SEXUAL ASSAULT NURSE EXAMINER (SANE) / FORENSIC NURSE EXAMINER (FNE) EVALUATION OF THE ADOLESCENT / ADULT VICTIM OF SEXUAL ASSAULT

This guideline was developed by the Wisconsin Chapter of the International Association of Forensic Nurses. This guideline is recommended for the care of the adolescent and adult when there is a history or concern of sexual abuse or assault. The guideline is not intended to include all the triage issues, medical evaluations, tests, and follow-up that may be necessary for appropriate care for an individual patient. Not all the steps outlined in this guideline will be appropriate for every patient. The purpose of this guideline is to provide direction for SANE / FNE in the care of the adolescent or adult sexual assault patient. The goal is to ensure that compassionate and sensitive services and care are provided in a non-judgmental manner. The physical and psychological well being of the sexual assault patient is given precedence over forensic needs. The guideline represents the basic standards in the assessment and care of the sexual assault patient. A review of the guideline by the members of the Wisconsin Chapter of the International Association of Forensic Nurses Documentation / Protocol Subcommittee will be conducted annually to ensure current standards of practice.

I. GENERAL INFORMATION

Purpose of Exam

Medical/Forensic

1. Identify and treat injuries. Injuries that require intervention beyond scope of practice of SANE/FNE should be referred to the physician for treatment
2. Assess risk of pregnancy and sexually transmitted infections
3. Provide prophylaxis for sexually transmitted infections and emergency contraception, when indicated
4. Document history
5. Document physical findings
6. Collect / document forensic evidence

Social/Psychological

1. Respond to patient's and family's immediate emotional needs and concerns
2. Assess patient safety and immediate mental health needs
3. Explain reporting process, Crime Victims Compensation, and resources for advocacy and counseling

Consult/Report/Refer

1. Refer for follow-up medical care
2. Refer for advocacy and counseling
3. In the case of minors report to Child Protective Services (CPS) and/or law enforcement ASAP
4. Report to law enforcement in the county where crime occurred, when indicated (See section "Mandated Reporting" below)

II. TRIAGE DECISIONS

Acute:

If assault within prior 96 hours

1. Medical/forensic exam is considered urgent
2. Advise patient, if possible:
   - Do not bathe before exam
   - Bring in clothes worn at time of assault and immediately after assault, especially undergarments
   - Bring change of clothing
   - Come to hospital with support person, if possible

Non-Acute:

If assault >96 hours prior

Forensic Exam — **Forensic exam is generally NOT indicated on emergency basis**

1. Individual case circumstances may warrant urgent evidence collection beyond 96 hours after an assault (i.e., little or no post assault hygiene, held captive, etc.) or when requested by law enforcement

Medical Exam

Medical evaluation is indicated for all patients at any time following sexual assault

1. Patients may be evaluated by the SANE / FNE or referred to primary care provider or clinic for medical care
2. Advise patient of mandated reporting to CPS and/or law enforcement when under 18 years old
3. Inform and/or assist adult patient in contacting police, if the patient gives his/her consent.
4. Refer to sexual assault center, advocacy organization or mental health counselor for psychological support

Emergency Department Triage

Medical stabilization always precedes forensic examination

1. The following history or conditions should be evaluated medically prior to the sexual assault exam:
   - History of LOC
   - Head injury
   - Altered consciousness or mental status
   - Significant facial injury
   - Possible fractures
   - Blunt injury to chest, abdomen or back
   - Active bleeding
   - Strangulation
   - Pregnancy with complications (i.e., bleeding, decreased fetal movement, abdominal pain, etc.)
   - Acute pain

2. Psychiatric illness
   - If apparent psychiatric illness complicates assessment of reported sexual assault, both psychiatric assessment and medical forensic exam generally will be necessary. Proceed according to patient tolerance and needs

Advocacy

SANE / FNE Programs will contact advocacy when the SANE / FNE is called and together will respond as a team.

Mandated Reporting

Life-threatening assault/use of weapons

1. Injury caused by any weapon or incidents involving life-threatening assault must be reported to law enforcement irrespective of reporting the sexual assault (WI Statute)

Minors <18 years

1. Nursing and medical providers are mandated to report to CPS and/or law enforcement ASAP when the victim is under 18 years of age (WI Statute)
2. Mandatory reporting applies even when minor has signed consent for their own care

Adults (18 and older)

If the patient is an adult age 18 years and older and is competent, notification of law enforcement is done only if the patient gives his/her consent

Documentation All mandated reporting must be documented within the medical record.

Consent **Informed consent for all procedures, evidence collection and treatments is obtained in all cases**

1. A patient seeking treatment for medical conditions related to reproductive health care may consent to such medical care or treatment at any age and without consent of parent/guardian (WI Statute). Abortion requires parental consent or judicial bypass.

III. HISTORY AND INITIAL EVALUATION

See the **WI-IAFN Sexual Assault Nurse Examiner (SANE) / Forensic Nurse Examiner (FNE) Adult/Adolescent Sexual Assault Report**

Patient Information **Document the following information if it is available and pertinent:**

1. Routine data: patient name, gender, ethnicity/race, age, birth date, medical record number, home address, phone number/contact information
2. Date and time of arrival
3. Who accompanied patient, and their relationship
4. Interpreter name, if used, and language
5. Advocate
6. Name of law enforcement agency and personnel
7. Name of CPS worker or adult protective case worker
8. Law enforcement case number, if available

History of Assault **Interview patient and document the following:**

Facts about assault

1. Source of information (patient, police, or other person)
2. Nature of concern
3. Time, place of assault, and jurisdiction/location if known
4. Time since assault
5. Number of assailants and identity of assailants, if known
6. Relationship of assailant(s), if known
7. Record narrative history of assault

Methods used for control

1. Patient had impaired consciousness
2. Known or suspected alcohol/drug ingestion
3. Verbal threats
4. Use of physical force
5. Use of weapon
6. Use of coercion

Physical facts of sexual assault

1. Which orifices assaulted
2. By what (finger, penis, mouth, foreign object)
3. Whether condom was used
4. Physical injuries
5. Whether bleeding or pain was reported

Post assault activity of the patient

1. Showered or bathed
2. Douched, rinsed mouth, urinated, defecated

3. Changed clothes, gave clothes to police at scene, or brought clothes worn at time of assault to emergency department/clinic

Risk factors of assailant regarding Hepatitis B/C, HIV, if known

1. Known or suspected IV drug user
2. Man who has had sex with men
3. From an endemic country
4. History of prostitution
5. Blood or mucous membrane exposure

Past Medical History

1. Significant medical problems, surgery, major injuries, chronic diseases, immune problems, developmental, cognitive, mental health and/or physical disabilities
2. Current medications
3. "Stated" height and weight
4. Recent ingestion of other drugs, including over-the-counter drugs, legal and illegal substances, and alcohol
5. Allergies
6. OB/GYN history
7. Birth control method (IUD, tubal, OCP, etc.)
8. LMP
9. Last consensual intercourse if <96 hours
10. Patient's history of Hepatitis B vaccine or illness
11. History of Tetanus vaccine

Plan of Care

1. Discuss options for medical and forensic examination
2. Discuss patient reporting to law enforcement
3. Discuss mandatory CPS and/or law enforcement reporting
4. Inform patient that written information and educational literature will be provided

IV. EVIDENCE COLLECTION & STORAGE

Forensic Evidence Collection

Standard Sexual Assault Evidence Collection Kit, provided by the Wisconsin State Crime Laboratory, is generally used for evidence collection. Someone is available at the Crime Lab 24/7 to answer questions at (608) 266-2031.

Chain of Custody of Forensic Specimens

One staff member must be responsible for maintaining chain of evidence at all times. That staff member:

1. Observes specimens **OR**
2. Designates another staff member to watch specimens **OR**
3. Store specimens in secured refrigerator, cabinet, or specific area

Injury Documentation

Obtain digital photographs or request law enforcement to obtain photos. Video or photocolposcopy may be used to document the anogenital exam. Alternatives are careful drawings using anatomical sheets, Polaroid photographs or 35mm camera with macro lens.

1. Obtain consent from patient for photographs
2. Include patient's ID in all photos
3. Take one photo of face and one of entire body, with clothes on, prior to exam
4. Include a ruler or coin in photos of injuries to document size of lesions

5. Document type of photos, parts of body in photos, and name of photographer in medical chart
6. Secure photodocumentation per hospital protocol.
7. Careful documentation with drawings is necessary even when photos are taken

Evidence Collection

General

It is the patient's right to consent or refuse any aspect of the exam and evidence collection.

The physical and psychological well being of the sexual assault patient is given precedence over forensic needs.

The proper collection of evidence is dependent upon the examiner and evidence beyond what is generally collected (as described in the kit instructions) should be collected when appropriate. Envelopes may be relabeled when used to obtain swabs from sites other than those outlined in the kit. The Crime Lab is available 24/7 @ (608) 266-2031 to answer questions about the collection of evidence.

The kit does not include everything that one needs to collect evidence. Materials such as scissors, tape, etc. will need to be collected from hospital stock.

Drying of collected materials is very important as moisture enhances the proliferation of bacteria and mold which will destroy biological and trace evidence. Drying may be accomplished by air drying or by the use of a drying box. Use of a drying box requires the development of policy which addresses the cleaning of the box and the methods used to prevent cross contamination of the swabs.

Wear powder-free gloves and change gloves frequently during all phases of evidence collection and processing.

Collect evidence which may be compromised by time or examination FIRST such as oral swabs and smear (in cases of an oral assault) and fingernail debris/scraping.

NEVER LICK evidence envelopes to seal.

NEVER store evidence in plastic bags or airtight containers.

Sexual Assault Report Form

Fill out all information requested on form. Have patient sign and date consent section, the SANE/FNE must sign and date form where indicated.

Oral Swabs and Smear

Collect **ASAP** when

1. Abuse/assault occurred or visible oral injury or history of oral/genital contact
2. Unwaxed dental floss can be used for areas between the teeth. Have the patient floss his/her own teeth *using a minimal amount of floss.* Do not return the used floss to the plastic bag – place in oral swabs envelope
3. Using 2 swabs simultaneously, thoroughly swab the oral cavity, especially between the cheeks and gums

4. Using swabs, rub a dime-sized area on center of slide/smear
5. Allow swabs and slide/smear to thoroughly air dry
6. Return slide/smear to holder and shut.
7. Place swabs in swab box, check off site on box
8. Return swabs and slide/smear to envelope
9. Seal and fill out all information requested on the envelope

Buccal Cell Standard (DNA)

Collect reference oral standard swabs to establish patient DNA

1. Rinse mouth with water prior to collecting sample
2. Using one swab, place the swab in solid contact with the inner cheek and gum surface
3. Gently move the cotton tip in and out five or six times, rotating the swab while rubbing
4. Repeat process with the second swab on the other inner cheek and gum surface
5. Do not collect from the teeth or along the edges of the teeth
6. Place the swabs on the sterile swab package to thoroughly air dry
7. Return the dried swabs to the envelope
8. Seal the envelope and fill out all information requested on envelope

Fingernail Evidence

Collect if patient reports scratching assailant or examiner believes nail debris may be related to assault. Obtain when visible debris or blood under nails, nails broken during assault and/or history suggests patient scratched assailant

1. Either patient or examiner may collect fingernail scrapings (if patient, examiner must observe).
2. Evidence from each hand should be collected individually. Place small paper sheet on flat surface
3. Using disposable plastic scraper, scrape under all five fingernails of left hand (or right), allowing any debris to fall onto paper
4. Bindle paper (fold all edges inward so that there are no open edges) to retain debris and scraper
5. Place each paper and scraper in a separate labeled envelope
6. Place both envelopes in the larger envelope
7. Seal envelope, place patient label over seal, sign over seal and store securely in the kit
8. Fingernail swabbings may be obtained if the fingernails are short. Use one moistened swab for each set of nails.

Debris

Collect when foreign material is visible on patient's skin or hair and patient reports, or examiner believes, debris is related to the assault. Collect grass, fibers, paint flecks, etc. which may adhere to patient's skin.

1. Collect any foreign debris (dirt, leaves, fiber, hair, etc.)
2. Separate debris – Do NOT collect unlike debris from one site or like debris from different sites in the same envelope
3. Note site from which debris is obtained on the envelope
4. Seal envelope, place patient label over seal, sign over seal and store securely in the kit

Trace Evidence/ Collection Paper

To collect foreign material which may fall when patient undresses.

1. Place bed sheet or large paper sheet on floor. This is to prevent floor debris from adhering to evidence collection paper
2. Place evidence collection paper sheet over the bottom sheet
3. Instruct patient to stand in the center of paper and remove clothing
4. Bindle paper (fold all edges inward so that there are no open edges) where patient stood, retaining any foreign material, and place in paper bag as forensic evidence: seal, label, and sign over seal

Clothing Collection

If assault occurred out of doors, or clothing was stained or damaged during assault, collection is particularly important. Collect the clothes the patient was wearing during or immediately after the assault except underwear which should always be collected. Wet clothing should be dried in a secure room or area, or transferred to law enforcement ASAP. Do not cut through any existing holes, rips, or stains. Do not shake out victim's clothing or trace evidence may be lost.

1. Do not fold wet or bloody clothing in a way which will transfer the blood or fluid to another site on the clothing – layer paper and/or linen prior to folding to prevent transfer
2. Consider taking photographs of relevant clothing i.e., rips, tears, body fluids, debris, etc.
3. Place each item of clothing in a separate paper bag labeled with contents
4. Place patient label on each bag, fold over top of bag, tape bag closed, and sign over tape
5. Document anything unusual about clothing i.e., rips, stains, bites which occurred through clothing, etc.
6. Maintain chain of evidence for clothing bags. Place in secured area when not directly observed

Underwear

Collect patient's underwear routinely even if changed after assault.

1. Pooled secretions may leak onto underwear
2. Package patient's underwear in a small paper bag labeled with contents.
3. Place patient label on bag, fold over top of bag, tape bag closed, and sign over tape

Other Items

Collect items which may contain forensic evidence, such as tampon or pad, and condom. These should be collected on a case-by-case basis. Contact Crime Lab for further drying and storage instructions if needed.

1. Air dry the item if possible. If unable to air dry, package the item in a non-air tight container, such as a urine cup with holes in the lid to allow the item to dry. Contact law enforcement for transport ASAP
2. Place patient label over seal, sign over seal, and store with kit or in separate paper bag.

Dried Secretions

Examples of dried secretions may be vaginal secretions on a penis, saliva on a bite mark, penis or external genital area and dried blood.

1. Use sterile cotton swabs.
2. To obtain swabs from dry areas (i.e., skin, fingertips, rectum, and any areas that may contain DNA) lightly moisten a swab with distilled water (soaking in water will prolong drying time and increase likelihood of specimen molding) and swab area of interest. Then swab moistened area with another dry swab. Collect both swabs.
3. When collecting a penile swab, the entire external area of the penis should be swabbed. Care should be taken to avoid the area around the urethral opening.

As each swab is obtained

1. Place swabs in drying rack from kit or drying box in secure area.
2. Allow swabs to thoroughly air dry.

When swabs are dry

1. Place all swabs from same site in one swab box and then into appropriate envelope.
2. Label swab box and envelope with site from which specimen is obtained.
3. Affix patient label to front of envelope.
4. Seal envelope with tape or patient label, sign over tape/seal and store securely in evidence kit.

Pubic Hair Collection

Pubic Hair Combings For Male and Female

To collect foreign hairs and debris. Omit if pubic hair is not present or has been shaved.

1. Either patient or examiner may do actual combing (if patient, examiner must observe).
2. Patient should be sitting or lying in dorsal lithotomy position.
3. Place paper sheet under the victim's buttocks.
4. Using disposable comb, comb pubic hair in downward strokes so that any loose hairs and/or debris will fall onto paper.
5. Bindle paper to retain both comb and any evidence present.
6. Place in envelope, place patient label on envelope with contents identified.
7. Seal envelope with tape or patient label, sign over tape/seal and store securely in evidence kit.

Pubic Hair Collection Male and Female

DO NOT PLUCK PUBIC HAIRS!!

1. The victim may collect his/her own pubic hair standards
2. Obtain at least 20 hairs by cutting them at the skin surface. The hairs should be collected from various areas within the pubic region
3. Place the hairs in the Pubic Hair Standards envelope, place patient label on the envelope and seal.

Vaginal Swabs And Smear

Collect when

1. Assault occurred within prior 96 hours **and**
2. History of penile-genital or oral-genital contact **or**

3. Report of contact to genitalia, perineum by any part of assailant's body **or**
4. Ejaculation occurred near anogenital area **or**
5. Visible acute genital injury **or**
6. Alternative light source scan is positive in anogenital area

Procedure

1. Using four (4) swabs simultaneously, thoroughly swab the vaginal vault.
2. Immediately prepare one smear using all four swabs simultaneously.
3. Allow swabs and smear to thoroughly air dry

When swabs/smear are dry

1. Return smear to slide holder and shut
2. Place all swabs from same site in one swab box and then into appropriate envelope
3. Label swab box with specimen site
4. Affix patient label to front of envelope
5. Seal envelope with tape or patient label, sign over seal and store securely in evidence kit.

Cervical Swabs And Smear

Collect when

1. Assault occurred within prior 96 hours **and**
2. History of penile-genital or oral-genital contact **or**
3. Report of contact to genitalia, perineum, by any part of assailant's body **or**
4. Ejaculation occurred near anogenital area **or**
5. Visible acute genital **or**
6. Alternative light source scan is positive in anogenital area

Procedure

1. Using two (2) swabs simultaneously, thoroughly swab the cervix including the os.
2. Immediately prepare one smear using both swabs simultaneously.
3. Allow swabs and smear to thoroughly air dry.

When swabs/smear are dry

1. Return smear to slide holder and shut
2. Place all swabs from same site in one swab box and then into appropriate envelope
3. Label swab box with specimen site
4. Affix patient label to front of envelope
5. Seal envelope with tape or patient label, sign over seal and store securely in evidence kit.

Rectal Swabs and Smear

Collect when

1. Assault occurred within prior 96 hours **and**
2. Report of contact to anus by any part of assailant's body **or**
3. Ejaculation occurred near anogenital area **or**
4. Visible acute anal injury **or**
5. Alternative light source scan is positive in anogenital area

Procedure

1. Lightly moisten swabs with distilled water if area is dry.
2. Using two (2) swabs simultaneously, thoroughly swab the rectal canal
3. Immediately prepare one smear using both swabs simultaneously.
4. Allow swabs and smear to thoroughly air dry

When swabs/smear are dry

1. Return smear to slide holder and shut
2. Place all swabs from same site in one swab box and then into appropriate envelope
3. Label swab box with specimen site
4. Affix patient label to front of envelope
5. Seal envelope with tape or patient label, sign over seal and store securely in evidence kit.

Crime Lab Toxicology

If drug facilitated sexual assault is suspected, specimens for analysis should be collected as soon as possible.

1. Collect only if date rape drugs are suspected of being ingested (i.e., victim lost consciousness or had significant periods of memory loss that are not explainable) and the patient is reporting to law enforcement.
2. Blood and urine should be collected within 24 hours of suspected drugging. Urine ONLY should be collected > 24 hours but within 4 days of suspected drugging.
3. Blood sample – fill a 10ml gray-top tube (State Lab of Hygiene Implied Consent Collection Kit) with blood. An alternative is to use 2 (7ml) lavender-top tubes.
4. Urine sample – Obtain urine as soon as possible. Collect the urine from the patient according to hospital protocol. Fill a 10ml gray-top tube (State Lab of Hygiene Implied Consent Collection Kit) with the collected urine.
5. Seal samples and place inside an appropriate biological mailing container (State Department of Hygiene Implied Consent Collection Kit). Fill out all information requested on the Optional Toxicology Samples label. Affix the label to the mailing container.
6. Transfer specimens to law enforcement to be processed by the Crime Lab. Do **NOT** send these samples to the State Laboratory of Hygiene.
7. Blood and urine samples must be kept refrigerated if not taken to the Crime Lab immediately.

Completing Evidence Collection Kit

1. Once all evidence has been placed inside the kit:
   a. Complete information requested on the cover of the kit
   b. Place a patient label on the kit, seal and initial
   c. Give the kit to the law enforcement representative and have the officer sign the cover of the kit
   d. Have the officer complete and sign the SANE/FNE Sexual Assault Report Evidence Collection Sheet for chain of custody
2. If no law enforcement representative is available, store the kit in a secure area, contact law enforcement immediately and give them the location of the completed kit so they can pick it up ASAP

Evidence Storage

Temperature

1. Dry evidence may be kept at room temperature
2. Damp or wet evidence specimens should be thoroughly air dried. If this is not possible, these specimens must be given to law enforcement with instructions for further drying

3. Blood tubes and/or urine samples (toxicology) must be kept refrigerated if not taken to Crime Lab immediately

Clothing

1. Each piece of dry clothing should be placed in a separate paper bag, sealed with tape, signed over seal, and labeled with patient ID and contents
2. Wet clothing should be dried completely – this may be done by law enforcement after SANE/FNE exam

To process as Forensic Evidence

1. Place all evidence in paper bag, envelope, or kit
2. Seal envelope, place patient label over seal, sign over seal, and place in evidence kit
3. Biological specimens (swabs, slides) should be labeled with site obtained from
4. All evidence in kit should be dry
5. Any wet evidence should be fully air dried, this may be done by law enforcement after exam
6. Store entire, sealed kit at room temperature in a secured area until transfer to law enforcement
7. Toxicology – blood tubes and / or urine samples should be sealed in the appropriate biological mailing container (State Laboratory of Hygiene Implied Consent Collection Kit) until transferred to law enforcement. These specimens should be refrigerated if not taken to Crime Lab immediately.

Drying Box

1. Clean drying box with antimicrobial cleaning solution per institution protocol

V. INITIAL LAB TESTS

<u>**Pregnancy Test**</u>

Obtain urine or serum pregnancy test on all patients at risk of pregnancy

<u>**Toxicology Tests**</u>

Obtain toxicology and/or alcohol level when:

1. Patient appears impaired, intoxicated, or has altered mental status
2. Patient reports blackout, memory lapse, or partial or total amnesia for event
3. Patient or other is concerned that he or she may have been drugged
4. Separate consents for toxicology specimens need not be obtained, but patient should be informed that specimens are obtained
5. Samples for toxicology should be obtained ASAP

Hospital toxicology

1. If toxicology and/or alcohol results are needed for patient care, stat hospital toxicology tests must be done

Crime Lab toxicology (if assault reported to law enforcement)

1. Drug and alcohol testing may be done for legal purposes; legal specimens follow a chain of custody and are given to law enforcement (not processed

through hospital lab)
2. See Section IV. **Evidence Collection & Storage**

Toxicology for non-reporting patients

1. Drug and alcohol testing may be done if the patient requests such testing
2. These specimens are not given to law enforcement
3. Testing should be done according to hospital protocol.
4. The results to such testing will become a part of the patient's medical record

VI. MEDICAL EXAMINATION

General Information

1. All patients should receive a complete head-to-toe physical examination.
2. It is the patient's right to consent or refuse any aspect of the exam and evidence collection.
3. The patient may have a support person (relative, friend, or advocate) present during the exam.
4. General
   a. Document developmental level, emotional status, mental status and general appearance
   b. Document objective observations: "patient avoids eye contact and is teary-eyed" is preferable to "patient is sad"
   c. Vital signs, height, and weight

Exam Procedure

The following sections outline the steps for the exam and collection of evidence. The order of these steps may vary by examiner preference or patient need.

Oral Exam

Document **Lacerations, abrasions, petechiae, and bruises and how injury acquired, if known. Document sites of pain even if no injury is noted. Check mucosa, palate, upper/lower frenula and tongue**

Forensic Swabs See Section IV. **Evidence Collection & Storage**

Skin Exam

Document **Bruises, petechiae, abrasions, lacerations, bite marks, and suction ecchymoses and how injury acquired, if known. Document sites of pain even if no injury is noted.**

1. Describe traumatic lesions and marks on anatomical sheets.
2. Ask patient how each injury occurred and document patient's statement.
3. Confirm that photos have been taken and/or a drawing completed of acute traumatic lesions.
4. Using alternative light source with room lights dimmed, scan patient's skin surface, including breasts, abdomen, perineum, hair, face, buttocks, and thighs:
   - Semen may fluoresce
   - Document presence/absence and location of fluorescence
   - If history indicates presence of evidence, collect blind swab from area even if no fluorescence is noted

Forensic Swabs See Section IV**. Evidence Collection & Storage**

<u>Genital Exam – Female</u>

Document **Genital lacerations, abrasions, bruises, petechiae, erythema, inflammation, bleeding, edema, discharge, degree of estrogenation. Document sites of pain even if no injury is noted.**

1. Use vaginal speculum to visualize vagina and cervix, and note lacerations, abrasions, petechiae, and bruising
2. <u>Do not use</u> lubricant for speculum. May rinse speculum in warm water for patient's comfort.

Forensic Swabs See Section IV**. Evidence Collection & Storage**

For young adolescents who have not had a prior pelvic exam, or any patient who cannot tolerate a speculum exam, forensic swabs may be collected by directly inserting swabs 2-3 inches into the vagina

Do not moisten swabs for areas that are moist

<u>Genital Exam – Male</u>

Document **Penile, scrotal or perineal abrasions, bruises, lacerations, petechiae, bleeding, edema, discharge, erythema, inflammation, tenderness and Tanner Stage. Document sites of pain even if no injury is noted.**

Retract foreskin to examine glans penis

Forensic Swabs See Section IV**. Evidence Collection & Storage**

<u>Perianal and Anal Exam</u>
<u>Male and Female</u>

Document **Perianal bruising, petechiae, edema, discharge, bleeding, tenderness, abrasions, lacerations, erythema, inflammation, and visible anal laxity. Document sites of pain even if no injury is noted.**

Exam Technique

1. Use good light source
2. Separate anal folds to visualize injuries
3. Digital exam is not indicated, except if concern for foreign body retention
4. Anoscopy is indicated if there is a report of anal assault, active rectal bleeding or rectal pain. May require physician consult.
5. Lubricant should be used for anoscopy. To avoid contamination by lubricant, perform anoscopy only <u>AFTER FORENSIC SWAB COLLECTION</u>

Forensic Swabs See Section IV**. Evidence Collection & Storage**

VII. DIAGNOSTIC TESTS FOR MEDICAL TREATMENT

The following tests and procedures are not recommended for forensic purposes but may be done for patient care

Pregnancy Test

Obtain urine or serum pregnancy test on all patients at risk of pregnancy prior to administration of emergency contraception

Toxicology Tests

See Section **V. Initial Lab Tests**

Vaginal Wet Mount

1. May be used to assess vaginitis if signs and symptoms are present
2. Request that lab check and report presence of sperm

STI Tests for Gonorrhea and Chlamydia

1. STI testing, if done at time of acute assault, should be repeated at follow-up visit
2. Specimens for STI testing go to hospital / clinic lab NOT to Crime Lab
3. Inform patient that these tests are related to health issues and are not exclusively for forensic purposes
4. Positive tests may indicate pre-existing infection
5. For vaginal or penile infection
   - Urine, cervical or penile/urethral swabs for MAD (Molecular Amplification Detection) test or vaginal or penile culture for gonorrhea and chlamydia
   - Positive MAD test must be confirmed by culture if results to be used for forensic purposes
6. For anal infection
   - Culture for gonorrhea and chlamydia
7. For pharyngeal infection
   - Culture for gonorrhea
   - Do not culture for chlamydia

STI Tests for Syphilis and Syphilis Serology

1. Syphilis baseline test may be offered with knowledge of community epidemiology
2. Syphilis serology is best done 3 months after exposure

HIV Testing

1. Baseline HIV testing is generally not recommended in the emergency department
2. Baseline HIV testing may be performed up to two weeks post assault and may be performed in follow-up visit or preferably by the primary care provider
   - If the patient wishes HIV serology testing in the emergency department, pre-test counseling must be done and post-test counseling arranged
   - Patient must exhibit understanding that testing does not reflect acquisition of HIV from the assault, but related to possible exposure 2 months or more prior
3. If testing is done, arrangements must be made for follow-up visit to discuss results

Hepatitis Serology

1. Indicated if patient is unsure of Hepatitis B immune status
2. Hepatitis B/C serology is best done 3 months after exposure

VIII. TREATMENT

Pregnancy Prevention

Every patient who is at risk for pregnancy will be offered prophylactic treatment for pregnancy prevention. Document on the medical record if the patient declines pregnancy prophylaxis.

Offer emergency pregnancy prophylaxis when:

1. Patient is at risk for pregnancy and
   - patient is not using highly reliable method of contraception such as oral contraceptives (no pills missed in a cycle), Depo provera or IUD and
   - pregnancy test is negative
2. Emergency contraception must be given within 120 hours of a sexual assault to be effective.

Medications used

"Plan B" or what hospital has within formulary.

- "Plan B" can be given 1 tab every 12 hours or as 2 tabs immediately, anti-emetics not needed

STI Prophylaxis

Every patient will be offered prophylactic treatment for sexually transmitted infections per current CDC guidelines

The following recommended antimicrobial regimen for treatment of chlamydia, gonorrhea, trichomonas, and BV may be administered to **pregnant** and **non-pregnant** adolescent and adult patients of acute sexual assault (MMRW, May 10, 2002 and http://www.cdc.gov/std/treatment):

Azithromycin 1.0 gm orally in a single dose (Chlamydia)
PLUS
Metronidazole 2 gm orally in a single dose (Trich/BV)
PLUS
Ceftriaxone 125 mg IM in a single dose (GC)

Alternative Medication Regimens

1. Chlamydia
   Erythromycin base 500mg PO QID x 7 days
   OR
   Erythromycin ethylsuccinate 800 mg PO QID x 7 days
   OR
   In non-pregnant patients:
   Doxycycline 100 mg PO BID x 7 days
   OR
   Ofloxacin 300 mg PO BID x 7 days
   OR
   Levofloxacin 500 mg PO x 7 days
2. Gonorrhea
   In non-pregnant patients:
   Ciprofloxacin 500 mg PO in a single dose
   OR

Ofloxacin 400 mg PO in a single dose
OR
Levofloxacin 250 mg PO in a single dose

Hepatitis B Vaccine

Offer when

1. Patient has not been previously fully immunized for Hepatitis B **and**
2. Patient has a negative history of Hepatitis B **and**
3. Secretion-mucosal contact occurred during assault **and**
4. Patient signs consent for immunization
5. Inform patient that repeat vaccine doses are necessary at one month and six months after initial vaccine

Tetanus Prophylaxis

Offer when

1. Skin wounds occurred during assault **and**
2. Patient is not up-to-date for Tetanus immunization (no immunization past 5 years)
3. Patient signs consent for immunization

HIV Prophylaxis

Every patient will be offered prophylactic treatment for sexually transmitted infections, with the exception of HIV. In the case of HIV, the patient will be offered information regarding HIV and appropriate medical follow up for HIV. Prophylactic treatment for HIV may be started in the emergency department if the emergency department has prophylactic HIV protocols in place

Generally prophylaxis not recommended, except in cases considered high risk:

- Assailant gay or bisexual male, IV drug user, prostitution history or from endemic area
- Assailant known to have HIV
- Multiple assailants

IX. DISCHARGE AND FOLLOW-UP CONTACT

Discharge

1. Discuss safety issues / plan
2. Appropriate medical follow-up will be identified for the patient with respect to the evaluation of possible sexually transmitted infections, pregnancy and any physical injuries sustained during the assault
3. Explain follow-up for test results
4. Offer patient education materials
5. Confirm plans for medical and counseling follow-up
6. Give phone number for sexual assault victim advocate and other support services
7. Follow-up counseling information will be provided to the patient by the sexual assault advocate or the forensic examiner
8. Give written discharge instructions for all treatment and follow-up

9. Information on area resources concerning medical follow-up, crisis intervention phone numbers, sexual assault crisis centers, shelters, CPS, Crime Victim Compensation Program, law enforcement and the district attorney's office will be given to the patient at the time of discharge
10. Per community protocol, refer minor patients to local child abuse intervention center for medical and forensic follow-up

Follow-Up

Recommended within two weeks of the initial exam

Review with patient or parent/guardian

1. Emergency department / clinic record
2. Lab results
3. Current physical symptoms
4. Emotional reactions (sleep disorders, anxiety, depressive symptoms, flashbacks, other)
5. Concerns for safety
6. Concerns regarding STIs and HIV
7. Assess social support (family, friends)
8. Additional history or any new information regarding the assault
9. If patient is a minor report any new allegations to law enforcement and/or CPS as appropriate
10. Document follow-up contact and additional referral(s) made within the medical record.

Referral

Refer for further medical follow-up, mental health and social services

RESOURCES

Wisconsin Coalition Against Sexual Assault (WCASA)………..…. (608) 257-1516

Wisconsin Coalition Against Domestic Violence (WCADV)……..... (608) 255-0539

National Domestic Violence Hotline………………………………... (800) 799-SAFE

Rape and Incest National Network (RAINN)…………………...… (800) 656-HOPE

Completed on March 1, 2006 by the members of the Wisconsin Chapter of the International Association of Forensic Nurses Documentation / Protocol Subcommittee:

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