 (83%) were medical professionals and 2/12 (17%) were nursing professionals (Table 4). 6/12 (50%) were working at Royal Prince Alfred Hospital, with 6/12 (50%) at Royal North Shore Hospital. 11/12 (92%) were female. The most common age group was 50-59 years (4/12; 33%) and 9/12 (75%) were aged 40 years or over.

Interview participants

Eight learners and seven supervisors completed interviews about their experiences with the MFCPSP. All learner interviewees were female and worked as nurses. Six attended placements at RPA and three attended RNSH, including one participant who completed placements at both sites (Table 3). Supervisor interviewees were predominantly female (n=6), worked as doctors (n=4) or nurses (n=3), and represented both placement sites (RPA n=4, RNSH n=3) (Table 4).

Focus group participants

Four healthcare professionals from each LHD (Hunter New England, Western NSW) participated in the focus groups (Table 4). These participants represented a range of roles within the LHDs, including VAN managers, medical leads, nursing staff and counsellors.

Table 3: MFCPSP Learner Characteristics

	Surveys n=21	Interviews n=8
Gender		
Female	21 (100%)	8 (100%)
Male	0	0
Nonbinary	0	0
Prefer not to say	0	0
Age group		
20-29	2 (9.5%)	0
30-39	2 (9.5%)	1 (12.5%)
40-49	9 (43%)	3 (37.5%)
50-59	8 (38%)	3 (37.5%)
60+	0	1 (12.5%)
Profession		
Nursing	20 (95%)	8 (100%)
Medical	1 (5%)	0
Other	0	0
Prefer not to say	0	0
Primary site		
Royal North Shore	8 (38%)	3 (37.5%)
Royal Prince Alfred	13 (62%)	5 (62.5%)

Table 4: MFCPSP Supervisor and LHD Staff Characteristics

	Surveys n=12	Interviews n=7	Focus groups n=8
Gender			
Female	11 (92%)	6 (85.7%)	7 (87.5%)
Male	1 (8%)	1 (14.3%)	1 (12.5%)
Nonbinary	0	0	0
Prefer not to say	0	0	0
Age group			-
20-29	0	0	
30-39	1 (8%)	1 (14.3%)	
40-49	3 (25%)	1 (14.3%)	
50-59	4 (33%)	1 (14.3%)	
60+	2 (17%)	2 (28.6%)	
Prefer not to say	2 (17%)	2 (28.6%)	
Profession			
Nursing	2 (17%)	3 (42.9%)	1 (12.5%)
Medical	10 (83%)	4 (57.1%)	3 (37.5%)
Psychosocial	0	0	3 (37.5%)
Other	0	0	1 (12.5%)
Prefer not to say	0	0	0
Primary supervising site			-
Royal North Shore	6 (50%)	3 (42.9%)	
Royal Prince Alfred	6 (50%)	4 (57.1%)	
LHD	-	-	
Hunter New England			4 (50.0%)
Western NSW			4 (50.0%)

RQ1: What happens on placement?

Motivations for placement attendance

In their pre-placement activity forms, learners were asked to list areas in which they would like more experience or training, and to describe what they would like to get out of the placement. Due to overlaps in how participants responded to these prompts, these questions were analysed together.

Overall, learners commonly expressed a desire to gain exposure to real cases (n=12) and experience (n=10) through their placements.

> *Mostly I would like exposure to real cases, and to be involved however appropriate.*
>
> Learner 7

The vast majority of learners sought experience with using the tools that are unique to the medical and forensic examination – the Sexual Assault Investigation Kit (SAIK) and Medical

Forensic Examination Record (MFER). Use of the SAIK to collect specimens (n=21) and documentation and use of the MFER (n=13) were the most frequently mentioned experiences desired. History taking (n=11), physical examination (n=10), speculum examination (n=8), consent (n=7) and medical management (n=6) were all commonly mentioned. Fewer participants wished for more experience/training around anoscope (n=5) use, injury interpretation (n=5), expert certificate writing (n=2), HIV post exposure prophylaxis (n=2) and photography (n=2). Six mentions were made of wanting to be exposed to the whole procedure.

In addition to these specific skills, some participants specifically desired the opportunity to receive feedback or supervision of their own practice (n=7).

> *...get advice/ constructive criticism of how I deal with clients and use it to improve my practice*. Learner 35

Learners' most common desired *outcomes* for the placement related to their personal and professional development.

> *Experience and knowledge providing me with more confidence to respond to presentations at my usual hospital*. Learner 13

This included gaining confidence in their practice (n=14), developing skills or converting existing skills to the forensic setting (n=6). Specifically developing skills to be able to provide forensic examinations and service provision was mentioned by an additional six learners. Consolidating learning or knowledge was mentioned by six.

> *Gain more confidence skills and knowledge. Be able to confidently attend to cases independently safely and with accuracy*. Learner 19

Activities during placement

Learners attended a mean of 4.56 cases during each one-week placement (SD=2.05, range 1 – 8+). Almost all (97.4%) placements involved case observation, and in 25 (64.1%) placements the learner performed at least one case under supervision. Only four placements involved learners performing three cases during the week**,** the number required to be able to perform cases under indirect supervision. The cases attended predominantly involved medical and forensic procedures, with toxicology procedures relatively less common (Table 5).

On second placements, learners tended to perform more cases: on average they observed two cases (SD=0.82, range 1-3) and performed two cases under supervision (SD=3.367, range 0-7) during this placement.

Table 5: Total Cases Observed and Performed Per Placement

	Observed *M (SD)*, range	Performed *M (SD)*, range
Total cases	3.05 (1.78), 0-7	1.13 (1.34), 0-7
With medical procedures	2.90 (1.73), 0-7	1.13 (1.34), 0-7
With forensic procedures	2.49 (1.57), 0-7	0.92 (1.09), 0-5
With toxicology procedures	0.77 (0.81), 0-3	0.28 (0.60), 0-2

Table 6 summarises the skills taught during the placement, and whether this teaching occurred primarily through cases, direct teaching or simulations, or a combination of both. Most skills were taught to all learners, with exceptions being photography skills (82.1%), expert certificates (76.9%) and early evidence collection (69.2%). Most skills were taught primarily through cases or a combination of cases and direct teaching/simulations; the exception was expert certificates, where 86.7% of learners primarily learned through direct teaching or simulations.

Table 6: Skills Taught and Teaching Modality

	Taught	Teaching modality, n (%)		
		Primarily cases	Primarily taught/ simulations	Both modes equally
Specimen collection and SAIK skills	39 (100%)	13 (33.3%)	0	26 (66.7%)
Anatomy	39 (100%)	13 (33.3%)	6 (15.4%)	20 (51.3%)
Speculum and anoscope	39 (100%)	20 (51.3%)	3 (7.7%)	16 (41.0%)
STI and medical care	39 (100%)	10 (25.6%)	0	29 (74.4%)
Expert certificates	30 (76.9%)	0	26 (86.7%)	4 (13.3%)
Injury documentation and interpretation	39 (100%)	14 (35.9%)	6 (15.4%)	19 (48.7%)
Early evidence collection	27 (69.2%)	14 (51.9%)	10 (37.0%)	3 (11.1%)
Photography skills	32 (82.1%)	16 (50.0%)	7 (21.9%)	9 (28.1%)

Supplementary teaching

On 23 placements, learners reported experiencing other training or teaching activities, most commonly case simulations (n=18). Other activities included observing follow-up appointments (n=3), completing a mock forensic history taking session (n=1), and participating in a facilitated departmental discussion on coercive control (n=1).

What is the meaning of the placement experience?

Being a Medical Forensic Examiner.

A key motivation for learners attending placement was discovering what it is to be a medical and forensic examiner – and for those already working in the field, to see contemporary and quality practice.

The majority of learners were undertaking the Graduate Certificate, or had recently completed the qualification but had not yet commenced working as MFEs, and were highly motivated to become examiners. For these learners, placement was seen as an opportunity to get experience and exposure to real life cases; similarly, observing experienced examiners helped learners to understand "*what it's like"* to work as an MFE.

> *Because I don't work in the industry at this time, I thought it would be a really good opportunity to gain some practical experience that I otherwise had not had a chance to have. I think it would also build my confidence in this area because, although I have a sexual health background which can complement sexual assault, it's still two very different worlds. So, I thought it would be super beneficial to just help me build my skills and make me a more competent clinician when you did move into that space.* Laura, learner

For some, the placement experience prepared them to move into the medical and forensic field, giving them greater confidence to apply for SANE jobs:

> *There's now jobs where I'm working, SANE positions, and I knew that was happening, so I wanted to have the clinical experience to consolidate what I learnt in theory before positions came up and have some idea of what it's like in the practical versus theory.* Clare, learner

A small number of learners had undertaken the Graduate Certificate in the past or were already working as MFEs, and were attending to refresh and update their practice or to reconnect with the work in some way.

> *I am in a rural environment and I went nearly a whole year without a call-out. You lose your confidence when you're not called out for a very long period of time, so I put my hand up to do this one week placement. It's enabled me to get some cases and to see some contemporary work being done. You don't know what you don't know when you're out there, so it's been really good for me to observe other practitioners, to observe their dialogue, how they tackle trauma-informed care.* Kate, learner

For many, the placement represented opportunities beyond simple case observation and skill acquisition; the experience also allowed learners to envision themselves as examiners, and imagine the type of professional they might be. Learners described being energised by the exposure and connection. to the values and mission underlying MFE work:

> *It made me actually want to do this even more, if anything. I didn't find anything was overwhelming or anything. I actually found that that's what I wanted to do. I found I was more passionate about doing this after being there.* Amy, learner

> *I think it's really helped shape me into the type of clinician that I want to be.* Laura, learner

This was particularly the case for learners with more experience of MFEs; as they didn't have to focus on skill acquisition, this allowed for more observation and reflection. Some subsequently returned to their LHDs motivated to share their renewed passion and new learnings with others, with benefits for the broader workforce:

> *"She [SANE] went and did the placement and came back with this absolutely new lease on life, wanting to educate the team.... now she's willing to be a lead."* (focus group medical lead discussing experience of a qualified examiner attending placement)

Whilst positive experiences were reported by most, learners who didn't get to witness many medical and forensic examinations were keen to have another placement, as being present at examinations was considered fundamental to learning how to be an examiner. In addition, the specific steps and processes required to do an examination, and the novel nature of the work, meant that there was anxiety about the ability to do an examination. Overcoming this anxiety was a key outcome for learners and it was only made possible by being present at multiple examinations.

Additional activities were appreciated, particularly the simulation session and the visit to the sexual health clinic, but learners described the feeling of "waiting" for an examination, and the schedule of activities was seen as a way to utilise the time, rather than the reason for being there.

From parts to a whole.

Learners and supervisors described the week as integrating and bringing together the knowledge gained during the Graduate Certificate, into a whole that was trauma informed and patient centred.

Learners described the teaching from the Graduate Certificate as good as a baseline, but expressed that learnings felt disjointed until used in an immersive experience. The individual parts of an examination had not been seen together as a whole, as even the simulation day at the Graduate Certificate did not run through an entire case from start to finish. Doing this in the simulation with a dedicated supervisor was described as very beneficial for those that had this opportunity.

After the placement learners described the benefits of the placement experience as bringing the work together.

> *making sure they're okay the whole time, you know, like – and when you're trying to think of, "I've got to do this, this, this and this," you know, it's hard to be then – to remember to be mindful of the case the whole time*. Sandra, learner

Supervisors described the benefits of learners seeing the whole process run together from start to finish. One supervisor reflected that the learners may not understand the importance of being flexible and trauma informed in their approach and wondered if this might be related to the Graduate Certificate training and its prescriptive approach to teaching skills. They felt that the coursework could better explain times when it is suitable to have "deviation from that script", with regard to consent, for example. This concern about inability for learners to appreciate the need for practice to vary in reality was also expressed by other supervisors.

> *There's a big difference between theoretical training and the reality, and I usually say to them that one of my aims is to make their first few true solo cases when they're out in the country a little easier because it's very, very difficult the first few times*. Gary, supervisor

> *You've got to be really, really, really perceptive to the person in front of you, and how they are presenting, and that will guide how you interact with them, because you need to gain their trust and you need to make them feel safe, and make them feel like they're in control, so those really, really specific nuanced things and a big part of that comes into the language that you use. And that's been really. I think a lot of our candidates have learnt a lot in that aspect, the types of language and trauma-informed care and why you do and don't say and do specific things*. Briony, supervisor

While supervisors described the need for the placement experience to be trauma informed and patient focused, learners also described identifying this. For example, one learner described the potential benefit of feedback from the patient on the service.

> *You don't get much feedback from the client, so that's interesting. I think a lot of them get lost a lot, so it would have been nice to see what the client thought of, if it was too gushy or – since it's all about trauma-informed care, you're fairly focused on getting ….your needs met, to get your forensic book filled out but it would have been nice to – but you never, ever know how those girls feel*. Kate, learner

Only by being able to see all the parts of the examination together, were learners able to look from a distance and reflect on ensuring the service provision is trauma informed. Observing was considered valuable as it gave a chance to see the examination process and different practitioners' approaches. In particular, observing the practitioner's approach to trauma

informed care was mentioned. The opportunity to ensure the response was patient centred was enhanced when the examination occurred in work hours and there was time to pre-brief the examination.

> *But if we get in work hours, we usually have anywhere from 30 minutes to three hours, even plus, before a patient actually comes in. So that's actually a really good time. That's where you can do some really good work in really getting the student to think about what they have to think about in terms of how they approach this callout. We can go on to EMR and look at notes, trying to get a sense of the person's overall health history, where they're at with their overall health, and just game plan, strategise how they're gonna do things*. Briony, supervisor

Observing practice at two different locations and by both doctors and nurses added to the benefits of observation. Observing gave an opportunity to see the way different counsellors and examiners interacted. Each presentation was different and observing different examinations provided a lot of learning.

> *...a particular case that I was observing but I definitely learnt a lot from because I was in the observation role, so it's easier just to look back and actually see what's going on*. Alex, learner

The EPAs potentially made learners focus on discrete skills rather than the entire patient. Supervisors described EPAs as too objective and not encompassing trauma informed care adequately.

> *I don't know if the EPA is asking those less tangential clinical skills. I don't know that they're assessing those or teaching those*. Briony, supervisor

RQ2: What are the outcomes of placement?

Changes in confidence

Table 7 presents the results of the repeated measures ANOVA exploring changes in confidence overall, and for individual skills. Overall confidence improved from pre-placement to post-placement, when averaged across placements. Confidence levels also improved significantly for all of the individual skills. These increases in confidence were similar regardless of whether learners had performed an examination or had only observed cases.

Confidence increases were most common for technical skills of decontamination (87.2% placements showed increased confidence), chain of evidence (76.9%) and specimen collection (71.8%). Learners on approximately two thirds of placements showed increased confidence in history taking (66.7%), consent (62.5%), examination (69.2%) and documentation (69.2%). Learners on about half of placements reported improved confidence in medical care and follow up (51.3%) and less than half reported improved confidence in using a vaginal speculum or anoscope (38.5% for both).

Table 7: Changes in Confidence from Pre-Placement to Post-Placement, for Individual Skills and Overall

Procedure	Confidence (*M, SD*)		Test of difference		% reporting improvement
	Pre	Post	*t*	*p*	
Obtaining consent	2.15 (.84)	2.95 (.56)	5.746	<.001	62.5%
History taking	2.08 (.62)	2.79 (.62)	5.233	<.001	66.7%
Medical and forensic examination	1.82 (.64)	2.69 (.61)	7.098	<.001	69.2%
Speculum use	2.59 (1.04)	2.97 (.84)	4.071	<.001	38.5%
Anoscope/proctoscope use	1.33 (.62)	1.69 (.77)	3.571	<.001	38.5%
Specimen collection using Sexual Assault Investigation Kit	1.85 (.75)	2.77 (.56)	6.868	<.001	71.8%
Documentation of response using Medical and Forensic Examination Record	2.03 (.78)	2.77 (.54)	5.913	<.001	69.2%
Photography	1.31 (.61)	2.00 (.83)	5.643	<.001	61.5%
Decontamination	1.79 (.77)	3.00 (.45)	9.400	<.001	87.2%
Chain of evidence	1.79 (.70)	2.90 (.60)	9.135	<.001	76.9%
Medical care and follow up	2.10 (.68)	2.74 (.72)	4.751	<.001	51.3%
Overall confidence	**1.90 (.50)**	**2.66 (.42)**	**10.440**	**<.001**	

Response scale: 1=Not confident; 2=Slightly confident; 3=Confident; 4=Very confident.

The role of confidence

Confidence on placement translated to confidence as an examiner

Confidence in medical and forensic examination skills was described as important for a successful placement experience and as an outcome of the placement, with specific benefits for the workforce. Confidence changes as a result of placement were attributed to the supportive environment and exposure to cases. Supervisor and learner interviews, as well as focus groups, provided rich data concerning confidence.

Both supervisors and learners described the importance of confidence in each other for a successful placement experience. Supervisors described the importance of making sure the learner felt supported and secure in order to be able to conduct a supervised examination. They wanted to make sure the learner felt safe and had "personal confidence" so they could practice their technical skills. Supervised described taking time at the start of placement to understand the learner, their existing skill set and their learning needs. Supervisors who were supervising a learner to do an examination, described reassuring the learners that they had the necessary skills to act as building blocks to conduct a medical and forensic examination.

> *...you talk to them throughout, you set them up to feel confident, show them around. My trainees had all had call-outs in the same settings, so they didn't need to be specifically inducted into that setting, but I always ask at the start, "Do you have any questions? Is anything not clear? I want you to know that I'm here, I'm with you. I'm not going anywhere."* Kate, supervisor

> *But I also see the change in confidence and, you know, and see them grow with their skills or just see them, you know, doing it and say, "Yes, you can actually do that." And so they feel better from what I've seen, if they've had enough cases and practice.* Camilla, supervisor

Learners described preparing for the placement in order to feel confident to do the placement, such as by reviewing the Graduate Certificate content and by participating in simulation before attending placement. On placement, learners felt supported by the supervisors.

> *So having those guys, I felt really confident that they were totally supporting me.* Alex, learner

The placement experience resulted in increased confidence due to a combination of factors, with a crucial factor being the support on placement.

> *I think it was probably a combination of my foundation knowledge, the new knowledge that I learned through the course, and then the support from the team on the placement. I think altogether – if you took any of that out, maybe I would have had a different experience. But I think altogether, those things is what really solidified it and made me feel confident*. Laura, learner

Exposure to multiple cases, especially if there was also the opportunity to conduct an examination under supervision, was considered a key benefit of placement that contributed to confidence gains.

> *The more and more you do it, the better you're going to become and the more confident you're going to become as well*. Sandra, learner

> *Well, before going into it, I didn't feel confident with anything because, as I said, I'm only just reading the stuff in the books. I didn't know how I was going to do the assessment or anything was going to be the right way, or even asking the questions. I mean, you can do mock things where you go through consent and things like that, or asking history and that, but when you're actually doing it with a patient, it's quite different. So I felt better after actually doing it with someone. Not a scripted someone*. Amy, learner

As a result of the increased confidence following placement, learners described being able to conduct examinations back in their LHD, obtaining new positions, and feeling confident to share their new knowledge with others back in their LHD.

Jo described conducting her first examination back in her LHD following the placement week.

> *I couldn't have done it without that placement, I don't think. So, I don't think I could be where I am today without that placement. It's just the truth and just how it is. I came away from that placement having a much bigger understanding of how smooth the process can be and how it should work*. Jo, learner

For Laura, the placement experience was important for starting to work in a sexual assault position.

> *Well, it's given me a bit of confidence, too, to actually come back and work in that role, in that space. Obviously, I'm still learning and – yeah, but it's – I think I would be far better off after attending that placement than I would have been if I hadn't attended and just tried to move into that space*. Laura, learner

The flow on benefits of learner confidence was also noted by the regional LHDs within the focus group discussions, and was particularly notable for those who had completed the Graduate Certificate some time ago but had not been conducting many cases due to their geographic location in a small regional area.

> *So it was a huge change in just a week, from being quite nervous about it to then feeling confident with some support, not face-to-face, but you know, over the phone or something, feeling confident that she can go out and do this.* Focus Group 2

> *Because she got that consolidation in that week, it has really improved her confidence to the point that now she's willing to be a lead and have other people shadow her, which she said at the time, "No way. I'm not confident enough for anyone to watch me do it." So, it's been really transformative in that regard.* Focus Group 1

Supervisors also noted that confidence gains seemed to be particularly strong for learners who were already working as examiners.

> *Yeah, that's right. Especially, if you haven't – if you're in doing the work, but you actually haven't had any cases for a long time, I think something like this is just really good for their confidence.* Elizabeth, supervisor

Performing cases under supervision

Who performed cases under supervision?

In total, 25 placements involved cases performed under supervision. A greater proportion of these were primarily RPA placements (23/25, 92.0%). Of those who only observed cases, half attended RPA as the primary site (RPA 7/14, 50.0%). Placements with cases performed under supervision were slightly more likely to involve current Graduate Certificate students (22/25, 88.0%), compared to 78.6% (11/14) of placements who only observed cases. A similar proportion involved learners who were already working as an MFE (7/25, 28.0% of placements with performed cases, 4/14, 28.6% of placements with only observed cases).

Is performing cases under supervision associated with improved confidence?

Table 8 presents the results of the repeated measures ANOVA examining whether changes in confidence differed significantly between placements where learners performed cases under supervision (*n*=25), compared to placements where learners only observed cases (*n*=14). Overall, while the change in confidence from pre- to post-placement remained significant as

described in Table 7 above, the magnitude of this change did not differ significantly between placement groups either overall ($F_{1,37}$=0.533, p=.470) or for any of the individual skills (Table 8).

Table 8: Changes in Confidence for Individual Skills and Overall, Comparing Placements with Only Observed Cases to Placements with Performed Cases

Procedure	Change in confidence (*M, SD*)		Test of difference	
	Observed only (*n*=14)	Performed cases (*n*=25)	*F*	*p*
Obtaining consent	+0.57 (0.94)	+0.92 (0.81)	1.480	.232
History taking	+0.50 (0.85)	+0.84 (0.85)	1.429	.240
Medical and forensic examination	+0.71 (0.73)	+0.96 (0.79)	0.919	.344
Speculum use	+0.21 (0.58)	+0.48 (0.59)	1.861	.181
Anoscope/proctoscope use	+0.50 (0.65)	+0.28 (0.61)	1.105	.300
Specimen collection using Sexual Assault Investigation Kit	+0.93 (0.83)	+0.92 (0.86)	0.001	.976
Documentation of response using Medical and Forensic Examination Record	+0.79 (0.70)	+0.72 (0.84)	0.061	.806
Photography	+0.93 (0.62)	+0.56 (0.82)	2.139	.152
Decontamination	+1.07 (0.83)	+1.28 (0.79)	0.603	.442
Chain of evidence	+1.00 (0.78)	+1.16 (0.75)	0.398	.532
Medical care and follow up	+0.43 (0.76)	+0.76 (0.88)	1.403	.244
Overall confidence	**+0.69 (0.40)**	**+0.80 (0.49)**	**0.533**	**.470**

Case simulation

Is completing a case simulation associated with improved confidence?

Table 9 presents the results of the repeated measures ANOVA examining whether changes in confidence differed significantly between placements involving a case simulation (*n*=18), compared to those without (*n*=21). Again, while the change in confidence from pre- to post-placement remained significant, the magnitude of this change did not differ significantly

according to MFE completion either overall ($F_{1,37}$=0.000 p=.992) or for any of the individual skills (Table 9).

Table 9: Changes in Confidence for Individual Skills and Overall, Comparing Placements with no case simulation to placements with case simulation

Procedure	Change in confidence (*M, SD*)		Test of difference	
	No case simulation (*n*=21)	Case simulation (*n*=18)	*F*	*p*
Obtaining consent	+0.76 (0.94)	+0.83 (0.79)	0.065	.801
History taking	+0.71 (0.85)	+0.72 (0.89)	0.001	.977
Medical and forensic examination	+0.95 (0.74)	+0.78 (0.81)	0.496	.486
Speculum use	+0.33 (0.66)	+0.44 (0.51)	0.338	.565
Anoscope/proctoscope use	+0.24 (0.70)	+0.50 (0.51)	1.719	.198
Specimen collection using Sexual Assault Investigation Kit	+0.95 (0.80)	+0.89 (0.90)	0.054	.817
Documentation of response using Medical and Forensic Examination Record	+0.81 (0.81)	+0.67 (0.77)	0.315	.578
Photography	+0.67 (0.86)	+0.72 (0.67)	0.050	.825
Decontamination	+1.33 (0.80)	+1.06 (0.80)	1.172	.286
Chain of evidence	+1.05 (0.74)	+1.17 (0.79)	0.237	.629
Medical care and follow up	+0.62 (0.86)	+0.67 (0.84)	0.030	.863
Overall confidence	**+0.77 (0.46)**	**+0.77 (0.47)**	**0.000**	**.992**

Qualities of a successful placement experience

From the post placement forms it was evident that the supportive environment enabled a feeling of safety.

Learners described having a dedicated placement supervisor who was supportive and warm as a key aspect of feeling safe and able to learn. Interactions with others were valued and the quality of the interactions was frequently described as being dedicated, generous and welcoming. The concept of support was frequently mentioned (n=17).

> ...*enabled my safety and maximized my learning experience.* Learner 6
>
> *Practical experience / observing experts /stuffing up under supervision.* Learner 8
>
> *The support from the nurses and medical officers was evident and made me feel comfortable and welcome. The cases which I observed were valuable learning opportunities, and reviewing and discussing cases with the staff was helpful.* Learner 4

The immersive experience, utilising a combination of exposure to cases and direct teaching, super charged the learning environment to make the most of the week.

Exposure to multiple cases and multiple practitioners was beneficial for developing a learner's own approach to work. In the majority of post placement forms, the most valuable aspect of placement included exposure to cases (n=21), and for some actually conducting cases (n=9). Exposure to a different service and different practitioners was mentioned in 11 post placement responses. Receiving direct feedback was considered invaluable for some. A variety of individual teaching activities or skills were mentioned as useful, although each only on one or two occasions.

> *The medical team were so welcoming and generous with their time and knowledge from informal and formal teaching opportunities, resource sharing and really immersing me into the team. It was the most beneficial clinical placement in my whole (many) years of nursing experience*. Learner 15
>
> *Before this placement I have never been supervised to do a medical/forensic examination and have learnt quite a lot from making mistakes*. Learner 30
>
> *Observing cases was so valuable as this was the first time I have observed any cases, and it helped me understand the process much better*. Learner 32

Placement experience

The placement experience was fundamentally a quality experience because of the generosity of the supervisors, in sharing their wisdom and skills and creating a safe space for learning. Interviews with learners and supervisors described the features of the safe learning space.

Leaners observed the team at the placement sites demonstrating cohesiveness and respectful behaviours amongst themselves. This included the medical and forensic examiners working alongside counsellors and social workers so there was a real sense of teamwork. Nurses and doctors were treated equally. The feeling that the team (including counsellors, nurses and doctors) was cohesive was reported. The team at the placement site demonstrated respectful behaviours with each other. This environment made it a good place to be on placement.

> *And for the rest of the days, I sat with the team in that room, you know, it was vibing really nice. I'm quite like, just leave me alone until you need me kind of person. And it felt nice. It was a really, really nice team.* Jo, learner

> *So it's a really nice team dynamic. They spend a lot of time all together and, you know, debriefing and talking, which I think is really important.* Sandra, learner

As a new addition to the team, the learners recognised the following as important for them to be able to actively participate. They noted that supervisors are crucial to creating an environment that making learning possible and that supervisors were actively doing this.

Mutual respect for each other was demonstrated through sharing of knowledge and including the learner even if they were just observing. Whilst doing observations, being given opportunities to contribute or having an opinion asked, made the learners feel involved from the start, and more comfortable about how communication would occur once leading examinations.

A commitment to the learner and the placement process was perceived and expressed as the feeling that the team was invested in the learner being able to work in this field. Features of this included good communication between supervisor and learner in particular, forming a common understanding of the goals of the placement.

> *They wanted you to do well, and that was really evident to me.* Julia, learner

Opportunities to actually conduct examinations and practice as an examiner were highly valued. Learners appreciated that the supervisors had more experience and could judge when the learner was ready to conduct an examination and if the case was suitable for the learner to do. Sometimes this might mean the supervisor stepped in and made the decision that the learner was not able to do the case.

Learners described having to be “pushed” or encouraged to start conducting examinations. However they always felt that they weren’t asked to do anything beyond their capabilities and

were always maximally involved for the skill set that they had. An example is not having sufficient knowledge about sexually transmitted infections and the supervisor seamlessly stepping in and taking over at that point.

Once the supervisor told them that they were ready to do the examination, the feeling of being an active part of the examination and treated as an equal was very powerful.

Supervisors felt that they opportunity for learners to practice their skills was a crucial part of the learning process.

> *I think there's an incredible difference between role play and online teaching to actual clinical placements. I think they're absolutely critical and I think that they make a huge difference.* Rachel, supervisor

RQ3a: What are the broader impacts on placement sites?

Positive impacts of being a placement site

Impact on placement sites was largely positive, despite the considerable demands of the program.

Supervisors described having the learners as enjoyable, because of their enthusiasm for the work, but adding slightly to the time for the examination. This was a concern because of the recognition of the impact on patient care, potentially shifting the focus from patient care. It was also more problematic at night where everyone just wants to get back to bed as soon as possible.

Supervisors also described the benefits of self-reflection and reviewing practice which was brought about by having learners present. Reflections included about how service is delivered, how it aligns with NSW Health ECAV teaching, making sure it is trauma informed and making sure the care delivered is patient centred and medico-legally sound, regardless of different practitioners' differences in practice.

> *...also reflect on how I'm perceived by the patient because I'm using it as a learning opportunity for the student. And then I have to kind of translate that so everything becomes a bit more – you're having a bit more – yeah, it becomes a bit more conscious. You become more conscious of what you're doing.* Camilla, supervisor

One supervisor found the process of being observed to be rewarding. It made the work more interesting, gave them feedback and information on recent practice as taught by NSW Health ECAV, and made them think more about their professional practice.

The process of having a learner present at an examination took additional time, but the benefits of supporting workforce, and enjoyment of working with enthusiastic and willing learners, negated a lot of the challenges due to time demands. Ons supervisor mentioned that patients did not mind having a learner present, and the extra explaining was potentially beneficial for some patients.

> *The patient felt very involved and actually really benefited from that discussion*. Briony, Supervisor

> *So it is very collaborative between the patient and I, and it just was that one more in-depth collaborative in terms of, I would be explaining why I would be asking certain questions and then ask the patient the question. That was a really positive experience for all three of us*. Briony, Supervisor

The supervisors described little direct contact with NSW Health ECAV and the on-site supervisor lead being crucial for information sharing and co-ordination of the learner's week. This resulted in considerable burden for the on-site supervisor. The site supervisor also spent considerable time with the learner to ensure they felt supported and that the placement met their needs.

> *It's very labour-intensive, I should say, depending on how well you want it to run*. Camilla, supervisor

It was described as more challenging to supervise someone as an on-call examiner when you don't know the person.

> *You might not feel necessarily as confident about them taking a history or doing the examination, like they're still quite early in their exposure. So just really understanding what their capabilities are and not expecting too much from them. And that's – I guess that's difficult when people have- like our after-hours staff might have somebody come and do a call out with them, but they don't really know what their experience is*. Elizabeth, supervisor

Another challenge described by a supervisor was physical crowding within the office space when an additional person was in the office.

RQ3b: What are the broader impacts on regional LHDs?

Benefits for service delivery

Benefits to the LHD were considerable, and a strong focus of the focus group discussion, whereas the contribution of placement to attaining the Graduate Certificate was less clearly articulated in the evaluation.

Benefits to the regional LHD that had supported learners to attend placement were a strong focus of focus group discussions. The placement enabled some examiners to start to conduct examinations under indirect supervision, which was particularly beneficial for LHDs with limited existing examiners.

> *Well, after the placement, then I had some more experience, and then as a result, because the area that I work in doesn't have anyone on-call, so it meant that I started doing cases with verbal support from our medical director. So it made a big difference, a big impact.* Alex, learner

For nurses who are required to have conducted three directly supervised examinations before working under direct supervision, the opportunity to progress along this supervision continuum in a week rather than many months was transformative.

> *I wouldn't be doing the work if I hadn't had the placement because it would take me months, months, months to get the amount of exposure to that clinical call-out because you have to supervise three witnessed. I wouldn't have that here.* Julia, learner

The regional LHDs described the challenges of trying to provide direct supervision of nurses in small regional sites.

> *It's really challenging with the caseload we see and then the stars aligning, that's really how it is to have two people be able to do it at the same time for that to work, is quite amazing. Because to get the three that they need to be observed locally takes months and months and months really. Focus Group 1*

As a result of the slow progress to indirect supervision, learners may become demotivated, or simply move away whilst still in training. As a result, the LHD may never benefit from the investment in the learner.

> *You know, we have very limited staff to help shadow and support those responses that it would almost – you know, it would really take years and years. And by then, we may lose the staff anyway.* Focus Group 1

Besides the opportunity to have supervised examinations, the LHDs benefited from learners being exposed to different ways of working.

A learner described that the approach to case review and the supportive and multi-disciplinary approach to case reviews witnessed on placement was quite different to what occurred in their LHD. They were able to take this back to their LHD and discuss with senior leadership a need to change the approach to the governance of their service.

Supervisors also were able to articulate the importance of the learners seeing a quality service and how this might benefit the LHD.

> *They already know how impactful their job is, but I hope that seeing- being able to actually see it and observe it – and what's really nice is our service provides continued care, which I know a lot of the services don't. But being able to see a patient at a callout and then the patient coming back for counselling and follow-up care, and just seeing the complete transformation compared to the person that we first met with, as opposed to the person that comes a week later, kind of just reinforces- I hope reinforces the work that they're doing, and how important it is.* Briony, supervisor

Learners identified practical changes they would like to make in their LHD after seeing how services were delivered on placement, such as practical layout of the examination room, access to hepatitis b vaccination and providing clothes for the patients.

A learner who was very motivated and passionate for the work after placement was disappointed that the regional LHD did not support her to progress her skills and contribute to improvements in the LHD.

> *I found I was more passionate about doing this after being there. So when I came back home, it was so disappointing when I just felt like I'd been stonewalled again like before. It did dishearten me a bit when I came home, actually. It was a shame.* Amy, learner

Placements were described as benefitting the LHD in terms of being able to provide a service and potentially avoid the risks associated with not having a service.

> *You know, we have to continue to convince the powers that be that, you know- I think the logic's there, that absolutely spending that money is worth it in terms of making sure we*

can maintain the SANE workforce and deliver the service that we have to. ....., you know, we need to find a way to quickly get people on board and we need to not sit with the risk of not being able to provide a service. And this is one way to be able to do that. Focus Group 1

Benefits for very small sites were significant.

So, there's a lot of remoteness here that is very different to the bigger cities. And so shortening that sort of gap (between finishing Grad Cert and being able to work unsupervised) might not sound like a lot, but it definitely is a lot for us out here. Focus Group 2

Regional LHDs reported that it was beneficial for their examiners to be exposed to different services' ways of working even if not directly related to examinations.

And also something that's come out of it for me, as I've spoken to the more recent participants who have exited the placement program, they've talked about what they've seen, not just with the examinations but with the processes of the service that they've been sitting with or both of them. Some have gone to both hospitals. And that's been really useful just to hear about what do other services do that we could potentially look at as well. And then some of that has parallel, filtered through medical forensic advisory too. So it's been really great to hear what they thought was good and what could be useful out here that we don't currently do. Focus Group 2

Particularly for learners who had some responsibilities to governance within their home LHD, the opportunity to observe practice systems and governance processes was useful. For example, mechanisms for recording cases on a REDCAP database and systems for creating photobooks of case photos.

So their governance structures were really good. Their REDCap was amazing, their database and their ability to follow up, that was amazing. As I said, the way they do their photo books and how they put all that together. Obviously, they're a team that's worked together a really long time and they've got really good processes, and that was something that I thought I would love to replicate here. Julia, learner

I think it's also been useful for the SANE to have come through to look at what our daytime SANEs do in their normal daytime roles, because that's what some of these will be doing. And because they're quite new roles, a lot of them aren't really quite sure what

they're meant to do yet. And so it's been really useful to see what our SANEs do. Elizabeth, supervisor

It was good to see how they have their day and how it works out, whereas we don't do anything like that at our workplace, because we don't have a permanent SANE on, where they have permanent people. But it was good to see what happened to the paperwork afterwards and how they followed up with the patients, that type of stuff too, so it was good. Amy, learner

Having feedback about the learners' experience was beneficial for the regional LHDs. The EPA feedback form was useful for feedback and was described as having improved the quality of feedback and perhaps consistency of teaching delivered on placements.

I think the introduction of the EPAs has been quite useful there as well. I feel as though we've got much better feedback from the placement as to how our candidate is and how they've gone and what we need to work with them on. Whereas, earlier on we weren't really getting as much feedback as what we are now. Focus Group 1

EPAs were also mentioned as useful for being able to provide ongoing professional development back in the regional LHD.

having some ability for us to now take that forward in terms of being comfortable to say, rather than just having a bit of an educated guess, no, this person's okay to be by themselves, can actually got a format, a schedule to refer to. So that's been really great. And I know the same team that set up the placement program has run those documents, which is incredibly helpful too. Focus Group 2

Some learners described the placement made the NSW Health ECAV Graduate Certificate work easier, and this probably related specifically to writing expert certificates and the moot court.

because you've got real-life case scenarios that you can draw on. Julia, learner

The benefit was also noted by the regional LHDs.

Just another thing I just thought of now is with going down for that week, what part of the training is being able to write expert certificates and then do the moot court. And some of the people doing the training have never seen – they haven't had any supervised cases. So being able to go down there, see some cases themselves and then use one of them for part of their training- obviously, de-identified, of course, but I think that's another positive. Otherwise, you've been given someone else's case that you're not

> *involved with and you know, it's sort of just a made up case study. So I think that's really helpful as well as a part of that ECAV training, is that people can use real life cases that they've been involved in to help with their studies*. Focus Group 2

Otherwise, the Graduate Certificate was seen as preparation for placement, which was a pathway to practice, rather than placement being seen as part of or an aid in completing the Graduate Certificate.

Graduate Certificate completion data

Interestingly, data on Graduate Certificate completions has not yet showed an increased graduation rate since placement has been introduced. This may be due to the time lag between placement and graduation being long and many who have been on placement not yet completing the Graduate Certificate.

However, since placements have been introduced, there has been an increase in both the total number and proportion of nurses enrolling in the Graduate Certificate. A possible factor is knowledge that the placement program is available to support their practical learning and that the SANE workforce is being prioritised.

> *It really is a pleasure to be training other SANEs to bulk this workforce, because- I've been a SANE for eight years now, and I am more than happy to be a part of the placement program to bulk the workforce. It's been really fantastic to see so many SANEs come through*. Briony, supervisor

RQ4: Sustainability factors to be addressed

Streamlined while supported, yet a stressful experience for the learners

Placement organisation took time but was generally considered to be a streamlined and relatively low burden activity for the learners, as their managers organised their rostering and NSW Health ECAV organised their travel. The process of going on placement remained stressful due to the unfamiliarity of the environment and fatigue.

Learners described an efficient process whereby manager arranged payment, NSW Health ECAV organised travel and timing, and the placement site looked after logistics once the placement commenced.

Having everything organised reduced the stress of the placement. In particular taxi vouchers, and the ability to request additional vouchers if required, reduced any stress about getting to nighttime examinations. Accommodation organisation was smooth and efficient. There were some challenges for being reimbursed meal allowances after placement. The distance between RPAH and RNSH presented some challenges for travel for learners attending both sites.

Arranging placements was more challenging for casual nurses who had substantive roles outside VAN services. Having the VAN manager do this negotiating with the other manager was helpful but it was still time consuming and potentially anxiety provoking when there were multiple roles to negotiate.

> *And I've got other things to think about in so far as I work with a different team. So, I had to let my nurse unit manager know, she's going to have to find somebody else to fill my role. I'm a clinical nurse specialist. It's not just anybody can jump in that role.* Jo, learner

The dedicated administrative support was highly beneficial in making all parts work smoothly, and explaining processes. The role even helped VAN managers advocate with other managers regarding having learners attend in a paid capacity.

> *She's really good at troubleshooting and providing advice 'cause some of it's just logistical for our nurses in terms of making sure they're reimbursed for, you know, the different arrangements. ... so it's really great because (MFCPSP admin) has provided really good sort of scripts that I can forward on and then discuss with the operational managers around the importance.* Focus Group 1

> *So, you know, I would say it actually works really well, but it is just to acknowledge the complexity, I guess, of our approval systems and arrangements.* Focus Group 1

Flexibility of placement duration was desired, both by some who desired shorter placements to fit in with learners' home lives, to learners desiring longer placements for more experience.

> *It's just a couple of days, I just wanted a couple more. And I've even said to my workplace, "Look, can I organise to do something like that again at my own expense?"* Amy, learner

On placement, challenges were tiredness and fatigue, particularly with nighttime examinations and prolonged periods on-call. Tiredness made it hard to function well and learners were aware of the importance of accuracy for medicolegal aspect of the work. The mental fatigue of paying attention to the different cases and the trauma experienced by patients was challenging.

> *The hard part is taking the history and hearing the story.* Kate, learner

Learners described needing to say no to cases for a rest and this being respected. One mentioned that the supervisors actively advised the learner to take a rest. Balancing opportunity to see cases with the need for rest was a frequently mentioned concern for both learners and supervisors. Supervisors also described recognising the impact of fatigue on learners. The fatigue and being on-call seven days in a row combined to increase risks to learners' mental health.

> *My big concern around student health is the idea of being available on call for seven days in a row. I don't think that's a safe practice.* Rachel, Supervisor

An evolving iterative program so far has resulted in improvements

The experiences during early placements differed from those during later placements due the evolving nature of the program.

Feedback from Post Placement Activity forms at Advisory group meetings meant the opportunity to continually adapt the placement experience. Resources to support placement were developed over the duration of the program, with some such as the EPAs not fully able to be utilised until 12 months into the program. The evaluation revealed the changing nature of the experiences for both learners and supervisors.

One supervisor described the challenge for learners of the first cases. Recognising this, the supervisor tried to provide a simulation of a case that had a level of difficulty for the learner, but not make it too difficult that it was distressing. The supervisor describes achieving this balance in training was tricky at first, but by seeking feedback from the other supervisors and from the learner, a better simulation experience was delivered.

Evolution was perhaps best seen in the focus groups where the members reflected on the experiences of learners from their local health district that had gone early versus those that had gone later. Focus group members reported that learners on earlier placement expressed more confusion about the variation in practice by supervisors. One learner who attended an early placement also spoke of challenges of working with different examiners who have different approaches.

Another evolution was the feedback to medical leads. Focus group participants described feedback from earlier placements was limited and was vastly improved by the EPA forms.

The willingness and ability of the placement sites to adapt in response to feedback was further evidence of their commitment to the learners and workforce development.

> *Then I could work out things that probably we need to make a bit clearer or a bit more consistent, …going through the ECAV curriculum …just seeing what didn't align.* Camilla, supervisor

Satisfaction

Sustaining quality requires pathways for feedback on satisfaction and quality of the placement experience. Routine data collection included a response for satisfaction with rating 1-5, with 5 being the most satisfied. Of 39 placements, 35 were rated 5, one was rated 1 however discordant comments suggest potential reversal of scoring, three were rated 3. Of these, two mentioned limited cases in comments and the other mentioned cab charge issues.

Survey Data

Overall satisfaction with the placement was high amongst both learners (*n*=21, *Mean rating*=9.48/10, *standard deviation*=0.870) and supervisors (*n*=12, *Mean rating*=8.83/10, *standard deviation*=0.830).

Agreement was demonstrated for all of the survey items for the majority of respondents (Table 10). 95% of learner respondents and 100% of supervisor respondents either agreed or strongly agreed that:

- 'Placement site staff were willing to work with others', 'were positive role models', 'were ethical and professional' and 'demonstrated respect and empathy toward patients'
- 'Learners were adequately supervised in clinical environment' and
- 'Learner/supervisor anticipates learner being able to apply learnings from placement'

The item with the lowest levels of agreement/strong agreement was: 'learner achieved learning objectives' (81% of learner respondents, 67% of supervisor respondents).

Discordant results were noted for agreement/strong agreement with the 'learner gained new skills and knowledge to further their practice' (95% of learner respondents, 75% supervisor

respondents) and with 'learner fully orientated to clinical area' (86% of learner respondents, 100% supervisor respondents).

Table 10: Agreement with Placement Evaluation Tool and Supervisor Evaluation Tool Items

Item	Agree/Strongly Agree, *n* (%)	
	Learner rating (*n*=21)	Supervisor rating (*n*=12)
Learner fully oriented to clinical area	18 (86%)	12 (100%)
Staff willing to work with learners	20 (95%)	12 (100%)
Staff were positive role models	20 (95%)	12 (100%)
Staff were ethical and professional	20 (95%)	12 (100%)
Staff demonstrated respect and empathy toward patients	20 (95%)	12 (100%)
Patient safety fundamental to staff's work	19 (90%)	12 (100%)
Learner felt/were valued during placement	20 (95%)	11(92%)
Learner felt/were safe (physically, emotionally, culturally) in clinical environment	20 (95%)	12 (100%)
Placement was good learning environment for learners	20 (95%)	11(92%)
Supervisors helped learners identify learning objectives	18 (86%)	11(92%)
Learners were adequately supervised in clinical environment	20 (95%)	12 (100%)
Learners received regular and constructive feedback	19 (90%)	10(83%)
Learners were supported to work within scope of practice	19 (90%)	11(92%)
Supervisors understood how to assess clinical abilities	20 (95%)	10(83%)
Learners had opportunities to enhance skills and knowledge	20 (95%)	11(92%)
Learners had opportunities to interact and learn with the multidisciplinary team	19 (90%)	9 (75%)
Learner achieved learning objectives	17 (81%)	8 (67%)
Learner gained skills and knowledge to further their practice	20 (95%)	9 (75%)
Learner/supervisor anticipates learner being able to apply learnings from placement	20 (95%)	12 (100%)

Overall, these findings suggest a broadly positive placement experience among both learners and supervisors. Supervision, service staff and learner safety emerge as particular strengths, whereas placement preparation, contextualisation of learning objectives and supervisor support and training may be important areas for further development.

Importantly, in addition to high levels of overall satisfaction, the vast majority (95%) agreed that they gained skills and knowledge to further their practice and anticipate that they will be able to

apply the learnings from placement. These ‘outcome-related’ findings align with other outcome data from the evaluation.

Discussion

This evaluation has described the activities that occur on placements, the outcomes for learners, the impact of placements on host sites and some of the impacts for regional services. In addition, it has attempted to identify factors that may play a role in sustaining the program into the future.

The purpose of the MFCPSP was to increase workforce, particularly nursing workforce, by increasing confidence and decreasing the time between training and being able to conduct examinations without direct supervision. Placement participants observed and often conducted medical and forensic examinations, a key activity of examiners. In NSW, conduct of three examinations under supervision is required for nurses to be credentialed to conduct examinations (NSW Health, 2020). As such, the placement was an opportunity to reduce time gap between training and being credentialed.

Few other placement experiences for medical and forensic examiners have been described. No previous papers have been published focused solely on the role of clinical placements for medical and forensic examiners. Previous reports of clinical placement as part of post graduate training have predominantly focused on clinical exposure occurring at the site of current or future work (Parekh et al., 2005; Burton et al., 2022; Sekula et al., 2022; Thomas et al., 2020) or of clinical observations without practical experience (Morris et al., 2022). Clinical placement for the purpose of conducting a supervised examination has been described as part of a program aimed at certification of nurses in underserved areas of the United States (Torregosa et al., 2023), and is the most similar to the MFCPSP in design. During the MFCPSP placement week, the majority of learners (64.1%) completed an examination under supervision, and learners observed a mean of 3 cases (range 0-7). Additional teaching was delivered on placement and a simulated case was the most commonly delivered discrete teaching activity.

Using pre and post placement measures, our evaluation found significant increases in confidence overall in the activities of a medical and forensic examiner, as well as in all individual skills assessed. Confidence increases occurred for the majority of learners for all procedures except use of speculum and anoscope, for which 38.5% reported improved confidence. The use of speculum is a key skill for examinations but is unlikely to be able to be learnt in one week. Nearly all (87.2%) reported increased confidence in decontamination, and most reported increased confidence with specimen collection (71.8%) and chain of evidence (76.9%). Overall confidence increases have been reported as a result of a larger program

including placement (Torregosa et al., 2023), however the separate impact of the clinical placement is not described.

Our evaluation found that the confidence changes were a result of a supportive environment and exposure to cases either via observation or conducting examinations. Growing confidence of examiners in the ACT was attributed to both education and practical experience (Parekh, 2005). In the United States program with dedicated clinical placement, an increased sense of self-confidence was found amongst trainees at least six months after completing SANE certification; however, this slowly diminished after one year (Torregosa et al., 2023). Our evaluation does not include outcome measures from participants after the end of placement, nor does it include any measures of achieving credentialing, which is a responsibility of the LHD. The EPA framework had potential to support credentialing within the LHD, however it was seen as a reductionist approach to assessment potentially at odds with the experience during placement. Our evaluation found the meaning of placement to be discovering what it means to be an examiner and to integrate individual skills into a whole trauma informed response. The separation of examination components, while beneficial for the LHD with responsibility for credentialing, was at odds with the meaning of placement, and challenging to assess individually given the limited time on placement.

The supportive environment on MFCPSP placements provided a sense of safety for learners. Undergraduate student nurses report positive placement experiences staff and educators are happy to help and have a positive attitude to student presence (Doyle et al., 2016; Luders et al., 2021). Our learners described feeling trusted to undertake examinations in a supervised and safe environment. Direct exposure to clinical cases was highly valued by learners who attributed this exposure to increased confidence and willingness to work in this field. Active participation of pre-intern medical officers on a novel placement was facilitated by trust, access to the tools required to do the work and clear expectations (Edmiston et al., 2023).

This evaluation includes outcomes for regional LHDs and a key finding is that placement supported LHDs with few existing examiners to be able to provide services. In the United States, rural SANE training has been a focus of a number of the described programs (Sekula et al., 2022; Thomas et al., 2020; Thomas eta al., 2022; Torregosa et al., 2023). Lack of preceptors, or direct clinical supervisors, and limited case exposure were found to be barriers to rural SANE training in a scoping review of studies in the United States (Sheeran et al., 2022). Similar barriers to workplace based clinical exposure are described by the regional LHDs in this evaluation. Host sites found the workload to be considerable; in the Duquesne University School of Nursing

program a dedicated SANE preceptor was required for 300 hours in order to supervise SANEs to certification (Sekula et al., 2022). Support from the NSW Health ECAV program team assisted host sites. These activities, such as the provision of student induction packs, are helpful for supporting successful placements (Rowland and Truman, 2023), but do not replace the work required from placement supervisors.

Using the sensitising lens of Activity Theory, two systems can be seen to be interacting (Engestrom &Sannino, 2021). One is the system with the objective of providing trauma informed medical and forensic examinations. The learner is part of this system when they actively participate in an examination. When they observe, they are still part of the system, particularly when they have the opportunity to discuss the case with the team afterwards or be involved in follow up care. In the second system, the ultimate objective is for learners to be able to eventually progress to do examinations without direct supervision. In order to do this, nurses need to complete the Graduate Certificate and be directly supervised doing three examinations. This system involves not only the placement site, but also the home LHD and NSW Health ECAV that prepare them to attend the placement.

These two different activity systems, with different objectives, create a contested space which is an opportunity for growth (Engestrom & Sannino, 2021). The learners may feel some discomfort in this space, however through this process they are able to integrate the experience and be an examiner. Supervisors and learners, to a lesser extent, identified a contested space around ensuring care delivery remained trauma informed whilst concordant with NSW Health ECAV teachings. Acknowledging the contested space can enable learners to learn and grow as professionals.

SANEs were a relatively small proportion of NSW Health MFEs until recent funding enhancements (NSW Health, 2023). Both doctors and nurses report on-call expectations and a lack of time with peers to be a barrier to participation in the NSW MFE workforce (Edmiston et al., 2025). Clinical placements described in this evaluation required considerable time on-call, potentially limiting opportunities for peer connection particularly with other nurses. Whilst the opportunity to attend examinations was a priority for learners, more time with SANE peers is desirable. As SANEs are a relatively new workforce in some LHDs, role expectations may not yet be clearly defined. Spending time with peers can be important for development of role identity. Other opportunities for time with SANE peers, particularly for SANEs from regional LHDs or LHDs that have not had many SANEs in the past, in addition to clinical placement would be

beneficial. The EPAs were useful for SANEs and their medical lead supervisors, to help clarify expectations of SANEs.

Limitations

The evaluation included data for placements from March 2024 until March 2025, with some surveys conducted up until May 2025. There is no information about placements that occurred after May 2025. The evolving nature of the program has been noted, and it is likely that placement experiences after May 2025 may differ from those described in this evaluation.

A strong desire to see placements continue may have influenced respondents to be reluctant to discuss negative aspects of placements. It is also possible that those with unfavourable experiences may have been less likely to respond to surveys or interviews. We were unable to interview learners that attended in the later months of the program, so their experiences are less well represented. For those who attended very early in the program, interviews were some time from their placement, potentially impacting recall of their experience. The collection of post placement activity forms adds some strength to the data as all learners completed these forms. It should be noted that these forms were not anonymous and were in fact also shared, with placement participants' knowledge and awareness, with their primary host site supervisors and home LHD medical leads. This is likely to have influenced responses. No routine data was obtained from supervisors to support the supervisor survey responses, which likely had some bias as they were essentially self-evaluations. No perspectives were gleaned from counsellors despite the requirement for responses to be an integrated approach. Patient perspectives on having an additional learner attend their examination were not reported and may be worthwhile considering in the future to ensure placements remain safe for all.

The evaluation team included three people (EF, NC, NE) who were employed by NSW Health ECAV at the time of the evaluation, potentially impacting the impartiality of the evaluation. The involvement of external investigators (SS, SR, RP, KA) as interviewers and in analysing data provided some external oversight. The use of an anonymous validated survey tool for both supervisors and learners also provided objective outcomes to support qualitative findings.

Our findings and recommendations are specific to the program and may have limited generalisability to other settings outside NSW, although some aspects of workforce development challenges to which the placement and evaluation respond are common throughout Australia and in the international published literature.

Recommendations

Recommendation related to MFCPSP continuation

1. NSW Statewide Medical and Forensic Leadership Group should prioritise the continuation of the MFCPSP.
2. High caseload services are preferred host sites. Placements should maximise opportunities to observe and participate in medical and forensic examinations, as these are what enables learners to see what it is to "be" an examiner. The focus of the experience should be on opportunities to observe and participate in examinations as a priority.
3. Placements should be entirely at one site, to provide more time for the learner and supervising team together, increasing trust and opportunities for active involvement with cases. One site placements will mean only one site orientation is required and site supervisors are better able to review the cases with the learner. Ensuring appropriate rest breaks is also better able to be achieved at one site.
4. Eligibility for placement should include learners other than current Graduate Certificate students and second placements for very small regional sites. Benefits of placements were significant for non-Graduate Certificate students, particularly in supporting progression to independent practice and workforce retention, meaning the placements and nomination process should remain open to people who are not current students. Learners based in very small regional locations, with no option for supervised cases locally, should be able to attend a secondary placement for the purpose of being supervised conducting examinations.
5. The maximum number of placements at a site per should be less than half of the year eg 26 and is probably best capped at around 14-20, to ensure sustainability by avoiding supervisor burnout.
6. NSW Statewide Medical and Forensic Leadership Group should continue to evolve the MFCPSP, with the prioritises as outlined at point 2 to 5, including exploring the possibility of placements at other high case load sites. Feedback mechanisms including pre and post placement forms would be valuable to ensure ongoing quality and clear governance process needs to be established within the Leadership Group. Host sites experiences and expertise are important contributions to governance and feedback. Acknowledging the contested space of clinical placements, where both learning and providing services are happening at once, can inform evolution of placements in future.

7. Host sites require direct funding for administrative support from NSW Health Medical Forensic Enhancement Funding. The current program required considerable work to be streamlined for the participant. Administrative support at host sites could manage allocating learners and support regional LHD in arranging suitable accommodation.
8. Learners and their home LHD supervisors should be encouraged to take responsibility for learners' professional development. Both observing and participating in examinations supported confidence gains. Future placement communication to learners and home LHDs should reinforce that transition to practice requires more workplace-based learning than the MFCPSP placement. One placement is not designed to achieve three supervised cases but increasing confidence is still obtained by observing. Learners should continue workplace-based learning after placement, using an Entrustable Professional Activity (EPA) personal portfolio both on placement and afterwards to record progress.
9. The Statewide Leadership Group needs to obtain formal legal opinion on the matter of host site supervisors writing expert certificates when requested by police for cases done by the learner. Who should write expert certificates remains a persistent area of uncertainty, potentially impacting active participation of learners.
10. Host sites need to offer case discussion and time with peers to help process the experience of clinical placement, including perceived conflicts between teaching and practice. Whilst care is sometimes seen to differ from formal teaching, learners' observation of variation is important for professional development.
11. As the governance body, the Statewide Leadership Group is responsible for ensuring learners are prepared for the placement experience emotionally. This can include a discussion about managing workload and vicarious trauma as part of the and identifying places for reflective practice to occur. Learners may be able to access this through the home LHD or may need assistance to arrange this. This preparation can be provided to Graduate Certificate students as part of the course but also needs to be available for non-Graduate Certificate students.
12. Preparation for placement should include orientation to local VAN service before placement. For Graduate Certificate students, NSW Health ECAV should implement a process of learners needing to document orientation during semester one, such as by using an orientation workbook.

Graduate Certificate relationship to MFCPSP

1. NSW Health ECAV must ensure minimum skill set before students commence Graduate Certificate and therefore placement eg speculum skills. Timing of placements after Graduate certificate face to face days will ensure basic medical and forensic skills have been obtained.
2. NSW Health ECAV should consider delivering start to finish simulation of a medical and forensic examination for Graduate Certificate students and others requiring upskilling and not able to obtain this in their home LHD.
3. NSW Health ECAV should maintain the focus of Graduate Certificate teaching on trauma informed care. Consider specific faculty training to ensure currency of practice and trauma informed care is a focus of teaching.

Workforce development

1. NSW Heath needs to invest in supervisors broadly- both placement site supervisors, medical leads and all examiners who may have a preceptor role, particularly during a period of workforce expansion. Preceptorship within the home LHD is likely to play an important role in maintenance of confidence gains from placement. Training in supervising others in the workplace, particularly in a trauma informed approach, is recommended.
2. The NSW Statewide VAN workforce, including the psychosocial workforce, needs to support the professional identity of medical and forensic examiners, particularly as practitioners of trauma informed care. This connects work to values, validates diversity in practice based on patient context and should lead to more confidence to be a supervisor both on placements and in LHDs.
3. NSW Health must invest in an ongoing community of practice eg SANE network and professional development groups.
4. LHD VAN services should build relationship with publicly funded sexual health clinics, as they are an excellent place for experiential learning of sexual history taking and genital examinations. Opportunities for SANEs to achieve sexual health nurse accreditation and work casually or be seconded to sexual health clinics would assist in building and maintaining skills. This may reduce the need for some of the direct teaching

that has been occurring on placement. NSW Ministry of Health PARVAN should communicate with NSW Centre for Population Health regarding the value of this collaboration.

5. NSW LHDs should support sharing of practices and values between LHDs including fundings site visits to other services. Site visits to see practice and resources in another LHD are useful for clinical nurse consultants and medical leads. Site visits provide the opportunity to observe different models of care such as follow up clinics. Site visits could also be optional for Graduate Certificate students and as site visits are purely observational, the requirements for students to have paid time may not be the same as for placements, whilst still providing an opportunity for time with peers.
6. NSW Health should continue to prioritise support for regional areas as significant differences and resource limitations make it challenging to develop and maintain workforce. This may include additional funding to the LHDs to ensure regional examiners can attend professional development opportunities such as placements and site visits.
7. NSW Health should support medical leads and senior nurses to understand and utilise EPAs as part of credentialing within the LHDs.

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Appendix 1

Study				Population		Placement			Outcomes	Elements supporting success
Author/Year	Title	Country	Study design	Number	Gender	Location	Duration	Aims	E.g., confidence, skills, retention.	E.g., Any reported, plus Activity Theory elements
Parekh et al., 2005	A Postgraduate Sexual Assault Forensic Medicine Program: Sexual assault medicine from scratch	AUS	Qual	N/A	N/A	ACT	16 session program. The resulting Forensic and Medical Sexual Assault Care (FAMSAC) began to offer comprehensive care 24 hours a day, 365 days a year in July 2001.	To equip doctors with the specific skills required o care comprehensively for survivors.	Improved knowledge of core elements of sexual assault medicine. All doctors intended to remain working in the service and saw a long-term future with FAMSAC. Growing confidence attributable to both education and practical experience.	Team-building, clinical support, expert presenters/preceptors, practical experience, university component. Program completion meant doctors now fulfilled the requirements of the university to be awarded the Graduate Certificate in Forensic Medicine.
Baker et al., 2016	SANE-A-PALOOZA: Logistical Development and Implementation of a Clinical Immersion Course for Sexual Assault Nurse Examiners	US	Program overview	N/A	N/A	US, within a nursing school, including a health assessment laboratory, a simulation laboratory, and a classroom.	A full-day course with 7.75 contact hours	To decrease the amount of time between initial training and independent practice as a SANE, as well as function as a skill refresher for SANEs with low caseload	Increased comfort, competence, and confidence	Expert presenters/preceptors, standardized/simulation patients.
Witt et al., 2015	SANE-A-PALOOZA: A Clinical Immersion Experience to Close the Gap for New Sexual Assault Nurse Examiners	US	Quant/Program overview	44	Female	US	8-hour	To briefly describe an educational method for SANEs based on adult learning principles and constructivist learning theory and to provide preliminary quantitative evaluation data, which are limited	Increased knowledge and comfort.	Standardized patients, human simulators, skills immersion experience with advanced practice nurses and experienced sexual assault nurses, and a hands-on practicum with a crime scene photographer

Study				Population		Placement			Outcomes	Elements supporting success
Author/Year	Title	Country	Study design	Number	Gender	Location	Duration	Aims	E.g., confidence, skills, retention.	E.g., Any reported, plus Activity Theory elements
								in contemporary literature.		
Burton et al., 2022	Ready for Anything: A Holistic Approach to Training Sexual Assault Nurse Examiners	US	Program overview	N/A	N/A	US	N/A	To explore a "holistic" approach to training SANEs wherein attention is given to multidimensional perspectives on trauma, diversifying trainee experiences with special populations and situations, and both clinical and practice based learning is incorporated. In turn, this may enhance SANE training and reduce turnover.	Trainees are prepared for a wide variety of patient encounters as well as for engaging with the community. Increased skills, knowledge, and develop peer support relationships.	Community engagement, peer support, skills learning and training content. Online photography training, standardized patients, Court testimony, culturally safety training for diverse patients
Gary, et al., 2023	Sexual Assault Nurse Examiner Education Needs in Texas	US	Program overview using qualitative survey data	40 registered nurses	N/A	Texas, The Center of Excellence in Forensic Nursing (CEFN) at Texas A&M Universiyy	Varied, depended on course	A program in Texas offers courses to educate and expand SANE skills to better provide trauma-informed care to vulnerable populations.	Common themes among self-reported SANE needs/barriers included: Not enough SANEs Large geographic area to serve Starting or expanding a SANE program Lack of education about SANE services Training or education barriers Employment barriers	Further education and training, interprofessional teams, a course on self-care for SANEs.

Study				Population		Placement			Outcomes	Elements supporting success
Author/Year	Title	Country	Study design	Number	Gender	Location	Duration	Aims	E.g., confidence, skills, retention.	E.g., Any reported, plus Activity Theory elements
Mackler et al., 2023	Gender-Affirming Sexual Assault Nurse Examiner Care: A Program Evaluation and Quality Improvement Project at a Community-Based Rape Crisis Center	US	Program overview and evaluation using quantitative questionnaire	20 nurses, 2 HCPs	Cisgender women	A community-based sexual assault forensic examination centre in North Carolina	1.5-hours, recorded via a live Zoom session	This study aimed to increase SANEs' self-perceived competence in caring for trans* assault survivors. The secondary purpose was to promote a trans*-inclusive environment at an RCC based on an environmental assessment.	Trans*-specific training can significantly impact SANEs' self-perceived competency in caring for trans* assault survivors. Participants reported feeling more competent in their ability to provide an initial assessment, medical care, forensic examination, and discharge and referral information to trans* clients after participating in the training. Results from the organizational environment assessment showed that areas in which the RCC was not ready to serve trans* clients included forms and paperwork, office records, non-discrimination policies, bathrooms, advertising, outreach, staff training, and environment.	The training was successful at increasing self-perceived competency. Including LGBTQ+ community members in outreach efforts
Marks et al., 2017	A Novel Approach to Sexual Assault Nurse Examiner Training: A Pilot Program	US	Program overview and evaluation using based on experiential learning	19 SANEs	N/A	The training was conducted at the authors' institution's simulation centre in Ohio.	2 training sessions, which spanned less than 1 year	In order to meet the institutional demands of recruitment and training of SANEs, Marks et al., developed a multimethod, simulation-based training	Simulation-based training increased the confidence of SANEs, their availability, and contributed to a positive learner experience.	Simulation-based training models, including the use of human manikin-based simulation and specially trained actors decreased total training time and training, increased the confidence of SANEs, increased the availability

Study				Population		Placement			Outcomes	Elements supporting success
Author/Year	Title	Country	Study design	Number	Gender	Location	Duration	Aims	E.g., confidence, skills, retention.	E.g., Any reported, plus Activity Theory elements
								model designed to streamline the educational process and preserve the quality of education.		of SANEs, and created a positive learner experience.
Morris et al., 2022	Indiana Sexual Assault Nurse Examiner Training Initiative: Positive Impacts for Medical Forensic Care	US	Mixed methods to assess the training needs of Indiana SANEs	160 nurses	N/A	Indiana	September 2018 to December 2019	The Indiana SANE Training Project was established to evaluate the forensic nursing workforce throughout Indiana and work to expand access to qualified SANEs through training and collaboration with stakeholders, with a focus on rural and underserved areas of the state.	Upon completion, participants re- ported 47% increase in confidence and 56% increase in competence related to caring for paediatric patients.	Statewide collaboration was identified as a significant aspect of "establishing a consistent approach to care, strengthening multidisciplinary partnerships, increasing access to medical forensic services across the life span and in rural and under- served areas, and promoting the Indiana Guidelines for Medical Forensic Examination of Pediatric Sexual Abuse Patients"
Sekula et al., 2022.	Development of the Duquesne University School of Nursing Sexual Assault Nurse Examiner Training Model	US	Descriptive program evaluation	152 nurses	N/A	Pittsburgh, Pennsylvania, the Duquesne University	Clinical Preceptor course = 3 days. + online self-paced didactic course	The university developed a hands-on clinical preceptor course and other support programming to supplement the existing SANE didactic course	Some nurses entering the didactic course or CPC phase struggled to secure opportunities for practice and clinical hours when they returned to their home institution	Feedback from all participants of full mock sexual assault examinations on live standardized patients. This included feedback from patient advocates, standardized patients, and written feedback utilizing a detailed skills

Study				Population		Placement			Outcomes	Elements supporting success
Author/Year	Title	Country	Study design	Number	Gender	Location	Duration	Aims	E.g., confidence, skills, retention.	E.g., Any reported, plus Activity Theory elements
								training. The aim was to create a comprehensive model that took students from initial SANE training through to certification.		checklist by the precepting SANE-A. One-on-one mentoring program, including access to a team of SANE-As who returned individual SANE-related questions and requests as quickly as possible and no longer than 12–24 hours. Monthly educational sessions and quarterly case review sessions held live on videoconference and recorded. Incentive to remain active in the online group through access to a funded spot in the program.
Thomas et al., 2022	Challenges and Collaborations: A Case Study for Successful Sexual Assault Nurse Examiner Education in Rural Communities During the COVID-19 Pandemic	US	Mixed methods program evaluation	6	N/A	South Florida	N/A	To explore the unique challenges and collaborations that have taken place in rural communities as we continued to train nurses during the COVID-19 pandemic.	A preceptor and SANE trainer, along with collaboration and commitment maintained by relevant community partners, fostered SANE trainees to function in a rural community. These strategies proved to retain trainees, but also the success of these strategies led other rural communities and agencies to seek these services.	The process model, dedicated SANE trainer, IAFN-accredited clinical and didactic courses, community collaboration, and commitment to these rural counties.

Study				Population		Placement			Outcomes	Elements supporting success
Author/Year	Title	Country	Study design	Number	Gender	Location	Duration	Aims	E.g., confidence, skills, retention.	E.g., Any reported, plus Activity Theory elements
Thomas et al., 2020	Rural health, forensic science and justice: A perspective of planning and implementation of a sexual assault nurse examiner training program to support victims of sexual assault in rural underserved areas	US	A ”perspective piece”	N/A	N/A	South Florida	N/A	In this perspective piece, a SANE program is described in the hopes that dissemination will lead to increased numbers of rural SANEs, increased reporting of sexual assaults in rural and underserved communities, increased prosecution rates of sexual assault perpetrators, and program sustainability through the provision of a nurse-centred approach to training and support.	N/A. This is a speculative piece on a program yet to come to fruition.	The project intends to provide educational and emotional support through the RUSANE trained group (RTG; graduates of the certification). The RTG aims to enhance SANE nurse retention by protecting against nurse burnout and secondary traumatic stress. Fostering community relations. The course is also broken up to provide nurses with the flexibility to attend training around their work schedule, so as to not negatively impact their income. Ongoing evaluation and subsequent modification of the training’s processes and methods based on participant feedback.

Study				Population		Placement			Outcomes	Elements supporting success
Author/Year	Title	Country	Study design	Number	Gender	Location	Duration	Aims	E.g., confidence, skills, retention.	E.g., Any reported, plus Activity Theory elements
Torregosa et al., 2023	Sexual Assault Nurse Examiner (SANE) program: Long-term impact on confidence and attitudes on SANE trainees	US	A descriptive longitudinal study with repeated measures	27	91% female sample	N/A	N/A	To examine the long-term impact of SANE programming on the confidence of SANE trainees and on their attitudes toward the SANE role after obtaining SANE certification.	Similarly, attitudes toward the SANE role deteriorated six months after obtaining SANE certification.	A mixture of didactic and practical training, as well as mental health support and debriefing to counteract vicarious trauma. This included a support group with a clinical psychologist. Trainees were also supplied with tuition and travel reimbursement and stipends during training to facilitate involvement.
Doyle et al., 2016	Happy to help/happy to be here: Identifying components of successful clinical placements for undergraduate nursing students	AUS	Mixed-methods placement evaluation	150 final year undergraduate nursing students	141 female 9 male	N/A – “a university”	800 hours	To assess nursing students' views of the learning environment during clinical placement with an emphasis on the pedagogical atmosphere, leadership style of the ward manager, and premises of nursing on the unit or ward.	Students felt satisfied with the placement, welcomed, and confident/encouraged to ask questions.	Student nurses value a welcoming and supportive workplace where staff and educators are happy to help and have a positive attitude to student presence on the wards. More than any other factors these ward-based factors appear to have the strongest influence on student satisfaction. Elements contributing to a "Happy to Help" environment included consistent friendliness from staff and positive feedback from both peers and ward personnel. Students noted positive cultural aspects, including uplifting posters displayed throughout the unit, with

Study				Population		Placement			Outcomes	Elements supporting success
Author/Year	Title	Country	Study design	Number	Gender	Location	Duration	Aims	E.g., confidence, skills, retention.	E.g., Any reported, plus Activity Theory elements
										an overall absence of sarcasm or negativity in the workplace.
Luders et al., 2021	Nursing degree students' clinical placement experiences in Australia: A survey design	AUS	Mixed-methods placement evaluation	1263 undergraduate nursing students	89.8% female	7 tertiary education institutions (6 AUS universities and 1 TAFE), across 3 AUS states	July 2019–February 2020	This study aimed to evaluate Australian nursing students' views of placements at seven tertiary education institutions with the use of the Placement Evaluation Tool (PET).	Whilst students' clinical experiences tended to be positive, a minority reported exposure to negative staff attitudes, in unsafe environments, with lifestyle detriments.	Luders et al. (2021) identify three key themes that influence the placement experience: 1. Staff Attitudes Toward Students, 2. Environment, and 3. Lifestyle.
Murray, 2018	An Overview of Experiential Learning in Nursing Education	US	Report on experiential learning	N/A	N/A	N/A	N/A	Using the works of Dewey (1938) and Kolb (1984), this paper sought to explain how experiential learning differs from other types of learning used in nursing classrooms, and describe the challenges of experiential learning theory as it relates to learners in nursing programs.	N/A	N/A

Study				Population		Placement			Outcomes	Elements supporting success
Author/Year	Title	Country	Study design	Number	Gender	Location	Duration	Aims	E.g., confidence, skills, retention.	E.g., Any reported, plus Activity Theory elements
Nagel, et al., 2024	Exploring experiential learning within interprofessional practice education initiatives for pre-licensure healthcare students: a scoping review	Canada	Scoping review	N/A	N/A	N/A	N/A	Nagel at al.'s (2024) scoping review sought to map peer-reviewed literature describing Interprofessional practice (IPP) education initiatives involving experiential learning (EL) for pre-licensure students in healthcare disciplines.	N/A	N/A
Rowland & Truman, 2023	Improving healthcare student experience of clinical placements	UK	Quality improvement report, mixed methods	N/A – "all students on a paid placement"	N/A	Berkshire	N/A	To increase reported rates of students' satisfaction to 100% for each item of the student experience survey by March 2024 within Berkshire Healthcare National Health	Belonging, culture of positive communication, improved relationships, communication and processes between the teams in Berkshire Healthcare around student placements	Student inductions, improved access to information technology, the provision of student induction packs, and the issuing of newsletters.

Study				Population		Placement			Outcomes	Elements supporting success
Author/Year	Title	Country	Study design	Number	Gender	Location	Duration	Aims	E.g., confidence, skills, retention.	E.g., Any reported, plus Activity Theory elements
								Service (NHS) Foundation Trust.		
Sweet & Broadbent, 2017	Nursing students' perceptions of the qualities of a clinical facilitator that enhance learning	AUS	Cross-sectional survey design	43 nursing students	N/A	Australian university	N/A	To explore undergraduate nursing students' perceptions of the qualities of a clinical facilitator that enhanced their learning.	Learning was maximised when the facilitator is flexible with their availability for when 'teachable moments' arise.	The availability, approachability, and provision of feedback of clinical facilitators

Appendix 2

Title	Date published	Author	URL	Overview	Objectives	Key features	Duration	Location
Evaluation of Monash University's "Course in Recognising and Responding to Sexual Violence	Not specified	ANROWS	ANROWS	Brief evaluation of a course aimed at enhancing the capacity to respond to sexual violence effectively.	To assess the effectiveness and impact of the training course for participants in various sectors.	To assess the effectiveness and impact of the training course for participants in various sectors.		Monash University
Sexual violence response training program expands with $6.4m funding package	2023	Monash University	https://www.monash.edu/medicine/news/latest/2023-articles/sexual-violence-response-training-program-expands-with-$6.4m-funding-package	Expansion of a training program aimed at improving responses to sexual violence with new funding.	To enhance training for healthcare professionals in recognizing and responding to sexual violence effectively.	- $6.4 million funding - Expanded training modules - Focus on practical skills and evidence-based practices	Specific duration not mentioned	Monash University
RMIT launches new vocational course in recognising and responding to sexual violence	April 2022	RMIT University	https://www.rmit.edu.au/news/all-news/2022/apr/new-course-in-recognising-and-responding-to-sexual-violence	Introduction of a new course aimed at educating health professionals on recognizing and responding to sexual violence.	To equip students and professionals with knowledge and skills to effectively respond to incidents of sexual violence.	- Evidence-based approaches - Practical skills training - Focus on prevention and response strategies	Specific duration not mentioned; typically includes multiple sessions.	RMIT University
Course in Recognising and Responding to	Not specified	RMIT University	https://www.rmit.edu.au/study-with-us/levels-of-study/vocational-study/vocational-graduate-certificates/course-in-recognising-and-responding-to-sexual-violence-c0052	A vocational graduate certificate aimed at equipping professionals with skills to	To build practical knowledge in recognizing and responding to	Attend weekly online facilitated 3 hour-long	6 months (part-time)	RMIT University (Online and campus options

Sexual Violence - 10994NAT				recognize and respond to sexual violence.	sexual violence, improving professional responses.	workshops, plus digital self-paced and community of learning engagement.		
Empowering Remote Community Workers to Respond to Sexual Violence	August 3, 2023	RMIT University	https://www.rmit.edu.au/news/all-news/2023/aug/empowering-remote-community-workers-respond-sexual-violence	This article discusses how the RMIT course - Recognising and Responding to Sexual Violence – helping community workers in remote areas gain skills to respond to sexual violence.	Equip workers with skills to prevent re-traumatization, promote recovery, and reduce re-victimization.	Funded by the Australian government; face-to-face, trauma-informed training.	Not specified	Northern Territory
Queensland Nurses and Midwives Trained to Provide Sexual Assault Services	July 30, 2021	Central Queensland University	https://www.cqu.edu.au/news/708516/queensland-nurses-and-midwives-trained-to-provide-sexual-assault-services	An online training program equips nurses and midwives in Queensland with skills to provide sexual assault services.	To train healthcare professionals to deliver trauma-informed care for sexual assault victims.	Modular format, combining online learning with a practical workshops.	Not specified	Queensland