Sexual Assault Nurse Examiners (SANE) Courses at Washington State University

BACKGROUND

The Washington State University College of Nursing received funding to develop and deliver a comprehensive SANE training program for registered nurses in Eastern Washington in July 2022. A sexual assault nurse examiner (SANE) is a registered nurse specifically trained to provide evidentiary examinations of sexual assault victims. In addition to other services, SANEs provide medical assistance while also assessing, documenting, and preserving evidence for potential prosecutions. The SANEs conduct forensic examinations where sexual assault evidence kits are collected. Currently, there is no state-issued license or endorsement to qualify as a SANE; the International Association of Forensic Nurses grants SANE-A certification to registered nurses upon completion of approved training courses.

The only didactic SANE education program in Washington was at Harborview Medical Center in Seattle until the enactment of HB 1622 by the state in 2022, which tasked the WSU College of Nursing with establishing a SANE education program in Eastern Washington. The Harborview course was offered using a blended delivery method (online and in-person lecture course content) but it did not offer the required two-day experiential intensive that is required for full SANE certification (https://www.forensicnurses.org/sane-certification-whats-the-scoop/). The legislation tasked the College with establishing the coursework that would establish and deliver a regional SANE didactic educational program and two-day clinical intensive pilot program (referred to as a leadership pilot program in the legislation) that would allow graduates to complete the SANE-A certification exam.

As follows is an overview of the WSU SANE education program and the SANE leader pilot program.

WSU SANE EDUCATION PROGRAM OUTCOMES 2024 (RCW 28B.30.360)

Since the law was passed, the College of Nursing has partnered with the International Association of Forensic Nurses (IAFN) to develop, offer Registered Nurses and Advanced Practice Registered Nurses (APRNs) nurses in Eastern Washington a comprehensive SANE training program. SANE Education Guidelines (https://www.forensicnurses.org/page/EducationGuidelinesAccess/) require a 40-hour didactic educational program and a clinical component that includes simulated patient encounters and skills competency evaluation. To facilitate immediate training for nurses in Eastern Washington, the College of Nursing adopted a two-pronged approach to program development and implementation. During year one (academic year 2022-23), the College provided access to:

(a) the 41 credit online didactic program offered by IAFN that prepares nurses to practice in the role of the SANE nurse with adolescent and adult patients (https://www.forensicnurses.org/page/40HourSANE/) and

(b) developed and began delivering an IAFN- credentialed (accredited) and nationally recognized SANE two-day clinical intensive professional development program.

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WSU SANE PROGRAM ONLINE TRAINING COURSE

During year two of funding (academic year 2023-24), the College prepared a 40-hour fully online didactic course provided at a reduced registration rate to RNs/APRNs in Eastern Washington. This course was developed to meet not only the IAFN national education requirements but to also address state and regionally-specific materials relative sexual assault statistics, scope of practice, responsibilities and accountabilities of the SANE nurse examiner, and agency-specific guidelines provided in the state law. It adds an additional option for nurses across the state of Washington to complete the 40-hour required didactic training without the need to attend an in-person lecture session and qualify to attend the two-day experiential/clinical training required for certification.

In addition to forensic nursing specific information, the modules also include varied video recordings from various multidisciplinary content experts including detectives from local law enforcement agencies, the FBI, advocacy agencies, Title IX coordinators, and the Washington State Crime Lab.

The course content for the WSU 40-hour didactic is comprised of 11 modules that provides instruction including:

- Scope and Standards of Practice, including national state and regional laws and regulations, and legal considerations.
- Victim Responses and Crisis Interventions providing information from regional and local law enforcement agencies
- Collaborating with Community Agencies that identifies regional and local community partners and resources (e.g., Mujeres in Action, YWCA resources, Lutheran Community Resources, county prosecutors)
- Medical Forensic History Taking
- Physical Examination Findings
- Medical Forensic Specimen Collection with video recordings from county laboratory personnel.
- Medical Forensic Photography
- Sexually Transmitted Infections that identifies county and regional treatment partners and clinics.
- Pregnancy Evaluation and Care
- Medical Forensic Documentation and Judicial Proceedings
- Discharge and Follow Up Care with interviews and information from local/regional agencies that accept referrals. Includes crime victims compensation

The WSU College of Nursing didactic modules have been designed to be immersive and interactive with a variety of learning modalities including: recorded podcasts, interviews with experts and agency personnel from Eastern Washington, static content that summarizes recordings and presented in a manner that encourages quick referral and review, references and resources, including a regional directory of service providers and non-governmental and governmental agencies that will ultimately be provided as an online and searchable database that can be an enduring resource for the Regional Leadership Program.

While submission of the program to IAFN for approval was planned for June 2024, completion of the WSU program was delayed as a result of personnel changes that have since been resolved. WSU now anticipates pilot testing the program in February 2025 with submission planned for April 1, 2025. In the interim, we have continued to offer the online IAFN trainings and offering scholarships to our participants to reduce the cost as identified in the previous legislative report and in accordance with the law. To date, all participants have accessed the IAFN online didactic course. The fee for the two-day course is $425 for individuals with an out of state RN license, while individuals with a Washington state RN license pay $225 after a $200 scholarship funded by the project budget. When the WSU College of Nursing course becomes available, Washington state residents will pay no more than $200 while out of state participants will pay $400.

Current staffing to complete the didactic online training includes an instructional designer and two nursing faculty, both holding IAFN certification, and a program coordinator to manage flow of information and data for course development.

WSU CLINICAL SKILLS COURSE

The two-day in-person clinical skills course develops and evaluates clinical skills competencies that include: physical exam components, correct instrumentation for examination, laboratory specimen collection, forensic photography, history taking and best practices for documenting the assault, discharge planning and instructions, and documentation of the examination, specimen collection and photography processes. Legal practices and scope of practice are again reviewed with all participants during the on-site component of the training. Training schedules include a didactic and demonstration sequence, practice sessions with the sexual assault evidence collection kit, instrument placement with task trainers and models, pelvic exam practice sessions with task trainers, evidence collection with task trainers, simulation experiences with different types of standardized patients, and case-based learning with a wide variety of scenarios. All participants will engage in practice-based competency evaluation sessions and simulation-based standardized patient scenarios. Refer to Appendix A attached.

Staff that currently manage this program include a (a) program coordinator to manage enrollment, meeting logistics, contract faculty/personnel scheduling, and equipment; (b) standardized patient coordinator to manage scheduling of our standardized patient models; (c) Center for Experiential Learning Assistant Dean to coordinate all education occurring within the two-day clinical immersion; (d) three to four clinical faculty dependent on cohort size to ensure adequate supervision of participants; (e) building operations manager to ensure that access to buildings and security; and (f) MarCom personnel who coordinate messaging and marketing for the program.

To date, the WSU SANE program has educated and graduated 30 SANEs who are prepared to engage in the clinical practice and then sit for the IAFN SANE-A certification exam.

In 2024, we offered the two-day skills program twice on the WSU Spokane Campus with three separate sessions scheduled for WSU Spokane (August and November, 2024) and Yakima (May 2024). In 2025, we will offer the program a total of four times with one session in Tri-Cities or Moses Lake.

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SANE LEADER PILOT PROGRAM OVERVIEW (RCW 28B.30.365)

In the first half of 2024, the program director for the WSU SANE Program explored needs within the region and state, opportunities for collaboration, interest across acute care and community-based agencies for sexual assault program assets in Eastern Washington. Activities included:

- Attendance and advocacy with the Forensic Services Subcommittee through Office of WA State Attorney General.
- Attendance at the Campus Sexual Assault Subcommittee for the House Committee on Post Secondary Education and Workforce.
- Established a partnership between Pullman Regional Hospital (PRH) and WSU to submit federal requests for funding to increase services at PRH and establish a regional Sexual Assault Center. In these efforts, WSU would provide training. Two grants submitted; none funded.
- Established academic partnerships across Eastern Washington to address increasing incidence of sexual assaults across college campuses. Events included:
    - Engaged students about sexual assault on college campuses and the role of SANEs.
    - Met with the Title IX investigators at WSU Pullman and shared information regarding the role of SANEs.
    - Collaborated with WSU officials to learn about Title IX resources available for WSU students. This information was added to the didactic and experiential sessions for SANE training and to provide continuing professional development for SANEs in the Providence Health Care Emergency Departments.
    - Provided additional Title IX resources for college students who have been sexually assaulted and sought services in across the Providence Health Care system in Eastern Washington.
    - Collaborating with Title IX representatives at Gonzaga who are working on connecting the universities in Eastern Washington.

This led to a proposed leading a one-day summit, organized by the WSU SANE Program, for healthcare facilities offering SANE but planning for this event took place, several platforms that currently exist were identified where leaders were discussing various aspects of SANE programs throughout the state and the program director made the decision to participate rather than duplicate these efforts.

Discussions are ongoing between College of Nursing leadership and key partners about how the WSU SANE Program can effectively contributed to existing efforts with a leadership program.

WASHINGTON STATE UNIVERSITY
College of Nursing

Sexual Assault Nurse Examination

Adult/Adolescent

Juliane L. Rohr, BSN, RN, SANE-A

Introduction to Forensic Nursing

- Specialized nursing care that focuses on patient populations affected by violence and trauma across the lifespan.
  - Education
  - Prevention
  - Detection
  - Treatment
- Understanding the effects of violence in individuals, families and communities
- Through leadership and interprofessional collaboration, the forensic nurse works toward an understanding of the health effects related to trauma and the effective interventions to prevent trauma and violence

History of Forensic Nursing

Scope and Standards of Practice

Module One

Key Aspects of Forensic Nursing: Scope and Standards of Practice

- Assessment
- Diagnosis
- Outcomes Identification
- Planning
- Implementation
  - Coordination of Care
  - Health teaching and promotion
- Evaluation

- Ethics
- Culturally congruent practice
- Communication
- Collaboration
- Leadership
- Education
- Evidence-based practice and research
- Quality of Practice
- Professional practice evaluation
- Resource utilization
- Environmental Health

Professional and Ethical Conduct

- Autonomy
- Beneficence
- Non-malfeasance
- Veracity
- Confidentiality
- Justice

Nursing Resources

- International Association of Forensic Nurses (IAFN)
- U.S. Department of Justice, Office on Violence Against Women – National Protocol
- SAFETa.org
- RAINN
- UW Harborview Abuse and Trauma Center – WA State Guidelines
- UC Memorial
- EVAWI

Nursing Resources

- OJP National Sexual Assault Protocol Adult-Adolescent
- EVAWI
- SAFETa
- Washington State Guidelines – Harborview

Vicarious Trauma

How does it make you feel?

- This is a change in your cognition and world view
- Acknowledge your own internal bias
- Nursing opinion vs. personal opinion
- Personal trauma that mirrors the victim
- Carrying and absorbing the feelings of others

Preventing Vicarious Trauma

- Self Awareness – understanding and recognizing how you feel. Hypervigilance, stress, sad, decreased interest in hobbies/activities
- Talk to someone. Therapist, coworkers, people who have jobs that experience difficult emotional situations
- Self-Care – Think of yourself. This is okay. Mental health day.

Types of Sexual Violence

Sexual

- Sexual Assault
- Child Sexual Abuse
- Intimate Partner Sexual Violence
- Incest
- Drug or Alcohol Facilitated Assault

BOX 1. DEFINITIONS OF SEXUAL VIOLENCE

The World Health Organization (WHO) defines sexual violence as: **'Any sexual act, attempt to obtain a sexual act, unwanted sexual comments or advances, or acts to traffic or otherwise directed against a person's sexuality using coercion, by any person regardless of their relationship to the victim, in any setting, including but not limited to home and work'**(*2*).

Coercion can encompass:

- varying degrees of force;
- psychological intimidation;
- blackmail; or
- threats (of physical harm or of not obtaining a job/grade etc.).

In addition, sexual violence may also take place when someone is not able to give consent – for instance, while intoxicated, drugged, asleep or mentally incapacitated.

While the WHO definition is quite broad, narrower definitions also exist. For example, for purposes of research, some definitions of sexual violence are limited to those acts that involve force or the threat of physical violence.

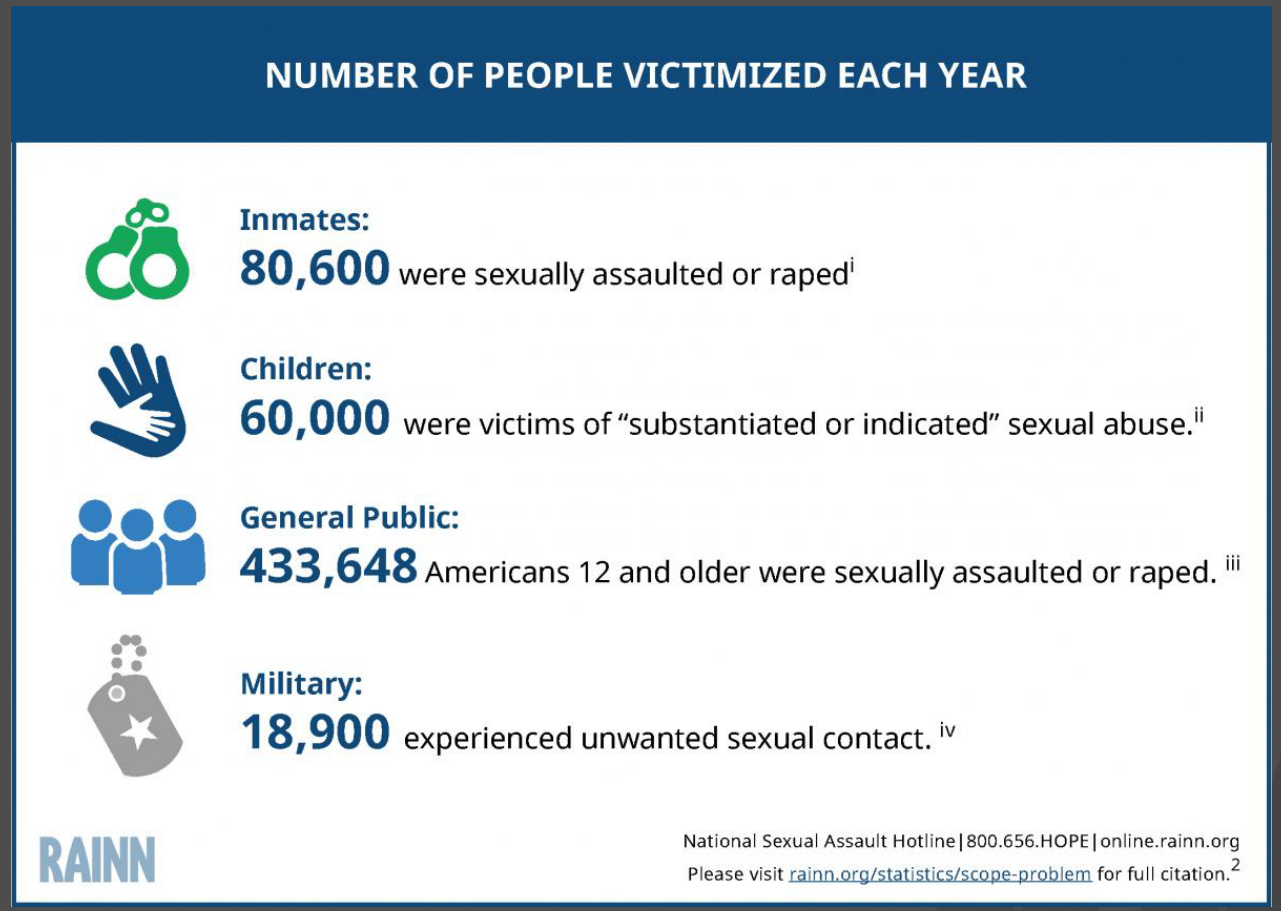
The *WHO multi-country study* (*3*) defined sexual violence as acts through which a woman:

- was physically forced to have sexual intercourse when she did not want to;
- had sexual intercourse when she did not want to, because she was afraid of what her partner might do; or
- was forced to do something sexual that she found degrading or humiliating.

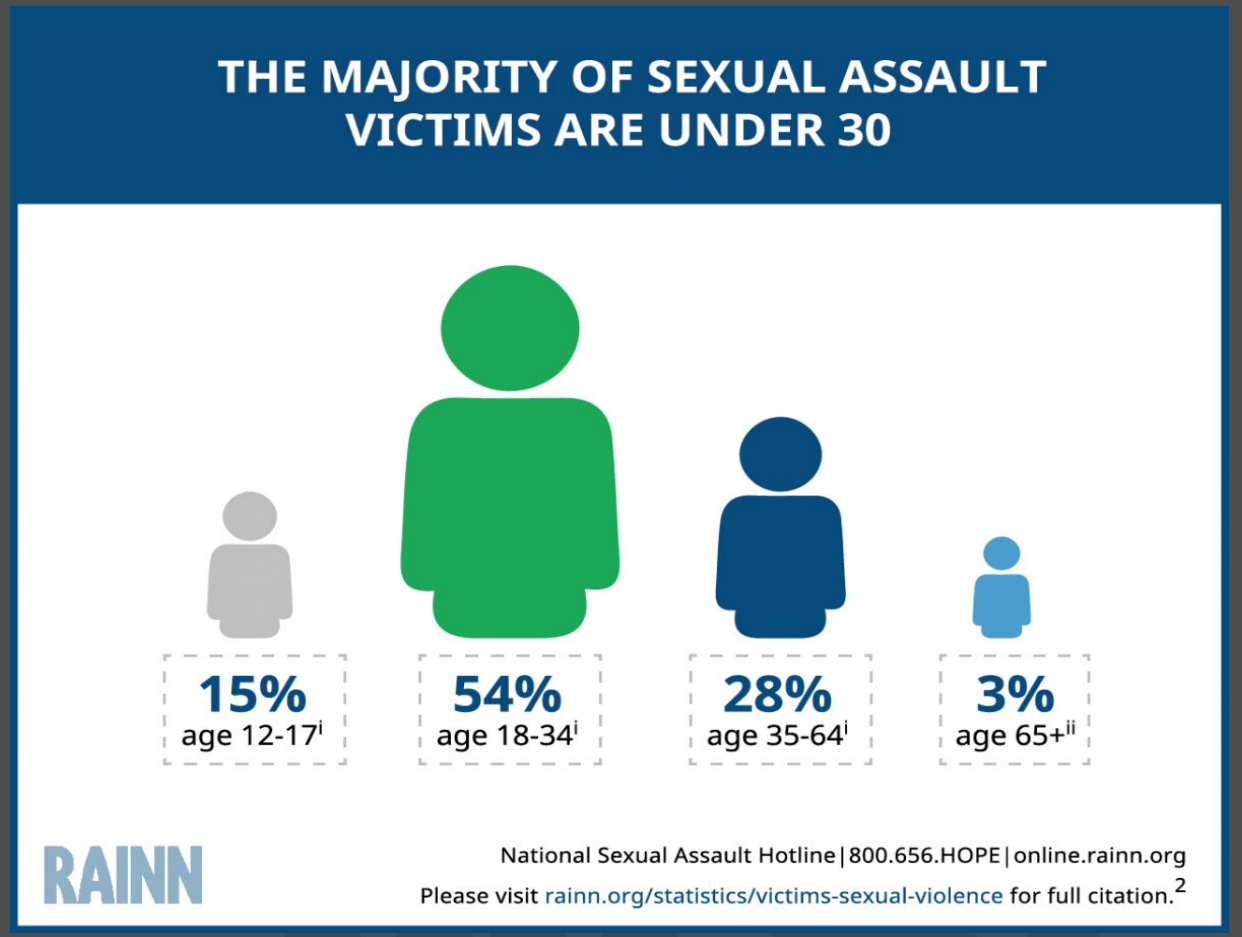
Types of Intimate Partner Violence

- Physical
- Sexual
- Stalking
- Psychological aggression
- Economic abuse

Incidence and Prevalence



- Female
- Age
  - Younger people are at a higher risk
  - College Age (18-24)
- Transgender
- Native Americans are at the greatest risk



Health Consequences of Sexual Violence and Abuse

- Depression
- PTSD
- Self Harm
- STIs
- Substance Abuse
- Dissociation
- Sleep Disturbances
- Suicide

Vulnerability

- Adverse Childhood Experiences (ACEs)
- Foster Care System
  - 90% experience trauma
- Mental Health Issues
- Homelessness
- Disability
- Vulnerable adults
  - Definition

Biases and Beliefs

What We Don't Think We Think

- Implicit Bias
- Victim blaming
  - Environment, engaging in high risk behavior

“Implicit … attitudes and stereotypes operate automatically, without awareness, intent, or conscious control. Because they are automatic, working behind-the-scenes, they can influence or bias decisions and behaviors, both positively and negatively, without an individual’s awareness. This phenomenon leaves open the possibility that even those dedicated to the principles of a fair justice system may, at times, unknowingly make crucial decisions and act in ways that are unintentionally unfair (Casey et al., 2012, p. 2)”

Unique Health Populations and Care

- Men
- Inmates – PREA
- GLBTQIA
- Patients with Disabilities
- Cultural Considerations
- Mental Health Populations
- Intellectual Disabilities or Language/Communication Barriers
- Military

Men

Inmates

LGBTQIA

Patients with Disabilities

- Sensory needs
- Avoid figurative speech
- Executive function and follow up care
- Increased risk
- Isolation
- Coercion and threats
  - Caregiver leaves
- Questions should be directed toward patient not caregiver
- Attempt to speak to patient alone
- Assume competence
- Don’t rush questions

Mental Health Populations

- Services severely lacking
- Social stigma
- Often dismissed
- Consider implicit bias and stigmatized attitudes

Language and Communication Barriers

- Multiple choice questions vs. open ended questions
  - A,B,C or something else
  - Avoid leading questions
- Avoid figurative speech or slang terms
- Use literal and direct language

Culturally Diverse Populations

- Ongoing part of professional development
- Extends beyond race and ethnicity
  - Rural immigrants
  - Gender
  - Age
  - Sexual orientation
  - Literacy
  - Undocumented populations
- How can this affect SANE exam experience
  - Access to preventative care
  - Real and perceived fears surrounding institutional racism and homophobia
- Secondary Survivors
  - Spouse, friends, family

Human Trafficking

Risk Factors for Perpetrators of Sexual Violence and Abuse

- Alcohol/Drug Use
- Early sexual initiation
- Exposure to explicit media
- Hostility toward women
- Prior sexual victimization or perpetration
- Family history of physical, sexual or emotional abuse
- Poor parent-child relationships
- Poverty
- Societal norms

Adult vs. Adolescent Sexual Assault

- Consent
  - Vulnerable adult
  - Mandatory reporting
- Medical history

- Consent
  - Age of patient and age of perpetrator
  - Mandatory Reporting
  - Position of power
  - Digital grooming
- Gynecological exams
- Development
  - Psychosocial responses
- Parents and disclosure

Module Questions

- 1. A 23 yr old female presents to the ER reporting being sexually assaulted. Patient presents with disorganized thoughts, pressured speech and a HR of 131. Pt is requesting a kit be collected. What is the first step to take?

a. Place an IV and collect lab work to include urine toxicology

b. Obtain a psych consult

c. Call an advocate and begin evidence collection

d. Tell the patient she will have to return for a kit when she calms down

2

- 2. A Spanish speaking patient presents to the ER stating she has been sexually assaulted. You had a coworker translate for you in order to gather the initial information for a chief complaint. How do you proceed?
- a. Place patient in a private room and have coworker translate the patient's account of events in their own words to determine next steps
- b. Once connected with a medical interpreter, gather necessary information and then disconnect the call
- c. Connect with a medical interpreter and have the medical interpreter remain on the line for the duration of the exam
- d. Tell patient they will need to have a family member come to the ER to translate

Victim Responses and Crisis Intervention

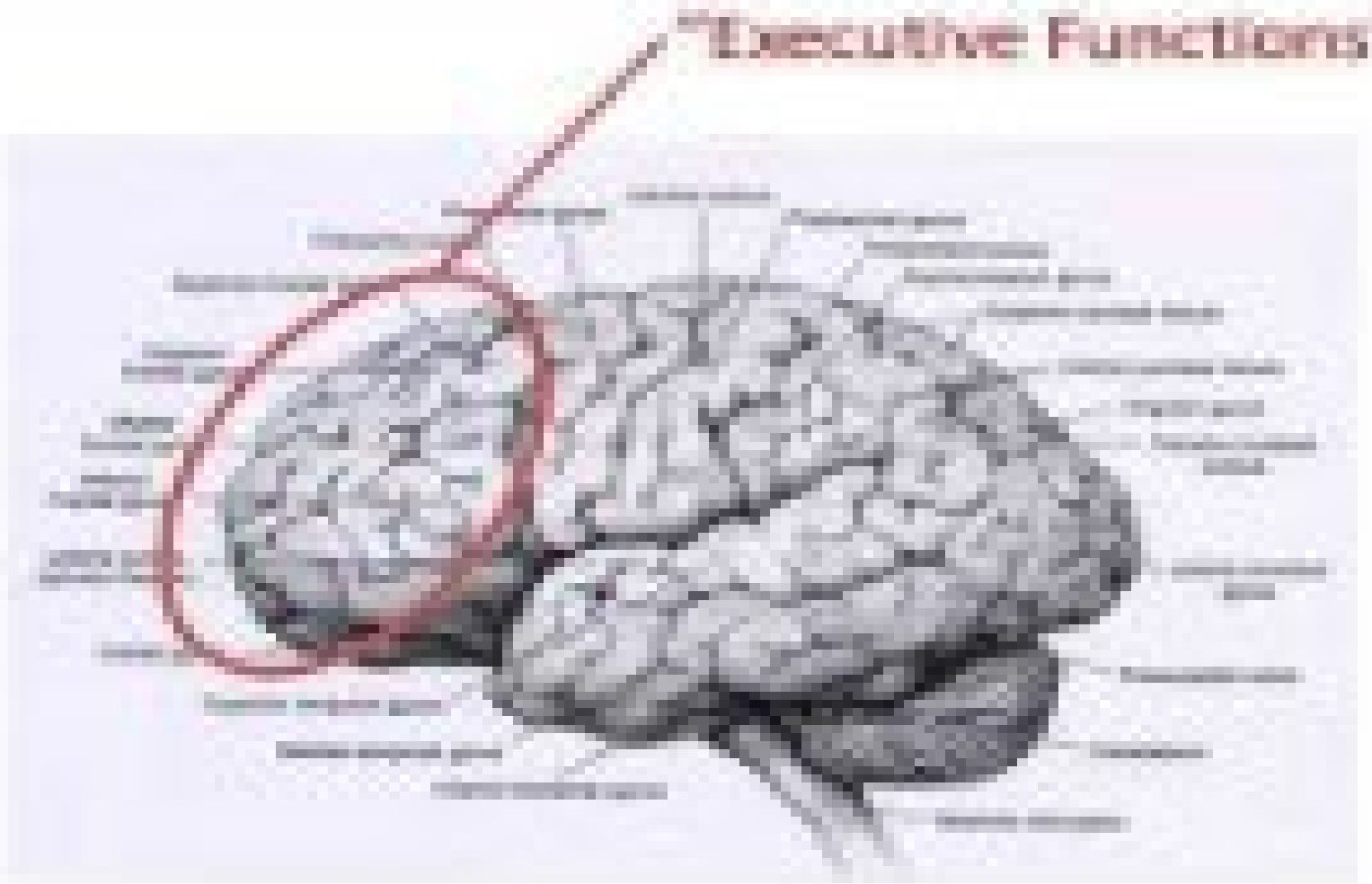
Module Two

Delayed Disclosure and Recantation

- Fear of creating problems
- Recantation before reaffirmation
- Perceived level of support
- Fear of participating in process post sexual assault
- Judgement
- Feel safe and secure in the response they would receive from support system

Psychosocial Responses

- Withdrawal from relationships
- Hypervigilance
- Depression
- High risk behavior
- Reproductive, gastrointestinal medical problems
- Substance abuse
- Sense of safety

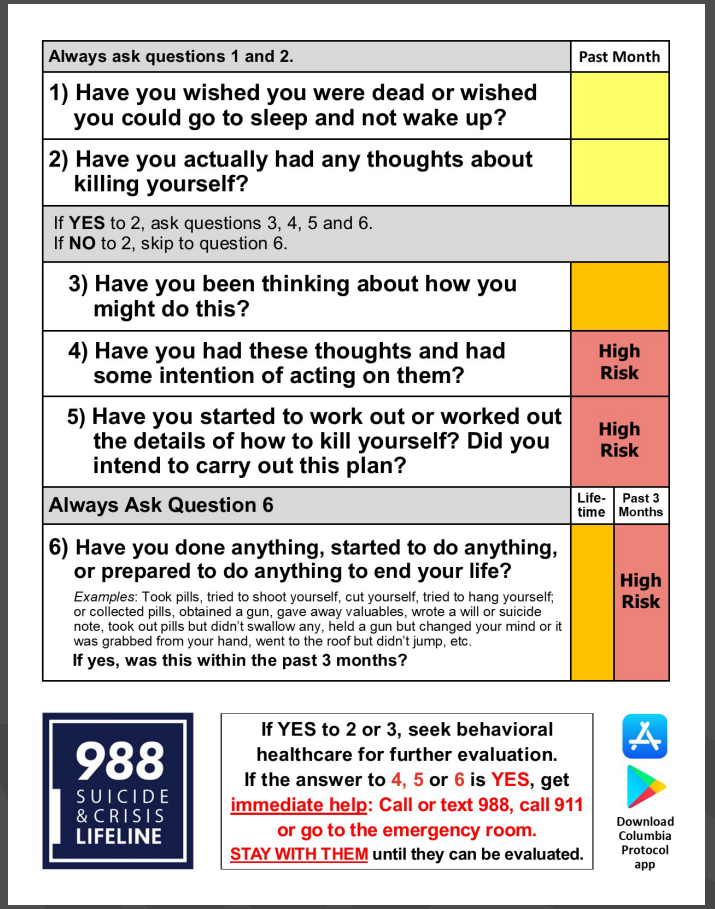

"Executive Functions"

Neurobiology of Trauma

- Brain and body interpret as life threatening event
- Fear circuitry takes over – primitive
- New brain vs. old brain
- Amygdala in control, no choice in response
- Amygdala → Hypothalamus → Pituitary gland → Adrenal glands → Hormone release → opioids and oxytocin
- Catecholamines
- Fight, flight, freeze and appease
  - Tonic immobility
  - Collapsed immobility

Suicide Risk Assessment

- Not confidential
- Identify risk factors
- Identify protective factors
- Suicide Inquiry
- Determine risk level
- Determine intervention



Always ask questions 1 and 2.	Past Month	
1) Have you wished you were dead or wished you could go to sleep and not wake up?		
2) Have you actually had any thoughts about killing yourself?		
If **YES** to 2, ask questions 3, 4, 5 and 6. If **NO** to 2, skip to question 6.		
3) Have you been thinking about how you might do this?		
4) Have you had these thoughts and had some intention of acting on them?	High Risk	
5) Have you started to work out or worked out the details of how to kill yourself? Did you intend to carry out this plan?	High Risk	
Always Ask Question 6	Life-time	Past 3 Months
6) Have you done anything, started to do anything, or prepared to do anything to end your life? *Examples*: Took pills, tried to shoot yourself, cut yourself, tried to hang yourself, or collected pills, obtained a gun, gave away valuables, wrote a will or suicide note, took out pills but didn't swallow any, held a gun but changed your mind or it was grabbed from your hand, went to the roof but didn't jump, etc. **If yes, was this within the past 3 months?**		High Risk

If YES to 2 or 3, seek behavioral healthcare for further evaluation.
If the answer to 4, 5 or 6 is YES, get immediate help: Call or text 988, call 911 or go to the emergency room.
STAY WITH THEM until they can be evaluated.

Safety Assessment

- Suicide risk
- Home
- Proximity of perpetrator
- Weapons
- History of violence
- Safe place
- Protection orders
- Medications and adherence
- Follow up care
- Barriers to service

Diverse Reactions to Sexual Assault

- Dissociation
- Laughing
- Tearful
- May not appear “traumatized”
- Flat affect
- Withdrawn
- Anger
- Depression
- Memory recall
- Guilt/shame

Acute and Chronic Manifestations

- Depression
- Hypervigilance
- Increased startled response
- Sleeping problems
- Memory problems
- Substance abuse
- High risk behaviors
- PTSD
- Flashbacks
- Nightmares
- Interpersonal conflict

Nonadherence

- Resources
- Low barrier vs high barrier
- Poor experience with healthcare staff or healthcare setting
- Vaginal exams
- Finances
- Understanding of discharge instructions/medications
- Support system
- Did they feel believed

Psychosocial Concerns

- Males
- Inmates
- GLBTQIA
- Adolescents
- Patients with disabilities
- Cultural
- Mental health
- Language/communication barriers
- People who are trafficked

Human Trafficking

- Fastest growing industry
- Canadian border
- Interstates
- Children and adolescents
- Possessions, documentation, someone always with them
- Immigration, language barriers
- Recognition
  - Recurrent need for medical care to treat injuries, STI's
  - Clothing appropriate for weather
  - Disclosure

HT Officer and Jaylynn video

Collaborating with Community Agencies

Module Three

Sexual Assault Response Team

- Nurses
- Medical Providers
- Prosecutors
- Detectives
- Forensic Scientists
- Advocacy (community based and systems based)
- Child Advocacy Centers

SART Models and Responsibilities

- Coordinated Approach
- Encourages and increases use of community resources
- Public and community safety
- Organize service delivery to enhance evidence collection
- Trauma-informed care, victim-centered care to reduce retraumatization
- Stretch resource dollars
- Evaluation of interventions

Advocacy

<u>Community Based</u>

LCS

Mia

YWCA

<u>Agency Based</u>

Spokane Police Department

FBI Advocates

Court advocates

LCS Advocate Video

MiA

YWCA

FBI HT - Jaylynn

SCSO – SVU Detective (Sataki?)

SPD SVU Detective (Humphreys?)

Crime Lab – Anna Wilson

Prosecutor

Concerns About Reporting

Start by Believing

- Judgement
- Safety
- Privacy
- Legal implications
- Trial
- Lack of support

Reporting Options

#1 Medical treatment and evidence collection with law enforcement notification

#2 Medical treatment and evidence collection *without* law enforcement notification

#3 Anonymous collection

#3 Medical treatment only, no evidence collection and no law enforcement notification

#4 Declines and chooses to go home

Military Reporting

Anonymous Reporting Considerations

Mandatory Reporting

Vulnerable Adults – RCW 74.34.020

(21) "Vulnerable adult" includes a person:

(a) Sixty years of age or older who has the functional, mental, or physical inability to care for himself or herself; or

(b) Subject to a guardianship under RCW 11.130.265 or adult subject to conservatorship under RCW 11.130.360; or

(c) Who has a developmental disability as defined under RCW 71A.10.020; or

(d) Admitted to any facility; or

(e) Receiving services from home health, hospice, or home care agencies licensed or required to be licensed under chapter 70.127 RCW; or

(f) Receiving services from an individual provider; or

(g) Who self-directs his or her own care and receives services from a personal aide under chapter 74.39 RCW.

Mandatory Reporting

Adolescents and Children

Post pubertal patients. Sexual assault is always a mandatory report for minors

Age matters for sexual contact. It is not consensual if the minor is

<12 years and perpetrator is 24 months older or greater

12-13 years and perpetrator is 36 months older or greater

14-15 years and perpetrator is 48 months older or greater

16-17 years and perpetrator is 60 months older or greater

Mandatory Reporting

- Be transparent with the adolescent about your duty to report and do it as soon as possible. Explain to them that their parents will likely find out
- Ideally, we would support the patient and assist in making a plan to tell parents together
  - Not all adolescents have a safe parent or any parent available at all
- Evidence collection is not a minor right in WA state. If wanting to proceed with evidence collection consult with the MD or advanced practice provider. The provider would need to determine if the mature minor provision is an option. Or a conversation with risk management and legal to determine next steps
- ALWAYS proceed according to your hospital or program's policies

Providing Health Care to Minors under Washington Law:

A summary of health care services that can be provided to minors without parental consent.

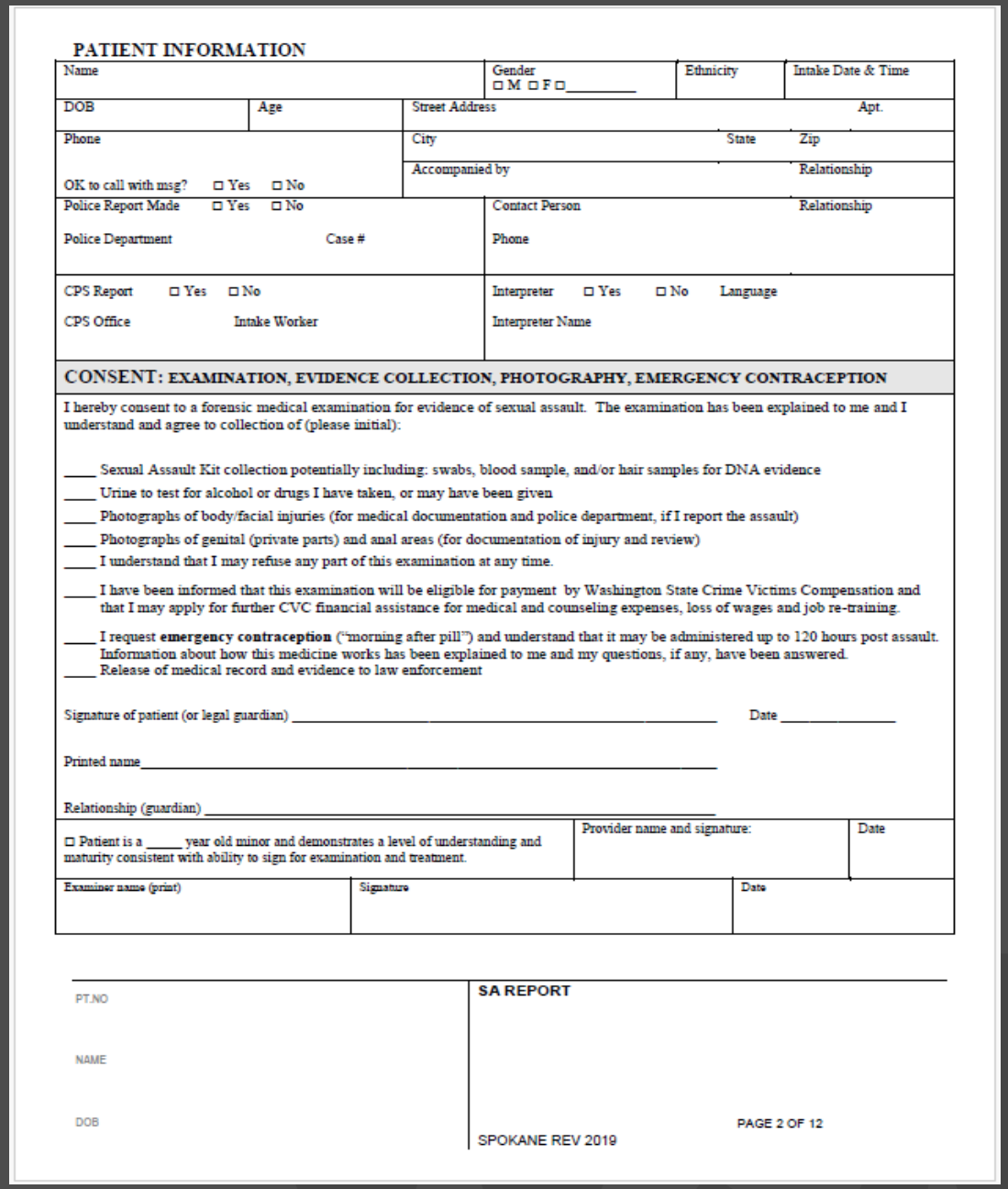
While Washington State's general age of majority for health care is 18 (RCW 26.28.010), a single, unemancipated* minor can receive treatment without parental consent in the following areas:

Service needed	*Minor Consent Sufficient for Confidential care*	*Parent/ Guardian Consent Required*	*Parent / Guardian Notification Required*	*Source and Notes*
Emergency medical services:	**Yes**	**No**	**No**	If the parent's consent is not readily available, the consent requirement is satisfied and the minor can receive medical services. RCW 7.70.050(4).
Non-emergency medical services:	**No, unless minor meets Mature Minor Doctrine (see Source and Notes section)**	**Yes, unless minor meets Mature Minor Doctrine**	**No**	If it is not a medical emergency or one of the types of services listed below, minors may still give a valid consent under the "Mature Minor Doctrine" if they are capable of understanding or appreciating the consequences of a medical procedure. In determining whether the patient is a mature minor, providers will evaluate the minor's ***age, intelligence, maturity, training, experience, economic independence or lack thereof, general conduct as an adult and freedom from the control of parents.***
Immunizations:	**No, unless minor meets Mature Minor Doctrine**	**Yes, unless minor meets Mature Minor Doctrine**	**No**	Minors may receive immunizations without parental consent under the Mature Minor Doctrine summarized above.
Sexually transmitted disease testing/ treatment (including HIV):	**Yes, if over 14** ♦ ***See Source and Notes section***	**No**	**No**	Minors may obtain tests and/or treatment for sexually transmitted diseases if they are ***14 years of age or older*** without the consent of a parent or guardian. RCW 70.24.110. ♦ Public Health – Seattle & King County will test and treat individuals regardless of age due to mandate to prevent and control the spread of communicable disease.
Birth control services:	**Yes**	**No**	**No**	Minors may obtain or refuse birth control services at ***any age*** without the consent of a parent or guardian. RCW 9.02.100(2).
Abortion services:	**Yes**	**No**	**No**	Minors may receive an abortion and abortion related services at ***any age*** without the consent of a parent, guardian or the father of the child. RCW 9.02.100(1); *State v. Koome*, 84 Wn.2d 901 (1975).
Prenatal care services:	**Yes**	**No**	**No**	Minors may seek prenatal care ***at any age*** without the consent of a parent or guardian. *State v. Koome*, 84 Wn.2d 901 (1975)..
Outpatient mental health treatment:	**Yes, if over 13**	**No**	**No**	Minors may receive outpatient mental health treatment if they are ***13 years of age or older*** without the consent of a parent or guardian. The parents will not be notified without minor consent. RCW 71.34.530.
Inpatient mental health treatment:	**Yes, if over 13**	**No**	**Yes**	Minors ***13 years of age or older*** may receive inpatient mental health treatment without parental consent. The parents must be notified, however. RCW 71.34.500.
Outpatient substance abuse treatment:	**Yes, if over 13**	**No**	**See Source and Notes section.**	Minors ***13 years of age or older*** may receive outpatient substance abuse treatment, without parental consent. The provider will inform the parents that the minor is receiving outpatient treatment within seven business days if the minor gives written consent or if the provider determines that the minor is not capable of making a rational choice to receive the treatment. RCW 70.96A.096, 230.
Inpatient substance abuse treatment:	**No, unless child is determined to be "CHINS" - Child In Need of Services**	**Yes, unless CHINS determination**	**Yes, unless CHINS determination**	Minors ***13 years of age or older*** may receive inpatient substance abuse treatment without parental consent if DSHS determines he or she is a "child in need of services." RCW 70.96A.235. If school district personnel refer a child to inpatient chemical dependency services, they must notify the parents within 48 hours. RCW 70.96A.096 Parental notification is required if parental consent is required.

**A legally emancipated minor or a minor married to either an adult or an emancipated minor is treated as an adult.*

Consent

- Competency vs. capacity
  - POA
  - Intoxication, psychosis
- Age
  - Adolescents
  - WA state law
- ICU
  - Reason to believe they will recover



PATIENT INFORMATION

Name		Gender ☐ M ☐ F ☐_____	Ethnicity	Intake Date & Time
DOB	Age	Street Address		Apt.
Phone		City	State	Zip
OK to call with msg? ☐ Yes ☐ No		Accompanied by		Relationship
Police Report Made ☐ Yes ☐ No		Contact Person		Relationship
Police Department	Case #	Phone		
CPS Report ☐ Yes ☐ No		Interpreter ☐ Yes ☐ No	Language	
CPS Office	Intake Worker	Interpreter Name		

CONSENT: EXAMINATION, EVIDENCE COLLECTION, PHOTOGRAPHY, EMERGENCY CONTRACEPTION

I hereby consent to a forensic medical examination for evidence of sexual assault. The examination has been explained to me and I understand and agree to collection of (please initial):

____ Sexual Assault Kit collection potentially including: swabs, blood sample, and/or hair samples for DNA evidence
____ Urine to test for alcohol or drugs I have taken, or may have been given
____ Photographs of body/facial injuries (for medical documentation and police department, if I report the assault)
____ Photographs of genital (private parts) and anal areas (for documentation of injury and review)
____ I understand that I may refuse any part of this examination at any time.
____ I have been informed that this examination will be eligible for payment by Washington State Crime Victims Compensation and that I may apply for further CVC financial assistance for medical and counseling expenses, loss of wages and job re-training.
____ I request **emergency contraception** ("morning after pill") and understand that it may be administered up to 120 hours post assault. Information about how this medicine works has been explained to me and my questions, if any, have been answered.
____ Release of medical record and evidence to law enforcement

Signature of patient (or legal guardian) _____ Date _____

Printed name_____

Relationship (guardian) _____

☐ Patient is a _____ year old minor and demonstrates a level of understanding and maturity consistent with ability to sign for examination and treatment.	Provider name and signature:	Date

Examiner name (print)	Signature	Date

PT.NO

NAME

DOB

SA REPORT

PAGE 2 OF 12

SPOKANE REV 2019

Exam Considerations

- Empathetic listening
- Avoid why questions
- Maintain dignity and privacy
  - Undressing
  - Urination
  - Vaginal exam
- Autonomy and choice
- Participation and control
- Vocabulary

- Establish rapport
- Allow patient to set the pace of questions or exams
- Assure them they are in control
- Consider age, developmental level, gender identity and culture

Medical Forensic History Taking

Module Four

Medical Forensic Exam Considerations

- Acute exam = 120 hours or 5 days – always ESI level II
- Non-acute exam = greater than 120 hours or 5 days
  - Assign ESI level according to hospital or institution policy (ESI level II)

- Evidence Collection window can be extended in certain cases
  - Homeless/haven't showered
  - Bed bound
  - Abduction (No window)

- Primary purpose is to address medical needs
  - Nurse first, evidence collector second

Beginning the Exam

Introduce yourself – Who you are and what you do

Services offered and discuss reporting options

Explain purpose of the exam and what to expect with evidence collection

Important to emphasize that they are in full control, and they can decline any portion of the exam

- Start with basic demographic information
- Then start a comprehensive medical history
- Move into LMP, date of last consensual intercourse
- Birth control if applicable etc.

Medical Forensic History vs. Forensic Interview

Medical Forensic History

- Purpose is to diagnose, treat and identify injury
- Report of event is to determine medical needs and guide evidence collection
- Not investigatory
- Medical, treatment, safety reason
- Limit history to medical and forensic implications

Forensic or Investigative Interview

- Component of sexual assault investigation
- Guides decision making in criminal, family or juvenile law cases
- Typically done by a certified forensic interview, CPS or law enforcement

Medical Forensic History Taking

- Medical history. Recent surgeries, injuries or medical treatment
- Allergies
  - Prophylaxis for penicillin allergy
- Current Medications
- Recreational drug use
- Vaccination status
  - Tetanus
- Anogenital – urinary history
  - UTI's, episiotomy
- Pregnancy hx
  - Postpartum
- Contraception
  - Plan B
- LMP
- Event History
  - Actual/attempted acts
  - Date and Time
  - Location (jurisdiction)
  - Limited assailant information
  - Use of weapons
  - In quotations in patient's own words

Medical Forensic History Taking Continued

- Concerns for DFSA or AFSA
- Condom use
- Ejaculation
- Pain or bleeding
- Physical assault
- Full head to toe
  - Start of exam or during evidence collection
- Strangulation
- Post assault activities
  - Shower, bathe, brush teeth

Medical Exception to Hearsay

- Statements for Purposes of Medical Diagnosis or Treatment. Statements made for purposes of medical diagnosis or treatment and describing medical history, or past or present symptoms, pain, or sensations, or the inception or general character of the cause or external source thereof insofar as reasonably pertinent to diagnosis or treatment.

- *Washington State vs. Hurtado*
- History taking should be separate from LE
- No investigatory questions

Accurate and Unbiased Documentation

- Patient's words in quotations
- Documentation should be objective
- Document what you hear, see, observe objectively
- Not investigating a crime or determining if a crime was committed
- No blank spaces
- If you didn't document it you didn't ask it or assess it

Physical Examination Findings

Module Five

Assessing and Observing

- Informed consent and assent. Consent is a continual process
  - Patient can decline any portion of the exam
- Patient concerns or comfort level with gender of examiner
  - Accommodate when and if possible
- Being mindful of comfort level during head-to-toe exam, clothing, personal possessions, body and anogenital exam
- Consider gender, culture and patient tolerance

General Appearance

- Clothing appropriate for weather
- Clean
- Well nourished
- Disheveled
- Note state of clothing (tears or stains)
- Speaks in a soft or quiet voice
- Makes eye contact
- Answers questions readily and appropriately
- Alert and oriented
- Avoid assuming feelings for patient (anxious, sad, hysterical)
- Steady gait

Physical Findings

- Skin intact
- Scratches
- Bruises
- Debris
- Swelling
- Injuries present prior to assault vs injuries present post assault

- Presence/absence of pubic hair
- Anogenital injury
  - Common sites of injury
- Bleeding

- Sexual Maturation
  - Elderly
  - Pre vs post pubescent

  - Estrogen effects on the hymen

Mechanical and Physical Trauma

Blunt Force Trauma: A forceful external impact, falls, punch, pressure\
contusion, abrasion, laceration, fracture,
shear force, friction

Penetrating Trauma: Gunshot wound or stab wound
Size and distinguishing characteristics
Do not reference entrance or exit

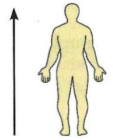
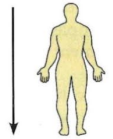
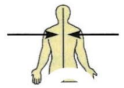
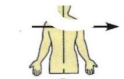
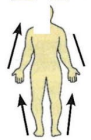
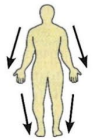
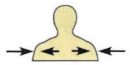
Strangulation: Compression of the neck and/or airway structures restricting blood and/or airflow

Terminology and Documentation

Feature	Notes
Classification	Use accepted terminology wherever possible, i.e. abrasion, contusion, laceration, incised wound, gunshot
Site	Record the anatomical position of the wound(s)
Size	Measure the dimensions of the wound(s)
Shape	Describe the shape of the wound(s) (e.g. linear, curved, irregular)
Surrounds	Note the condition of the surrounding or nearby tissues (e.g. bruised, swollen)
Colour	Observation of colour is particularly relevant when describing bruises
Course	Comment on the apparent direction of the force applied (e.g. in abrasions)
Contents	Note the presence of any foreign material in the wound (e.g. dirt, glass)
Age	Comment on any evidence of healing. (Note that it is impossible to accurately identify the age of an injury, and great caution is needed when commenting on this aspect)
Borders	The characteristics of the edges of the wound(s) may provide a clue as to the weapon used
Depth	Give an indication of the depth of the wound(s); this may have to be an estimate

- Include type of injury but do not speculate on the cause of injury
- Document patient's report of how injury occurred
- Document on body diagrams

TABLE 1.1 Orientation and Directional Terms

TERM	DEFINITION	EXAMPLE	
Superior (cranial)	Toward the head end or upper part of a structure or the body; above		The head is superior to the abdomen.
Inferior (caudal)	Away from the head end or toward the lower part of a structure or the body; below		The navel is inferior to the chin.
Ventral (anterior)*	Toward or at the front of the body; in front of		The breastbone is anterior to the spine.
Dorsal (posterior)*	Toward or at the back of the body; behind		The heart is posterior to the breastbone.
Medial	Toward or at the midline of the body; on the inner side of		The heart is medial to the arm.
Lateral	Away from the midli[illegible] of the body; on the o[illegible]r side of		The arms are lateral to the chest.
Intermediate	Between a more medial [illegible] more lateral structure		The collarbone is intermediate between the breastbone and shoulder.
Proximal	Clos[illegible]t[illegible]he [illegible]igi[illegible] of[illegible]e [illegible]y par[illegible]ne p[illegible]int[illegible] attachment of a limb to the body trunk		[illegible]elbow is proximal to the wrist.
Distal	Farther from the origin of a body part or the point of attachment of a limb to the body trunk		The knee is distal to the thigh.
Superficial (external)	Toward or at the body surface		The skin is superficial to the skeletal muscles.
Deep (internal)	Away from the body surface; more internal		The lungs are deep to the skin.

*The terms *ventral* and *anterior* are synonymous in humans, but this is not the case in four-legged animals. *Anterior* refers to the leading portion of the body (abdominal surface in humans, head in a cat), but *ventral* specifically refers to the "belly" of a vertebrate animal, so it is the inferior surface of four-legged animals. Likewise, although the dorsal and posterior surfaces are the same in humans, the term *dorsal* specifically refers to an animal's back. Thus, the dorsal surface of four-legged animals is their superior surface.

Injury Identification and Documentation

- Abrasion
- Laceration/Tear
- Cut/Incision
- Bruise/Contusion
- Hematoma
- Swelling/edema
- Redness/erythema
- Petechiae
- Bitemarks

- Size with measurements
- Round, linear
- Irregular or regular borders
- Color
- No dating or staging
- Ecchymosis vs. bruise/contusion

Body Surfaces

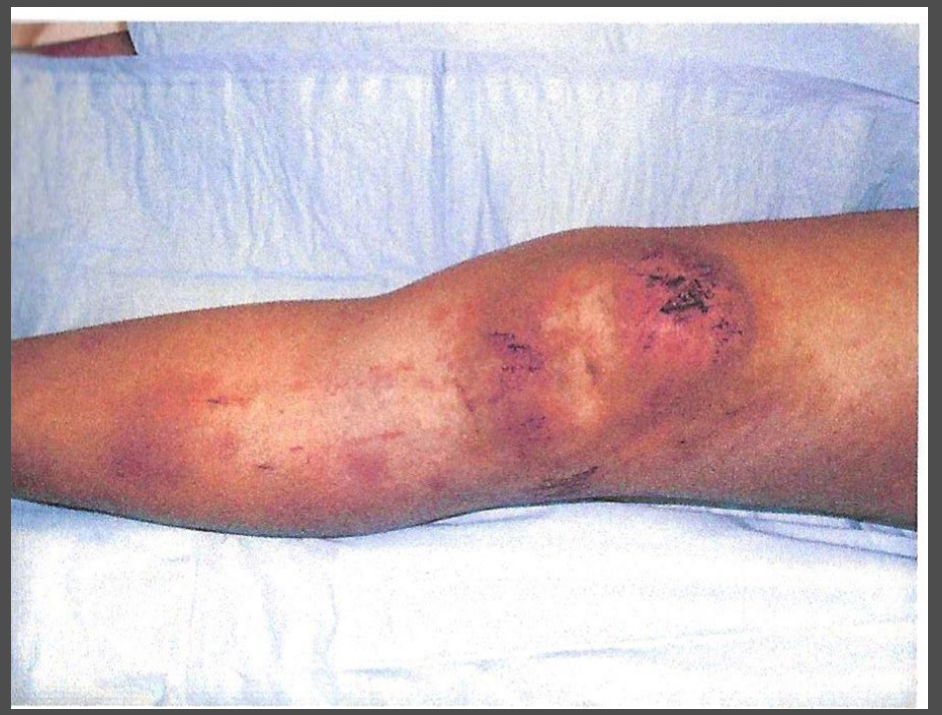
- Neck
- Breasts/chest
- Fingers/nails
- Thighs
- Mons Pubis
- Lips
- Areas of aggressive handling
  - Bruises
  - Erythema

- Possible semen, lubricant, saliva
- Collect even if patient has showered
- If patient cannot recall events
  - Areas of possible contact, saliva

- Physical findings if present as a guide

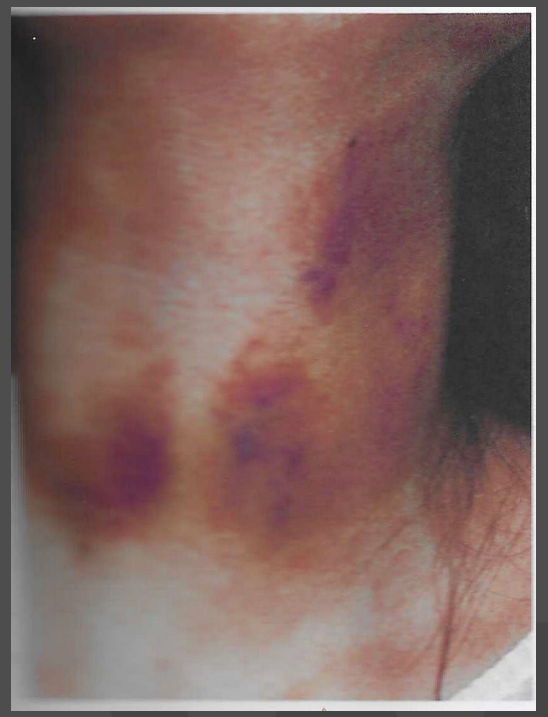
Abrasion

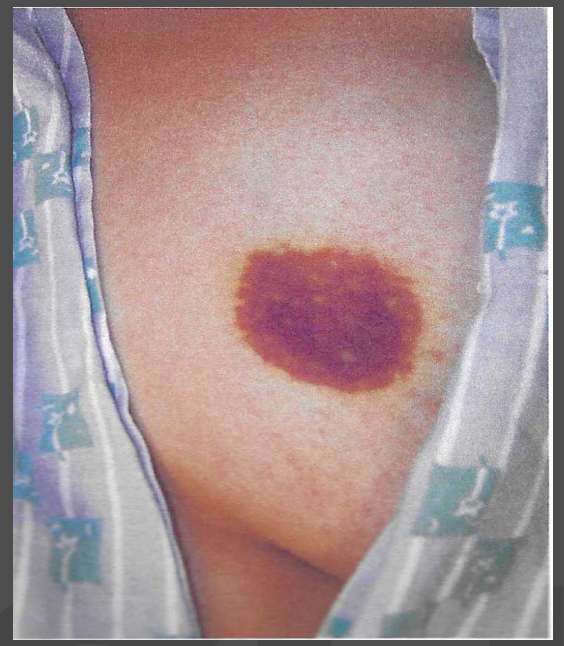
- Removal of the superficial layer of skin (epidermis) by friction, pressure or rubbing
- Road rash, scrape
- Scabs over when healing



Bruise/Contusion

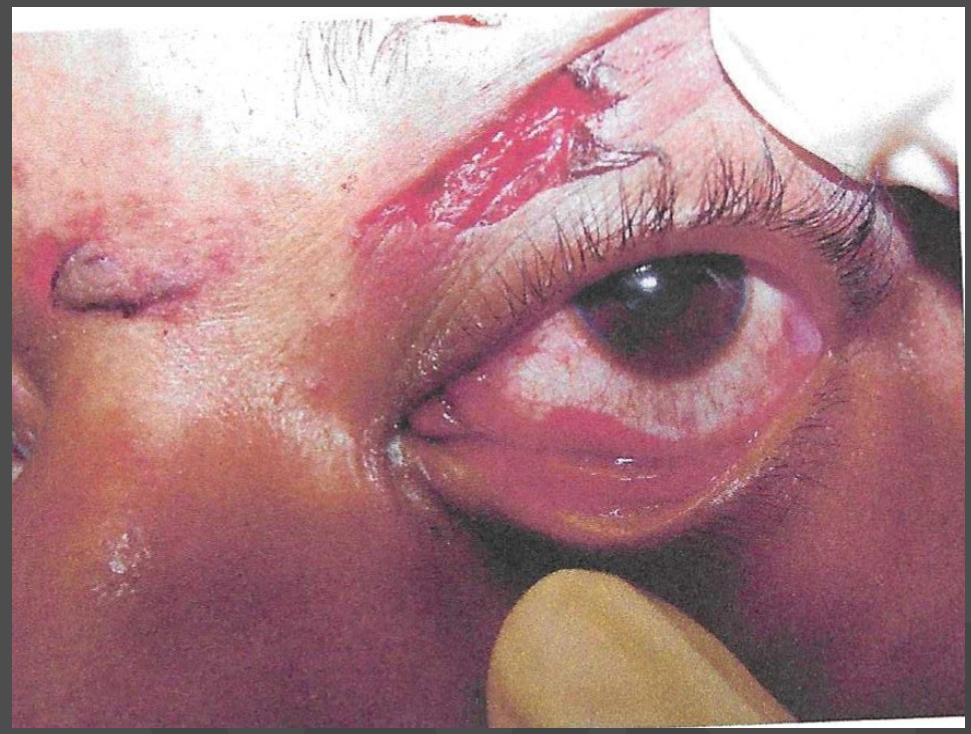
- Not the same as ecchymosis
- Rupture of blood vessels and blood leaking into the surrounding tissue
- Caused by blunt force trauma, pressure, force
- Bruises cannot be dated by color.
  - Yellow = 18 hrs or greater
  - Describe injury but do not refer to time or stages of healing





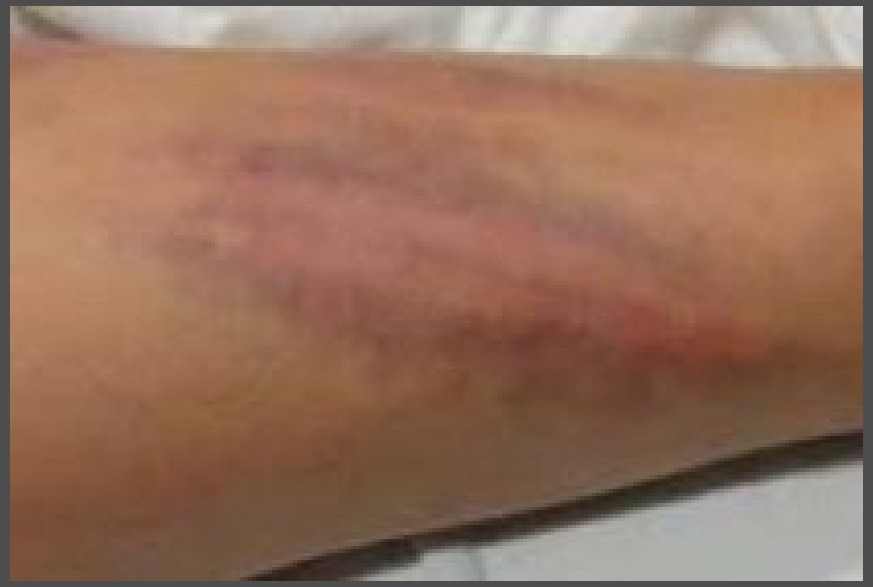
Laceration/Tear

- Tearing, ripping, shearing or overstretching of skin
- Irregular edges
- Can be accompanied by other injuries such as contusion, abrasion
- Measure depth if able
- Not a stab wound

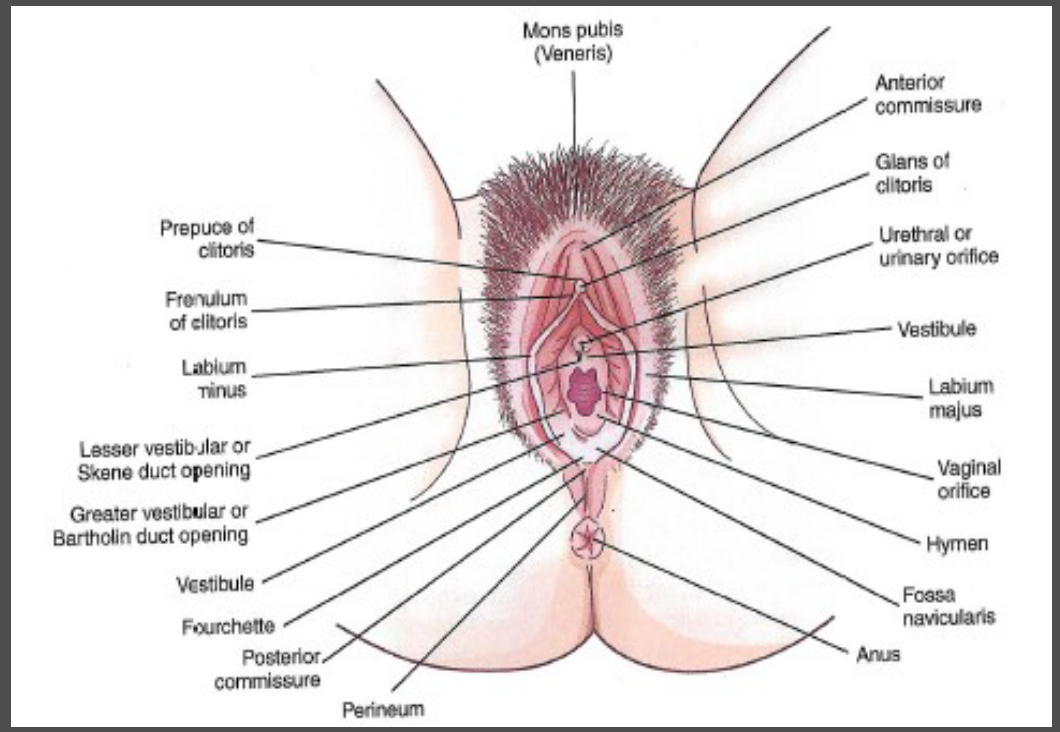


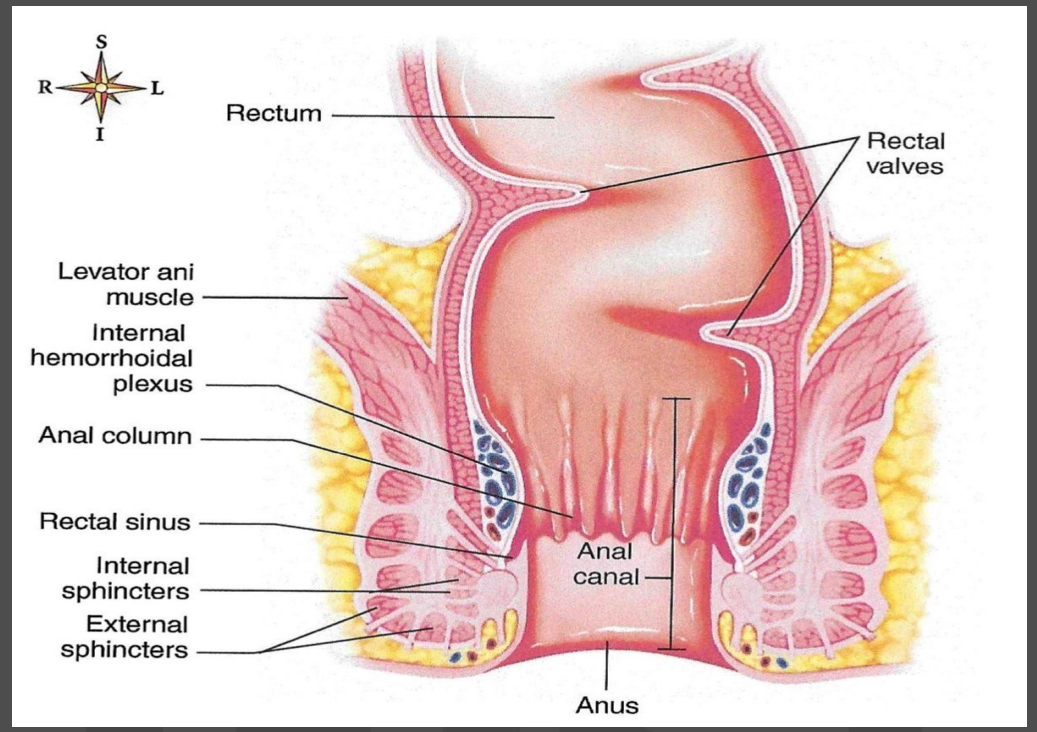
Other Injuries

- Swelling/edema
- Hematoma
- Patterned injuries
  - Belt mark
  - Finger pad bruises
  - Slap mark
  - Drag mark
  - Bite mark
  - Tram bruising
- Traumatic alopecia
- Petechiae
- Sucking Injury
- Redness/erythema

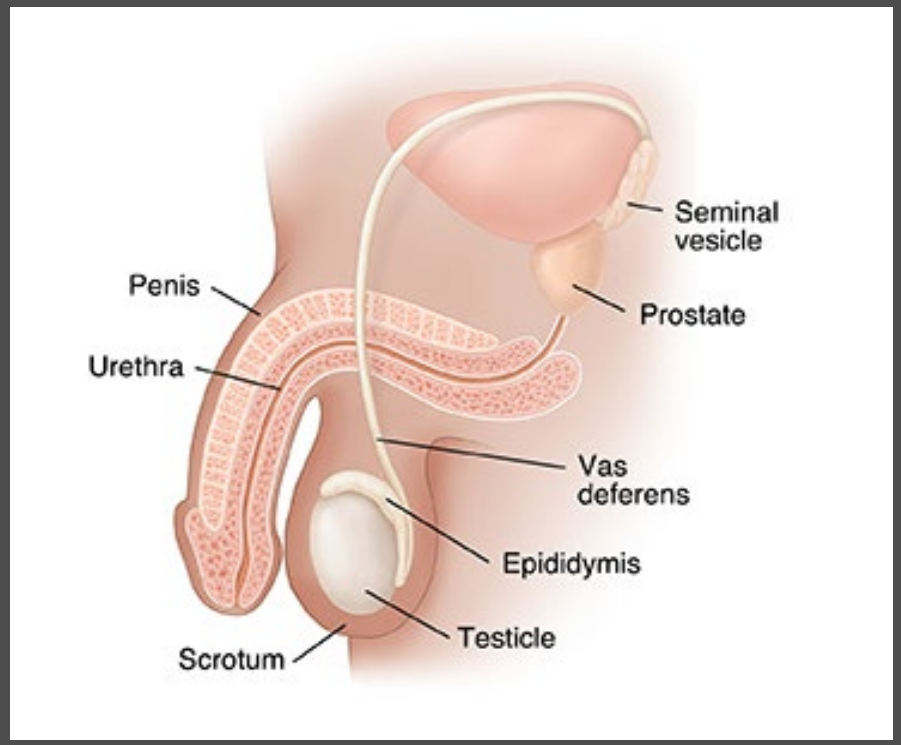


Anogenital Structures



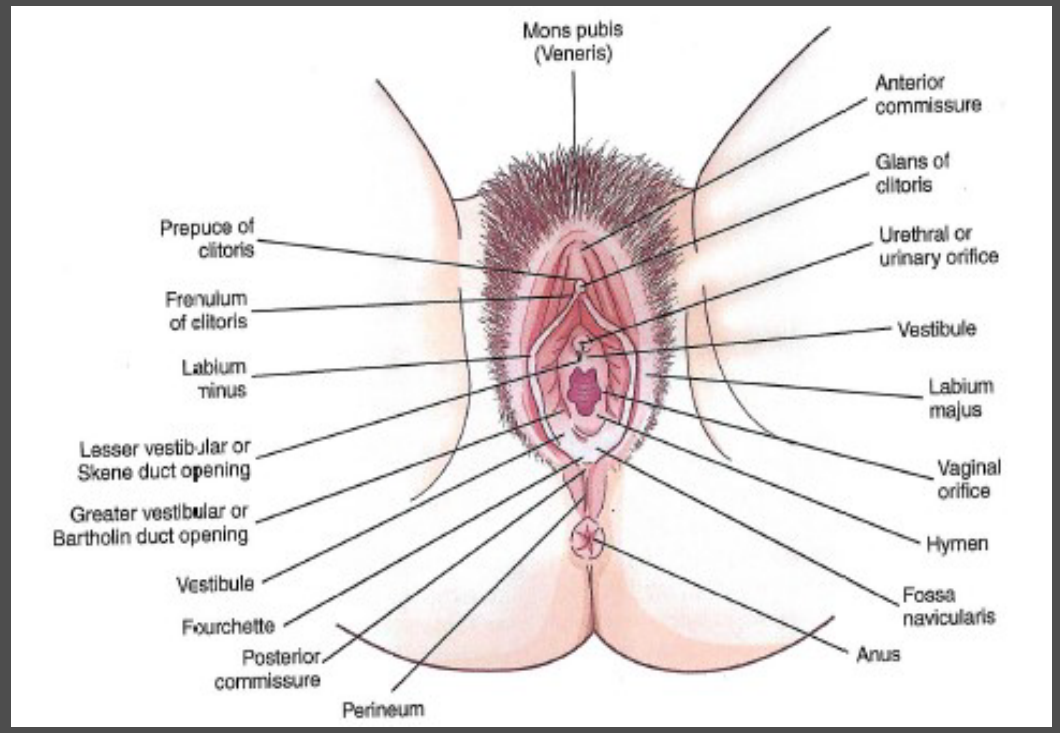


Anogenital Structures



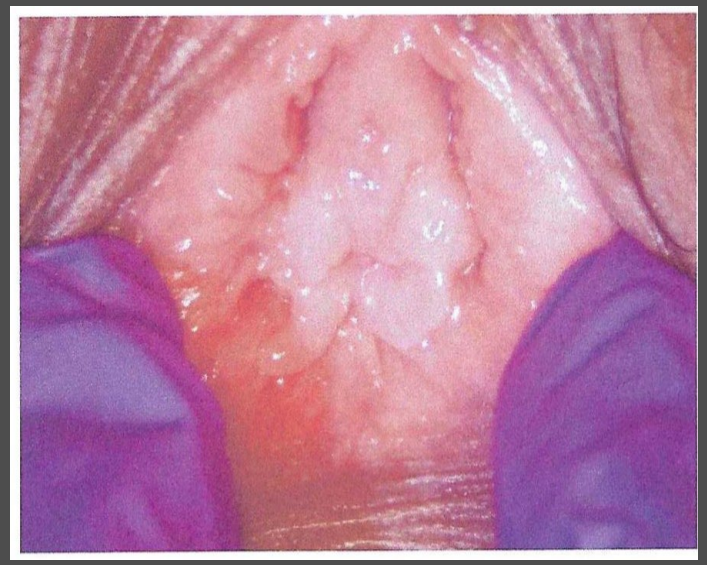
- Circumcised vs. Uncircumcised
- Foreskin
- Glans
- Scrotum
- Perinium

Anogenital Structures



- Posterior Fourchette – band of tissue formed by labia minora. Weak tissue, injury to this site not uncommon (tampon insertion, separation and traction etc.
- Fossa Navicularis - concave depression inferiorly to hymen
- Hymen – thin membrane that surrounds or partially covers vaginal opening

Hymen – Post-pubescent



- Appearance is not related to virginity or sexual history
- Appearance changes throughout life with estrogens effects
- If there is a tear or laceration to the hymen it will bleed very little if at all as the hymen is not highly vascularized
- Very sensitive and painful if touched for pre-pubescent
  - No speculum exam unless emergent

Normal Variants

- If you will be doing the genital examination, it's important that you have the appropriate training
- Hospital/program policy
  - Competency
- Familiarize yourself with normal variants so they are not misrepresented as injury

- Pigmentation variations
- Papillae
- Some redness to vulva and vaginal walls is normal
- Folliculitis
- Mucous or Bartholin gland cysts
- Anal pooling

Anogenital Injury

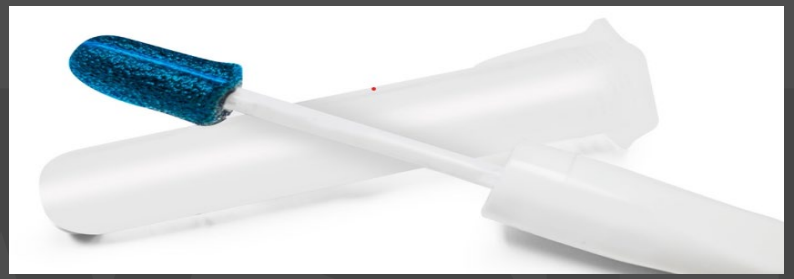
- The presence of vaginal injury is not exclusive to non-consensual sexual contact (International Association of Forensic Nurses, 2013)
- Research is varies widely and is not conclusive
- Consider presentation time
  - Vaginal injury heals rapidly
- Consider skin pigment and injury identification
- Incapacitated victims vs. forcible penetration
- Kind of penetration
- Lacerations and abrasions to posterior fourchette, hymen or fossa navicularis more common
- Bruises or contusion also common more common to labia minora
- Two or more anogenital injuries
- Often other bruises or injuries
- Anal injuries
  - Internal vs. external
  - Lacerations

Examination Techniques and Forensic Adjuncts

- Separation and traction
- Positioning
  - Supine/lithotomy
  - Elderly
  - Supine knee/chest – anal assessment
  - Supine frog leg
  - Lateral decubitus

Consult with your provider : significant vaginal bleeding, how many pads an hour? Insertion of a foreign object? Retained foreign object? Lacerations that may need sutures? Anal bleeding and lacerations? Signs and symptoms of a disease process?

- Toluidine blue dye
- Foley catheter technique
- Saline – floating the hymen
- Colposcope
- Anoscopic visualization
- Speculum
- Peer review or expert consultation



Non-Fatal Strangulation

"Strangulation is the intentional obstruction of breathing and/or blood flow to or from the brain which can cause serious injury or death."

– National Strangulation Institute

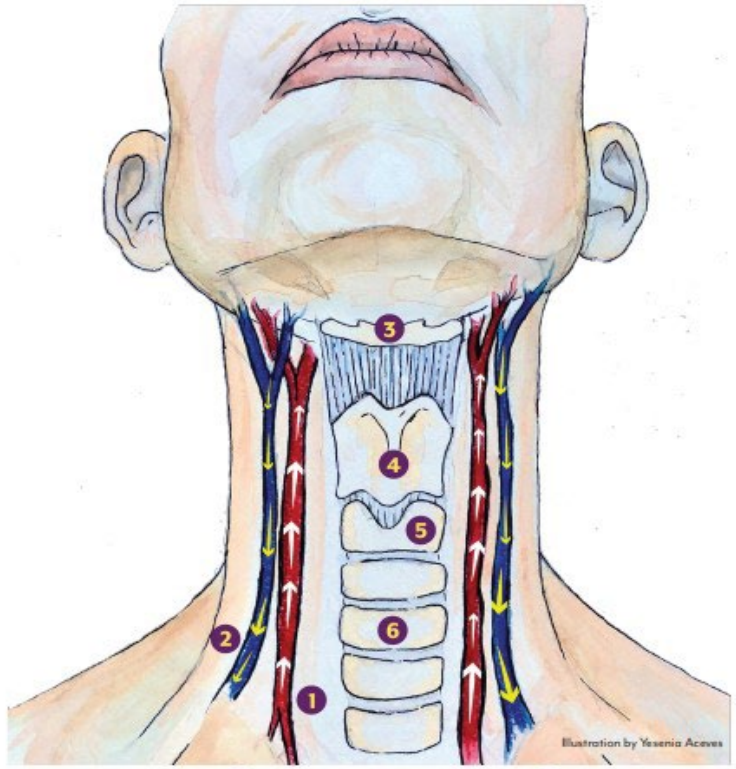
- Initial presentation may be subtle
- Risk is often under appreciated
- Someone can be strangled to death without visible injury
- Woman who has been strangled by partner has a 750% increased chance of being murdered by that partner

VITAL NECK STRUCTURES

Arteries, Veins and Cartilage

TRAINING INSTITUTE OF STRANGULATION PREVENTION

ALLIANCE for HOPE INTERNATIONAL



1 Carotid Artery

2 Jugular Vein

3 Hyoid Bone

4 Thyroid Cartilage

5 Cricoid Cartilage

6 Tracheal Rings

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Non-Fatal Strangulation

- Suffocation – smothering, obstruction of air passages
- Choking – obstruction of air below epiglottis
- Strangulation
  - Ligature: constricting band with tightening force
  - Manual Strangulation: hands, forearms, limbs
  - Mechanical Asphyxia – restriction of respiratory, external chest compression
  - Postural asphyxia
  - Hanging

Form of asphyxia. Two forms – ligature and manual

Level of Hypoxia

- Carotid – lateral neck – 11 lbs of pressure, fast
- Jugular – lateral neck – 4.4 lbs of pressure, slower
- Tracheal – anterior neck – not as common, fx 33 psi, 20 psi to open soda can

- Where was the pressure applied?
- How much pressure was applied?
- How long was pressure applied?

- Lethality – level of hypoxia

Petechiae

- Localized, geographic, smooth, flat, pinpoint redness
- Generalized throughout body in suffocation
- Occur above the level of compression
- Non-blanchable – erythema vs petechiae
- Arterial flow continual while jugular vein being compressed
  - Capillary rupture

What can cause petechiae?

  - Low PLT count, disease, vasculitis, sepsis, allergic reactions, sneezing, vomiting, child birth, heavy lifting, snorkeling, Valsalva strain
  - Important to document what has not occurred for patient
- Assessment
  - Ear drum, eyes, conjunctiva, scalp, inside mouth, palate, behind ears, under tongue

Symptomology

- LOC, ALOC
- Shortness of breath
- Coughing, drooling, voice changes, painful swallowing
- Neck pain, swelling, bruising, tenderness
  - Scratches
- Incontinence
- Heart rate and rhythm
- Loss of memory or impaired memory recall
- Inability to speak
- Dizziness, changes in vision

Physical Findings

- Petechiae
- Bruising
  - Breadth, and depth
- Scratches
- Swelling
  - To measure the neck or not measure the neck?
- Subconjunctival and scleral hemorrhage
- Photography
  - May not be visible
  - 50% of patients have no visible injury
- Patterned injury
  - Finger marks, ligature, jewelry

Non-Fatal Strangulation

- Imaging Recommendations
  - Ocular migraine
  - CTA head and neck
  - MRI
- Need to conduct history taking, assessment and lethality risk
  - Advocate for imaging
- Evidence
  - Neck swabs – cohabitant
  - Shirts with collars

Medical Forensic Specimen Collection

Module Six

- All components of exam require a patient's consent and they have the right to withdraw consent at any time

Clothing

Toxicology - prioritize

Trace and biological evidence

Photography

The kit

Release of records to LE

Inform them about any mandatory reporting

Drug and Alcohol Facilitated Assault

AFSA

- Alcohol is the most common substance used to facilitate sexual assault
- Patient's who are intoxicated need to be monitored per facility policy until nurse can obtain consent
- BAC is not required to determine if the patient can or cannot consent
- Clinical assessment is a better indicator for ability to consent

DFSA

- Long list of possible substances used
- Prescription medications more likely
- Quickly metabolize and may not be detectable
- Hospital toxicology only if medically necessary
  - Smaller drug panel and no chain of custody

Drug and Alcohol Facilitated Assault

AFSA

- Always screen for possibility of DFSA or AFSA
- Indications include difficulty recalling events, missing time, impaired memory recall, blacking out
- Kit asks to collect urine within 72 hrs. Can be collected up to 120 hrs.
- Blood within 24 hrs.

DFSA

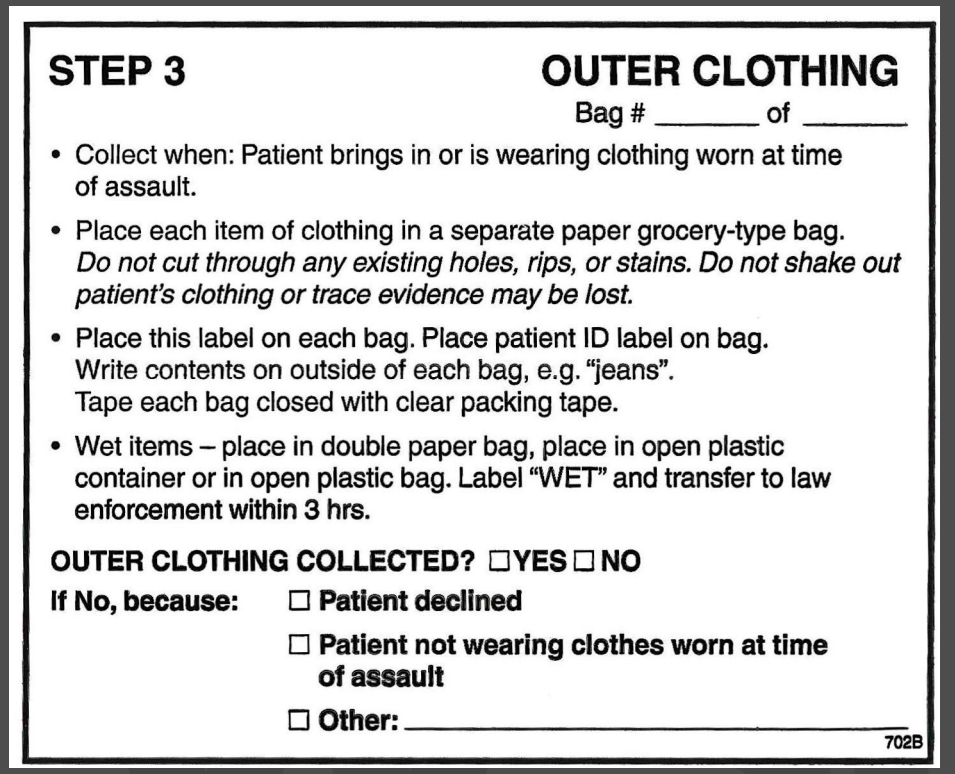
- Benzodiazepines (Ativan)
- Muscle relaxers (Robaxin)
- Anti-depressants
- Antihistamines (Benedryl)
- Sleep Aids (Unisom)
- Opioids
- Toxicology occurs in Central, WA
  - Anonymous kit considerations

Swab Collection Techniques

- Light but firm pressure
- Roll swab back and forth while moving across surface
- No more than two swabs
- Change gloves between each step and collection and wear a mask
- Allow swabs to dry as much as possible
  - How long does it take?
  - Should not be overly saturated
- You can use swab boxes with covers. Dryers (no fan). WA state you can place directly into the box and wait to seal to allow more exposure to air
  - If not available weigh risk vs. benefit of having swabs out and exposed with others in the room

Clothing and Personal Possessions

- Clothing worn at time of assault
  - Underwear – collect in all cases
  - What not to collect
- Clothing given to LE prior to patient's arrival?
- Packaging
  - Paper bag, never plastic
  - Fold over once then tape
  - Seal with evidence sticker



STEP 3 **OUTER CLOTHING**

Bag # _____ of _____

- Collect when: Patient brings in or is wearing clothing worn at time of assault.
- Place each item of clothing in a separate paper grocery-type bag. *Do not cut through any existing holes, rips, or stains. Do not shake out patient's clothing or trace evidence may be lost.*
- Place this label on each bag. Place patient ID label on bag. Write contents on outside of each bag, e.g. "jeans". Tape each bag closed with clear packing tape.
- Wet items – place in double paper bag, place in open plastic container or in open plastic bag. Label "WET" and transfer to law enforcement within 3 hrs.

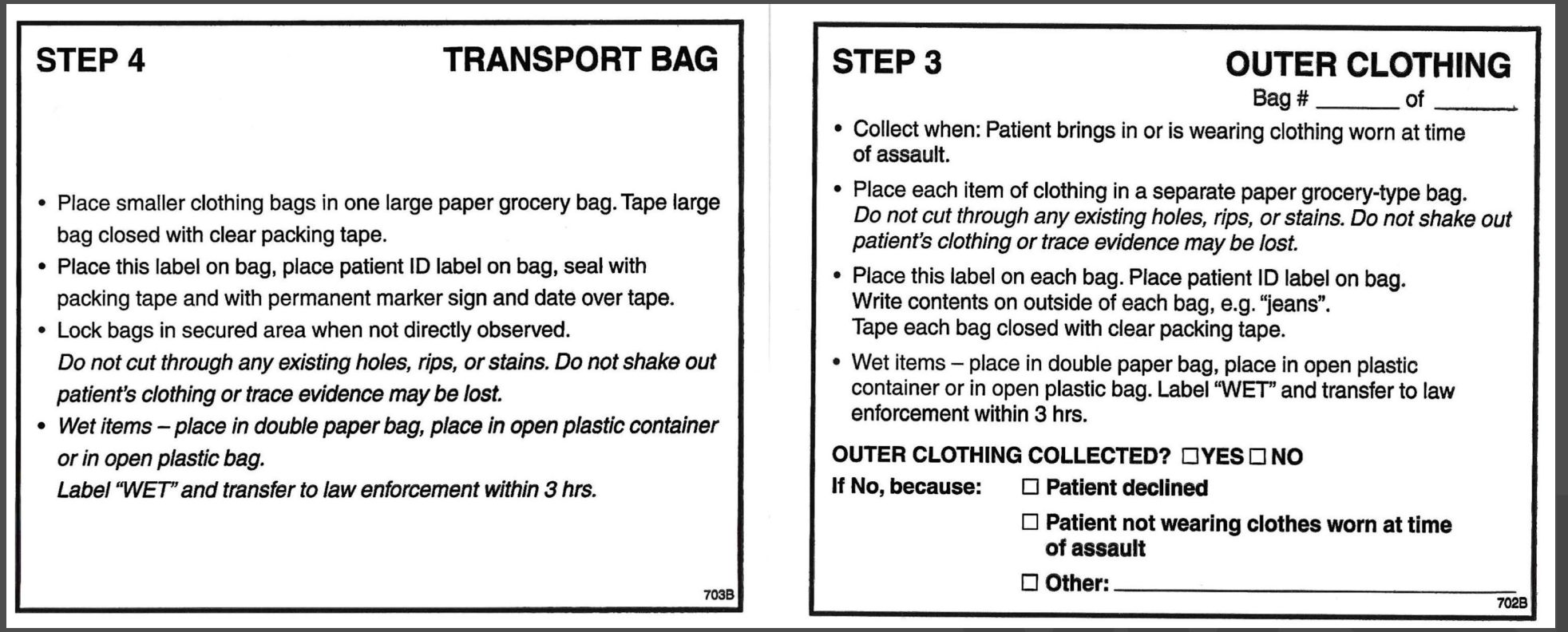
OUTER CLOTHING COLLECTED? ☐YES ☐NO

If No, because:

- ☐ **Patient declined**
- ☐ **Patient not wearing clothes worn at time of assault**
- ☐ **Other:** _____

702B

Clothing Packaging



STEP 4 **TRANSPORT BAG**

- Place smaller clothing bags in one large paper grocery bag. Tape large bag closed with clear packing tape.
- Place this label on bag, place patient ID label on bag, seal with packing tape and with permanent marker sign and date over tape.
- Lock bags in secured area when not directly observed.
  Do not cut through any existing holes, rips, or stains. Do not shake out patient's clothing or trace evidence may be lost.
- *Wet items – place in double paper bag, place in open plastic container or in open plastic bag.*
  Label "WET" and transfer to law enforcement within 3 hrs.

703B

STEP 3 **OUTER CLOTHING**

Bag # _____ of _____

- Collect when: Patient brings in or is wearing clothing worn at time of assault.
- Place each item of clothing in a separate paper grocery-type bag.
  Do not cut through any existing holes, rips, or stains. Do not shake out patient's clothing or trace evidence may be lost.
- Place this label on each bag. Place patient ID label on bag.
  Write contents on outside of each bag, e.g. "jeans".
  Tape each bag closed with clear packing tape.
- Wet items – place in double paper bag, place in open plastic container or in open plastic bag. Label "WET" and transfer to law enforcement within 3 hrs.

OUTER CLOTHING COLLECTED? ☐YES ☐NO

If No, because:
- ☐ **Patient declined**
- ☐ **Patient not wearing clothes worn at time of assault**
- ☐ **Other:** _____

702B

Suspect Exams

- Does your program or facility provide suspect exams?
  - If they do make sure there is a policy in place
- A warrant or court order says you can but it does not force your hand. You MUST have a patient's verbal and written consent. And you must disclose the purpose
  - If patient does not provide consent you cannot proceed
  - The legal system can decide how to proceed
  - If warrant/court order you must only swab what is outlined in order.
- Suspect narrative and documentation of injuries still important.
- Check with your jurisdiction about how this is handled.

Evidence Collection

- There is evidence to support collecting up to 6 days.
  - Cases where touch DNA evidence has been recovered up to 8 days with 2 showers. Not prevalent enough or enough evidence to support extending timeline to 8 days. Weigh pros and cons and discuss with patient.
- Do not discourage a patient from having a kit collected – regardless of post assault activities.
- Nurses or providers do not decide what has probative value. If it applies or is relevant get as much information as you can.

Types of Evidence

- DNA Evidence
- Trace/non-biologic evidence (lubrication from condom worn, debris)
- Biological evidence (semen, saliva, touch DNA)
- Physical findings – patterned injuries, torn clothing
- Foreign bodies

Wet Evidence

- Products of conception
- Diaper
- Tampon

Erin Daniels/Crime Lab

Medical Forensic Photography

Module Seven

Medical Forensic Photography

- Policy and procedures must be in place for your program or organization
- Forensic photography is considered a bare minimum for sexual assault patient care
- DO NOT EVER SEND PHOTOS OR SD CARD WITH KIT
- Follow program or facility policy regarding when to take photos and when not to. Facility policy on how to store and maintain will differ
- It is not advised to take photographs of "normal genitalia" Photographs should only be taken to document injuries.
- Additional patient health security measures should be in place ie: forensic epic, program policy. Do not take photos only for the purpose of peer review
- Patient consent required and also discuss with your program/facility about peer review, consent and/or provisions in place.

Sexually Transmitted Infections

Module Eight

Sexually Transmitted Infections

- Gonorrhea
  - Rocephin Im
- Trichomoniasis
  - Flagyl
- Chlymidia
  - Doxycycline –
- Hepatitis B

Medications

HIV Prophylaxis

Pregnancy Evaluation and Care

Module Nine

Emergency Contraception

- Most effective is placement of the IUD up to 120 hrs. after unprotected intercourse – 99%
- Vomiting – 3 hrs.
- Spotting
- Early or late menses
- Side effects – fatigue, nausea, vomiting, diarrhea, headache
- Delay in cycle >7 days – follow up with MD for preg test

- *Ella (Ulipristal acetate)*
  - Preferred
  - Weight
- *Plan B (Levonorgestrel)*
- Both have high efficacy
- The sooner it is taken the more effective

WAC 246-320-286

Medical Forensic Documentation

Module Ten

Documentation

- Electronic – note. Will depend on hospital or program.
- Objectivity – your documentation should not demonstrate a bias toward believing or not believing
- Narrative should be in patient's own words, quotations. Brief and concise. No social information that is not pertinent to medical care.
- Investigatory vs. Medical
  - Description of assailant. Size weight? Clothing? Car?
  - Medical or evidence related reason for every question you ask
    - Can you ask about race?
- Location – general area/address for jurisdictional purposes. No other details are needed. Cross streets etc.

Yes

- Patient reports, “
- RN clarifies, slang
- RN needed to redirect patient
- RN discontinued any documentation or evidence collection on arrival
- Excited statements

No

- “He has a history of this, he’s done this shit before.” REDIRECT
- Patient was sexually assaulted by…. (needs to be in quotes and not a definitive statement)

Accuracy

- Double check work
  - Dates, Time, signatures
- Evidence seals with initials
- Document any interruption in your care. Another came in etc.
- Review of vitals
- MSE

Terminology

- "He has a history of this, he's done this shit before." REDIRECT
- Patient was sexually assaulted by…. (needs to be in quotes and not a definitive statement)

Discharge and Follow-Up Care

Module Eleven

Discharge and Follow-Up

- Discharge plan based on individual needs
- Consider barriers to follow up care and/or connection with other agencies
- Follow up STI and pregnancy testing
- Assess support system
- Follow up exam are very important although lacking

Legal Considerations and Judicial Proceedings

Module Twelve

Legal Considerations

Civil

Criminal

Legal Definitions

- Indictment
- Arraignment
- Plea Agreement
- Sentencing
- Deposition
- Subpoena
- Direct Examination
- Cross Examination
- Objections

Fact Witness

- You being called to court to testify about an exam you performed.
- What you observed, assessed and documented
- You are not in trouble
- You don't' need to "clean up" the patient
- It is what it is
- It is not your job to get a conviction for a prosecutor.

Expert Witness

- Judge qualifies you
- You have enough experience, training and education to be able to speak as an expert on a particular topic
- You can speak about your knowledge and training but do not ever open the door on an expert field that you are not an expert in
- If you testify to it, you MUST be able to back up your opinion with research and examples

Nurses Role in Proceedings

- Education
  - Ethical and Effective testimony – Objectivity. If you are not willing to provide an opinion that "could" be detrimental to a victim, you should not be on the stand as and expert.
    - It must be honest and objective
    - You have a duty to the nurse practice act which includes maintaining public trust
  - Demeanor and appearance
  - Objectivity
  - Accuracy – memorize your report or the discovery
  - Evidence-based testimony – do your research. Do not pose as an expert on something you are not an expert on.
  - Professionalism – always be polite not matter the side/party. Common courtesty always
  - Tips – dressing, hallway, who to discuss with initially when you are subponead. CV, resume. Elevator speech

Universities – Title IX

Crime Victims Compensation

Module Thirteen

CVC Compensation

- CVC Compensation vs CVS Continuing Benefits
  - Compensation = form that is filled out by the hospital or nurse

  - CVC Continuing Benefits
    - Packet that you often see. Advocates are very well versed in how to assist
    - Continuing benefits such as loss of wages, ongoing therapy medical appointments REQUIRE a report to law enforcement (current legislation)

- CVC Compensation (form filled out at the hospital)
  - Does not require a report to LE
  - Any sexual assault exam, strangulation exam (without SA) or strangulation with SA will be paid for by CVC

Washington State Department of Labor & Industries

Crime Victims Compensation Program

Sexual assault exam report / Domestic Violence strangulation report form

Exam performed in: ☐ Office (Independent Clinic) ☐ Hospital (ED or Floor)	Exam Level/Billing Code: ☐ No Exam/0130C ☐ Level 2/0132C (46–119 minutes) ☐ Level 1/0131C (5–45 minutes) ☐ Level 3/0133C (120+ minutes)
Time elapsed since assault:	_____ Hours _____ Days _____ Months _____ Unknown
Patient's age at exam (in years):	_____
Circumstances of visit:	
Address or approximate location of assault:	City and state where assault occurred:
At the time of the assault, was the victim confined or living in any county or city jail, federal jail or prison or in any other federal institution, or any state correctional institution maintained and operated by the Department of Social and Health Services or the Department of Corrections? ☐ No ☐ Yes If yes, where?	☐ Sexual assault without strangulation ☐ Sexual assault with strangulation Is this Domestic Violence? ☐ No ☐ Yes ☐ Domestic Violence strangulation Forensic Evidence kit completed? ☐ No ☐ Yes Anoscopy performed? ☐ No ☐ Yes Physical exam completed? ☐ No ☐ Yes Colposcopy performed? ☐ No ☐ Yes
Diagnostic Testing: *(Bill Separately)* Lab Work ☐ No ☐ Yes Imaging: CTA, CT, MR ☐ No ☐ Yes Other Imaging Study ☐ No ☐ Yes	**Medication Given:** *(Bill Separately)* Prophylaxis for STDs ☐ No ☐ Yes Prophylaxis for HIV ☐ No ☐ Yes Emergency Contraception ☐ No ☐ Yes Hepatitis B Vaccine ☐ No ☐ Yes Tetanus Vaccine ☐ No ☐ Yes
Exam performed by (name – please print):	Form completed by (name – please print):
☐ RN ☐ MD ☐ PA-C ☐ ARNP ☐ DO ☐ Other: _____	(Signature)
Additional comments:	Police report made? *For data collection purposes only* ☐ No ☐ Yes ☐ Unknown
Claimant (patient) Name – may use patient ID label:	Medical facility where exam performed:
Medical Record #: _____ Gender: ☐ F ☐ M Date of Birth: _____	Date of exam (use the month/day/year format):

A health services provider who requests from the department payment for providing services shall maintain all records necessary for the director's authorized auditors to audit the provision of services. A provider shall keep all records necessary to disclose the extent of services the provider furnishes to a victim of crime. At a minimum, these records must provide and include prompt and specific documentation of the type of service for which payment is sought. Records must be maintained for audit purposes for a minimum of five years.

RESET

Discharge