INTERNATIONAL ASSOCIATION OF Forensic Nurses

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Sample Policies and Procedures

FOR FORENSIC NURSING PROGRAMS

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Introduction

Professional nursing practice regulations serve to protect the healthcare consumer, the patient (ANA, 2021). Regulation of professional nursing practice encompass multiple components, including evidence, independent professional actions of the nurse in their setting, influencers, safety and quality (ANA, 2021). Influencers include the nursing Code of Ethics, Nursing Scope and Standards of Practice, specialty certification, practice setting, organizational policies and procedures, Nurse Practice Acts, administrative codes, position statements and board of nursing regulation (ANA, 2021). As such, policies and procedures are essential to clinical nursing practice, regardless of setting.

Policies and procedures should reflect the most current evidence base, as well as any accreditation requirements or federal, state or local rules (ANA, 2021). All policies and procedures should follow organizational expectations with regard to the development and approval process, as well as expectations regarding frequency of review and update.

The sample policies and procedures found here represent examples that may be used to craft policies and procedures for forensic nursing programs in need of templates to assist in the development the program's own policies and procedures. They are not all-inclusive of local-level rules, regulations and laws. If a program chooses to utilize any of the policies and procedures contained in this manual, they should take care to adhere to their own organizational and local laws, rules and regulations. Additionally, the samples provided here are commonly needed within forensic nursing programs, but do not necessarily represent all the policies necessary at a given program.

For additional assistance with policy development IAFN encourages you to reach out through safeta@forensicnurses.org or to consult your local authorities.

REFERENCES

American Nurses Association (2021). Nursing Scope & Standards of Practice (4th Ed.). Silver Spring, MD. ANA.

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Sexual Assault Medical Forensic Examination Policy	
Effective Date:	Replaces Policy:
Approval Date:	Policy Owner:

Statement/Rationale

Sexual Assault Nurse Examiner (SANE), is a registered nurse who has received specialized education in the provision of comprehensive care to patients of all ages and genders who have been or are suspected of having been sexually assaulted, abused or exploited. The SANE demonstrates competency in conducting a complete medical forensic exam, including evidence collection where appropriate, and implementation of an individualized treatment plan in collaboration with appropriate professionals both inside and outside the health system.

Policy

The first priority of the Emergency Department personnel is to provide appropriate medical care for any life-threatening injury that may be present. After appropriate treatment has been rendered for life-threatening injuries, the SANE will obtain a history, conduct a head-to-toe exam, perform a detailed anogenital exam, collect forensic specimens for evidentiary purposes where appropriate and provide treatment to the patient on an individualized care level appropriate for both the patient's developmental and cultural needs, within the mandatory reporting requirements of state law. Whenever possible, the SANE will work contemporaneously with the ED team in the provision of this care.

Standard of Care

The SANE/SAFE will facilitate a timely medical forensic exam, provide consistency throughout the exam, deliver a compassionate and sensitive approach, and provide detailed referrals for follow up. The patient who presents to the ED with known or suspected sexual assault has the option of receiving evidence collection as part of their care if they are examined acutely (within 120 hours for adolescents or adults; within 72 hours for prepubescent children) following the assault (IAFN, 2023). The patient has the right to understand the limits of confidentiality as it applies to the medical forensic examination, the examiner's mandatory reporting requirements and the patient's right to cooperate or not with law enforcement (USDOJ, 2013).

Standards of Practice

Emergency Department Admission

When a patient presents to the ED reporting sexual abuse or assault, the patient will be triaged to assess the urgency of the patient's condition. In addition, the triage nurse will notify the in-house

or on-call SANE and (insert name of local community-based advocacy org) our local victim advocacy agency, to respond to the ED.

A. Stabilizing the patient's medical condition is a priority. All reported sexual assault patients presenting to the ED will receive a medical screening exam (MSE) by a physician or a SANE.

B. A member of the ED staff will be assigned to assist the patient by providing information about the ED process and SANE procedures. The designated staff member will remain in contact with the patient until the victim advocate and SANE arrives. All patients will be provided as much privacy as possible for registration and waiting until the Victim's Advocate and SANE have arrived. ED staff should keep patient informed of calls to advocacy and SANE and the estimated time of arrival.

C. An ED record will be generated with appropriate authorization for medical/surgical treatment. The ED record and the medical/forensic documentation of the examination and treatment shall be the official medical record for all medical treatment rendered.

Guidelines for Physician Consultation

A. The SANE is responsible for obtaining physician consultation at any time during the exam if the patient's history or physical exam reveal the following:

1. Patient reports history of loss of consciousness
2. Patient reports strangulation or suffocation
3. Decreased level of consciousness, disorientation or other neurologic deficit
4. Patient reports any specific physical complaints such as chest or abdominal pain, head injury or twisting/blunt force injury of extremities resulting in limited range of motion.
5. There is any evidence of bodily injury, trauma or physical deformity that requires intervention
6. There is evidence of genital trauma requiring intervention
7. There is reported history or evidence of rectal or vaginal instrumentation.
8. Evidence of significant substance use/abuse
9. Bleeding from an unidentified source

B. The SANE will use professional judgment regarding additional consultation criteria and obtain physician intervention when needed. If a physician consultation is obtained, the SANE remains responsible for head- to-toe assessment and injury documentation, photo-documentation, evidence collection, appropriate medication prophylaxis or treatment, and discharge education.

C. In the event that serious/life-threatening trauma exists, the evidentiary exam will be deferred until such time that it can be performed without interfering with acute/trauma care but as soon as practical to preserve existing evidence. Assisting ED and trauma personnel regarding evidence protection/preservation will be undertaken when necessary.

Patient History-Taking

A. Provide an area for the patient that provides the following:

1. Sound and visual privacy
2. Environmental comfort

B. The entire assessment and examination procedure should be explained, allowing ample time for questions and answers.

1. All procedures and options should be carefully explained. If the patient declines any portion of the exam and/or evidence collection, review with patient positive and negative aspects of that decision so they may make an informed decision.
2. Assess the patient's ability to tolerate the examination physically and emotionally.
3. Obtain the patient's consent and signature on the appropriate forms.

Obtaining a History

A. The history is obtained to assist in determining diagnosis and treatment.

1. The first objective is to identify and delineate specific historical information and any acute complaints that require immediate medical intervention and/or treatment.
   i. Evaluation and intervention for acute injuries in the sexually assaulted patient should proceed immediately. Historical data regarding medication allergies, current medications, hepatitis B and tetanus immunization status, as well as risks from exposure (pregnancy, STI, HIV, etc.) are essential to ensure optimal medical care
2. The second objective is to guide the evidentiary aspects of the medical /forensic examination.

B. The history should be detailed enough to focus the examiner's effort on the area of injury, potential disease process or evidence.

C. If the patient is choosing to cooperate with law enforcement, the SANE may, at their discretion, allow the investigating officer to interview and process the police report before or after the physical examination. Law enforcement should not remain in the exam room for either the history-taking or examination.

Emergency Department Record

A. The medical/forensic record must be completed to include the ED record, SANE standing orders, documentation of history, detailed head to toe examination, detailed anogenital examination and collection of forensic evidence per state protocols, as well as treatment rendered.

B. The medical/forensic record should be completed at the time of evaluation.

Equipment Needed

A. Gather the following equipment:
   1. State/territory approved kit for the sexual assault victim
   2. Evidence tape
   3. Urine collection container (for uHCG or DFSA)
   4. Vaginal speculum for adult/adolescent examinations
   5. Appropriate cultures as indicated for pediatric and adult examinations
   6. Vaginal and overhead light sources, ALS, colposcope, toluidine blue swab and foley catheter
   7. Envelopes and paper bags

B. Patient labels.

C. Pre-label collection envelopes, slides, and bags as much as possible, before starting the collection process.

Physical Examination and Evidence Collection

A. The accurate collection and preservation of evidence is essential. Once the evidence collection begins, the SANE should maintain chain of possession until evidence has been given to law enforcement. Powder-free gloves should be worn and changed as necessary during all collection steps.

B. Each step of the examination and collection process should be explained to the patient prior to collection.

C. The patient will be instructed to remove the clothing worn at the time of the assault/abuse while standing on the provided drapes. Place the patient in a hospital gown; ensure that the patient is comfortable with temperature of room.
   1. Refold the upper drape to contain any trace evidence and place in envelope; discard the lower drape.
   2. Collect patient's clothing as appropriate depending upon whether or not the patient has changed clothes since the assault.
   3. Advise patient of availability of clothing kit (provided at no cost through the (insert charitable organization name here) or arrange for fresh clothing to be brought to the ED. Explain why clothing may not be returned once collected. Follow these guidelines when collecting clothing:
      i. Each article of clothing should be dried and placed in a separate paper bag and labeled appropriately. Note any damage and report to law enforcement. If clothing cannot be fully dried prior to packaging, it should be packaged in appropriate paper bags, sealed and placed in an open plastic bag. This should be communicated with the retrieving law enforcement official.
      ii. Sanitary napkins, panty liners and/or tampons should be air-dried, placed in a

paper bag or envelope, sealed and labeled. Tampons may be difficult to dry. If this is the case, the SANE should package in a urine specimen cup after ensuring holes in the container have been created.

iii. Each bag/container should be labeled with the patient's name, medical record number, date & time collected, description of article and collector's initials.

Head to Toe Assessment

A complete head to toe inspection must be done to assess for any signs of trauma and/or foreign material.

A. Include inspection, auscultation and palpation (where applicable) and document findings on the medical/forensic record.

B. Consult with ED physician for further studies if indicated.

Collection procedures

A. Trace evidence- place any extraneous hairs, fibers, plant material soil, glass, paint, etc. (when found on the patient or left behind on the examination table) in a bindle. Fold bindle to contain trace evidence, place bindle in envelope, seal and label. Note location(s) of recovery in documentation and on envelope

B. Oral evidence collection (for oral penetration)- rub around gum line and buccal area with two cotton swabs held together. Prepare smear slide, air dry, label and seal in holder. Dry swabs utilizing swab dryer. Place in envelope, seal and label. Patient should rinse mouth after this step and wait 15 minutes prior to buccal swabs for controls.

C. Anal contents (for anal penetration)-swab crypt with two cotton swabs held together (may be dampened with sterile water or saline to minimize discomfort). Prepare smear slide, air dry, label, place in holder and seal. Dry swabs utilizing swab dryer, place in envelope, seal and label including identification of any liquid used to assist collection (i.e., Saline or water).

D. Detailed genital examination- with the patient in the appropriate position for developmental stage (lithotomy, supine knee-chest etc.), the SANE will examine the external genitalia visually using labial separation and traction and with colposcope, if available, to assess for signs for trauma or disease process. The internal structures will then be examined in the same manner if developmentally appropriate.

1. Use an appropriate size speculum, moisten with water or minimal amount of lubricant (i.e., KY jelly), for estrogenized adolescents and adults.

2. Sample vaginal vault with two cotton swabs held together. Prepare smear slide, air dry, label, place in slide holder and seal. Dry swabs utilizing swab dryer., place in envelope, seal and label**. For the male patient**, swab the penile shaft and scrotum with two cotton swabs held together and moistened with sterile water or saline, **avoiding** the urethral opening. Dry swabs utilizing swab dryer, place in envelope, seal and label.

3. In the adolescent/adult sample cervical os and face of cervix with two cotton swabs held together, prepare smear slide, air dry, place in slide holder, label and seal. Air dry all swabs, place in envelope, seal and label.

4. The hymenal rim (in the estrogenized female) may be best visualized using a Foley catheter inserted into the vagina. Inflate the balloon with air and pullback slowly on the catheter until the hymen is stretched over the balloon and document any signs of trauma. The hymen can also be evaluated running the rim with a fox swab. The fox swab should be covered with an exam glove or moistened with saline prior to running the rim. Neither of these techniques should be used in the prepubescent child.
5. Prepubescent anogenital examination
    i. Place the patient in the supine frog-leg position and examine the genital structures visually and with colposcope utilizing labial separation and traction assessing for trauma. The hymen should be inspected for signs of trauma and documented. Redundant hymenal tissue may be best visualized by instilling water/saline on the hymen, or by examining the child in knee-chest position.
    ii. If any drainage or signs of infection are visualized, swabs of the drainage should be obtained and cultured. Remember to establish a chain of custody for any specimens sent to lab. See protocol for obtaining STI cultures in children. **Avoid touching the prepubescent child's hymen with a swab.**
    iii. Place the patient in the knee-chest position to complete hymenal visualization. The rectal area should also be visualized from this position looking for trauma, drainage and rectal tone abnormalities. In the male patient the SANE will visually inspect the genitalia and use the colposcope to document any signs of trauma observed.
6. In the male patient the SANE will visually inspect the genitalia and use the colposcope to document any signs of trauma observed.

E. Foreign stains on body- use two cotton swabs, held together, dampened with sterile water/saline to remove foreign stains deposited found on the patient's body. Dry swabs utilizing swab dryer. Place in envelope, seal and label including location.
    1. Bite marks - swab inside and outside bite mark area, and photograph with digital camera with and without the ABFO # 2 standard.

F. Fingernail swabbings - if indicated use enclosed swabs to swab under each nail on both hands, place swabs in envelope provided. Seal envelope and complete label.

G. Buccal swabs (to obtain the patient's DNA sample)- rinse patient's mouth and allow nothing by mouth for 15 minutes prior to collecting sample. Hold two swabs together and swab both inner cheeks. Dry swabs utilizing swab dryer, place in envelope, seal and label.

H. All evidentiary specimens collected are returned to the evidence kit, along with the designated copies of documentation and sealed with evidence tape. If kit tracking system is in place, scan kit information according to process. Sign the chain of custody and ensure law enforcement signs the chain of custody. Inform law enforcement of any needs regarding refrigeration. Release the evidence.

Drug Facilitated Sexual Assault (DFSA)

A. Depending on the circumstances surrounding the assault, testing for the presence of drugs and /or alcohol may be considered part of the evidence collection and significant to the

investigation of the sexual assault.

B. Routine drug screens and/or alcohol levels are not recommended but should be obtained if medically indicated.

C. Collect specimens according to the following guidelines if the patient exhibits symptoms associated with possible 'date rape' drug ingestion.
   1. If ingestion was within 24 hours, collect both blood (gray top) and urine specimens (90cc) according to state protocol. Blood specimen should be refrigerated as soon as possible. Urine specimen should be frozen as soon as possible.
   2. If ingestion was between 24 and 120 hours, collect only the urine specimen.
   3. If ingestion was greater than 120 hours, collect NO specimen.
   4. Complete a chain of custody form on each specimen and transfer to the appropriate law enforcement agency when transferring the kit.

Treatment

A. Pregnancy prophylaxis will be offered to every estrogenized female with a history of reported sexual assault involving penile-vaginal contact, within 120 hours of the assault following the standard order set. A negative HCG, is **required** prior to consideration for prophylaxis. A consent form must also be obtained.

B. Prophylaxis for sexually transmitted infections will be offered to all patients (adolescent/ adult) with a history of vaginal, oral, and/or anal/rectal penetration following the standard order set.

C. Prophylaxis for tetanus will be offered to all patients with any injury that breaks the epidermis if the patient has not received tetanus immunization in the past ten years following the standard order set.

D. If the patient falls into the high-risk category for having been exposed to HIV during the sexual assault, and they are within the first 72 hours following the assault, the SANE will consult with the ED physician to offer HIV non-occupational post exposure prophylaxis (HIV nPEP). If the patient consents to HIV nPEP, the SANE will collect lab work according to the standard order set and begin the recommended nPEP regimen.

Discharge

A. Patient Education
   1. The SANE is responsible for educating the patient on any medication prescribed or given during the visit including how and when it should be taken, the length of time it should be taken, possible side effects and how to manage them
   2. The SANE is responsible for educating the patient on next steps regarding reporting and evidence collection follow-up where appropriate.

B. Follow-up

1. The SANE will outline necessary follow-up STI testing, including where and when it can be obtained
2. If the patient has opted for HIV nPEP, the SANE will outline necessary follow-up for prescriptions, testing, management of side effects and follow-up with infectious disease if necessary.
3. If the patient was strangled, the SANE will ensure strangulation specific discharge instructions are provided.
4. The SANE will provide patient with applicable phone numbers of community resources, including advocacy and the sexual assault hotline.
5. The SANE will answer any questions for patient and/or family

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Pelvic Examination of the Adolescent or Adult Patient Policy	
Effective Date:	Replaces Policy:
Approval Date:	Policy Owner:

Statement/Rationale

According to the American College of Obstetrics and Gynecology (ACOG), a pelvic exam is an examination of your sexual and reproductive organs, including external visualization of the vulva, internal visualization of the vagina and cervix through the use of a speculum and bimanual examination of the uterus and adnexa (ACOG, 2022). During the course of the sexual assault medical forensic exam (SAMFE) of an adolescent who has reached the onset of menses or an adult, a pelvic exam would be indicated if there was a concern or a report of a vaginal assault. The pelvic exam can assist in assessing the vagina and cervix for injury, foreign materials, and foreign bodies, for medical and evidentiary purposes (USDOJ, 2013).

Purpose

This policy provides guidelines for Sexual Assault Nurse Examiners (SANEs) on the administration of the pelvic exam during the SAMFE for a patient who has experienced sexual assault/abuse.

Policy

The pelvic exam should be performed by a SANE who has been trained and evaluated as competent in conducting a pelvic exam, and for whom the exam is within their professional scope of practice (insert the state/territory practice act here). If the SANE is performing the exam and there are indications for intervention outside of the SANE's scope of practice, that SANE must follow their institutional guidelines for obtaining an advanced practice provider's consultation. Patients have the right to decline a pelvic exam. The SANE should educate the patient on the benefits of the pelvic exam as well as the risks of not having the exam performed (e.g., inability to rule out injury, or disease process, and the inability to collect evidence.

If the patient suspected of being assaulted is unconscious due to injury or as yet undiagnosed reasons, the SANE should (insert institutional policy expectations based on approval of legal and ethics departments). If the exam is deferred, care should be taken to avoid activities that could result in loss of evidence (e.g., bathing, washing, etc.) (Constantino et al., 2014; Pierce-Weeks & Campbell, 2008).

If the patient has not reached the onset of menses, a pelvic exam should not be performed unless injury, bleeding or foreign body removal requires the patient be sedated or anesthetized. If there is a concern for significant anogenital injury, bleeding, or foreign body, the SANE should work collaboratively with an advanced practice provider to ensure appropriate sedation or anesthesia to facilitate the examination and evidence collection where indicated (USDOJ, 2016).

Equipment Needed

- Gloves
- Examination table with stirrups (or stretcher with bed pan/pelvic wedge/pillow/towel)
- Speculum (metal or plastic)
- Light source
- Lubrication (Non-spermicidal and water-soluble)
- Colposcope/camera
- Drape

Procedure

A. The procedure is explained and informed consent is obtained from the patient

B. Each step of the procedure is explained to the patient prior to implementation and patient questions are addressed.

C. Gather and arrange necessary supplies.

D. Ensure patient is in a facility gown without underwear on.

E. Apply gloves.

F. Assist patient into lithotomy position (consider other positions if the patient is unable to tolerate this).

G. Position the bed for optimal anogenital assessment

H. Assess all anogenital structures with gross visualization, palpation where appropriate, labial separation and labial traction.

I. Photograph structures using camera or colposcope equipment

J. Complete indicated evidence collection

K. Utilize toluidine blue dye, foley catheter for hymenal assessment, and/or fox swab for hymenal assessment as indicated prior to speculum insertion.

L. Set-up and use appropriate light source for internal vaginal visualization.

M. Apply a small amount of lubrication to the outside tip of the speculum blades if needed.

N. Separate the labia majora posteriorly with one hand while inserting the closed, appropriately-sized speculum into the vaginal orifice and secure in place when cervix is visualized and in place at the end of the speculum blades (if no cervix, secure in place).

O. Inspect all surfaces of the cervix and visible vaginal walls.

P. Photograph structures using camera or colposcope equipment

Q. Collect indicated evidence collection from vagina and cervix.

R. Collect sexually transmitted infection cultures (STIs) as needed.

S. Remove the speculum from the vaginal canal.

T. Complete bimanual exam (if within the scope of the practice of the SANE) to assess for cervical and/or adnexal tenderness.

U. Assist the patient with sitting up in bed and allowing them to use the bathroom or get dressed as appropriate. (Bialy, A., Kondagar, L., & Wray, A, 2022)

If utilizing camera or colposcope for visualization and photography, see appropriate policy.

References

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Colposcopic Exam for the Patient who has Experienced Sexual Assault Policy	
Effective Date:	Replaces Policy:
Approval Date:	Policy Owner:

Statement/Rationale

The use of the colposcope during the anogenital exam can assist with the assessment and identification of injuries of the anogenital structures (Lenahan, et al., 1998). Although there are other techniques available, such as gross visualization, point-and-shoot cameras, and magnification tools, there are benefits to using a colposcope in the exam. This tool allows for substantial magnification, still photo or video documentation, and a light source, and can be easily used in any setting (i.e., child advocacy center, family justice center, Emergency Department.) This is distinguished between colposcopy, which uses the same instrument during a diagnostic procedure to evaluate the cervix, vagina and vulva after an abnormal Pap test (Cooper & Dutton, 2022).

Purpose

This policy provides guidelines for Sexual Assault Nurse Examiners (SANEs) with guidance on how to use the colposcope to help aid in injury identification and documentation during the anogenital exam.

Standard of Care

When using the colposcope with a camera function, the standard of care is to obtain anogenital photo documentation regardless of the presence or absence of injury or disease process at the time of the assessment if the patient consents. The benefits of obtaining colposcopic photo documentation during the exam includes: comparison of findings at follow-up, continuity of care at follow-up, education of the patient and other clinicians, quality assurance review and potential use within the criminal justice system.

Equipment Needed

- Gloves
- Colposcope
- Depending on the type of colposcope- SD card, computer/laptop, monitor
- Drape

Policy

A. The colposcope should be considered as an aid in visualization, assessment and documentation during the anogenital exam and should not be used as an alternative for direct visualization.

B. The colposcope should be used in conjunction with other assessment techniques, such as labial separation and traction, and if indicated toluidine blue dye, foley catheter or fox swab for hymen visualization in pubertal or older patients, evidence collection, etc.

C. Considerations should be made for the type of abuse the patient has experienced. If a camera was used as part of the abuse, using this tool may be traumatizing. Obtaining a history, ensuring informed-consent/assent and allowing for the patient to decline any portion of the exam is imperative to a trauma-informed approach during the exam. If the patient does decline the use of photography, the colposcope can still be utilized for visual examination and documentation with patient consent.

Procedure

A. Explain the colposcope and its use to the patient in developmentally appropriate terms.

B. Obtain consent for colposcope use with or without photography. (If photography, see Medical Forensic Photography Policy).

C. Gather necessary supplies.

D. Perform anogenital assessment using labial separation and traction without the colposcope, identifying all the necessary structures.

E. If using photographs, begin the anogenital series with a photo of the patient identifier (e.g., patient label with name, date of birth etc.).

F. Perform anogenital assessment using labial separation and traction with the colposcope, identifying all the necessary structures while looking through the scope.

G. Obtain colposcopic images of the anogenital structures

H. If an abnormal finding or injury is visualized, obtain an initial photograph of the area, then increase magnification as needed to obtain photographs that depict what is seen. Obtain photographs of each level of magnification and then return to the initial setting before moving on with the assessment.

I. When photographs are complete, end the anogenital series with a photo of the patient identifier.

J. Document assessment and findings in the medical record using the written word and appropriate body maps/diagrams.

K. Secure photo documentation/video per policy.

L. Clean off the colposcope in between each patient and document per policy.

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Medical Forensic Photography Policy	
Effective Date:	Replaces Policy:
Approval Date:	Policy Owner:

Statement/Rationale

The forensic nurse, is a registered nurse who has received specialized education in the provision of comprehensive care to patients of all ages and genders who have been or are suspected of having been exposed to violence including sexual assault, child maltreatment, intimate partner violence, and others. It is the responsibility of the forensic nurse to provide accurate and objective documentation of the medical forensic exam (MFE) (Day et al., 2021). All aspects of patient care should be documented in a complete, accurate, descriptive, and objective manner. The medical forensic record may include written, electronic, and photographic documentation. Medical forensic photography preserves injuries and other findings visualized during the physical examination of a patient who has experienced violence (USDOJ, 2018). It provides a true and accurate representation of the injuries and other findings discovered during the examination, serves as evidence if the case is pursued by the criminal justice system, and becomes an integral part of the patient's medical forensic record (Moore, 2021).

Policy

Photographic images taken during the MFE should be considered part of the patient's medical record maintained by the health care facility (USDOJ, 2016). Due to the sensitive nature of the examination, photo documentation should only be conducted by the forensic nurse. The use of photography after suffering violence can be retraumatizing for the patient, and the forensic nurse must explain the purpose and use of the photographs taken during the examination (USDOJ, 2013). The patient must be made aware of the potential use of photographs during investigation and prosecution, and the need to obtain additional photographs following the exam (USDOJ, 2013). Informed consent (adult patients and caregiver of minor patients) and assent (minor patients) must be obtained prior to photo documentation of any aspect of the medical forensic examination. The forensic nurse must also be aware of potential legal issues associated with the use of filters, alteration of images, and the use of unauthorized equipment and images obtained by law enforcement (International Association of Forensic Nurses, 2018).

Medical Forensic Photography Procedure

A. The forensic nurse should be familiar with photographic equipment operation and be prepared to use it during the examination (USDOJ, 2016).

B. Forensic photograph equipment can include many types of digital cameras or other still or video image capturing devices with magnification capabilities.

C. The fundamental equipment required for taking photographs include a camera (typically digital), tripod, lighting, and measurement device. Some programs may use a colposcope or other device for anogenital photo documentation (Moore, 2021).

D. Informed consent (adult patients and caregiver of minor patients) and assent (minor patients) must be obtained prior to photo documentation.

E. The first and last photographs taken should be of a label that includes the patient's name, date of birth, and medical record number (USDOJ, 2013; USDOJ, 2016).

F. In some jurisdictions a full body photograph is taken as an identification photo, and to show scope of injury or state of clothing.

G. At least three photos at different distances from the body should be taken of each injury (USDOJ, 2016):

    1. Overview image – photo of the injury's location which includes anatomic landmarks for orientation of the injury.
    2. Medium range image – photo of each injury with a wide enough view to identify the specific anatomical site being photographed.
    3. Close-up image of injury – photos taken with and without measuring device. The goal is to capture subtleties in texture and color and any pattern injuries that may be observed. This also demonstrates that the measuring device did not conceal anything important.

H. All injuries noted upon head-to-toe assessment should be photo documented including close-up of hands and fingernails to show traces of blood, skin, or hair; damage to nails, and bite marks.

I. Photo documentation of the anogenital exam with and without injuries varies by age of patient and jurisdictional policy.

J. Photo documentation of the anogenital exam with or without injuries during the medical forensic examination is the standard of care in prepubescent child sexual abuse cases (USDOJ, 2016).

K. Photo documentation of the anogenital exam with or without injuries during the medical forensic examination in the adult/adolescent patient varies between programs and jurisdictions. Some programs only photograph anogenital injuries; others photograph both injuries and normal exam (USDOJ, 2013).

L. Follow-up medical forensic photo documentation may be indicated to document evolution and healing of injuries:

    1. Bruising may appear days later
    2. Clarify nonspecific findings (i.e., erythema) or mimics of injury (i.e., failure of midline fusion) noted on initial exam
    a. Document healing of cutaneous and anogenital injuries

Medical Forensic Photography Review Procedure

A. All photo documentation of the medical forensic examination will be reviewed by the clinical supervisor or medical director.
B. Peer review of written and photo documentation will be conducted per institutional policy.
    1. Every patient seen by program
    2. Specific cases as assigned by clinical supervisor or medical director.

Medical Forensic Photography Storage, Retention, and Release Procedure

A. All components of the medical forensic record including photo documentation should be maintained and retained in compliance with applicable healthcare laws, standards of accreditation bodies, and civil and criminal statutes of limitation (USDOJ, 2018).
B. Storage be secure and maintain patient confidentiality.
C. Forensic patients should provide written consent for release of the medical forensic record unless there is a legal obligation requiring release (i.e., subpoena or mandatory reporting requirements).
D. All adult medical forensic patients should have the right to access their entire medical forensic record, including photo documentation.
E. Non-offending parents/legal guardians of minor forensic patients should have the right to access their child's medical record, however, access to photo documentation is dependent upon institutional policy (i.e., some programs may not release anogenital photos to parent/guardian.
F. If the there are concerns that the health, safety, or well-being of a minor forensic patient could be in jeopardy if medical forensic photographs are released to a parent/guardian, the facility should establish appropriate policies that allow for denial of access.

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Drug Facilitated Sexual Assault Policy	
Effective Date:	Replaces Policy:
Approval Date:	Policy Owner:

Statement/Rationale

A drug-facilitated sexual assault (DFSA) is one in which "a person is subjected to nonconsensual sexual acts while they are incapacitated or unconscious due to the effect(s) of alcohol, a drug and/or other intoxicating substance and therefore prevented from resisting and/or unable to consent" (Society of Forensic Toxicologists, n.d.). The Sexual Assault Nurse Examiner (SANE) must recognize when to be concerned regarding possible DFSA, obtain informed consent/assent from the patient for any testing, and be knowledgeable regarding appropriate toxicology specimen collection and storage.

Policy

The SANE should be concerned about possible DFSA (USDOJ, 2013; USDOJ, 2016):

A. If a patient's medical condition appears to warrant toxicology screening for optimal patient care (i.e., the patient presents with drowsiness, fatigue, light-headedness, dizziness, physiologic instability, memory loss, impaired motor skills, or severe intoxication)

B. If a patient or accompanying persons states the patient was or may have been drugged

C. If a patient suspects drug involvement because of a lack of recollection of event(s) or loss of consciousness

Procedure

A. Informed consent (adult patient or caregiver of child/adolescent) and assent (adolescent and developmentally appropriate child) must be obtained from patients prior to collecting toxicology samples.

B. The following information should be provided to patients/caregivers during the DFSA consent process (USDOJ, 2013; USDOJ, 2016):

   1. The purpose of toxicology testing and the scope of confidentiality of results (i.e., in a child sexual abuse case results will be shared with law enforcement and child protective services to facilitate the investigation)
   2. The ability to detect and identify drugs and alcohol depends on collection of toxicology samples within a limited time period following ingestion

3. There is no guarantee that testing will reveal that substances were used to facilitate the assault/abuse
4. Testing may reveal other drugs or alcohol that patients may have ingested voluntarily
5. Follow-up testing and/or treatment may be necessary if testing reveals the presence of drugs
6. Test results showing voluntary use of drugs and/or alcohol may be discoverable by the defense and used to attempt to discredit patients or to question their ability to accurately perceive the events in question (however, these results could also help substantiate that voluntary drug and/or alcohol use sufficiently impaired patients' consent and prevented legal consent)
7. Whether there is a local prosecution practice of charging sexual assault victims with a crime for illegal voluntary drug and/or alcohol use revealed through toxicology screening
8. Declining testing when indicated by circumstances may negatively impact the investigation and/or prosecution
9. When and how the patient can obtain DFSA testing results
10. Who will pay for DFSA testing (when testing is completed as a component of the medical forensic examination typically a governmental agency will pay)
11. If toxicology testing can proceed without a report to law enforcement (adult cases)

C. Drug-facilitated sexual assault specimen collection (USDOJ, 2013; USDOJ, 2016):
    1. Collect a blood sample if it is within 24 hours since the assault/abuse
        i. At least 20 ml blood in a gray-top tube
    2. Collect the first available urine specimen if it is within 120 hours since the assault/abuse
        i. At least 30 ml but preferably 100 ml urine
        ii. Does not need to be a clean catch urine specimen
        iii. Document number of times patients has urinated since assault/abuse and toxicology urine sample collection
    3. Mark each biological specimen with the patient's name, date, and time of collection and collector's initials (Covington, Hornor, & Jennings, 2021).
    4. Seal specimens with evidence tape and follow chain-of-custody procedure

D. (Insert name of institution) uses (insert name of toxicology lab) for drug-facilitated sexual assault testing
    1. Follow toxicology lab requirements for collection, packaging, labeling, and storage of specimens
    2. Refrigerate blood and urine specimens per toxicology lab specifications while maintaining chain of custody (may require locked refrigerator)

3. Follow jurisdictional policies for transportation of toxicology specimens to laboratory for analysis (typically law enforcement transports specimens)
4. Certain jurisdictions or states may have a drug-facilitated sexual assault kit that should be utilized

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Foley Catheter for Pubescent and Adult Hymen Visualization Policy	
Effective Date:	Replaces Policy:
Approval Date:	Policy Owner:

Statement/Rationale

The Foley Catheter is a thin and flexible tube, typically used to drain urine from the bladder (Merriam-Webster, n.d.). In the context of the Sexual Assault Medical Forensic Exams (SAMFE) it can be used to visually assess the hymen. The visualization of all structures during the anogenital exam is important to the identification of injury or disease process. Visualization of the post-pubescent hymen with a foley catheter allows for better assessment of the hymen than with gross visualization alone or labial separation and traction. The estrogenized hymen is often redundant, with folded tissue that can hide injury and therefore the use of the foley can aid in visualization of all aspects of the hymenal tissue. (Henry, 2013). This technique *should not* be used in the pre-pubescent population.

Purpose

This policy provides guidance for Sexual Assault Nurse Examiners (SANEs) on the use of the foley catheter visualization of the post-pubescent hymen during the anogenital exam.

Equipment Needed

- Gloves
- Lubrication (Non-spermicidal and water-soluble)
- Foley Catheter (14 French/16 French, preferably a straight tip, but a curved tip can also be used if needed) with balloon[1]
- 30 ml leur lock syringe
- Colposcope/Camera

Policy

A. The procedure is explained and informed consent/assent is obtained from the patient and/or guardian.

[1] Consider if a patient is allergic to latex and have latex-free foley catheters available.

B. Foley catheter should ***only*** be used on the pubescent female population.

C. Sterile technique is not indicated for this procedure.

D. The use of the foley catheter for hymen visualization should not cause pain or be traumatic with insertion or balloon inflation (Persaud et al., D., 1997). If there is significant pain, refrain from inserting foley and/or remove foley, and follow guidelines for advanced practice provider involvement to consider possible pathological/medical concerns.

Procedure

A. Gather supplies and apply gloves.

B. Test the balloon to insure its patency

C. Explain the procedure to the patient.

D. With patient in a supine lithotomy position, complete visualization of the genital area, including labial separation and traction.

E. Apply lubricant to the insertion tip of the foley catheter if needed.

F. Insert foley catheter tip through the hymenal opening into the vagina until the balloon is inside the vagina.

G. Inflate the balloon with 10 to 30 mL of air.

H. While maintaining labial separation with one hand, guide the balloon to the hymenal edge by pulling the catheter toward the examiner. To help maintain control of the foley catheter, the examiner should hold onto the catheter close to the patient's body.

I. Assess all edges of the hymen utilizing the inflated balloon.

J. Capture any findings with photo documentation (if a colposcope/camera is used in your setting).

K. Deflate and remove the foley catheter.

L. Document findings in the medical record.

M. If urinary catheterization occurs during the exam, remove the foley and coordinate with advanced practice provider for further steps.

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The Use of the Swab for Hymen Visualization Policy	
Effective Date:	Replaces Policy:
Approval Date:	Policy Owner:

Statement/Rationale

The GYN Swab is a large cotton swab which can be used in the context of the Sexual Assault Medical Forensic Exams (SAMFE) to visually assess the hymen if a foley catheter is not available (Garfield et al., 2021) or by examiner preference.

The swab can be used either moistened with saline or with a medical glove placed over it to be placed behind the hymenal edge and run along the rim to reveal all aspects of the tissue, or to highlight absent or injured areas of tissue, circumferentially (Adams, Botash, & Kellogg, 2004). The visualization of all structures during the anogenital exam is important to the identification of injury or disease process. Visualization of the post-pubescent hymen with a swab allows for better assessment of the hymen than with gross visualization alone or with labial separation and traction. The estrogenized hymen is often redundant, with folded tissue that can hide injury and therefore the use of the GYN swab can aid in the visualization of all aspects of the hymenal tissue. This technique ***should not*** be used in the pre-pubescent population.

Purpose

This policy provides guidelines to clinicians on the use of the GYN swab to visualize the hymen during the anogenital exam of an adolescent or adult.

Equipment Needed

- Gloves
- GYN swabs
- Sterile saline
- Colposcope/Camera

Policy

A. The procedure is explained and informed consent/assent is obtained from the patient and/or guardian.

B. The GYN swab should only be used on the post-pubescent female population.

C. The use of the GYN swab for hymen visualization should not cause pain or be traumatic with insertion and assessment. If there is significant pain, refrain from inserting and/or removing the swab and follow guidelines for advanced practice provider involvement to consider possible pathological/medical concerns.

Procedure

A. Gather supplies and apply gloves.

B. Explain the procedure to the patient.

C. Complete the visualization of the genital area, including labial separation and traction.

D. Moisten the tip of the swab or place the swab into the glove finger and twist to make tight around the tip of the swab.

E. Insert swab tip through the hymenal opening, just behind the hymen rim.

F. While maintaining labial separation with one hand, guide the GYN swab tip behind the hymenal tissue to assess all circumferentially.

G. Capture any findings with photo documentation (if a colposcope/camera is used in your setting).

H. Remove the GYN swab.

I. Document findings in the medical record.

References

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Toluidine Blue Dye Policy	
Effective Date:	Replaces Policy:
Approval Date:	Policy Owner:

Statement/Rationale

Toluidine Blue Dye (TBD) (Toluidine blue or "T-Blue") is a nucleic stain (basic thiazine metachromatic dye) that binds to nucleated squamous cells as it has a high affinity for acidic tissue components, and stains DNA- and RNA-rich tissues. It is commonly used to detect vulvar cancer (Kotze & Brits, 2017; Jones et al. 2004). In sexual assault care, TBD can be used when injury, or suspicion of injury is noted upon anogenital assessment. TBD is not used on vulvar mucosal tissues such as the hymen, vaginal canal, urethral meatus or cervical tissue as it does not contain nuclear cells and therefore can be hard to interpret, but should be used for perianal, perineum and skin assessment (Jones et al, 2004). Typical application sites include perianal tissue, posterior fourchette, fossa navicularis and the perineum. TBD is used to highlight injuries noted through gross visualization, and in some cases to improve the ability to visualize injury. Hirachan (2019) used TBD to detect anogenital injury following consensual intercourse and after TBD application.

If there is significant injury, TBD use may cause pain on application. Consider photo documentation of injury without the use of TBD. Evidence collection from the external genitalia should occur prior to use of TBD if the assessment is being completed at the time of a medical forensic exam. Speculum insertion or bimanual exam should be completed after TBD use. (Hochmeister et al., 1997, Jones et al. 2004; International Association of Forensic Nurses, 2013).

Understanding of limitations of TBD is important as the dye may adhere to findings other than injury as it will adhere to all exposed nucleated cells (ex. Vulvar cancer, vulvitis, herpes, ulcerations and self-inflected injuries, anal fissures resulting from constipation, surgical procedures, inflammation, etc.) (McCauly et al., 1987; Kotze & Brits, 2017, Jones et al. 2004; Hochmeister et al., 1997; International Association of Forensic Nurses, 2013). TBD does not interfere with STI testing (Hochmeister, et al., 1997).

Purpose

This policy provides guidelines for clinicians on the use of Toluidine Blue Dye during the anogenital exam.

Standard of Care

TBD is a tool and technique that may be used to assist in the documentation of anogenital findings during an exam in the pediatric and adult population. The Material Safety Data Sheet (MSDS) should be reviewed regarding the use of this product.

Equipment Needed

- Gloves
- Gauze (2x2 or 4x4)
- Baby wipes (hypoallergenic)
- Toluidine blue 1% aqueous solution dye (multidose or single-use applicator)
- Cotton swabs (if a multidose vial is used)
- Medicine cup (if a multidose vial is used)
- Lubrication (Non-spermicidal and water-soluble)
- Colposcope/Camera

Procedure

A. Gather supplies and apply gloves.

B. Assess the area where the suspected injury or abnormal finding is and obtain photo documentation of the finding prior to utilizing the dye (if a colposcope/camera is used in your setting).

C. If using a single dose vial squeeze the tube to introduce the dye into the swab applicator, if using a multidose solution apply directly to the swab.

D. Apply to the suspected area of injury or abnormal finding directly, do not spread beyond the areas of concerns. Be cautious so as to not apply anywhere not intended, as the dye will stain clothing and skin.

E. Using the baby wipe or gauze with a pea sized amount of lubrication, gently dab the area to wipe away any excess dye.

F. Complete photo documentation after dye has been wiped away (if a colposcope/camera is used in your setting).

G. Use a different applicator (cottons swab or TBD applicator) between sites (ex. After using dye for vulva assessment, use a new swab for anal assessment).

H. Document findings in the medical-forensic record

1. Any dye that adheres and is not able to be wiped away can be documented as “positive Toluidine Blue Dye uptake”.
2. If there is no dye that adheres, or if there is non-linear/diffuse uptake, this can be documented as “negative Toluidine Blue Dye uptake”. (McCauly et al., 1987)

I. Patient education should be provided throughout the exam and at discharge. Patient education and safety are of the utmost importance and a discussion must be had about the implication of the dye use, for example, if the patient is going back to the suspect, then this could put them in harm’s way if found on the skin or as it can shed into the underwear.

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Sexual Assault Nurse/Forensic Examiner Policy	
Effective Date:	Replaces Policy:
Approval Date:	Policy Owner:

Statement/Rationale

Sexual Assault Nurse Examiners (SANEs) are registered nurses or advance practice providers who have completed specialized education and clinical preparation in the medical-forensic care of the patient who reports or is suspected of having a history of sexual assault or abuse. The SANE completes a time sensitive examination that includes: assessing, treating and documenting injuries, identifying risks and providing preventative treatment for negative health outcomes associated with sexual assault including exposure to infection, unintended pregnancy, and long term psychological and physical sequelae, collecting evidence, maintaining the chain of custody, safety planning, and providing support with appropriate community referrals. (Plitcha & Houseman, 2007; Sampsel et al., 2009; Cybulska, 2013). The SANE often collaborates with other disciplines in the community who provide unique services to victims of sexual assault in order to assist with the continuity of care and resources. (International Association of Forensic Nurses, 2022). The use of a SANE can enhance the care provided as well as establish standardized and evidence-based approach to these patients.

Purpose

This policy provides guidelines for establishing the role of the Sexual Assault Nurse/Forensic Examiners in providing care to patients who have experienced sexual violence and/or abuse.

Sexual Assault Nurse Examiner (SANE), is a registered nurse who has received specialized education in the provision of comprehensive care to patients of all ages and genders who have been or are suspected of having been sexually assaulted, abused or exploited. The SANE demonstrates competency in conducting a complete medical forensic exam, including evidence collection where appropriate, and implementation of an individualized treatment plan in collaboration with appropriate professionals both inside and outside the health system.

Sexual Assault Forensic Examiner (SAFE) is an advanced practice provider who has received specialized education in the provision of comprehensive care to patients of all ages and genders who have been or are suspected of having been sexually assaulted, abused or exploited. The SAFE demonstrates competency in conducting a complete medical forensic exam, including evidence collection where appropriate, and implementation of an individualized treatment plan in collaboration with appropriate professionals both inside and outside the health system.

Sexual Assault Medical Forensic Exam (SAMFE) "is an examination of a sexual assault patient by a health care provider, ideally one who has specialized education and clinical experience in the collection of forensic evidence and treatment of these patients.

The examination includes gathering information from the patient for the medical forensic history; an examination; coordinating treatment of injuries, documentation of biological and physical findings, and collection of evidence from the patient; documentation of findings; information, treatment, and referrals for STIs, pregnancy, suicidal ideation, alcohol and substance abuse, and other non-acute medical concerns; and follow-up as needed to provide additional healing, treatment, or collection of evidence. The exam is referred to as the "forensic medical examination" under the Violence Against Women Act (VAWA)." (U.S. Dept of Justice, Office on Violence Against Women, 2013).

Standard of Care

The SANE will facilitate a timely medical forensic exam, provide consistency throughout the exam, deliver a compassionate and sensitive approach, and provide detailed referrals for follow up. The patient who presents to the ED with known or suspected sexual assault has the option of receiving evidence collection as part of their care if they are examined acutely (within 120 hours for adolescents or adults; within 72 hours for prepubescent children) following the assault (IAFN, 2023). The patient has the right to understand the limits of confidentiality as it applies to the medical forensic examination, the examiner's mandatory reporting requirements and the patient's right to cooperate or not with law enforcement (USDOJ, 2013).

Policy

Education and certification:

A. The SANE must have a valid Registered Nursing (RN) license (equivalent in the country practicing). If an advanced practice provider, a valid license in the field practicing is required.

B. The SANE must have at least two years of clinical work as a Registered Nurse (RN), preferably in acute care as the role of the SANE is to work autonomously and make practice decisions at the top of their scope of practice.

C. The SANE must complete an IAFN approved Adult/Adolescent Didactic Training per the SANE Education Guidelines (International Association of Forensic Nurses, 2018, a)

D. The SANE must complete an IAFN approved Adult/Adolescent Didactic Training per the SANE Education Guidelines if evaluating prepubescent sexual assault patients. (IAFN, 2018, a)

E. The SANE must complete a 2-day Clinical Skills lab (CSL) training (or preceptorship).

F. The SANE must maintain (insert the required number of hours) hours of continuing education a year pertaining to the sexual assault patient. (This is in conjunction with the state's/facilities requirement for nursing continuing education).

G. The SANE can sit for the Sexual Assault Nurse Examiner Adult/Adolescent and Adolescent/Pediatric (SANE-A® and SANE-P®) once they have met all certification examination requirements (IAFN, 2023).

H. The SANE must maintain competency for all procedures pertaining to the MFE (i.e., the utilization of the foley catheter, utilization of Toluidine Blue Dye, utilization of the colposcope, etc.)

Responsibilities:

A. The SANE will sign up for (insert the required number) shifts per schedule, including (insert the required number) holiday per year.

B. Participation in the quality assurance process is an expectation of all staff.

C. Staff meeting requirements.

D. Staff research participation requirement

E. Education/yearly goals

F. Possible attendance to yearly conference (in state or out of state) with the availability of funds and determining staff desire to participate, this will be determined on a case-by-case basis.

G. Collaboration with other healthcare staff and community stakeholders is an expectation with each patient encounter.

Procedure:

A. The SANE will take on the responsibility to facilitate the care of the sexual assault/abuse patient.

B. The SANE will arrive to the hospital within one hour of being made aware the patient has presented reporting a sexual assault.

C. The SANE will obtain report from the original RN/Provider that triaged the patient.

D. The SANE will follow guidelines and policies pertaining the MFE.
   1. Medical screening exam/triage
   2. Obtaining physical consultation
   3. Consenting the patient (Including reporting options, exam options, etc.)
   4. Patient history-taking
   5. Physical examination
   6. Evidence Collection
   7. Standing orders (i.e., Prophylaxis, treatment and testing)
   8. Photodocumentation

9. Documentation
10. Specialty assessments (i.e., Lethality/risk assessments, Drug Facilitated Sexual Assault Assessments, Human Trafficking Assessments, Strangulation Assessments, Elder/Child abuse assessments if co-occurring).
11. Discharge and safety planning

E. Stabilizing the patient's medical condition is a priority.

F. Collaborate with providers and community response members.

G. Mandatory requirements must be met according to federal, state and tribal regulations and documented accordingly.

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Download a MS Word version of this policy to use as a template.

Standing Orders Policy	
Effective Date:	Replaces Policy:
Approval Date:	Policy Owner:

Statement/Rationale

Research indicates that the use of standing orders and associated nurse empowerment leads to a cultural shift to allow nurse-initiated work-ups which leads to sustained improvement in patient outcomes (Reynolds et al., 2020). Standing orders facilitate prompt provision of medical forensic care. The majority of sexual assault nurse examiners are registered nurses and having a written protocol allowing them to administer prophylactic medications and obtain sexually transmitted infection (STI) testing without first having to obtain a physician order helps to ensure timely and comprehensive medical forensic care (Leubner & Wild, 2018).

Purpose

To initiate appropriate testing based on the registered forensic nurse assessment and patient care needs, to provide rapid and efficient quality care while potentially shortening duration of visit, to ensure provision of comprehensive medical forensic care, and improve patient outcomes.

Policy

It is the policy of (insert name of institution) that forensic registered nurses, in compliance with their professional scope of practice, can initiate the following Standing Orders based on their professional assessment, the patient's history and patient care needs. This protocol was developed in collaboration with the physicians (or medical director) and forensic registered nurses of (insert name of institution).

Procedure

A. All orders initiated by this policy will be authenticated by an Attending Emergency Department physician or Medical Director who is responsible for overseeing the patient's care during the encounter.

B. The forensic RN must place the order(s) specified in this policy using the Standing Orders mode in electronic order entry, or on paper order sheets, placing the words Standing Orders in the order documentation.

C. This policy can only be initiated while patient is physically in the Emergency Department (or other site of care such as free-standing clinic).

D. Designated responsible individual, such as Forensic Nursing Program Coordinator, will notify patient/caregiver of lab results, order treatment necessary for positive results, and coordinate any medical follow-up required relating to the laboratory testing.

E. Forensic nurse will obtain patient informed consent/assent prior to obtaining any laboratory specimens.

F. For all female patients Tanner Stage 2 or higher the forensic nurse will complete a urine Human Chorionic Gonadotropin (HCG). If unable to obtain a urine, a serum HCG should be obtained.

G. For all sexual abuse/assault patients the STI testing indicated below should be completed (CDC, 2021a):

History / Physical Findings	Testing Indicated
• Genital-genital contact • Unexplained genital injury • Genital discharge • Sibling with an STI	• For all males and prepubescent females: Urine DNA amplification for chlamydia/GC/trichomonas • For pubescent females vaginal/cervical swab DNA amplification for chlamydia/GC/trichomonas; obtain urine if vaginal/cervical swab unavailable • Human immunodeficiency Virus (HIV)/Rapid Plasma Reagin (RPR)-Syphilis/Hepatitis C antibody/Hepatitis B surface antigen
• Anal-genital contact • Unexplained anal injury • Anal discharge • Sibling with anal chlamydia or GC	• Anal DNA amplification for chlamydia/GC • HIV/RPR/Hep C antibody/Hep B surface antigen
• Oral-genital/anal contact (patient-offender) • Sibling with oral GC	Oral DNA amplification for GC
Oral-genital (offender-patient) contact	Urine DNA amplification for chlamydia/GC
Oral-anal contact (offender-patient)	Anal DNA amplification for chlamydia/GC

H. For all sexual abuse/assault patients with concerns for anogenital warts (HPV) or anogenital herpes (HSV) the STI testing below should be completed (CDC, 2021a):

Physical Findings	Testing Indicated
Anogenital warts (HPV) Diagnosed by examiner visualization of lesions	• Genital warts in all males and prepubescent females: Urine DNA amplification for chlamydia/GC/trichomonas • Genital warts in pubescent females vaginal/cervical swab DNA amplification for chlamydia/GC/trichomonas; obtain urine if vaginal/cervical swab unavailable • Anal warts in all males and females: Anal DNA amplification for chlamydia/GC • Genital or anal warts: HIV/RPR/Hep B surface antigen/Hep C antibody
Anogenital herpes (HSV) Diagnosis confirmed by PCR or culture of lesion	• PCR or culture of lesion • Genital herpes in all males and prepubescent females: Urine DNA amplification for chlamydia/GC/trichomonas • Genital herpes in pubescent females: vaginal/cervical swab DNA amplification for chlamydia/GC/trichomonas; obtain urine if vaginal/cervical swab unavailable • Anal herpes in all males and females: Anal DNA amplification for chlamydia/GC • Genital or anal herpes: HIV/RPR/Hep B surface antigen/Hep C antibody

I. For all sexual abuse/assault patients requiring initiation of HIV post-exposure prophylaxis the following laboratory tests should be drawn (CDC, 2021a):
   1. HIV antibody
   2. Hepatitis B surface antigen
   3. Hepatitis C antibody
   4. ALT
   5. AST

6. Alkaline phosphatase
7. BUN
8. Creatinine

J. For all adult/adolescent sexual abuse/assault patients the following prophylactic medications are recommended if genital-genital, anal-genital, oral-genital contact occurred/suspected within 72 hours (CDC, 2021a):

Sexually Transmitted Infection	Medication
Gonorrhea	• Ceftriaxone 500 mg IM x 1
Chlamydia	• Doxycycline 100 mg PO bid x 7 days or if compliance is a concern • Azithromycin 1 gm PO x 1
Trichomonas (females only)	• Metronidazole 500 mg PO bid x 7 days or if compliance is a concern • Metronidazole 2 gm PO x 1

See CDC (2021b) gonococcal infections, CDC (2021c) chlamydia infections, and CDC (2021d) trichomoniasis treatment & care for alternative treatment.

K. For all females or trans males of reproductive capacity pregnancy prophylaxis is recommended if genital-genital contact occurred/suspected within 5 days (CDC, 2021a):
   1. Ella (ulipristal acetate) 1 tab PO x 1, or
   2. Plan B One-Step (LNG-only) 1 tab PO x 1; or
   3. Copper IUD

L. For all adult/adolescent/pediatric identified as at risk for HIV transmission (genital-genital or anal-genital contact by unknown perpetrator or perpetrator known to be HIV positive or at risk for HIV) if last sexual contact within 72 hours, offer a 28-day course, 3-drug antiretroviral agents (CDC, 2016):

Adult/adolescent regimen

1. Tenofovir DF 300 mg with emtricitabine 200 mg PO daily x 28 days plus raltegravir 400 mg PO bid or dolutegravir 50 mg PO qd x 28 days or alternative regimen
2. Tenofovir DF 300mg with emtricitabine 200mg daily x 28 days plus darunariv 800mg and ritonavir 100mg PO daily x 28 days

Pediatric regimen – *consult pharmacy*

M. Other medications may be indicated for the adult/adolescent sexual assault patient:

1. Antiemetic (patient complaining of nausea/receiving prophylaxis) Zofran 8 mg PO q 12 hours
2. Pain relief – Acetaminophen 650 mg PO x 1 or Ibuprofen 800mg PO x 1

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Forensic Nurse Examiner Policy	
Effective Date:	Replaces Policy:
Approval Date:	Policy Owner:

Statement/Rationale

A forensic nurse examiner (FNE) or forensic nurse (FN), is a registered nurse or advanced practice nurse who has received specialized education and clinical preparation to provide care for patients impacted by violence including but not limited to sexual assault, intimate partner violence, human trafficking, child and elder maltreatment and physical assault. The FNE/FN completes a time sensitive examination that includes: assessing, treating and documenting injuries, identifying risks and providing preventative treatment for negative health outcomes associated with violence including exposure to infection, unintended pregnancy, and long term psychological and physical sequelae, collecting evidence, maintaining the chain of custody, safety planning, and providing support with appropriate community referrals. (Plitcha & Houseman, 2007; Sampsel et al., 2009; Cybulska, 2013). The FNE/FN collaborates with other disciplines in the community who provide unique services to victims of violence in order to assist with the continuity of care and resources. (International Association of Forensic Nurses, 2022). The use of a FN can enhance the care provided as well as establish standardized and evidence-based approach to these patients.

Purpose

This policy provides guidelines for establishing the role of the Forensic Nurse Examiner/Forensic Nurse in providing care to patients who have experienced violence and/or abuse.

Standard of Care

The FNE/FN will facilitate a timely medical/forensic exam in collaboration with the patient's healthcare team, provide consistency throughout the exam, deliver a compassionate and sensitive approach, and provide detailed referrals for follow up. The patient has the right to understand the limits of confidentiality as it applies to the medical/forensic examination, the examiner's mandatory reporting requirements and the patient's right to cooperate or not with law enforcement.

Policy

Education:

A. The FNE/FN must have a valid Registered Nursing (RN) license (equivalent in the country practicing). If an advanced practice provider, a valid license in the field practicing is required.
B. The FNE/FN must complete specialized forensic nursing education on the populations served (i.e., human trafficking, child and elder maltreatment, etc.)
C. The FNE/FN must maintain 10 hours of continuing professional development a year pertaining to forensic patient populations. (This is in conjunction with the state's/facilities requirement for nursing continuing education).
D. The FNE/FN must maintain competency for all procedures pertaining to the MFE (i.e., camera, etc.)

Responsibilities:

A. The FNE/FN will sign up for (insert required number) shifts per schedule, including (insert required number) holiday(s) per year.
B. Participation in the quality assurance process is an expectation of all staff.
C. Insert staff meeting requirements
D. Insert staff research participation requirements
E. Insert education/yearly goals
F. Possible attendance to yearly conference (in state or out of state) with the availability of funds and determining staff desire to participate, this will be determined on a case-by-case basis.
G. Collaboration with other healthcare staff and community stakeholders is an expectation with each patient encounter.

Procedure

A. The FNE/FN will participate in care as one member of the overall healthcare team providing services.
B. The FNE/FN will arrive to the hospital within one hour of being made aware of the patient.
C. The FNE/FN will obtain report from the patient's primary RN and Provider.
D. The FNE/FN will follow guidelines and policies pertaining the MFE.
    1. Consenting the patient (Including reporting options, exam options, etc.)
    2. Collaborating with the Provider on plan of care

3. Patient history-taking
4. Physical examination
5. Evidence Collection if warranted
6. Photodocumentation
7. Documentation
8. Specialty assessments (i.e., Lethality/risk assessments, Drug Facilitated Sexual Assault Assessments, Human Trafficking Assessments, Strangulation Assessments, Elder/Child abuse assessments if co-occurring).
9. Discharge and safety planning

E. Stabilizing the patient's medical condition is a priority.

F. Collaborate with community response members.

G. Mandatory requirements must be met according to federal, state and tribal regulations and documented accordingly.

References

Cybulska, B. (2013). Immediate medical care after sexual assault. Best Practice & Research Clinical Obstetrics and Gynecology 27, 141-149.

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Provider/Advanced Practice Provider Intervention Policy	
Effective Date:	Replaces Policy:
Approval Date:	Policy Owner:

Definition

For the purposes of this policy, a provider is considered to be a clinician who is a provider or advanced practice provider such as a nurse practitioner.

Policy

Acute medical needs (i.e., bleeding, altered consciousness, unstable vital signs) always supersede evidence collection. Regardless of setting (emergency department or community-based), acute/emergent medical needs requiring intervention by a provider may occur at any time during the course of a medical forensic exam. The procedure to obtain provider consultation will differ based upon site of medical forensic care, however, indications necessitating provider involvement do not vary. A critical element of forensic nursing care involves recognizing when it is necessary to consult a provider regarding care of the patient to ensure health and safety (USDOJ, 2013; USDOJ, 2016).

Indications for Provider Consultation

The forensic nurse is responsible for obtaining provider consultation at any time during the exam if the patient's history or physical exam reveal the following:

A. Patient reports history of loss of consciousness

B. Patient reports strangulation or suffocation

C. Decreased level of consciousness, disorientation or other neurologic deficits

D. Patient reports any specific physical complaints such as chest or abdominal pain, head injury or twisting/blunt force injury of extremities resulting in limited range of motion.

E. There is any evidence of bodily injury, trauma or physical deformity that requires intervention

F. There is evidence of genital trauma requiring intervention

G. There is reported history or evidence of rectal or vaginal instrumentation.

H. Evidence of significant substance use/abuse

I. Bleeding from an unidentified source

J. Unstable vital signs

K. Additional concerns identified by the forensic nurse

Procedure (Emergency Department)

A. Forensic nurse informs patient of need for provider consultation due to identified medical concern.

B. Forensic nurse remains responsible for head- to-toe assessment and injury documentation, photo-documentation, evidence collection, appropriate medication prophylaxis or treatment, and discharge education.

C. In the event that serious/life-threatening trauma exists, the evidentiary exam will be deferred until such time that it can be performed without interfering with acute/trauma care but as soon as practical to preserve existing evidence. Assisting ED and trauma personnel regarding evidence protection/preservation will be undertaken when necessary.

Procedure (Community-based clinic/setting)

A. Forensic nurse informs patient of need for transfer to emergency department due to medical concerns requiring provider intervention.

B. If life-threatening medical concerns noted, forensic nurse calls 911 to obtain emergency medical services transportation to the emergency department.

C. If non-life-threatening medical concern noted, forensic nurse facilitates patient transport to the emergency department via accompanying patient support person (family or friend).

D. If non-life-threatening medical concern noted and no support person available to provide transportation, forensic nurse facilitates transport to the emergency department via private ambulance service or emergency medical services (program/community specific).

E. Forensic nurse notifies emergency department of patient's imminent arrival, gives report regarding identified medical concerns requiring provider consultation to appropriate personnel and discusses patient's medical forensic exam needs including evidence protection/preservation.

References

U.S. Department of Justice, Office on Violence Against Women. (2013). *A national protocol for sexual assault medical forensic examinations: Adult/adolescent.* Retrieved from https://www.ojp.gov/pdffiles1/ovw/228119.pdf

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Medical Forensic Record Policy	
Effective Date:	Replaces Policy:
Approval Date:	Policy Owner:

Policy

The Medical Forensic Record is comprised of all components of care delivered during a patient visit (i.e., provider and nursing records, radiology, lab work, etc.). Record storage, retention, and release must be compliant with institutional policy as well as applicable privacy and confidentiality laws. It is the responsibility of the forensic nurse (FN) to provide accurate and objective documentation of the medical forensic exam, including evidence collection (Day et al., 2023). All aspects of patient care should be documented in a complete, accurate, descriptive, and objective manner. The medical forensic record may include written, electronic, and photographic documentation. The medical forensic record is one essential component of the larger record of the patient's visit. The medical forensic record may by subpoenaed for use in the criminal justice system (USDOJ, 2013; USDOJ, 2016), or the adult patient may consent to have copies released to outside agencies to aid with investigation and potential prosecution (USDOJ, 2013).

Medical Forensic Record Procedure

A. All documentation should occur contemporaneously with the provision of medical forensic care.

B. All aspects of care should be documented: consent, the medical and surgical history, history of abuse/assault, detailed physical examination including anogenital exam, photo/video documentation of genital and non-genital injury/physical findings, forensic samples collected, interventions (including lab and radiology, sexually transmitted/pregnancy testing and prophylaxis, or consultations with medical or other staff), referrals, discharge education, and reporting to appropriate governmental agencies.

C. The FN may also need to document elements of above on jurisdictional exam report forms.

D. A copy of jurisdictional exam report forms become part of the medical forensic record.

E. Explicitly document the patient's demeanor, statements made by the patient during the encounter, and accompanying caregiver statements regarding the history of events (Day et al., 2023).

F. Use quotations whenever possible when gathering the patient and/or caregiver history.

G. Use only authorized abbreviations.

H. Written description of any physical injuries should include type, size, site, shape, surrounds, color, contents, age, borders, depth and pattern (WHO, 2003).

I. Follow the medical forensic documentation template with a standard set of questions (Day et al., 2023).

Medical Forensic Record Storage, Retention, and Release Procedure

A. All components of the medical forensic record should be maintained and retained in compliance with applicable healthcare laws, standards of accreditation bodies, and civil and criminal statutes of limitation (USDOJ, 2018).

B. Storage must be secure and maintain patient confidentiality.

C. Forensic patients should provide written consent for release of the medical forensic record unless there is a legal obligation requiring release (i.e., subpoena or mandatory reporting requirements).

D. All adult medical forensic patients should have the right to access their entire medical forensic record, including photo documentation.

E. Non-offending parents/legal guardians of minor forensic patients should have the right to access their child's medical record.

F. Redaction of portions of the medical forensic record of minors may be necessary prior to release to parent/guardians (i.e., adolescent consensual sexual activity, anogenital exam photo documentation).

G. If the there are concerns that the health, safety, or well-being of a minor forensic patient could be in jeopardy if the medical forensic record is released to a parent/guardian, the facility should establish appropriate policies that allow for denial of access.

References

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Mandatory Reporting Policy	
Effective Date:	Replaces Policy:
Approval Date:	Policy Owner:

Statement/Rationale

The forensic nurse (FN), is a registered nurse who has received specialized education in the provision of comprehensive care to patients of all ages and genders who have been or are suspected of having been impacted by violence including sexual assault, intimate partner violence, child maltreatment, elder abuse, or exploitation. It's crucial for forensic nurses to know their state/territory laws related to mandated reporting and their legal obligations as health care professionals in the context of their clinical practice.

Policy

Forensic nurses, as health care professionals, may be required by state/territory law to report sexual assault, abuse, and exploitation to governmental agencies such as law enforcement, child protective services (CPS), and adult protective services. State/territory laws vary as to when the health care professional is required to report a specific act of sexual assault, intimate partner violence, child maltreatment, or elder abuse. The FN must be knowledgeable regarding state/territory law related to mandatory reporting in their state/territory of practice, what circumstances require reporting, and specifically what information is *required* by law when reporting (USDOJ, 2013).

Child Maltreatment

All states in the United States (US) have laws requiring health care professionals to report a suspicion of child abuse or neglect (Child Welfare Information Gateway, 2019 a). The report is made to the CPS agency where the child lives (may be a county or state-wide system of reporting) and the law enforcement agency where the child maltreatment occurred (Mandadi et al., 2021). Some states do not require a report to law enforcement be made by the mandated reporter; in those states the onus of reporting to law enforcement falls upon CPS. However, even if not legally required, the mandated reporter can make a report to law enforcement. Failure to report a suspicion of child maltreatment by a health care professional can result in significant penalties (Child Welfare Information Gateway, 2019b). Due to the variation in mandated reporting laws among states the Child Welfare Information Gateway (2023) maintains a website that health care professionals can search to view up to date state child maltreatment reporting laws. The ultimate goal of the reporting and investigation of child maltreatment is to prevent re-abuse of the target child and abuse of other children by the perpetrator (Mandadi et al., 2021).

Child Maltreatment Reporting Procedure

A. (Insert your state name) state law regarding mandatory reporting of child maltreatment states (insert your state law).

B. Child presents to the Emergency Department and a concern for child maltreatment is identified.

C. FN meets with accompanying parent or caregiver (if they are not complicit in or suspected of being complicit in the abuse) to discuss child maltreatment concern and explains mandatory reporting requirements to CPS and law enforcement.

D. FN determines suspicion of child maltreatment is present (this may be evident upon initial meeting with caregiver or may develop as medical forensic examination progresses).

E. The FN is part of a multi-disciplinary health care team the FN will often consult with social work or an advanced practice provider regarding the decision to report.

F. FN informs accompanying parent or caregiver (and child when developmentally appropriate) of mandating reporting law and the need to report to child protective services and law enforcement per jurisdictional policy.

G. FN makes a report to child protective services and law enforcement (typically via phone) of suspected child maltreatment.

H. Child protective services and law enforcement may come to the Emergency Department to meet with the child and parent or caregiver.

I. Child protective services will determine safe discharge plan for the child.

J. Whenever doubt exists regarding the need to report, a phone call to CPS and law enforcement is indicated to clarify concerns.

K. Mandatory reporting should be done as soon as possible to facilitate the timely development of a safe discharge plan for the child.

L. Report of suspected child maltreatment made to the appropriate agency, including the agency's response, must be documented in the patient's medical record.

Elder and Vulnerable Adult Abuse

All states in the US with the exception of New York, have laws requiring health care professionals to report a suspicion of abuse of elderly adults and adults with disabilities. The report is made to the appropriate agencies based on jurisdiction such as adult protective services where the adult lives (county or state/territory-based) and to the law enforcement agency where the act occurred. However, there is much variability among states regarding who is included in the definition of this vulnerable population and the occurrence of which specific acts necessitate reporting. The National Adult Protective Services Association (n.d.) has developed a guide to

assist with decisions regarding the need to report the abuse of a vulnerable adult. As with mandatory reporting of child maltreatment, the ultimate goal of reporting is to protect the target vulnerable adult from further abuse while potentially protecting other vulnerable adults (such as in a group home or nursing home).

Elder and Vulnerable Adult Abuse Reporting Procedure

A. (Insert the name of your state) state law regarding mandatory reporting of elder and vulnerable adult abuse states (insert your state law).

B. Vulnerable adult presents to the Emergency Department with a concern of sexual assault, abuse, or exploitation.

C. FN meets with the vulnerable adult (and caregiver if present in the Emergency Department) and explains potential mandatory reporting requirements should information (statements made by the adult or exam findings) reveal a concern for abuse.

D. FN determines suspicion of abuse is present (may be evident upon initial presentation for care or may develop as medical forensic examination progresses).

E. The FN is part of a multi-disciplinary health care team the FN will often consult with social work or an advanced practice provider regarding the decision to report.

F. FN informs vulnerable adult (and the caregiver, with consent, if present and not complicit in or suspected of the abuse) of mandatory reporting law and the need to report to appropriate agency per jurisdiction such as adult protective services and law enforcement to ensure their safety.

G. FN makes a report to the appropriate agency per jurisdiction such as adult protective services and law enforcement (typically via phone) of suspected elder or other vulnerable adult abuse.

H. Adult protective services and law enforcement may come to the Emergency Department to meet with the vulnerable adult.

I. Adult protective services will determine safe discharge plan for the vulnerable adult.

J. Whenever doubt exists regarding the need to report, a phone call to adult protective services and/or law enforcement is indicated to clarify concerns.

K. Report to adult protective services and law enforcement as soon as possible to facilitate the timely development of a safe discharge for the vulnerable adult.

L. Report of suspected abuse of a vulnerable adult to the appropriate agency must be documented in the patient's medical record, including the agency response.

Intimate Partner Violence and Sexual Assault

Health care professionals, including FNs, are generally not required to report the sexual assault of non-vulnerable adults to law enforcement (USDOJ, 2013). The decision to report the sexual assault of a non-vulnerable adult generally lies in the hands of the victim. Unfortunately, sexual assault often occurs within the context of intimate partner violence (IPV) [Boserup et al., 2020). State laws exist mandating health care professionals, including FNs, to report IPV to law enforcement. Few states mandate universal reporting of IPV but many mandate reporting under certain circumstances (i.e., IPV in the presence of children, use of a weapon, strangulation). The FN must be knowledgeable of state laws defining mandated reporting of IPV. Futures Without Violence (2019) has developed a guide to assist with decisions regarding the need to report IPV.

Intimate Partner Violence Reporting Procedure

A. (Insert the name of your state) state law regarding mandatory reporting of intimate partner violence states (insert your state law).
B. Adult presents to the Emergency Department with an injury resulting from intimate partner violence.
C. FN meets with the patient to discuss the medical forensic examination and explains IPV mandatory reporting requirements per state/territory law (i.e., if the FN must report to law enforcement if patient discloses IPV involving a weapon or in the presence of children).
D. FN determines the context of the IPV meets the requirements for mandated reporting.
E. The FN is part of a multi-disciplinary health care team and the FN will often consult with social work or an advanced practice provider regarding the decision to report.
F. FN informs patient of need to report IPV to the appropriate agencies per jurisdiction such law enforcement and/or child protective services if children are involved.
G. FN makes a report to the appropriate agencies per jurisdiction (typically via phone) of IPV.
H. Law enforcement may come to the Emergency Department to meet with the patient.
I. FN or other member of the multi-disciplinary team (i.e., social work or advocate) must discuss safety planning with patient to ensure safe discharge.
J. Report of suspected intimate partner violence made to law enforcement and/or CPS must be documented in the patient's medical record, including the agency response.

Physical Assault and Sexual Assault

Health care professionals, including FNs, are generally not required to report the sexual assault of non-vulnerable adults to law enforcement (USDOJ, 2013). The decision to report the sexual assault of a non-vulnerable adult lies in the hands of the victim. Unfortunately, it is not unusual for a victim to also be physically assaulted during the perpetration of sexual assault. State laws

exist requiring health care professionals to report physical assault to law enforcement. State law varies as to what assaultive acts require reporting. A few states require health care professionals to report any injuries resulting from any act of physical assault, while others only if the injuries are life-threatening or resulted from the use of a weapon (i.e., gun, knife, poison). The FN nurse must be knowledgeable regarding state laws defining mandatory reporting of physical assault. The Victim Rights Law Center (2014) has developed a guide to assist with decisions regarding the need to report physical assault injuries.

Physical Assault Reporting Procedure

A. (Insert the name of your state) state law regarding mandated reporting physical assault states (insert your state law here).
B. Adult presents to the Emergency Department with a concern of physical assault injuries.
C. FN meets with the patient to discuss the medical forensic examination and explains physical assault mandatory reporting requirements.
D. FN determines physical assault meets the requirements for mandated reporting.
E. The FN is part of a multi-disciplinary health care team and the FN will often consult with social work or an advanced practice provider regarding the decision to report.
F. FN informs patient of need to report physical assault injuries to law enforcement.
G. FN makes a report to law enforcement (typically by phone) of physical assault injuries.
H. Law enforcement may come to the hospital to meet with the patient.
I. FN discusses safety plan with patient.
J. Report of suspected physical assault made to law enforcement must be documented in the patient's medical record, including the agency response.

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