SANE Module 2: Assessment & Evaluation

A Special Note to Participants

The New York State Coalition Against Sexual Assault (NYCASA) and the New York State Nurses Association (NYSNA) have collaborated to provide content leading toward certification as a Sexual Assault Nurse Examiner (SANE). This program is **only** available to nurses currently enrolled in the Adult/Adolescent Sexual Assault Nurse Examiner (SANE) 40-hour training.

The SANE program consists of 40-hours of training and a preceptorship. The online didactic program, consisting of five modules, makes up the first twenty hours of content. The next twenty hours must be completed in a clinical practicum with a New York State SANE certified educator, and finally, a required preceptorship must be completed after the clinical practicum.

The development of these five online modules was funded through a grant from the New State Division of Criminal Justice (DCJS).

NYSNA Continuing Education

The New York State Nurses Association is accredited as a provider of continuing nursing education by the American Nurses Credentialing Center's Commission on Accreditation.

This module has been awarded 4 contact hours and contains two components: an online written format and an online discussion forum. **Participants must read the online material, contribute to the discussion forum, pass an online exam with at least 80%, and complete an evaluation in order to receive a certificate of completion.**

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How to Take This Module

Please take a look at the steps below these will help you to progress through the module.

1. **REVIEW THE OBJECTIVES**

   The objectives provide an overview of the entire module and identify what information will be focused on. Objectives are stated in terms of what you, the participant, will know or be able to do upon successful completion of the module.

2. **STUDY EACH SECTION OF THE MODULE IN ORDER**

   Keep your learning "programmed" by reviewing the content in order. This will help you understand the sections that follow.

   You will need to enter the online discussion forum as directed throughout the module. When you see the rotating stop sign, you are expected to enter the online forum to answer questions or engage in discussion with your SANE educator. **Participation in the online forum is required and will be monitored by your SANE educator.**

3. **COMPLETE THE MODULE EXAM**

   After studying the module and completing the requested activities in the forum, click on the "Course Exam" option located on the module navigation toolbar. Answer each question by clicking on the button corresponding to the correct answer. All questions must be answered before the exam can be graded; there is only one correct answer per question. You may refer back to the module material by minimizing the exam window.

4. **GRADE THE MODULE EXAM**

   Next, click on "Submit Test." You will know immediately whether you passed or failed. If you do not successfully complete the exam on the first attempt, you may take the exam again. It is highly recommended to review the material for the questions missed **BEFORE** attempting the exam again. If you are unsuccessful on your second attempt, you will need to contact your SANE educator.

5. **COMPLETE THE EVALUATION FORM**

   After passing the module exam you will be prompted to complete an evaluation. You will have access to the certificate of completion **after you have passed the discussion forum, passed the exam, and completed the evaluation**. At this point, you should print the certificate and keep it for your records. You will need to provide a copy of all five certificates to your SANE educator as proof of completion of the 20 hours of didactic content.

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Objectives

Upon completion of this course, the learner will be able to:

- Discuss the consent process.
- Identify the components of the medical history.
- Identify the components of the forensic history.
- Explain the steps of the trauma assessment.
- Distinguish between blunt force and other injuries.
- Name the elements of documentation in the assessment of a sexual assault patient.

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Introduction

The sexual assault patient presenting for treatment offers a complex and challenging case for most medical professionals. The patient often presents with no outward signs of trauma or physical injury yet is more in need of acute and immediate attention than many presenting patients. Where then do you begin? The physical assessment of the sexual assault patient is at the core of injury identification and evidence collection. When completed with precision and attention to detail, this portion of the examination will result in a solid foundation on which to base the patients' plan of care.

This module will discuss topics related to obtaining consent, the physical examination of the sexual assault patient, injury identification, a review of male and female anatomy and the documentation required following an assessment and evaluation.

You will be introduced to the different considerations when obtaining consent for the medical assessment and forensic evaluation of the sexual assault patient. The legal and ethical concerns related to obtaining consent from incapacitated patients will be discussed and the rationales that influence these decisions. You will be asked to identify your local resources for making decisions related to obtaining consent.

A Word about the Activities of this Module

A private, online discussion forum has been set-up for your region of New York State. Throughout this online module you will be asked to read brief case studies, identify injuries, and provide feedback on presented questions. You should complete the discussion board postings **in sequence** as you come across them in the module content. It may be helpful to keep the course window and discussion forum window open at the same time so you can move more quickly between the module and the forum. When you enter the discussion forum, the first posting includes instructions on how to post your responses.

When you see the rotating stop sign you will have access to a link that directs you to the discussion forum entrance page, where you will be prompted for a username and password. Enter the username and password assigned to you. Next, click on your region specific forum and enter the appropriate password. As a reminder, NYSNA e-mailed username and password information at the time of your course enrollment.

We encourage you to read each other's postings and respond. **Reminder!** Your participation in the discussion forum will be monitored by your educator.

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About the Author

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Erin Ptak, RN SANE-A, NYSAFE is the facilitator for this module of the SANE program. Ms. Ptak is the SAFE/FNE Program Coordinator for Family Services, Inc. in Poughkeepsie, New York. She has been the coordinator of the forensic nursing programs since 2003. In that role, she oversees all aspects of the program, including grant writing, clinical oversight, recruitment, and clinical care for patients. She also works in collaboration with the Dutchess County Child Advocacy Center as part of the medical team responsible for the evaluation of sexually abused children. She prepared this module using her clinical expertise and from information extracted from the National Protocol for Sexual Assault Medical Forensic Examinations, the Office for Victims of Crime, the New York State Department of Health, International Association of Forensic Nurses, and the American College of Emergency Physicians.

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Consent

An Overview

The beginning of any examination involves obtaining consent. Consent is defined as "to give assent or approval, agree" (Consent, 2009). Informed consent is defined as "consent to surgery by a patient or to participation in a medical experiment by a subject after achieving an understanding of what is involved" (Informed consent, 2009).

As characterized by the American Medical Association (n.d.), "informed consent is more than simply getting a patient to sign a written consent form. It is a process of communication between a patient and physician that results in the patient's authorization or agreement to undergo a specific medical intervention."

A patient must receive enough information in order to give informed consent. It is imperative that the patient has not been forced or misled to give consent, but that the decision is completely voluntary.

Some components of informed consent include:

- The patient is aware of the nature and purpose of the treatment.
- The patient understands the risks and benefits of the treatment.
- The patient understands the risks and benefits of no treatment.

Sexual Assault Exam Consent

Nowhere in medical care is the principle of informed consent more essential to a patient's emotional well being than in the case of sexual assault. As you have learned from module 2, sexual assault may affect a patient's sense of control. It becomes important to assure the patient is allowed to determine the course of their treatment, especially since those treatments will encroach on his or her body in a very personal and invasive way.

Patients who are victims of a sexual assault must understand the full nature of their consent to each procedure and examination for which consent is sought. The SANE is responsible to provide education so that the patient is able to make an informed decision. The decision of whether to accept or decline a procedure is entirely theirs. Some emphasis may be required to let the patient know that some of the findings may need to be released to other parties, including the police or other agencies when domestic violence or abuse has occurred.

If a patient does decline a procedure, the SANE has a responsibility to make the patient aware of the consequences of the decision because there could be a negative effect to their quality of life. They should also be told that by declining a particular procedure, it could reflect negatively during a court proceeding such as being used to discredit them. The SANE should document the reasons why a procedure or examination was declined.

The U.S. Department of Justice (2004) recommendations to healthcare providers and other responders that request patients' consent during the exam process include:

- Seeking informed consent as appropriate throughout the exam process for medical evaluation and treatment and the forensic exam and evidence collection (to be covered in Module 3).

- Coordinate efforts to obtain consent among the responders involved in the assault.

- Be aware of statutes and policies governing consent in cases of minor patients, vulnerable adult patients, and patients who are unconscious, intoxicated, or under the influence of drugs. In all

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cases; however, the exam should never be done against the will of the patient.

In regard to confidentiality, the U.S. Department of Justice (2004) recommends that:

- Involved responders must be aware of the scope and limitations of confidentiality related to information gathered during the exam process.
- Confidentiality is intricately linked to the scope of patients' consent.
- Members of a Sexual Assault Response Team (SART) or other collaborating responders should inform victims of the scope of confidentiality with each responder and be cautious not to exceed the limits of victim consent to share information in each case.

Sexual assault patients should be given the opportunity to consent to each portion of the sexual assault examination (see Table 1). Unlike many other procedures the patient may pick and choose the portions of the sexual assault examination they wish to have completed. The patient should also be reassured that they may withdraw consent at any time during the examination.

Table 1. *Portions of Sexual Assault Exam Consent*

Medical Exam	**Forensic Exam**
Speculum exam	Forensic evidence collection
Treatment of injuries	Take photographs if needed
HIV prophylaxis	Release to Law Enforcement
Emergency contraception	Release to District Attorney
STD Prophylaxis	Drug-facilitated sexual assault kit (DFSA)

Special Consents

Facility policies may vary, but they are important and exist to guide the process of informed consent, especially in the case of the populations we are about to discuss. Be aware of your facility policies.

Certain interventions present unique risks and benefits and require additional consent. Examiners should beware of circumstances which require additional consent, the state mandated forms needed and the appropriate disposition of those forms.

1. HIV Testing

Testing for HIV is always *voluntary*. Before testing any patient the examiner must supply the patient with the New York State Department of Health (NYSDOH) "Part A" brochure (see Appendix A). Make sure to give the patient adequate time to read the information provided and ask questions. If the patient wishes to have the test done they must read and sign the NYSDOH HIV consent form or "Part B" (see Appendix A). Both of these forms can also be found online at: http://www.health.state.ny.us/forms/signature/doh-2556.pdf.

2. Drug Facilitated Sexual Assault (DFSA)

Examiners may encounter patients who report, suspect, or present with symptoms of a drug facilitated sexual assault. In New York State, any victim who reports within 96 hours of the incident should be offered the option of collecting a DFSA kit. All appropriate paperwork necessary for the completion of this kit, including the consent, are located in the kit. Patients should be informed of all risks and benefits of collecting the information requested in the kit. The patient should be informed by the examiner that even if the use of voluntary drugs by the patient is demonstrated, the seriousness of the suspected DFSA is not reduced. Disclosure of all prescription, over-the-counter, and recreational drug ingestion is a mandatory part of the documentation tool inside the kit.

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3. New York State Crime Victims Board Medical Provider Forensic Rape Examination Direct Reimbursement Claim Form

On April 1, 2005, a law became effective which allows providers of sexual assault forensic health care examination services direct reimbursement by the Crime Victims Board (CVB). The law protects the personal privacy of sexual assault victims, while reimbursing providers when the victim does not have private health insurance coverage or chooses not to use such insurance coverage for the forensic examination (New York State Crime Victims Board, n.d.). A copy of the Forensic Rape Examination (FRE) form is enclosed in each evidence collection kit (see Appendix B). It should be completed and signed by the patient and the examiner at the conclusion of the exam. The FRE form can also be downloaded from http://www.cvb.state.ny.us/Files/FREClaimForm407.pdf.

Ability to **C**onsent

Several factors influence the ability of a patient to give informed consent. Not every case that presents for evaluation and treatment offers a clear course of action for obtaining consent. Many times sexual assault patients present with difficult practice, legal and ethical issues.

Table 2. *Types of Patients: Determination of the Ability to Consent*	
Age	Unconscious patient
Intoxicated patient	Developmentally delayed or Persons with disabilities
Psychiatrically unstable	Elderly

The New York State protocol *Acute Care of the Adult and Adolescent Patient Reporting Sexual Assault* does not provide specific guidelines on how to proceed when the patient is incapacitated or unable to give informed consent. In the case of an incapacitated adult patient, New York's Healthcare Proxy Law requires practitioners to first determine if a healthcare proxy exists; and if it does, to follow the directives of the person designated in the proxy as the surrogate decision maker.

With respect to adult patients, the normal rules governing provision of medical care to incapacitated patients (e.g., healthcare proxy or guardianship) would apply to the elements of the sexual assault examination that constitute medical treatment. However, forensic evidence collection does not itself constitute medical treatment.

According to the New York Civil Liberties Union (NYCLU), there does not appear to be any clear authority that would permit a hospital, guardian, or healthcare proxy to consent on behalf of an incapacitated adult patient to forensic evidence collection without a specific grant of general decision-making authority over the patient.

Note: The following information that comprises items 1 through 6 was adapted from New York State Department of Health (2004).

1. Age

In New York State there is no minimum age for consent in reproductive health matters. Many sexual assault programs use 12 years of age as a guideline for age of consent. Regardless of age, or any other mitigating factor, no exam should be completed on a patient against their will. According to NYCLU (2006), "minors in New York State can consent to all aspects of health care following a sexual assault and any resulting treatment must remain confidential." However, you must review your facility policy regarding specific patient scenarios. You may also need to consult with your facility's attorney. In cases where the basis for the exam is exclusively that the patient is below the age of

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consent for sexual activity (17), it is the patient who retains the right to determine the scope and course of treatment they receive.

Because minors have the authority to consent on their own to post-sexual assault medical care, as well as to forensic evidence collection, treating providers should ensure that the minor is truly incapable of consenting on his or her own before resorting to parents as surrogate decision makers. The law gives minors the authority to consent on their own to post-sexual assault services including the collection of forensic evidence, provided they are able to give informed consent. Therefore, healthcare providers should not automatically give parents the authority to consent to the performance of a rape kit on the minor's behalf if there is a reasonable chance that the incapacity is temporary (NYCLU, 2006).

2. The unconscious patient

On occasion you may encounter an unconscious patient who family, friends, law enforcement, or medical professionals suspect was sexually assaulted. Without the patient's expressed consent for the collection of forensic evidence no forensic examination should be completed. Implied consent will allow an assessment of injuries and interventions. Forensic examinations are not considered emergent or life threatening conditions and not covered by implied consent. Any items or specimens collected in the normal course of treatment may be preserved using strict chain of custody for possible release once the patient is able to consent. When the patient's condition is life threatening you may be tempted to collect evidence before the patient expires. However no forensic examination should occur. If the patient expires the medical examiner will collect the evidence at the time of the post mortem exam.

3. The intoxicated patient

The fact that a sexual assault patient has ingested drugs or alcohol does not render the patient incapable of giving consent. Completing an assessment of the patient's ability to understand the components of the consent can determine if informed consent is possible. If it is determined that the patient is unable to give consent, the examination is delayed until such time when consent can be obtained.

4. The patient with developmental disabilities

The functional level required for giving informed consent or making medical decisions and that required in making legal or life decisions may be very different. Make sure to assess each individual's ability to understand and consent to treatment before accepting parental or outside consent. Institutional consent for medical treatment is not sufficient for forensic examinations. Be aware and ask questions of the person presenting in order to determine their ability to give consent. Only the health care proxy can give consent in medical matters. A power of attorney allows for a person to make legal and financial decisions but not medical ones.

5. The psychiatrically unstable patient

According to the results of a U.S. study by Teplin, McClelland, Abram, and Weiner (2005, August), the type of violent crime (e.g., rape/sexual assault, robbery, assault) created a victim prevalence that was 6 to 23 times higher among persons living with severe mental illness (SMI) than people in the general population. People with SMI are more likely to be victims of violent crime. Any patient who presents for treatment and is deemed to be unable to consent due to psychiatric illness will need to be psychiatrically cleared by a provider before consent may be obtained. It may be difficult or impossible to determine what, if any, contact occurred when the patient is experiencing changes in their perception of reality. Although some evidence may be lost by waiting, you will avoid the possibility of traumatizing a patient who may not be able to determine the difference between past and present events.

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6. The elderly patient

The U.S. Census Bureau (2008) projects that more than 54 million Americans — about 16 percent of the population — will be 65 or older in 2020. Be careful of assuming an elderly patient is unable to give consent for treatment. The aging of the "baby-boomers" has created an over 65 generation that is more fit and active than in the past. The elderly patient may present with dementia or other illness that prevents them from giving informed consent. Remember that only the health care proxy can give consent in medical matters. A power of attorney allows for a person to make legal and financial decisions but not medical ones. As with the psychiatrically unstable patient it may be difficult or impossible to determine what if any contact occurred when the patient is experiencing changes in their perception of reality.

If there are questions about how an examiner should proceed in a specific situation, they should consult with their facility's legal counsel, their administration, or call the NYCLU for guidance.

Key Points to Remember

- ✓ Minors have the authority to consent on their own to post-sexual assault medical care, as well as to forensic evidence collection.
- ✓ Treating providers should ensure that the minor is truly incapable of consenting on their own before resorting to parents as surrogate decision makers.
- ✓ People with severe mental illness are more likely to be victims of violent crime.

Activity #1

Read the following case study.

You are called to the hospital medical surgical unit to evaluate an 81-year-old female who reports she was sexually assaulted. When you arrive, the primary RN reports the patient stated that a man came into her room at the nursing home where she resides, and touched her inappropriately. The RN further reports that the patient, who has a history of dementia, insists the incident occurred during the night and woke her from sleep. The patient's granddaughter is present and is inclined to believe that her grandmother is delusional and no such incident occurred. You are aware that a similar incident was reported by a heavily sedated, end-stage cancer patient last year from this same unit in the same nursing home. The hospital has stated that they will make a sexual assault exam available to the patient should the granddaughter request one. The young woman seeks your input before making her decision. Note. From the author's personal clinical experience.

Go to the discussion forum and post your responses to the following:

- What input will you provide to the granddaughter?
- Identify any additional information you will need prior to initiating an examination should a sexual assault exam be requested by the granddaughter.

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Physical Assessment and Evaluation

A Word about Documentation

Included in every evidence collection kit is a sample documentation form. Many sexual assault examiner programs have facility specific charting tools. Examiners should be aware of the expectations of the facility or program they work with. No chart material should ever be returned enclosed inside the evidence collection kit. The disposition of the chart will follow individual facility policy and procedure.

These charts need to be a clear and accurate representation of your examination. It is important for the examiner to document in a manner that reflects not only the patient before them, but also the meticulous nature of the assessment and interventions provided. The documentation should be 'textbook perfect' whenever possible and should reflect the same amount of detail the examiner puts into the examination.

Make sure to:

1) Write legibly
2) Be thorough in collecting evidence and document through writing, photographs and diagrams of injuries
3) Put the chief complaint and as much of the patient's account of the event in quotes: "I was raped."
4) Document comprehensively regarding the examination.
5) It is important that the spelling is correct.

What to Document

- History (medical and assault)
- Full body assessment
- Genital exam
- Evidence collection
- Photography
- Plan of care

Avoid the use subjective of terms when documenting assessment findings. The examiner must document in objective terms (see Table 3).

Table 3. *Examples of Objective and Subjective Terms*

Objective	Subjective
Crying	Hysterical – "The patient appears hysterical"
Reports	Alleges
No injury noted	Within normal limits (WNL)

Remember to document using the victim's own words. You may have to clarify what those words mean to him or her. It is imperative both of you are referencing the same body part or form of sexual contact.

Include in the documentation everyone that is present in the room during the exam. This includes the SAFE, other hospital staff, advocate(s), law enforcement, family and friends.

Body maps and photographs are meant to *support your written documentation*, not replace it.

Injury Documentation

Photo-document each injury three times:

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- First in relation to the body;
- Then using one to two times magnification and without a scale; and
- Finally, using one to two times magnification with a scale.

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Note injuries with regards to anatomic landmarks. Include location and measurements whenever possible. Include location in the narrative and use the body charts as accurately as possible. Use the face of the clock for describing genital or cervical injuries.

- T – Tear (laceration) or tenderness
- E – Ecchymosis, contusions, bruises
- A – Abrasion
- R – Redness, erythema
- S – Swelling, edema

(Brown, Streubert, & Burgess as cited in Slaughter & Brown, 1997)

When describing injuries the examiner should use which ever unit of measure, such as centimeters or inches, that is your facilities' accepted practice. While measuring in centimeters is common medical practice, many law enforcement agencies, and of course juries, can easily relate to inches. Which ever unit of measure you use, keep it consistent. Don't switch back and forth between inches and centimeters or even centimeters and millimeters.

Circular injuries may be described using a common point of reference such as a dime or quarter. However the more accurate method is to describe the injury in terms of centimeters in diameter. Document the orientation, size, and shape of each injury. Ask yourself:

- Is it vertical, horizontal or diagonal?
- Is it circular, oval, crescent or v-shaped?
- Are the edges of the wound smooth or jagged? Include the presence of active bleeding.
- Does the injury reflect the pattern of an object that may have been responsible for the injury?
- Is the tissue pink, reddened or bruised? Is it red, purple, blue, green, yellow?
- Is there a distribution of bruises? Are petechiae visible?

<u>Documentation Using "The Clock"</u>

To give a more accurate description of where an injury is in relationship to other structures, it is important to use the clock when documenting genital injuries. Imagine placing the face of a clock over the vulva while the patient is in the supine position. **Twelve o'clock is always at the urethra, while 6 o'clock is at the perineum or toward the patient's back**.

Here are a few examples:

- There is a 4 mm tear, without bleeding or drainage noted to the posterior fourchette at 6 o'clock.
- To document a range of an injury you can write: "blue bruising to the hymen from 3 o'clock to 6 o'clock."

We will practice this more in the clinical portion of the course.

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The Medical History

Subjective and objective findings can be obtained from a health history and a review of the body systems. The subjective is what the patient states, and should be documented in his or her own words. The objective data is collected during the physical examination.

Demographic information needs to be collected from every patient. The information can be obtained through the medical record, emergency department chart, or directly from the patient. It should include:

- Name
- Date of birth
- Address
- Phone
- Social security number (if applicable)

A full set of vital signs must also be obtained and documented on the chart, including:

- Blood pressure
- Pulse
- Respirations
- Temperature
- Pain rating

Other elements to include in the documentation of the admission assessment are:

- Past medical history
- Surgical history
- Reproductive history including number of pregnancies, miscarriages, and terminations
- Last voluntary sexual contact and the nature of that contact
- Last menstrual period (recorded as the first day of the patient's last menstrual cycle)
- Medications - prescription, over-the-counter and those the patient has recently stopped taking
- Allergies and patient's reaction to each allergen
- Disabilities
- Immunization status
- Pre-existing injuries
- Emotional status or demeanor (documented in objective terms such as quiet, crying, tense, restless, twisting fingers, agitated, reluctant or responsive or laughing)
- ETOH & drug use

Key Points to Remember

- ✓ Remember to document using the victim's own words.
- ✓ Body maps and photographs are meant to *support your written documentation*, not replace it.

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Forensic History

The forensic history:

- Involves obtaining information about an incident that relates to the physical and emotional well-being of the victim, with regards to a crime.

- Relates to any crime that involves physical injuries.

What information is collected in the forensic history?

General information about the assault will assist the examiner in discovering forensic evidence that may remain after an assault. The history is critical in guiding the subsequent examination for forensic evidence. The forensic history can be divided into three types of information:

1. Information on the assault or assault history
2. Information related to the nature of contact
3. Information on the activities since the assault

Assault History

The history is best taken from the victim using open-ended questions that encourage the victim to relate details. Avoid questions that allow for simple yes or no answers. Record the victim's own words using quotation marks. Start with general questions and move to more specific questions. Allow the patient sufficient time to answer your questions.

Table 4. *Components of the Assault History*

Date and time of assault	Relationship of victim to assailant	Lapse of consciousness
Pain or injury	Acts described by the patient	Condoms/lubricants/jelly
Location of assault	Did ejaculation occur	Sexual dysfunction
Name/number of assailants	Any kissing/biting/sucking	Restraints/grapping/grasping
Physical blows	Weapons	Burns
Threats of harm	What position was used	Strangulation

The Nature of the Contact from an Expert

The nature of the contact between the assailant and the patient will determine the most probable sites from which foreign DNA may be collected. The SANE needs to document the nature and number of times each contact occurred. It is also important to note the order in which the contact occurred. Take the time during your history to adequately answer each of the following questions.

1. Was there penetration of the vulva/vagina by his/her penis, fingers or any foreign objects?

   This question could guide the SANE toward the possible collection of evidence from semen, skin, sweat, or foreign matter left behind by a foreign object such as splinters, glass or plastic. It will also impact on the assessment and interventions the SANE should expect to complete. For example if a patient reports she was penetrated by a finger the SANE would evaluate the patient for possible scratches or fingernail marks left on the labia or vagina. The SANE would also collect swabs for possible foreign DNA on the vulva and vagina.

2. Was there penetration of the anus by his/her penis, fingers or any foreign objects?

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This question could guide the SANE toward the possible collection of evidence from semen, skin, sweat, or foreign matter left behind by a foreign object such as splinters, glass or plastic. The SANE should recognize the cultural and religious beliefs that may affect the ability of the patient to openly discuss this portion of their assault. It is the responsibility of the SANE to obtain the information with as much respect for the patient's beliefs as possible. This information will impact on the patient's risk of HIV exposure, it will also impact on the assessment and interventions the SANE should expect to complete.

3. At any time did the assailant's mouth come in contact with the patient's genitals?

   Some patients may report this type of oral contact. The SANE will use this information in the collection of evidence using the vulvar swabs which will be discussed in Module 3.

4. At any time did the patient's mouth come in contact with the assailant's genitals?

   This form of sexual contact is not uncommon in sexual assault. It is important for the SANE to document the nature and duration of this contact as well as the order in which it occurred. The SANE also needs to complete a thorough examination of the patient's mouth to ensure no injury has occurred.

5. At any time did the assailant's mouth come in contact with the patient's anus?

   While this form of sexual contact is not common in sexual assault it is important to note for several reasons. First it identifies an assailant's preference for such acts. This information could link the assault to a specific assailant or the assailant, if his identity is known, to other assaults. Secondly, it guides the SANE in the collection of evidence from the perianal area. Lastly it could add to the number of charges brought against the assailant.

6. At any time did the patient's mouth come in contact with the assailant's anus?

   Again this form of sexual contact, though not common, can yield a great deal of information about the assailant. It may also be a topic the patient finds difficult to discuss.

Please note that while we have discussed that obtaining this information could aid in the identification and prosecution of the assailant, it remains outside the role of the SANE to investigate the incident. The primary goal of the information gathered during a history is to guide your evaluation, assessment, and intervention of the patient. The SANE should ask the appropriate questions but should also accept the level of information the patient is comfortable disclosing.

Activities since the Assault

The patient's activity since the assault directly impacts the type and quality of evidence the examiner will be able to collect. The patient's activities can account for the presence or absence of physical evidence. It is important that the examiner documents the information accurately. In the case of a patient whose kit yields no physical evidence, such findings could be consistent if they reported having showered and changed clothing.

Essential Elements

The following is the description of the essential elements of the medical forensic history excerpted from *A National Protocol for Sexual Assault Medical Forensic Examinations: Adults/Adolescents* (U.S. Department of Justice, Office on Violence Against Women, 2004, p. 83).

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Obtain the medical forensic history. The specific questions asked of patients by examiners for the medical forensic history vary from one jurisdiction to the next, as do forms used to record the history. However, the following information should be sought routinely from patients:

1. Date and time of the sexual assault(s): It is essential to know the period of time that has elapsed between the assault and the collection of evidence. Evidence collection may be directed by the time interval since the assault. Interpretation of both the physical exam and evidence analysis may be influenced by the time interval between the assault and the exam.

2. Pertinent patient medical history: The interpretation of physical findings may be affected by medical data related to menstruation, recent anal-genital injuries, surgeries, or diagnostic procedures, blood-clotting history, and other pertinent medical conditions or treatment.

3. Recent consensual sexual activity: The sensitivity of DNA analysis makes it important to gather information about recent consensual intercourse, whether it was anal, vaginal, and/or oral, and whether a condom was used. A trace amount of semen or other bodily fluid may be identified that is not associated with the crime. Once identified, it may need to be associated with a consensual partner, and then used for elimination purposes to aid in interpreting evidence.

4. Post-assault activities of patients: The quality of evidence is affected both by actions taken by patients and the passage of time. It is critical to know what, if any, activities were performed prior to the examination (e.g., have patients urinated, defecated, wiped genitals or the body, douched, removed/inserted a tampon/sanitary pad/diaphragm, used oral rinse/gargled, washed, brushed teeth, ate or drank, smoked, used drugs, or changed clothing?).

5. Assault-related patient history: Information such as whether there was memory loss, lapse of consciousness, vomiting, non-genital injury, pain and/or bleeding, and anal-genital injury, pain, and/or bleeding can direct evidence collection and medical care. Collecting toxicology samples is recommended if there was either loss of memory or lapse of consciousness, according to jurisdictional policy.

6. Suspect information (if known): Forensic scientists seek evidence on cross-transfer of evidence among patients, suspects, and crime scenes. The gender and number of suspects may offer guidance to types and amounts of foreign materials that might be found on patients' bodies and clothing. Suspect information gathered during this history should be limited to that which will guide the exam and forensic evidence collection. Detailed questions about suspects are asked during the investigative interview.

7. Nature of the physical assault(s): Information about the physical surroundings of the assault(s) (e.g., indoors, outdoors, car, alley, room, rug, dirt, mud, or grass) and methods employed by suspects is crucial to the detection, collection, and analysis of physical evidence. Methods may include, but are not limited to, use of weapons (threatened and/or injuries inflicted), physical blows, grabbing, holding, pinching, biting, using physical restraints, strangulation, burns (thermal and/or chemical), threat(s) of harm, and involuntary ingestion of alcohol/drugs. Knowing whether suspects may have been injured during the assault may be useful when recovering evidence from patients (e.g., blood) or from suspects (e.g., bruising, fingernail marks, or bite marks).

8. Description of the sexual assault(s): An accurate but brief description is crucial to detecting, collecting, and analyzing physical evidence. The description should include any:

    - Penetration of genitalia (e.g., vulva, hymen, and/or vagina of female patient), however slight;
    - Penetration of the anal opening, however slight;
    - Oral contact with genitals (of patients by suspects or of suspects by patients);

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- Other contact with genitals (of patients by suspects or of suspects by patients);
- Oral contact with the anus (of patients by suspects or of suspects by patients);
- Non-genital act(s) (e.g., licking, kissing, suction injury, and biting);
- Other act(s) including use of objects;
- If known, whether ejaculation occurred and location(s) of ejaculation (e.g., mouth, vagina, genitals, anus/rectum, body surface, on clothing, on bedding, or other); and
- Use of contraception or lubricants.

These questions require specific and sometimes detailed answers. Some may be difficult for patients to answer. Examiners should explain that these questions are asked during every sexual assault medical forensic exam. The examiner should also explain why each question is being asked.

Activity #2

Please go to the discussion forum and post your responses to the following:

- What barriers in the past have you had when attempting to obtain a patient history?
- What are the barriers you expect to encounter in sexual assault patients?
- With what portion of the history are you most uncomfortable, and why?

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Physical Evaluation/Head-to-Toe Assessment

A Quick Review

A physical assessment should be adjusted to the patient, based on his or her needs. It can be:

- A complete physical assessment
- An assessment of a body system
- An assessment of a body part

The physical assessment is the first step in the nursing process and provides the foundation for the nursing care plan. Nursing assessment and observation play an integral part in assessment, planning, intervention, and evaluation.

A physical assessment should be performed in a systematic and organized manner so that important information is not overlooked or missed. A review of the elements of a physical examination can be viewed from the following Web site: http://www.brooksidepress.org/Products/Nursing_Fundamentals_II/lesson_6_Section_1.htm.

Table 5. *Head to Toe Examination Guide*

General survey	**Upper back and side**
State of health	Inspection of the back and axilla
State of awareness	Inspection and palpation of the spine
State of emotions: mood, distress, grooming	Auscultation of the lungs
Motor activity, posture, gait	
Speech	**Anterior chest Respiratory pattern, chest symmetry**
General Parameters	Auscultation of lungs
Height and weight	Auscultation of heart signs
Vital signs	Breast inspection
Skin: assess for the following during inspection of each area of the body: color, elasticity and turgor, moisture, temperature and lesions	
	Abdomen
	Inspection
	Auscultation of bowel sounds
Head	Palpation for pain
Eyes: symmetry, eyelids, conjunctiva and sclera cornea and lens, papillary reflex and accommodation, visual acuity, extraocular movement	Palpation of the femoral arteries
	Lower back
	Inspection of sacrum and buttocks
Ears: external structures, external auditory canal	
Hair	**Extremities**
Scalp	Inspection of skin
Face: skin, synetry of movement, muscle strength of jaw, pain sensation	Inspection of nails Capillary refill
Nose: nares, septum, vestibule	Swelling or pitting edema
Mouth: lips, teeth, gums, mucous membranes, pharynx, tongue	Pulses: radial and brachial on arms; dorsalis pedis and posterior tibialis in feet
	Sensation
Neck	Muscle strength: arms, hands, legs, ankles
Swallowing	Range of motion
Carotid Pulses	Coordination
Jugular vein distention	
Position of Trachea	
Range of motion	

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Basic Techniques for a Physical Examination

Include the following elements of a physical examination. A review in a basic fundamentals textbook is a good place to refresh your knowledge of these essential exam elements:

- **Inspect** the body in a systematic and orderly manner
- **Palpate** through touch to note the texture, location, size, and consistency of the parts of the body
- **Auscultate** by listening using a stethoscope
- **Percuss** areas of the body

The physical assessment of a sexual assault patient needs to be guided by what the patient says and what he or she does not say.

Victims of sexual assault may be in such overwhelming emotional pain that they may be unaware of physical pain. The examiner should listen carefully to the assault history in order to know where to look for injury. But, the examiner also needs to assess the entire body for injuries and pain the patient has **not** reported. Make note of behaviors such as favoring one leg over the other while denying any pain to the area.

Be observant of and suspicious for possible injury.

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Types of Exams

Integrated Exam

An integrated exam refers to the process of incorporating evidence identification, documentation, and collection into your physical assessment. The examiner should remember to first identify the injury/evidence, then document/photo-document the injury/evidence. Finally collect and then palpate and further assess.

For example: You are in the process of assessing a young woman who was assaulted earlier in the day. While doing your assessment, you note that she has a bite mark to her abdomen. She reported pain to the abdomen during the history.

- First, identify that she has injury, then
- Photo document the injury, next
- Swab the bite mark using the "dried secretions envelope" (more detail in the third module) of the sexual offense evidence collection kit; and when all of that is done,
- Continue with your physical assessment of the abdomen, including palpation.

Trauma Assessment

A trauma assessment, as used in the Emergency Nurses Association (2008) Trauma Nurse Core Curriculum (TNCC) for sexual assault patients, employs the process of applying the letters A through I to assist the SANE in the assessment and documentation of the different parts of a physical assessment. The following models the TNCC assessment guidelines.

Primary Assessment

A	Airway
B	Breathing
C	Circulation
D	Disability or Deficit

Secondary Assessment

E	Expose
F	Full set of Vitals
G	Give Comfort
H	Head-to-Toe Assessment
I	Inspect Back
J	Jot it down

Physical Assessment

The physical assessment of a sexually assault patient needs to be guided by what the patient says and what he or she doesn't say. Victims of sexual assault may be in such overwhelming emotional pain that they may be unaware of physical pain. The examiner listens carefully to the assault history in order to know where to look for injury. However, the examiner also needs to asses the entire body for injuries and pain the patient has not reported. Make note of behaviors such as favoring one leg over the other while denying any pain to the area. Be observant of and suspicious for possible injury.

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Focused Assessment by Head-to-Toe Body Site

Head

Injuries to the head may be caused by physical blows, falling and/or strangulation. When assessing the head the examiner needs to palpate for areas of pain. Remember to check behind the ears for injuries and move the patient's hair to inspect for injuries or areas of missing hair. Possible assessment findings include:

- Lacerations
- Point tenderness
- Petechiae
- Abrasions
- Redness
- Areas of scalp with missing hair
- Lumps and bumps
- Contusions

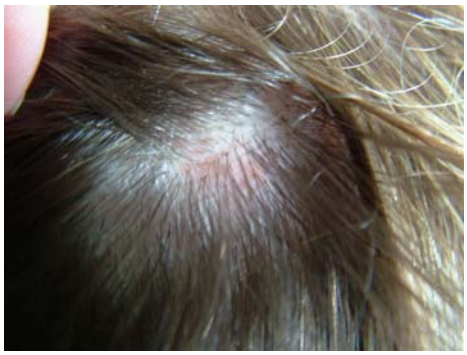

Figure 1. *Areas of missing hair*

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Neck

Assessment of the neck needs to include looking for physical injury, palpating for tenderness, listening to the assault history, and observing the patient's behavior. Injuries to the neck may be a result of physical blows, strangulation, suction, bites, and/or burns. The examiner should asses the neck for:

- Pain
- Ligature marks
- Lacerations
- Difficulty or painful swallowing
- Swelling
- Bite marks
- Difficulty breathing
- Coarse or hoarseness of the voice
- Contusions
- Abrasions
- Point tenderness

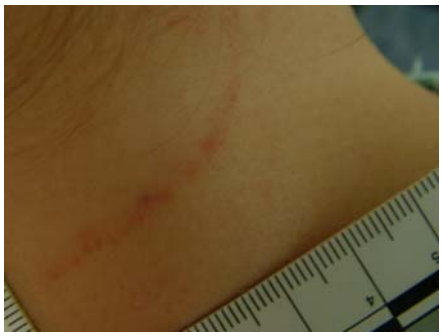

Figure 2. *Abrasion to the neck*
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Face

Assessment of the face needs to include a full inspection of the mouth, eyes, and nose. Swelling to the face due to trauma can sometimes be very difficult to photo-document. Precise documentation on the narrative and body mapping sections of the chart is therefore very important. Because of its many body prominences facial injuries can be dramatic. Injuries to the face may result from physical blows (both open and closed handed), falling, strangulation, and/or forced oral sexual activity. The examiner should assess for:

- Contusions
- Swelling
- Redness
- Petechiae
- Lacerations
- Point tenderness
- Abrasions
- Missing or broken teeth

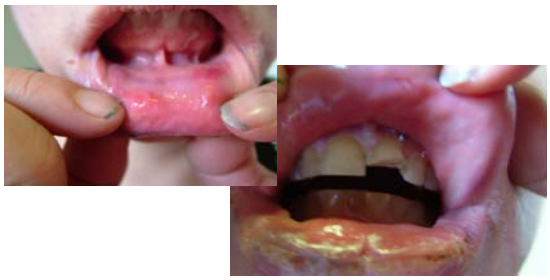

Figure 3. *Broken teeth*

Chest/breasts

Assessment of the chest and breasts needs to include auscultation of the lungs, symmetrical expansion of the chest, and any strider or visible signs of shortness of breath or difficulty breathing. Possible injuries may result from physical blows, suction, bites, burns, pinching, or fondling. Breasts are a more probable site for possible injury during sexual assault because even though "breasts are a part of sexual anatomy that is unrelated to reproduction…in American society, they have a great deal of erotic allure and sexual symbolism" (Sinclair Intimacy Institute, 2002).

The examiner should document the developmental stage of sexual maturation using the Tanner scale. The Tanner scale exists for boys and girls and is a scale that, for girls, is based upon a girl's breast shape and size and distribution of pubic hair, and, for boys, is based upon development of genitalia and distribution of pubic hair (actual pictures will be shared in the clinical practicum).

Remember to include palpation for point tenderness. Injuries to the chest and/or breasts may include:

- Lacerations
- Petechiae
- Difficulty breathing
- Abrasions
- Pain
- Bite marks
- Point tenderness

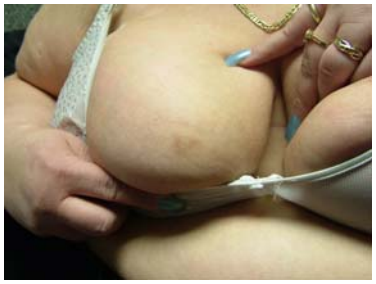

Figure 4. *Bruising - suction injury to breast*

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Abdomen

The abdomen is not a frequent site of traumatic injury in sexual assault. The assessment of the abdomen; however, plays a very important role in the evaluation of the sexually assaulted patient. Complaints of pain to the abdomen can be a result of blunt force trauma from physical blows such as punching or kicking. Blunt force trauma to the abdomen may result in a number of life threatening conditions. Injuries to the liver, spleen, pancreas, kidneys, and bowel may occur. In addition abdominal pain may indicate internal bleeding from an abdominal or pelvic source. A full and detailed assessment should be completed on every patient. The examiner should also be aware that "stomach" or abdominal pain is a common somatic complaint in trauma survivors. The examiner should assess for and document the presence of:

- Soft vs. Rigid
- Contusions
- Redness
- Bowel sounds
- Lacerations
- Swelling
- Non tender vs. Tender
- Bite marks

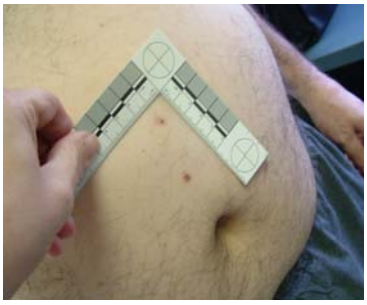

Figure 5. *Pellet gun injury to the abdomen*
Courtesy of: Dr. Kari Reiver, and used with permission.

Back

As in most trauma assessments, it is important to inspect the back for injuries. Since the majority of sexual assaults are perpetrated with the victim on their back, it is a logical area to look for injuries. In addition, traumatic injury from falls and muscle injury that occurs as a direct result of a physical struggle, are also possible findings. The examiner should assess for:

- Contusions
- Redness
- Pain
- Lacerations
- Point tenderness
- Abrasions
- Swelling

Upper and Lower Extremities

The extremities are areas that are more frequent sites of injuries in sexual assault. Injuries may range from applied restraint, such as bruising from being held down, to ligature marks from physical restraints such as ropes or handcuffs. The upper extremities may also sustain injuries as a victim fends off his or her attacker or defensive wounds.

Lower extremities may be injured as a result of forced positioning. Injuries may also result from physical blows including punches, stomping and kicks. Every examiner should assess for:

- Presence of pulses, and
- Pedal edema. Note the color and temperature.

Consider checking the soles of feet for debris. The examiner needs to document the presence of the following injuries to the upper and lower extremities:

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- Lacerations
- Bite marks
- Redness
- Deformity
- Abrasions
- Burns
- Swelling
- Broken nails
- Contusions
- Decreased range of motion
- Pain Point tenderness

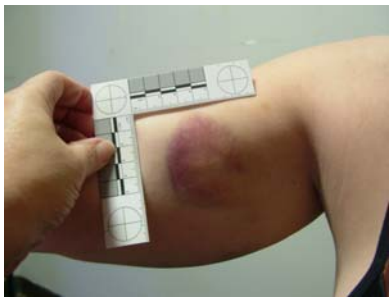

Figure 6. *Bruising to right arm*
Courtesy of: Dr. Kari Reiver, and used with permission.

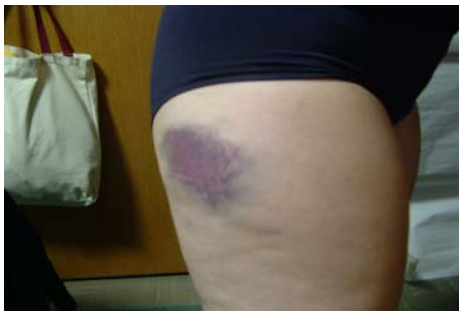

Figure 7. *Bruising to right leg*

Buttocks

New York State Penal Law (Section 130.52) involves the forcible touching of the sexual or other intimate parts of another person for the purpose of degrading or abusing such person; or for the purpose of gratifying the actor's sexual desire. Forcible touching includes the squeezing, grabbing, or pinching of such other person's sexual or other intimate parts (Forcible Touching, 2003). The buttocks, like the breast can be viewed as sexually erotic. This makes the buttocks a unique target for injury.

The examiner should assess for:

- Contusions
- Burns
- Pain
- Abrasions
- Redness
- Bite marks
- Lacerations

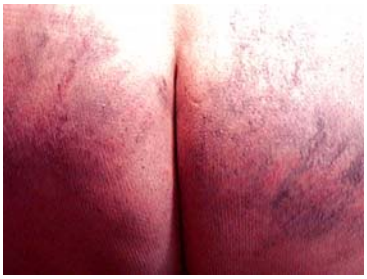

Figure 8. *Bruising to buttocks with patterned injury*

Anus

The anus is the opening or outlet of the rectum to the outside of the body. The perianal area is made up of folds of tissue that spread out from the anus in a concentric ring. These folds should be relatively uniform and pink in color. The tissue is very pliant and aids in dilation of the anus. Assessment of this area needs to include physical injury, bleeding or discharges.
The examiner should assess for:

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- Lacerations
- Redness
- Abrasions
- Bleeding
- Swelling

Genitalia

Both male and female genitalia need to be assessed for physical injury, bleeding or discharge. The female genitalia should be pink and may be slightly moist. Remember, this is very pliable tissue and injuries may be small and difficult to identify with simple visual inspection. The use of a colposcope may be helpful.

The examiner should assess for:

- Redness
- Abrasions
- Point tenderness
- Swelling
- Lacerations
- Contusions
- Tears

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Assessment Techniques

Positioning

Positions used for assessing the genital and anal structures may vary depending on:

- Patient's mobility
- Area to be examined
- Age of the patient
- Preference of the examiner

The **lithotomy position** refers to placing a patient on their back, in a supine position, with their feet in stirrups. For adult and adolescent patients, it is the most commonly used position for the examination of the genitalia.

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Figure 9. *Lithotomy position*

Knee-chest position describes a patient lying supine on their back holding their knees to their chest. This position is used to better visualize the anus in the adult and adolescent patient.

Figure 10. *Knee-chest position*

The **left-lateral position** describes placing the patient on their side with their knees drawn up to their chest. It can be an effective position for the evaluation of the anus. It is also used for the evaluation of the elderly patient who has limited mobility or who does not tolerate the lithotomy position.

Figure 11. *Left-lateral position*

Methods of Examination

There are several methods which enhance the visualization of the genital and anal structures. It is common for examiners to use more than one method during an examination. Neither the New York State Protocol for the Acute Care of the Adult Patient Reporting Sexual Assault nor the National Protocol for Sexual Assault Medical Forensic Examinations identifies one method of examination as preferable over

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another. The determination of which method used will depend on the area to be examined and the preference of the examiner.

A study by Boyle, McCann, Miyamoto, and Rogers (2008) noted a multi-method examination approach:

> The supine labial separation method provides the examiner with an excellent view of the labia, the posterior fourchette, and the perineum, but it may not afford a good view of the vestibule, surface of the hymen, and the fossa navicularis as does the supine labial traction technique. Neither the supine labial separation method nor the supine labial traction was as successful as the prone knee-chest position in smoothing out the hymen and allowing the examiner to view the interior of the vaginal canal. The study findings show that the results of a medical examination will vary by the method employed. While no single method detected all the injuries, the use of the multimethod examination approach did prove to be a valuable addition in the evaluation of both the prepubertal and the pubertal girl's genitalia, particularly in the identification of a hymenal laceration. (p. 229)

Figure 12. *Labial separation*

Labial separation refers to gentle separation of the labia majora and/or minora in a lateral direction. This can be accomplished using two fingers: place one finger on each labia and push in an outward motion.

Labial traction refers to the separation of the labia majora and minora in a slightly lateral and forward motion. This can be accomplished by grasping both the labia between the thumb and forefinger of each hand. Very gently pull the labia toward you and slightly to each side.

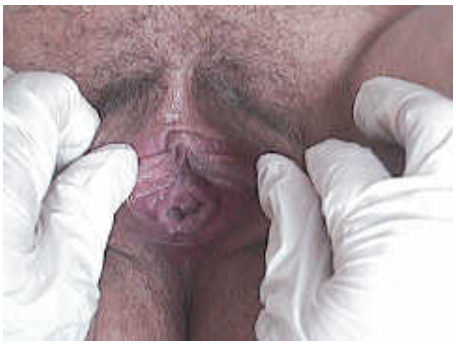

Figure 13. *Labial traction*

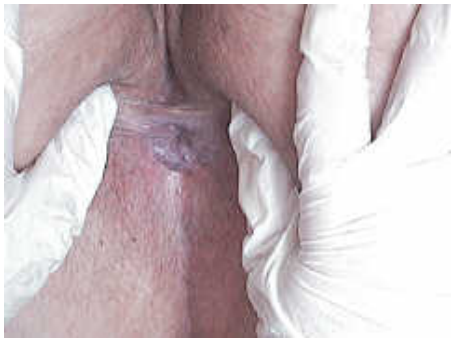

Figure 14. *Anus*

Dilation of the anus can be produced by applying slow steady pressure to the buttocks. This is accomplished by placing one hand on each buttock on each side of the anus. Gently apply outward pressure separating the buttocks. Ask the patient to relax. It is possible the examiner will need to apply pressure for several minutes before dilation occurs using this method.

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Speculum examinations refer to the insertion of a speculum into the vaginal opening to get a better visual of the vagina and cervix. This can be accomplished by turning the speculum until the blades are in line with the labia and inserting the speculum into the vaginal opening. Rotate the speculum 90 degrees and finish inserting the speculum. Once fully inserted, the examiner should open the blades until the cervix becomes visible.

Figure 15. *Plastic speculum*

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Anatomy & Physiology

The SANE needs to be able to identify normal and abnormal-normal findings. It is also important to know the most common areas of trauma and why these areas are most at risk for injury. Knowledge of the normal human sexual response is important for the examiner to understand because injuries can occur if the normal sexual response has not occurred. The examiner must also distinguish acute injuries from chronic changes.

Normal Findings

Oral

Mouth:

The lips should be consistent in color and may have dry or cracked opposing surfaces. The buccal mucosa, hard and soft palates, and the tongue should also be uniformly pink and free of lesions. The dorsum of the tongue is covered by papillae, which appears rough. A thin white coating of the tongue is not uncommon. The undersurface of the tongue is smooth with evident blood vessels and an intact frenulum.

Above and behind the tongue are two arches: palatoglossal and palatopharyngeal. Both are supported by their respective pillars. These vertical portions of the arches are called the *anterior* and *posterior pillars.* The *tonsils* can be seen in the cavities between the pillars. At the center of the *palatoglossal arch* is the *uvula.* Possible areas of injury include:

- vermilion and mucosal surfaces of the lips
- frenula
- hard and soft palate
- palatoglossal arch
- uvula

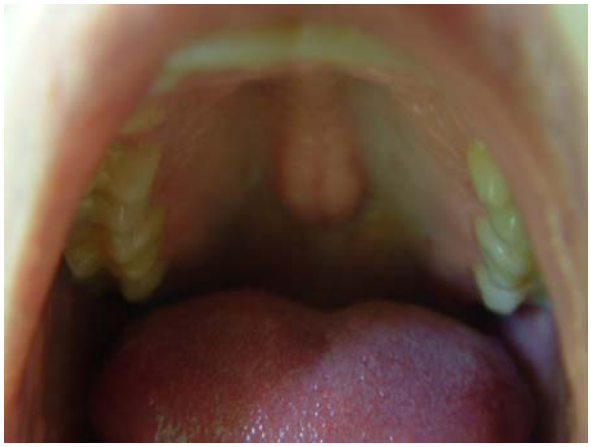

Figure 16.Soft and hard palate
Courtesy of: Erin Ptak

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Male anatomy

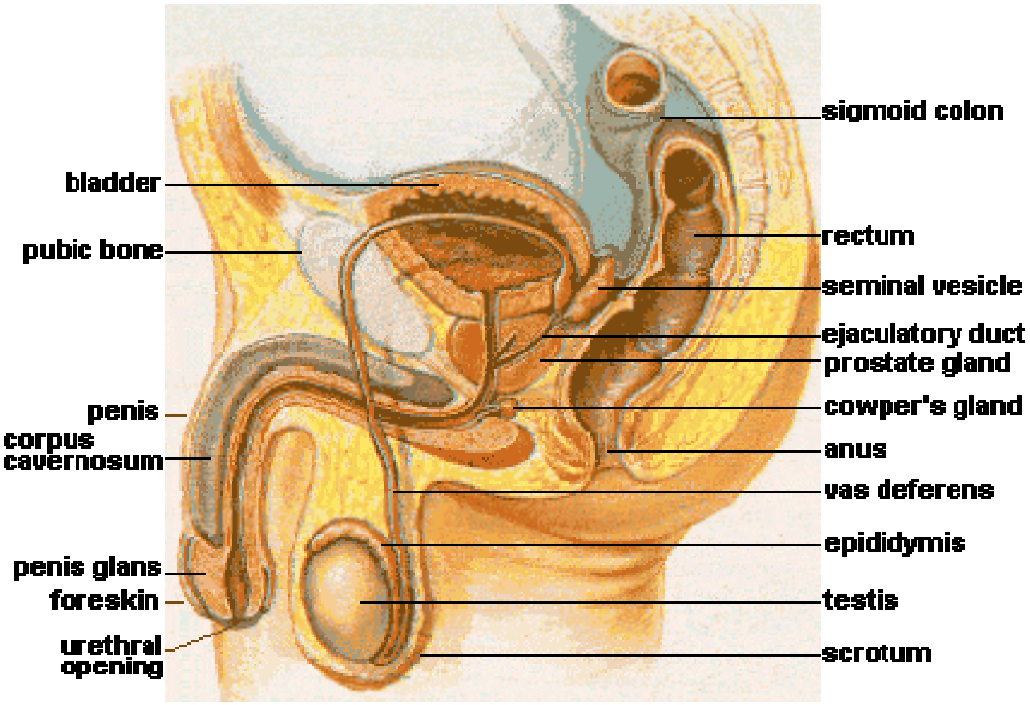

Figure 17. *Male Anatomy*
Downloaded from: http://en.wikipedia.org/wiki/File:Male_anatomy.png

Penis:

The penis is a cylindrical, erectile structure composed of:

- glans
- body
- prepuce
- frenulum

The body is composed of:

- three erectile structures
- two corpora cavernosa
- one corpus spongiosum

The erectile bodies are covered by thin, loosely attached skin without fatty tissue or hair, except at the base. The prepuce is a fold of similar tissue with no subcutaneous fat whose interior surface appears more like a mucous membrane. The glans may be covered by a *"foreskin".* The prepuce is attached to the underside of the penis by a frenulum that contains its own artery. Circumcision involves the removal of both the prepuce and frenulum and cautery of the artery. The urethral meatus is present at the apex of the glans.

Scrotum:

This is a saclike structure composed of:

- skin

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- muscle
- connective tissue

It serves to protect the testicles and associated structures. Scrotal skin is thin, elastic, and has obvious rugae. During puberty, the scrotum develops a thin covering of pubic hair and increased pigmentation.

Testis:

These are oval structures composed of a compact array of:

- tubules
- connective tissue components
- hormone-secreting cells
- sperm-producing cells

Testicles are readily palpated through the thin skin of the scrotum.

Epididymis:

This is a long, narrow, tube-like structure that carries sperm from the testicle to the seminal vesicle. It is composed of a:

- head
- body
- appendix

It may be palpated through the thin skin of the scrotum until it enters the inguinal canal.

Anus:

The anus is the opening of the rectum through which feces are extruded. This opening is surrounded by both internal and external sphincter mechanisms. Collectively they make up the anal sphincter.

The tissue that overlies the external sphincter is referred to as the anal verge. The external anal tissues generally have a symmetric appearance of circumferentially radiating skin folds also known as rugae. The typical perianal appearance is of a symmetric, pigmented, puckered mucous membrane. It has natural tone and reflexively tightens when the buttocks are separated. During puberty, coarse pubic-like hair surrounds the pigmented tissue in both females and males. The perianal area is delicate and pain sensitive. The external part of the anal canal is also made of delicate sensitive skin.

The internal part of the anal canal is lined with pain “insensitive” mucous membrane. This tissue should be pink-to-salmon colored and free of lesions.

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Female anatomy

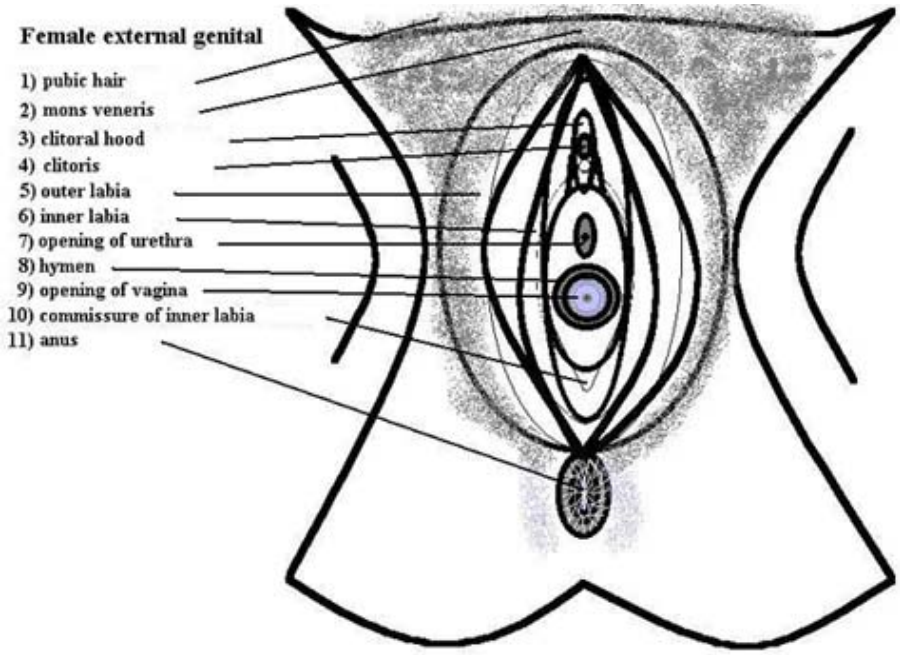

Figure 18. *External Female Genitalia*
Downloaded from: http://en.wikipedia.org/wiki/File:Vulva_anatomy.jpg

Mons Pubis:

The mons pubis is the rounded, median elevation in front of the pubic symphysis. After puberty, it is covered with coarse hair. Possible injuries to the mons pubis include bruising, lacerations, and abrasions.

Labia Majora:

The labia majora are longitudinal folds of both fatty and connective tissue that are covered by skin (see Figure 19). During puberty, they become covered with pubic hair. The inner aspects are smooth and hairless. Possible injuries include lacerations and abrasions.

Labia Minora:

The labia minora are thin folds of mucous membrane tissue protected by the labia majora (see Figure 19). Anteriorly, each labium divides into lateral and medial wings. The lateral labia fuse anteriorly and form the prepuce of the clitoris. The medial labia then fuse to form the clitoral frenulum. Posteriorly, the labia fuse to form the posterior fourchette. There are no hair follicles on the labia minora. The skin covering is smooth, moist and pink.

Labia minora are one of the most common sites of injury in sexual assault. Injuries include:

- lacerations
- abrasions
- fingernail divits
- bruising

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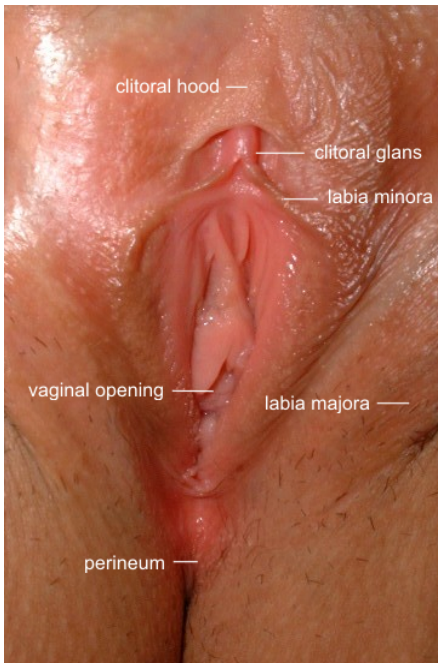

Figure 19. *Vulva*
Downloaded from: http://en.wikipedia.org/wiki/File:Vulva_labeled.jpg

Clitoris:

The clitoris is a cylindrical erectile structure that consists of a:

- glans
- prepuce
- frenulum
- body

It is located behind the anterior commissure of the labia majora (see Figure 19). Most of it is hidden by the labia minora. This structure is more commonly injured during a frontal or standing assault. The clitoris is a good source of assailant DNA in cases of oral contact with the victim's genitals.

Urethra:

The urethra forms the outlet of the urinary system. Its opening is called the *urethral meatus*. It is located just anterior to the hymen (see Figure 20). Mucoid secretions offer protection to the meatus during coitus. It is not a common site of injury during sexual assault. Recurrent urinary tract infections can be suspicious for possible sexual abuse in children.

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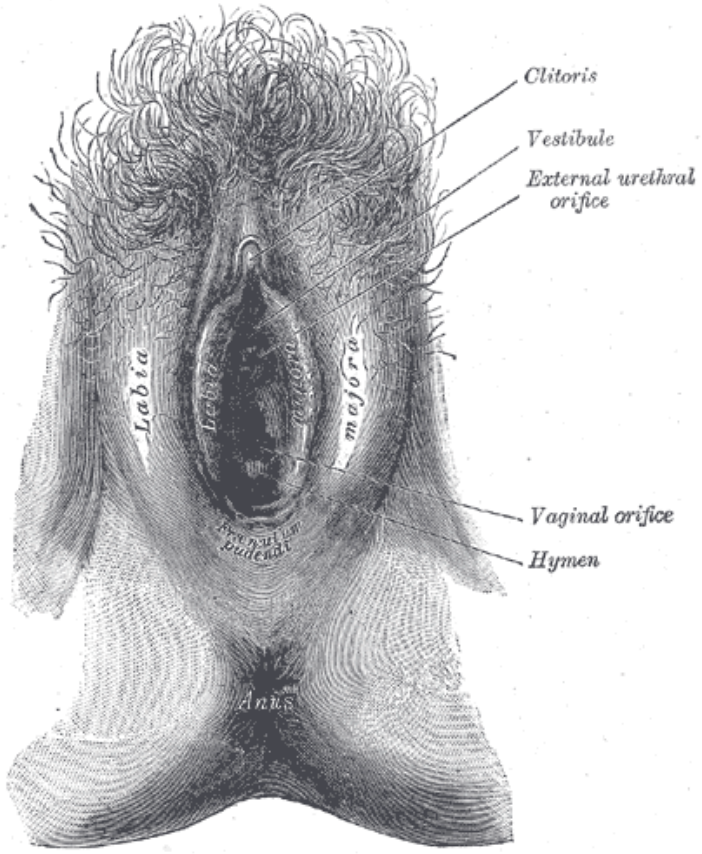

Figure 20. *Vaginal Opening*
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Vaginal Vestibule:

This is an area bounded by two structures:

- The lateral boundary is formed by the medial aspect of the labia minora and fourchette.
- The internal boundary is the anterior surface of the hymenal membrane.

Hymen:

The hymen is a membranous collar or semicollar that surrounds the vaginal opening or *"introitus".* It separates the external genitalia from the vagina (see Figure 21). The inner surface is a mucous membrane. In prepubescent girls it is extremely tender and should never be touched with a dry swab. All females have this structure and there is wide anatomic variation. An assessment of the hymen includes its:

- appearance
- size and shape
- relative estrogen effects
- any signs of trauma or scar tissue

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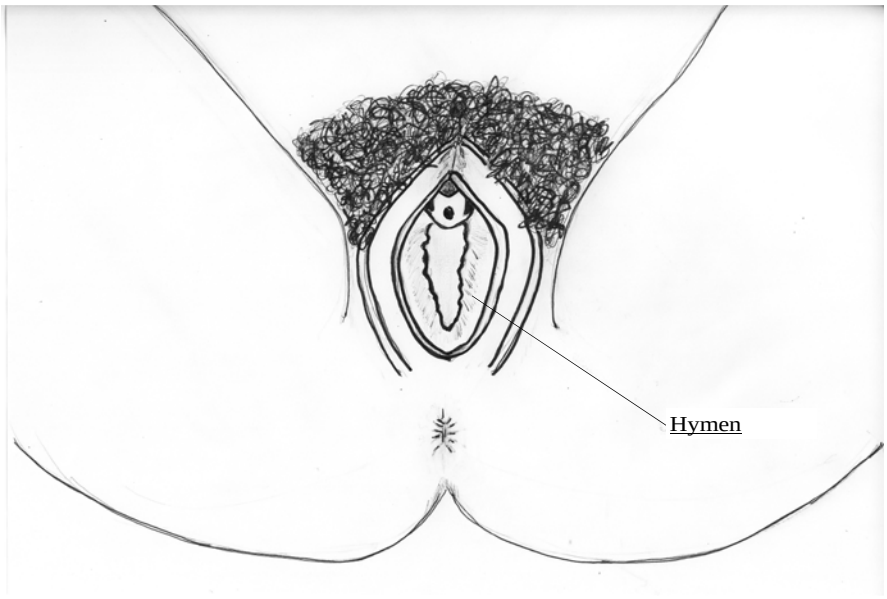

Figure 21. Hymen
Sketch drawn by Erin Ptak, and used with permission.

Terms to know that relate to the hymen:

Estrogenized

- The effect or influence of estrogen resulting in changes to the genitalia.
- The hymen takes on a thickened, redundant pale appearance.

Fimbriated

- The hymen has multiple projections along the edge creating a ruffled appearance.

In the pre-pubertal child the external surfaces of the hymen and perihymenal tissues are characterized by a lacelike vascular pattern. During puberty, the hymenal membrane changes due to the effects of estrogen and results in a thickened redundant tissue that has lost its vascular appearance and takes on a pinkish-white coloration. A spectrum of variability exists in the appearance of the hymen and its orifice shape.

The normal size of the hymen is a contested issue. The size of the orifice may vary during exam owing to positioning and the state of relaxation of the patient.

The term *"imperforate hymen"* refers to a rare condition in which no orifice is present.
The terms *"intact hymen"* or *"virginal hymen"* are inexact and only lead to confusion. As such, these terms should ***never*** be used either in conversation or in documentation of the findings.
The hymen is always present and with age it merely changes its appearance.

Fossa Navicularis:

This is a concave area between the posterior attachment of the hymen to the vaginal wall and the posterior fourchette. The fossa navicularis is a space on the labia minora and not a separate structure. **It is a common area of injury in sexual assault.**

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Posterior Fourchette:

This is the point at which the labia minora meet posteriorly. Like the fossa navicularis the posterior fourchette is a space on the labia minora not a separate structure. **It is a common site of injury in sexual assault.**

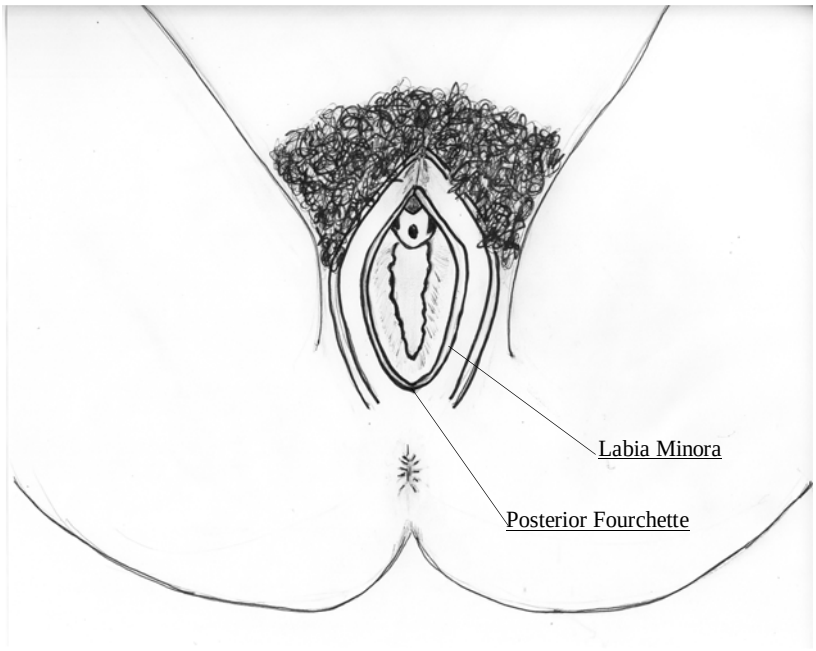

Figure 22. Posterior Fourchette
Sketch drawn by Erin Ptak, and used with permission.

Vagina:

The vagina is an expansible vault or space that responds to the sexual stimulation in preparation for intercourse. It is a tubular structure with convoluted rugae that stretch anatomically from the hymen to the cervix.

The vaginal walls should be pink with rugation. The vaginal rugae account in part for the ability of the vagina to distend. The vagina is composed of epithelial cells. Under the influence of increasing ovarian estrogen, the vaginal epithelium:

- increases in thickness
- causes vaginal secretions to acidify
- causes the labia majora and minora to become larger and fuller

Cervix:

The cervix is the neck of the uterus. It is about 2.5 cm in length. It has a rounded surface that protrudes into the vagina. For descriptive purposes, the rounded surface is divided in half at the “cervical os”, into the anterior and posterior cervical lips.

The cervical canal, to which the cervical os is the opening, consists of unstratified columnar epithelium. There may be a circumscribed area around the os of exposed columnar epithelium from the cervical canal. This is known as ectropion or eversion and is a common finding in women of all ages.

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Common sites of injury to external female genitalia:

- clitoris
- urethra
- labia minora
- vaginal orifice
- hymen
- fossa navicularis
- posterior fourchette

Let's look next at the normal sexual response.

Normal Human Sexual Response

The *human sexual response* is a theory that describes a series of changes that the human body goes through in preparation for "non-traumatic" intercourse. This entire concept was studied extensively by Masters and Johnson in the 1960s. According to Masters and Johnson (1966), there are four stages that make up the human sexual response. The four stages are*:*

1. Excitement
2. Plateau
3. Orgasmic
4. Resolution

The **excitement phase** in both females and males develops as the result of somatic or psychological stimuli.

FEMALE	MALE
There is clitoral tumescence, or enlargement. Vaginal lubrication is mostly from transudate through the vaginal walls. The Bartholin glands and cervical mucous produce only a negligible amount of lubrication.	The penis enlarges from its average flaccid length of 8.5 cm to an erect length of 16-19 cm which can be double the length or more. The flaccid circumference average of 3 cm will increase to an erect average circumference of 3.5 cm. The testes also elevate as a result of shortening of the spermatic cords.

During the **plateau phase**, in both sexes, the sexual tension intensifies. The duration varies with desire and stimulation.

FEMALE	MALE
The uterus elevates, tilts back, and the fundus contracts to form a reservoir for sperm. The inner 2/3 of the vagina distends from 2 cm wide x 7.5 cm long to 5.75 cm wide x 10.5 cm long ventrally up into the abdominal cavity. The vagina is an expandable vault or space that can accommodate the delivery of a full-term infant's head (approximately 32-36 cm circumference). The labia minora engorge, which add 1 cm to the length of the vagina. This removes its anatomic cover and also provides penile support.	The diameter of the glans penis increases to an average of 3.5 cm. The scrotum becomes vasocongested, and the testes continue to engorge and elevate. Neither muscular development, nor flaccid size relates to erect penile size. Neither circumcision nor age automatically leads to impotence.

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In the **orgasmic phase** for both sexes, vasocongestion and myotonia are released. This may last a few seconds.

FEMALE	MALE
This consists of regularly recurring contractions of the vaginal walls. It is confined to the outer 1/3 of the vagina. This varies in intensity and duration.	Ejaculation occurs at this time. Approximately 2-7 ml of seminal fluid is ejaculated. This may contain sperm greater than 20 million per ml. In retrograde ejaculation, the fluid may be discharged into the bladder. This is common after a prostatectomy.

Finally, in the **resolution phase** there is an involuntary period of tension loss. This returns the individual through the plateau and excitement stages to an unstimulated state.

FEMALE	MALE
There is muscle relaxation. The cervical Os remains dilated for 20-30 minutes. The anterior vaginal wall collapses, placing the cervix in the sperm pool. The female can return to another orgasm at any time during resolution.	There is also muscle relaxation; however, there is a refractory period after the resolution stage which prohibits the male from returning to orgasm.

Why then do injuries occur? The normal sexual response may be typically absent in the victim during a sexual assault. This may result in no pelvic tilt, no partner assistance with insertion or increase in lubrication, and no relaxation.

Key Points to Remember

- ✓ Labia minora are one of the most common sites of injury in sexual assault.
- ✓ The normal sexual response may be typically absent in the victim during a sexual assault.

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Injuries

It is very important during forensic examinations to know the different types of injuries. It is equally important to use the correct language when describing each injury. All breaks in the skin are not lacerations. Not all discoloration of the skin is bruising.

There are few situations where it will be possible to state that a specific injury has been sustained in a particular way or with a particular object. In many cases it can only be concluded that the injury was caused by blunt trauma (e.g., "a black eye" or bruising about the eye) or sharp trauma (e.g., an incised wound to the head). Falls that occur during an assault or when fleeing from an assailant may produce a number of injuries. These will usually be abrasions or bruises (and occasionally lacerations) to the bony prominences (e.g., forehead, nose, elbows, knees, hips), with the severity of the injuries being proportional to the distance fallen (Lynch, 2006).

Factors Influencing Injury in Sexual Assault

Many misconceptions exist about injuries from sexual assault. Television and media outlets have fostered the incorrect perception that sexual assault patients sustain significant or even life threatening genital and non-genital trauma. While some sexual assault patients do sustain high levels of injury the majority of cases do not.

Time

The amount of time elapsed from when an injury is sustained until the time the patient presents for treatment directly impacts the examiner's ability to identify traumatic injuries. Genital and oral injuries heal quickly. Delays in seeking treatment may result in an injury having healed the subsequently unidentified injury at the time of the exam. This is particularly true of erythema to the neck due to manual strangulation. Conversely, a contusion resulting from physical blows may take several days to fully develop. Patients presenting directly after the assault may appear to have no injuries.

The Alaska Sexual Assault Nurse Examiner Study by Rosay and Henry (2008) examined injuries, both non-genital and genital injuries. The study looked at cases of sexual assault in Alaska from 1996 to 2004 and 1,699 patient records were examined. The results demonstrated that neither the time since the assault or the condition of the patient had an impact on the resultant genital injury. Other studies conclude that the time that has elapsed since the genital injury occurred ***is*** significant and supports the need for examiners to evaluate patients closer to the time of the genital injury (Crane, 2006). Additional research is ongoing.

Rosay et al. (2008) also found that there were several non-genital injuries that included bruising, redness, abrasions, lacerations, swelling, fractures, bite marks, pain, and other to the following locations:

- Head/face
- Mouth
- Neck
- Shoulders
- Hands
- Chest
- Abdomen
- Back
- Buttocks/hips
- Arms
- Legs
- Feet

Non-genital injuries were noted on 52% of patients with further breakdown as shown in Figure 23. Bruising and abrasions accounted for most of the injuries.

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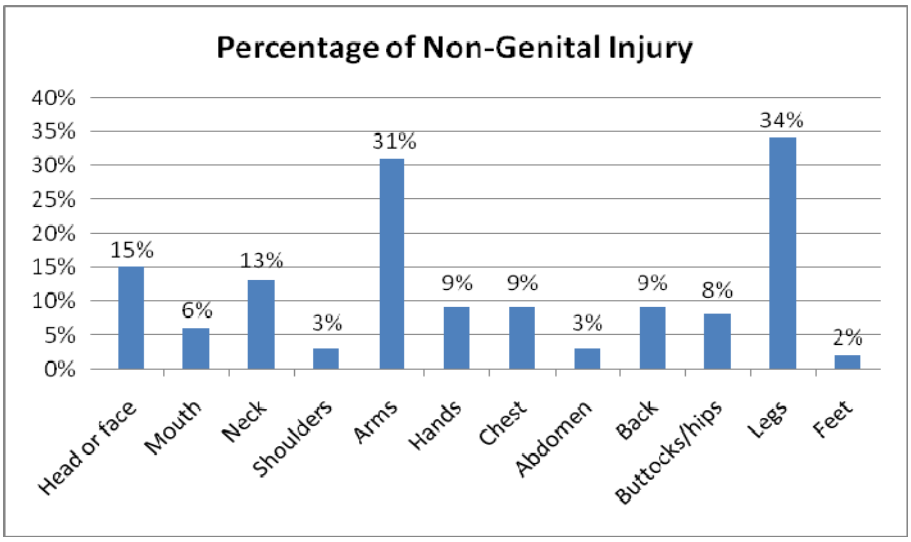

Figure 23. *Percentage of Non-Genital Injury*. Adapted from Rosay et al. 2008

Genital injuries in females occurred most frequently as abrasions, lacerations and tenderness to fifteen different sites including:

- Mons pubis
- Labia majora
- Labia minora
- Labia majora/minora junction
- Clitoral hood
- Clitoris
- Periurethra
- Hymen
- Fossa navicularis
- Posterior fourchette
- Perineum
- Vaginal walls
- Cervix
- Anus and rectum

Genital injuries in males also included bruising, abrasions and lacerations, but the location was to the anus and rectum.

Methods of Evaluation

Technology has greatly impacted the examiner's ability to detect and document physical injury. Before the advancement of sexual assault care through SANE programs, most patients reporting sexual assault were examined using simple direct visualization.

A colposcope is a tool used by providers in gynecology, and provides for a microscopic evaluation of the cervix, vagina, and vulva to detect disease and injury. The colposcope can magnify over 30 times the actual size thereby permitting the evaluation and identification of tears, bruises, and abrasions that would not have been visible otherwise. The colposcopic examination provides for an objective evaluation of injuries for the victim of sexual assault.

A message from your experienced SANE author about finding injuries:

> *Injuries in sexual assault can be very difficult to detect. You have to ask yourself, why is that? If this is such a violent and invasive act, how is it that you don't get those kinds of injuries? You have to remember that genital tissue is extremely pliant; it is meant to let the head of a baby come through.*
>
> *The best analogy that I have found over the years is to take a balloon (a regular latex balloon), blow it up about 1/3 of the way, and tie it off. Now you have a balloon that you can bang against the table, wrap around your finger, and nothing is going to happen to it. You're not really going to*

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hurt it. Then take a pin or a small needle and make a hole in the balloon, and over time you let the air naturally find its way out. Now go back, pick up that balloon and without stretching it try and find that hole. It can be very, very difficult.

*This is the same thing as in a sexual assault. What happens is that genital tissue gets stretched to the point where it finally **gives** and you get those lacerations and small abrasions. Once that tissue is back to its normal configuration those injuries are very difficult to find. What you need to do is have the proper training, the proper techniques, and the proper equipment (something like a colposcope) to find those injuries. That's what you are learning in this course.*

Blunt Force Injuries

A blunt force injury is produced by an impact against a hard surface. Blunt force trauma results when a body strikes a hard surface *or* when a hard surface strikes the body.

The appearance of injury depends upon the:

- Mechanism of applied force
- Location of the injury on the body
- Shape and texture of the impacting object
- Physiologic status of the individual

Types of blunt force injuries include four categories (Sheridan & Nash, 2007):

1. Abrasions
2. Contusions
3. Lacerations
4. Fractures

Sheridan et al. (2007) finds that a hand strike is the most common mechanism of injury.

Abrasions

According to Lynch (2005), abrasions occur when the outermost layer of skin is removed by a sliding force over a rough surface or object. An abrasion may be enough to rub away part of the skin. Scratches are also included as an abrasion.

Note: Unless otherwise noted, all images in this section on types of injuries were taken by the author, **Erin Ptak**, and are used with permission.

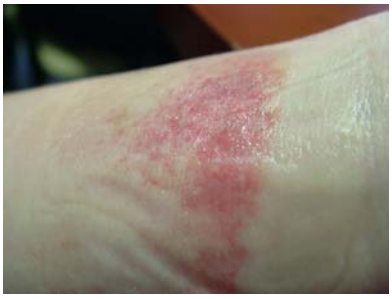

Figure 24. *Abrasion*

Contusions

Contusions may also be called bruises and are classified as eccymosis or hematomas. The SANE should describe the injury. Lynch (2005) describes bruises and contusions as injuries that have bleeding

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or leakage of blood into the tissue such that small vessels are torn (see Figures 25 and 26). Accuracy in documenting is essential since the origin of these injuries may not be as a result of the assault.

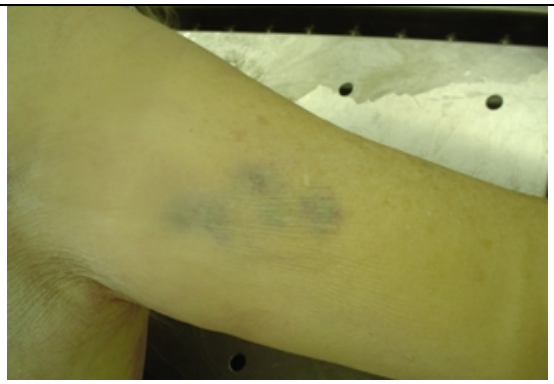

Figure 25. *Contusion of the arm*

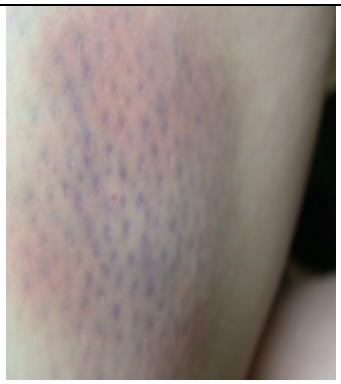

Figure 26. *Close-up of bruising*

Lacerations

Lacerations result in a break in the skin that causes a defect in the soft tissue. The laceration may result from blunt force trauma such as a tear, rip, crush, or overstretching (Lynch, 2005). SANEs need to be able to distinguish between a cut and a laceration because they are not the same.

To help distinguish between lacerations and cuts, Wright (2003) states that blunt objects produce lacerations and sharp objects produce cuts.

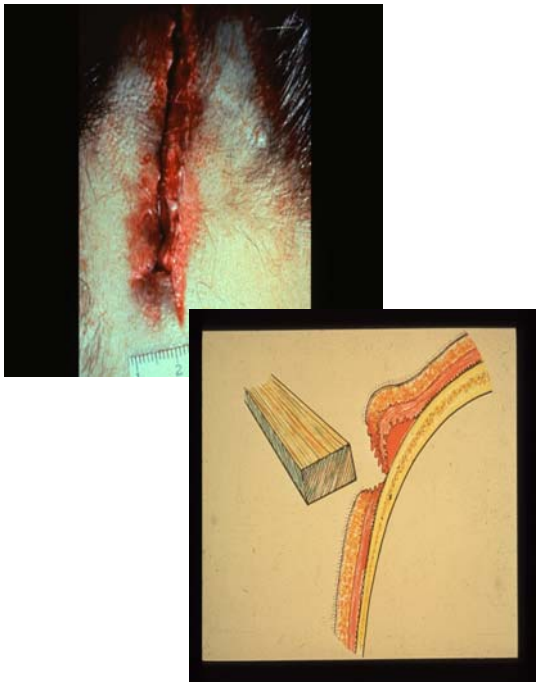

Figure 27. *Laceration and illustration of laceration formed by blunt object*
Courtesy of: Dr. Kari Reiver, and used with permission.

Fractures

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Fractures are not common occurrences in sexual assault but can occur. Orbital fractures have been cited as one type of fracture that can occur to a victim. Other types of fractures can result when the victim is pushed or shoved or even knocked down stairs during the attack.

Point Tenderness

The physical assessment of every sexual assault patient should include the identification and documentation of point tenderness. The examiner needs to remember that contusions/ bruises may not be apparent at the time of presentation for treatment. In some cases bruising may not become visible. In these cases the documentation of point tenderness may be the only indication of injury.

Sharp Force Injury

A sharp force injury is an injury caused by impact against a sharp-edged surface (cutting wound). Examples include:

- Incised wounds or cuts
- Stab/puncture wounds

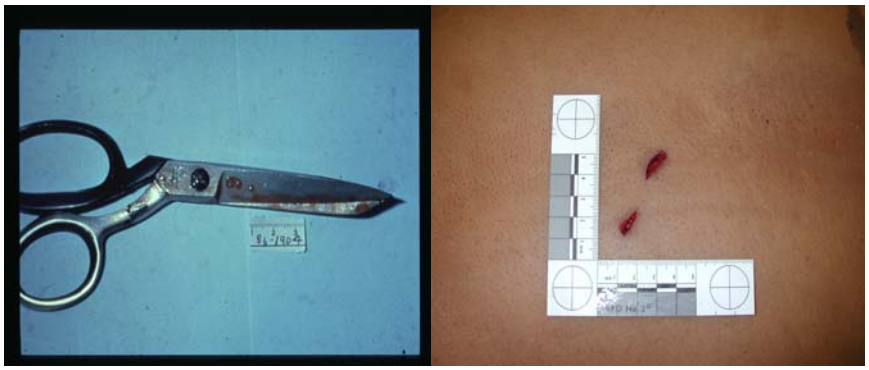

Figure 28. *Stab or puncture wound and scissors as the possible sharp instrument*
Courtesy of: Dr. Kari Reiver, and used with permission.

Firearm Injuries

According to a National Crime Victimization Survey by the U.S. Department of Justice (2005):

- More than 400,000 victims of violent crimes faced a perpetrator with a firearm.
- Of the 4.7 million violent crime victims, inclusive of rape and sexual assault, incidents involving firearms represented 9% of the cases.

Examiners can expect the use of firearms as a method used to threaten and intimidate victims of sexual violence. Firearms may also be used as a weapon by either striking the victim to cause injuries or by firing the weapon and causing penetrative gun shot wounds. Injuries from firearms during sexual assault are rare.

Chemical Injuries

Chemical injuries resulting from sexual assault can occur from an action of the assailant or the victim themselves. Chlorine bleach is widely recognized not only as a way to sanitize but also to denature or eliminate DNA or biological material.

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Patterned Injuries

A patterned injury is an injury that demonstrates a particular object that caused the injury. The pattern may be easily identified or more difficult as the pattern becomes unique to the weapon that inflicted it. A patterned injury is a repeated injury caused by the use of the same weapon over and over.

In physical abuse, patterned injuries can be manifested as bruises to a specific area, such as the back, in different stages of healing. In cases where a broad surface weapon/instrument is used, the pattern may show a defined linear area of bruising on the edges while the center remains blanched or un-bruised.

The distribution of force can be evenly divided over the surface or it can have an increased area of force on the edges. This pattern is frequently seen from items such as two by fours, baseball bats and open fist blows of the hand.

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Bite Injuries

Bite injuries may have the appearance of an oval or a circular shape. Care of the wound from a human bite is important since infection can pose a significant risk to the victim.

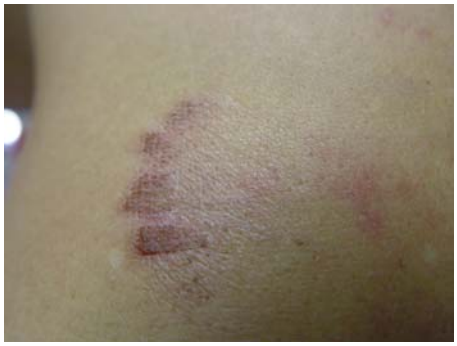

Figure 29. Bite marks

Bite marks are a good example of a patterned injury. Bite marks are a unique piece of forensic evidence. First they are a patterned injury that can reflect the tooth and arch size of the perpetrator. They also present the examiner the opportunity to collect possible DNA material from the injury.

Other examples of patterned injuries include:

- Cord loops
- Belts
- Cigarette burns

Activity #3

Please look at the following pictures of an injury that occurred during an assault.

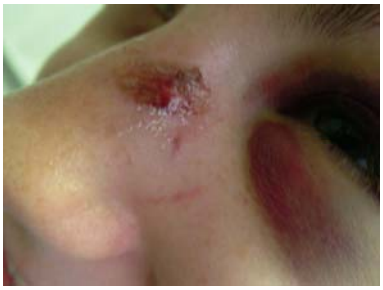

Figure 30. *Left side of face*

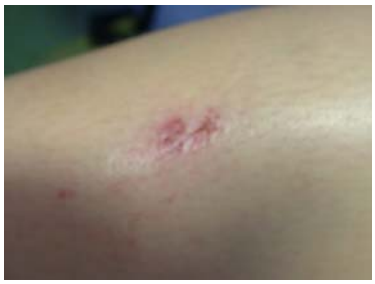

Figure 31. Right thigh

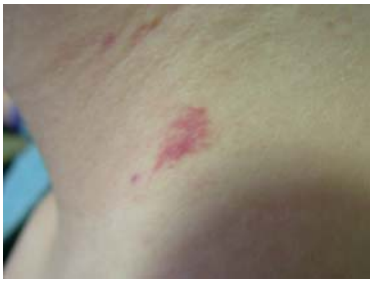

Figure 32. Left side of neck

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After reviewing the images, please go to the discussion forum and answer the following questions:

- Based upon your readings, what types of trauma do you think caused these injuries?
- Identify and document the possible mechanism of injury for each picture.

Injuries Associated with Asphyxia

Patients may use the term choking to describe manual strangulation. The examiner should document the patient's subjective statement using quotation marks, but should not use the term in describing injuries from manual or ligature strangulation.

According to Lynch (2006), strangulation is asphyxia that obstructs the main airways and/or blood vessels supplying the brain, thus impairing the delivery of oxygen. Because of the slowly compressive nature of the forces involved in strangulation, the clinician should be aware of the potential for significant complications including:

- Laryngeal fractures
- Upper airway edema
- Vocal cord immobility

Survivors are most often assaulted during an incident of intimate partner violence or sexual assault, and need to be specifically asked if they were strangled. Survivors of strangulation may not volunteer this information. Findings associated with asphyxia include:

- Cyanosis
- Petechial hemorrhages
- Pulmonary edema

The patient may present with complaints of:

- Soreness of the neck or throat
- Difficulty swallowing
- Hoarseness of voice
- Difficulty breathing

Bruising may be present to the neck and/or behind the ears or jaw (see Figure 33). These may be faint and take days to fully develop. Fingerprint bruising may be roughly circular or ovoid in shape.

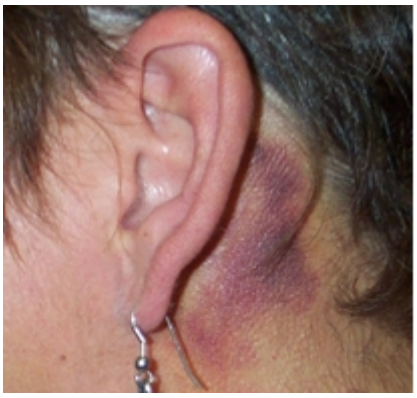

Figure 33. *Fingerprint bruising from strangulation*

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Abrasions to the neck may be related to manual or ligature strangulation. Ligature marks may mirror or reflect the item used during strangulation. Sometimes the item is easily identified while other times they are more subtle.

The SANE should first identify and then document ligature marks with photographs.

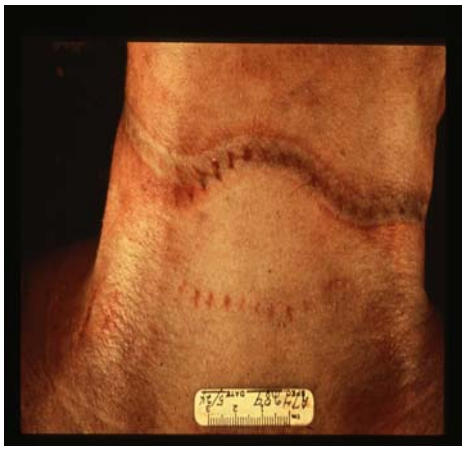

Figure 34. Ligature marks to neck
Courtesy of: Dr. Kari Reiver, and used with permission.

Other Types of Injury

Sexual assault patients may present with a variety of other injuries. Listed below are some additional types of injuries you may encounter.

- *Petechiae* refers to small (1-2 mm) red or purple spots on the body, caused by a minor hemorrhage (broken capillary blood vessels). Petechiae on the face and conjunctiva (eyes) can be a sign of asphyxiation.

- *Hematomas* are an abnormal localized collection of blood in which the blood is usually clotted or partially clotted and is usually situated within an organ or a soft tissue space, such as within a muscle.

- *Swelling in the genital area* may be related to trauma, allergic reaction or disease process. Some sexually transmitted diseases (STDs) present with swelling, redness, and discharge (to be discussed further in Module 4).

- *Redness in the genital area* is commonly associated with irritation. The presence of redness after a traumatic event is common. The presence of redness in and of itself is not definitive for trauma.

- *Ecchymosis* is bluish discoloration of an area of skin or mucous membrane caused by the extravasation of blood into the subcutaneous tissues as a result of trauma to the underlying blood vessels or fragility of the vessel walls. Ecchymosis can occur as part of a disease process or medication that increases leaking of the blood vessels. The term is not commonly used in denoting injuries resulting from trauma.

The examiner should be aware of normal variants or conditions which could mimic traumatic injury.

- Anal skin tags are shapeless flaps or lumps of flesh usually found at the anal verge, where the inside of the anorectal canal becomes the outside of the body.

- Birthmarks such as Mongolian spots or port wine stains look deceptively like bruising. If you are unsure that the area in question is an injury, first ask the patient if the spot has always been there or if it is new.

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Documentation Exercise

Activity #4

Part A. The following patient presents for the evaluation of a sexual assault. During your assessment you note the injury to the patient's left arm. Look closely at these pictures and then go to the discussion forum to post your response to the following:

- How would you describe this injury in your documentation?

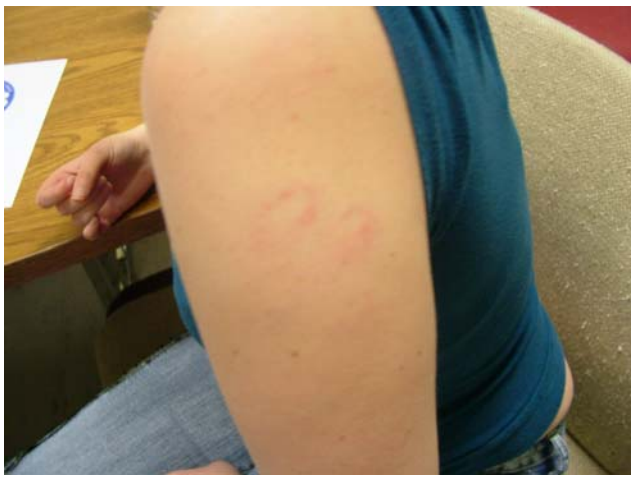

Figure 35a.
Courtesy of: Erin Ptak, and used with permission.

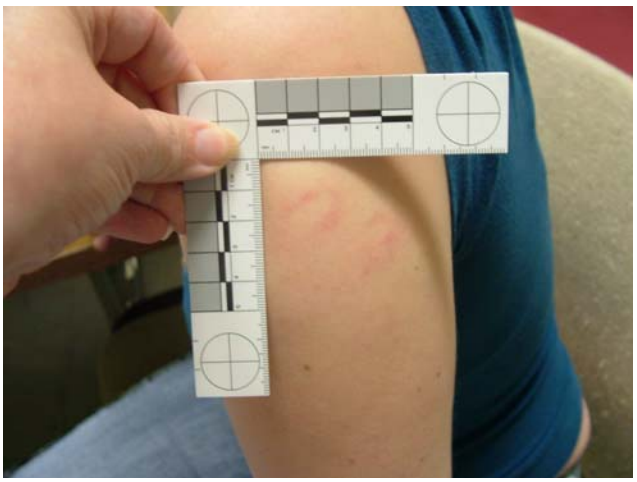

Figure 35b.
Courtesy of: Dr. Kari Reiver, and used with permission.

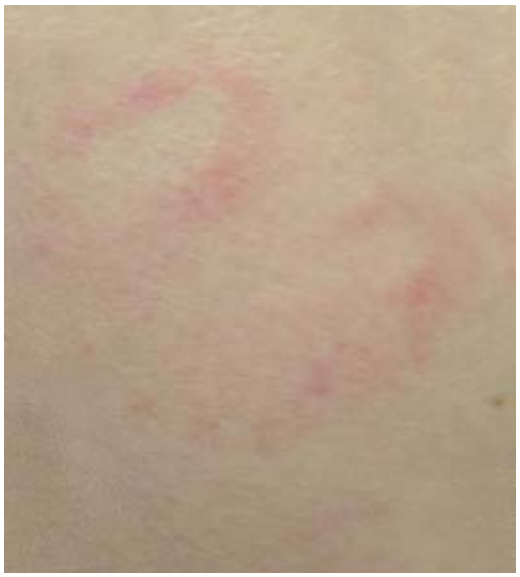

Figure 35c.
Courtesy of: Erin Ptak, and used with permission.

Part B. Use the body map and documentation tool provided in Appendix C to document the injury. You will need to print out Appendix C, complete the form, and **mail this activity to your educator**. The mailing address was provided in your orientation packet.

Feedback will be provided by your instructor.

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Conclusion

A detailed and thorough understanding of the assessment of the sexually assaulted patient will allow the SANE to integrate information obtained from the patient history with information obtained from the physical assessment. The information and skills you learn in this module are critical in that they form the foundation on which you base your plan of care. The SANE's assessment of the patient must be comprehensive and the documentation concise and accurate.

Reminder! If you have not already completed the required activities for the discussion forum please post your responses **BEFORE** attempting the examination.

You may take the examination for module 2 prior to receiving instructor feedback for the final activity.

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Appendix A – New York State Department of Health Informed Consent Brochure (Parts A and B)

Important Phone Numbers

New York State HIV/AIDS Hotlines (toll-free)
Call the Hotlines for information about HIV and AIDS and to find HIV testing sites

- 1-800-541-AIDS (2437) • English
- 1-800-233-SIDA (7432) • Spanish

New York State TTY/TTD HIV/AIDS Information Line

- 1-212-925-9560

Voice callers use the NY relay:

- 711 or 1-800-421-1220 and ask the operator for: 1-212-925-9560

New York State HIV/AIDS Counseling Hotline

- 1-800-872-2777

NYSDOH Anonymous HIV Counseling and Testing Program
For HIV information, referrals, or information on how to get a free, anonymous HIV test, call the Anonymous HIV Counseling and Testing Programs.

- Albany Region 1-800-962-5065
- Buffalo Region 1-800-962-5064
- Nassau Region 1-800-462-6785
- New Rochelle Region 1-800-828-0064
- Queens Region 1-800-462-6785
- Rochester Region 1-800-962-5063
- Suffolk Region 1-800-462-6786
- Syracuse Region 1-800-562-9423

NYCDOHMH HIV/AIDS Hotline: 1-800-TALK-HIV (1-800-825-5448)

New York State PartNer Assistance Program: 1-800-541-AIDS

New York City Contact Notification Assistance Program: 1-212-693-1419

Confidentiality

- New York State Confidentiality Hotline 1-800-962-5065
- Legal Action Center 1-212-243-1313 or 1-800–223-4044

Human Rights/Discrimination

- New York State Division of Human Rights 1-800-523-2437
- New York City Commission on Human Rights 1-212-306-7500

NEW YORK STATE DEPARTMENT OF HEALTH
AIDS Institute

Informed Consent to Perform HIV Testing

HIV testing is voluntary. Consent can be withdrawn at any time by informing your provider. Please read Parts A and B of this form, and sign at the bottom of Part B, if you understand the following information and want HIV testing.

HIV infection is a serious health concern. The New York State Department of Health recommends HIV testing. For pregnant women, the Department recommends HIV testing early in pregnancy and again late in pregnancy.

Except for expedited HIV testing on labor units, this form replaces other HIV testing consent forms as of June 1, 2005.

NOTE: this form is intended to be used in conjunction with DOH-2556, Part B.

Part A

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HIV is the virus that causes AIDS.

- HIV is passed from one person to another during unprotected sex (vaginal, anal or oral sex without a condom) with someone who has HIV.
- HIV is passed through contact with blood as in sharing needles (piercing, tattooing or injecting drugs of any kind) or sharing works with a person who has HIV.

The only way to know if you have HIV is to be tested.

- HIV tests are safe. They involve collecting one or more specimens (blood, oral fluid, urine).
- Your counselor or doctor will explain your test result as well as any other tests you may need.

Your HIV test today includes:

- A test to see if you have HIV infection (an antibody test or a test for the virus);
- If you are HIV positive, additional tests may include tests to:
  - help your doctor decide the best treatment for you.
  - help guide the health department with HIV prevention programs.

Several testing options are available.

- You can choose to have a confidential test where the result becomes part of your medical record and can be given to your health care provider for HIV and other health care services, or
- You can choose to have an anonymous test, which means that you don't give your name and no record is kept of the test result. If your anonymous test is HIV-positive, you can choose to give your name later so you can get medical care more quickly.
- To get more information about options for testing and free or anonymous testing sites, ask your counselor/doctor or call 1-800-541-AIDS.

HIV testing is important for your health.

- If your test result is negative, you can learn how to protect yourself from being infected in the future.
- If your test result is positive:
  - You can take steps to prevent passing the virus to others.
  - You can receive treatment for HIV and learn about other ways to stay healthy. As part of treatment, additional tests will be done to determine the best treatment for you. These tests may include viral load and viral resistance tests.

HIV testing is especially important for pregnant women.

- An infected mother can pass HIV to her child during pregnancy or birth or through breastfeeding.
- It is much better to know your HIV status before or early in pregnancy so you can make important decisions about your own health and the health of your baby.
- If you are pregnant and have HIV, treatment is available for your own health and to prevent passing HIV to your baby. If you have HIV and do not get treatment, the chance of passing HIV to your baby is one in four. If you get treatment, your chance of passing HIV to your baby is much lower.
- If you are not tested during pregnancy, your provider will recommend testing when you are in labor. In all cases, your baby will be tested after birth. A positive test on your baby means that you have HIV and your baby has been exposed to the virus.

If you test positive:

State law protects the confidentiality of your test results and also protects you from discrimination based on your HIV status.

- In almost all cases, you will be asked to give written approval before your HIV test result can be shared.
- Your HIV information can be released to health providers caring for you or your exposed child; to health officials when required by law; to insurers to permit payment; to persons involved in foster care or adoption; to official correctional, probation and parole staff; to emergency or health care staff who are accidentally exposed to your blood; or by special court order.
- The names of persons with HIV are reported to the State Health Department for tracking the epidemic and for planning services.
- The HIV Confidentiality Hotline at 1-800-962-5065 can answer your questions and help with confidentiality problems.
- The New York State Division of Human Rights at 1-800-523-2437 can help if you think you've been discriminated against based on your HIV status.

Your counselor/doctor will talk with you about notifying your sex or needle-sharing partners of possible exposure to HIV.

- Your partners need to know that they may have been exposed to HIV so they can be tested and get treated if they have HIV.
- If your health care provider knows the name of your spouse or other partner, he or she must report the name to the health department.
- Health department counselors can help notify your partner(s) without ever telling them your name.
- To ensure your safety, your counselor or doctor will ask you questions about the risk of domestic violence for each partner to be notified.
- If there is any risk, the Health department will not notify partners right away and will assist you in getting help.

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NEW YORK STATE DEPARTMENT OF HEALTH
AIDS Institute

Informed Consent to Perform HIV Testing

Part B

My health care provider has answered any questions I have regarding HIV testing and has given me written information with the following details about HIV testing:

- HIV is the virus that causes AIDS.
- The only way to know if you have HIV is to be tested.
- HIV testing is important for your health, especially for pregnant women.
- HIV testing is voluntary. Consent can be withdrawn at any time.
- Several testing options are available, including anonymous and confidential.
- State law protects the confidentiality of test results and also protects test subjects from discrimination based on HIV status.
- My health care provider will talk with me about notifying my sex or needle-sharing partners of possible exposure, if I test positive.

I agree to testing for the diagnosis of HIV infection. If I am found to have HIV, I agree to additional testing which may occur on the sample I provide today to determine the best treatment for me and to help guide HIV prevention programs. I also agree to future tests to guide my treatment. I understand that I can withdraw my consent for future tests at any time.

For pregnant women only:

In addition to the testing described above, I authorize my health care provider to repeat HIV diagnostic testing later in this pregnancy. I understand that my health care provider will discuss this testing with me before the test is repeated and will provide me with the test results. The consent to repeat diagnostic testing is limited to the course of my current pregnancy and can be withdrawn at any time.

Signature: _____ Date: _____
(Test subject or legally authorized representative)

If legal representative, indicate relationship to subject: _____

Printed Name: _____

Medical Record #: _____

Except for expedited HIV testing on labor units, this form replaces other HIV testing consent forms as of June 1, 2005.

NOTE: this form is intended to be used in conjunction with DOH-2556i, Part A.

DOH-2556 (5/05)

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Appendix B – FRE form

NEW YORK STATE CRIME VICTIMS BOARD
MEDICAL PROVIDER FORENSIC RAPE EXAMINATION
DIRECT REIMBURSEMENT CLAIM FORM

INSTRUCTIONS: This form is to be used when a healthcare provider is directly billing the New York State Crime Victims Board for reimbursement of costs associated with providing a forensic rape or sexual assault examination.

(1) Fill in all blanks on this form.
(2) Attach: Itemized bill including Physicians Procedural Terminology (CPT) Codes.

All Sections ONE through THREE **must** be completed.

(3) Mail the completed form and all attachments to:
New York State Crime Victims Board
Attn: FRE Processing
1 Columbia Circle, Suite 200
Albany, New York 12203

SECTION ONE. VICTIM INFORMATION (TO BE COMPLETED BY MEDICAL PROVIDER)

Date of Crime_____ Location of Crime: (city)_____(county)_____(state)_____

Victim's Name_____

Address_____

Date of Birth_____ Social Security Number_____

Was a Sexual Offense Evidence Collection Kit or Drug Facilitated Sexual Assault Kit used? ☐ Yes ☐ No

It is not necessary that the crime be reported to the police. If applicable and available, provide the following information:

Police Department_____Complaint#_____

SECTION TWO. BILLING PROVIDER INFORMATION (TO BE COMPLETED BY MEDICAL PROVIDER)

Billing Provider Federal I.D. Number_____ Date of Forensic Exam_____

Billing Provider Name _____Operator Certificate or Facility I.D.#_____

Address_____

Billing Department Contact Person_____ Phone Number (____)_____

The Provider, by law, shall not bill the victim for these services. Payment made to the Provider by the New York State Crime Victims Board for the forensic rape examination or other physical examination conducted for the purpose of gathering evidence as a direct result of the sexual offense shall be considered by Provider as payment in full.

SECTION THREE. VICTIM INSURANCE WAIVER (TO BE COMPLETED BY VICTIM/GUARDIAN)

- The law requires that the victim be advised orally and in writing that he or she may decline to provide insurance information.
- I have been fully advised of the options of payment for the forensic exam and the outcomes resulting from my forensic payment decision. I understand that I may use private insurance benefits, including Medicaid, Medicare, HMO or any other insurance program for payment of the forensic exam provided to me. I choose not to use my private insurance benefits but request that the NYS Crime Victims Board be billed directly.
- I decline to provide such information regarding private health insurance benefits because I believe that the provision of such information would substantially interfere with my personal privacy or safety.
- I have been advised that I will have to use my private insurance if I file a claim with the Crime Victims Board for other medical services outside of the forensic exam.

Victim/Guardian Name (Print or Type):_____

Victim/Guardian Signature:_____Date_____

Forensic Examiner Name (Print or Type):_____License #:_____

Forensic Examiner Signature:_____ Date_____

If you have questions, call the NYS Crime Victims Board at (800) 247-8035 or (518) 457-8727.

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FRE DIRECT REIMBURSEMENT INSTRUCTIONS:

PRINT LEGIBLY – ILLEGIBLE CLAIM FORMS WILL BE REJECTED. ALL BLANKS MUST BE FILLED IN - FIELDS LEFT BLANK WILL RESULT IN REJECTION OF THE CLAIM

SECTION ONE

- Fill in the date and location of crime including city, county and state. If the date of crime can not be determined, please provide an approximation. This can be a year, a season, or a range of dates. Do not leave the date field blank. Do not use "unknown" or "not applicable" in this blank. Claims without a date or approximation of the date of crime will be rejected.
- Print the victim's name including the first and last name; address where the victim currently resides including city, state and zip code; victim's date of birth including the month, day and year of birth and victim's Social Security Number (SSN).
  NOTE: If the victim is undocumented or is an infant without a SSN, mark the SSN field "UNDOCUMENTED" or "INFANT, NOT ISSUED." If the facility is otherwise unable, after diligent effort, to obtain a Social Security number from the victim, mark the SSN field "NOT AVAILABLE" or N/A. Do not leave this field blank.
- Indicate whether an evidence collection kit was used by checking box yes or no. Note: Even where a kit is used, itemized bill must include CPT codes and rates/costs for each procedure performed during sexual assault forensic exam.
- If the crime was reported to the police, print precinct/department and the complaint number, if known.

SECTION TWO

- Print the billing provider's federal tax identification number.
- Print the date that the forensic examination was performed including the month, day and year of the examination.
- Print the name of the billing provider. This may be the name of a hospital or other Article 28 health care facility, a clinic, a private physician's office, a child advocacy center, a rape crisis center, etc.
- Print the facility's operating certificate number or facility ID number. If these numbers are unknown, contact the hospital administrator. If the facility is not a hospital or other Article 28 facility and does not have an operator's certificate or facility identification number, mark this field with "NOT APPPLICABLE" or "N/A" and indicate the type of facility in which the examination was performed. e.g. *"N/A – Child Advocacy Center."* If the facility is affiliated with a hospital, you may use the hospital's operating certificate number or facility ID.
- Print the address of the billing provider. THIS IS THE ADDRESS TO WHICH THE PAYMENT WILL BE MAILED.
- Print the name and telephone number of the billing department representative.

SECTION THREE

- Read the payment options to the victim and make sure that the victim understands their options.
- Have the victim or guardian print their name on the form and then sign and date the form. A minor may sign their own claim form so long as it is reasonable to conclude that he or she understands both the form and the payment options. Claim forms must bear an original signature. Unsigned claim forms will be rejected.
- The licensed health care provider who performed the sexual assault forensic examination must record their license number on the form and must also sign and date the form. Claim forms must bear an original signature.
- An itemized bill for services MUST be attached to each claim form. The law provides that the Board's reimbursement rate is to be reviewed and adjusted annually. In order to do so, the Board requires cost data whether or not the facility actually charges for the services provided.
- The Board requires that the itemized bill contain a service charge associated with each CPT code listed on the bill. Make sure to use the most current code set. In addition, the sum total of all charges must appear on the bill even if the total exceeds the maximum reimbursement rate.
- The itemized bill must include a diagnostic code or description indicating that "sexual assault," or "sexual abuse" is the primary diagnosis.
- The itemized bill MUST include a CPT office visit, office consultation, ER, or other visit code that is defined as "comprehensive," "detailed" or "complex" ("simple" visit codes are not acceptable).
- In addition to the CPT visit code and diagnosis described above, every claim involving an adult victim, (18 years of age or older) must include at least one of the CPT codes for the labs, pharmaceuticals and other services listed on the Board's website at http://www.cvb.state.ny.us/FRE.htm, and the attendant rates or charges on the itemized bill.

NOTICE: CPT CODES ARE SUBJECT TO CHANGE. YOU MUST USE THE MOST CURRENT CODE SET IN ORDER FOR THE CLAIM TO BE TIMELY PROCESSED.

FRE-01 Rev. 04/03/2007

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Appendix C – Sample Documentation Form

Confidential Document Chart #

Sexual Assault Information

Sexual Assault Forensic Examiner Program

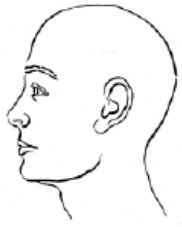
SEXUAL ASSAULT EXAMINATION AND OBSERVATIONS

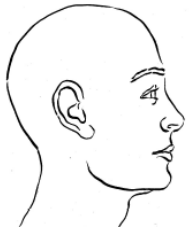
GENERAL APPEARANCE AND DEMEANOR: (include condition of clothing)

BODY SURFACE

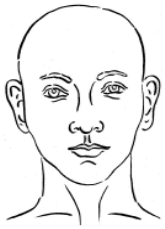
MOUTH/FACE
(include teeth, gums, conjunctiva, jaw)

HEAD/NECK
(Include hair, scalp, ears, throat, c-spine)



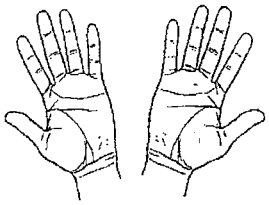


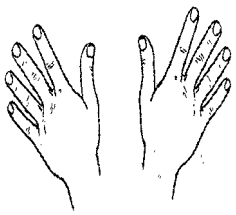
BACK/BUTTOCKS



CHEST/BREASTS

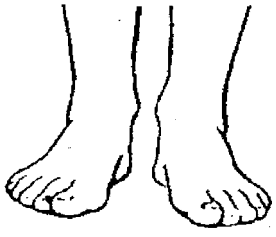
ABDOMEN

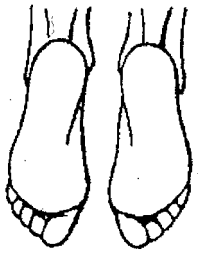




EXTREMITIES
UPPER (Include deformities, range of motion)

LOWER





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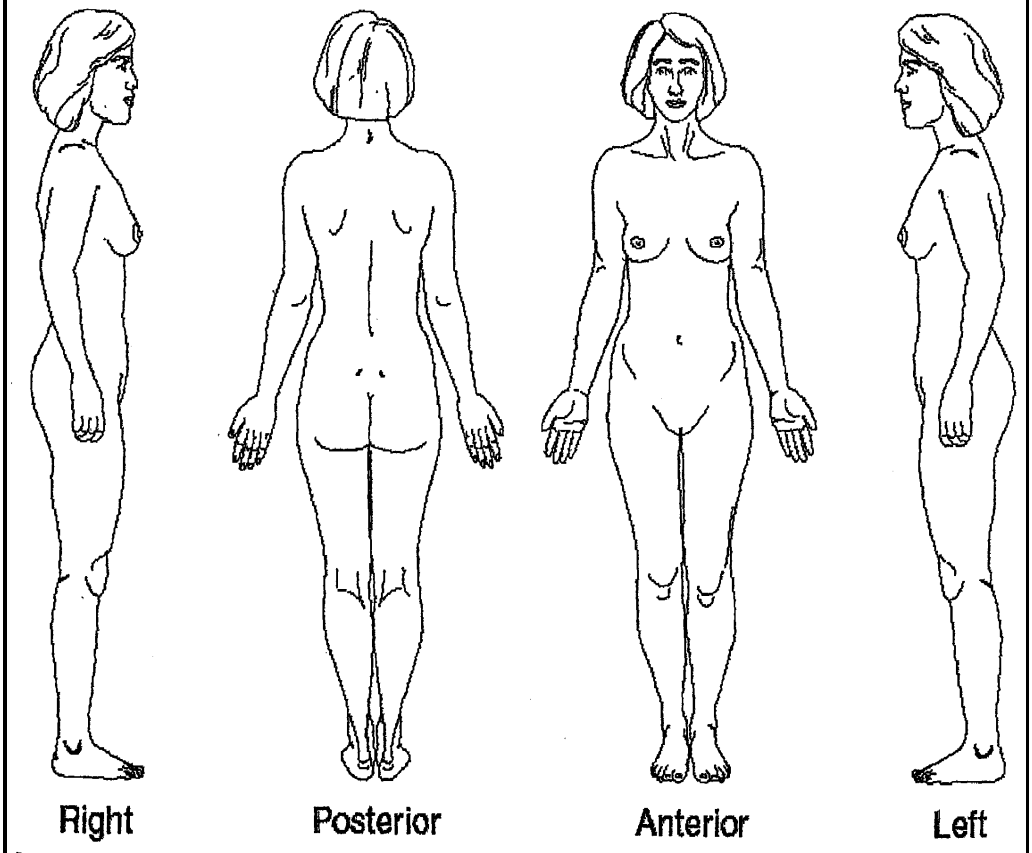
Confidential Document

Chart #

Sexual Assault Information

Sexual Assault Forensic Examiner Program

SEXUAL ASSAULT EXAMINATION AND OBSERVATIONS



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SANE Module 2: Assessment & Evaluation
Module Exam

After studying the downloaded course and completing the exam, you need to enter your answers online. **Answers cannot be graded from this downloadable version of the module.** To enter your answers online, go to e-leaRN's Web site, www.elearnonline.net and click on the Login/My Account button. As a returning student, login using the username and password you created, click on the "Go to Course" link, and proceed to the exam.

Please use the following case study to complete the examination questions.

A 24-year-old female presents to the local emergency department with a report of being "held captive and abused" by her spouse for 36 hours. She reports the incident began when she informed him she wanted out of the relationship. During the course of the emergency department's evaluation and treatment she disclosed that her spouse also raped her repeatedly over the course of the 36 hours. You are called to conduct a sexual assault exam on this patient. She has visible physical injury to her face, chest, arms, legs, abdomen, and buttocks. She reports being struck multiple times to her face by his open hand, and beaten repeatedly on the buttock with his hands and fists.

1. When taking the patient's medical history, the sexual assault examination should include all of the following except:

    a. Past surgeries, medical conditions
    b. Allergies, immunization status
    c. Last menstrual period, current medications
    d. History of sexual assault

2. The patient's assault history should include all of the following except:

    a. Date, time and location of the assault
    b. Use of weapons, restraints or threats
    c. Why she was finally reporting the abuse
    d. Acts performed by the assailant, number of times

3. The last menstrual period is reported as two and half months ago. This information is most important because:

    a. The patient will not be able to take the post exposure medications.
    b. The speculum examination and swabbing could put a pregnancy at risk.
    c. The patient's assessment demonstrated bruising to the abdomen.
    d. The patient may drop charges to maintain financial support if she is pregnant.

4. Assessment of the patient shows bruising to the face that presents as three linear lines starting at the ear and ending at her mouth. Each bruise is approximately 1 inch apart. The sexual assault exam documentation should reflect:

    a. The injury is in the pattern of a hand print.
    b. The injury is a patterned injury that reflects a blow by an open hand.
    c. The injury is a patterned injury.
    d. The injury is a pattern of injury reflecting multiple blows by an open hand.

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5. SANE's frequently use the TEARS classification system to document injuries. TEARS represents:

   a. Tears in the genital area, **E**xternal cuts, **A**ltered skin integrity, **R**edness, and **S**wollen tissue
   b. **T**orn or gashed skin, **E**cchymosis, **A**brasions, **R**aw appearing skin, and **S**oreness
   c. **T**ears in tissue, **E**cchymosis, **A**brasions, **R**edness, and **S**welling, edematous tissue
   c. **T**orn cracks, **E**dematous areas, **A**brasions, **R**edness**,** and **S**wollen tissue in the anus

6. Assessment of the patient presented in the case study should include:

   a. Assessment for oral injuries
   b. Assessment for genital trauma
   c. Assessment for anal trauma
   d. All of the above

7. The assailant arrives at the ED and insists on access to information related to the health of an unborn child. The SANE should:

   a. Acknowledge the rights of the unborn child's father.
   b. Tell the patient this is an attempt by the assailant to assert power and control over her.
   c. Request the assailant be removed by security.
   d. Follow your institutional policy on access to information and confidentiality.

8. During the genital assessment the SANE notes the patient has generalized swelling to the labia majora and minora. She also complains of point tenderness to the right labia minora. She reports "That's where it kept hurting every time he kept forcing it there." The SANE should:

   a. Document the swelling because it is an objective finding but not the pain because it is a subjective statement.
   b. Document the swelling and note that the patient complained of pain.
   c. Document the swelling, the areas of pain and put the statement of pain in quotes.
   d. Document the swelling, photograph the swelling and swab the entire area.

9. The patient reports the assailant ejaculated each time he assaulted her. Which of the following questions would be important to elicit from the patient?

   a. Where did he ejaculate?
   b. Did you wash or shower after the assaults?
   c. Did the perpetrator wear a condom?
   d. All of the above.

10. Physical assessment of the patient shows bruising to the face, a chipped tooth and missing hair from her scalp. Bruises are noted on all extremities, the breasts and the entire buttocks. A small circular bruise is noted to the abdomen. There is swelling to the labia majora and minora bilaterally and the patient complains of pain to most of the genital and anal structures. All of the injuries are:
    a. Consistent with interpersonal violence but not a sexual assault
    b. Consistent with blunt force trauma
    c. Inconsistent with the amount of force she reports during the assault
    d. Irrelevant since she will probably go back to him anyway

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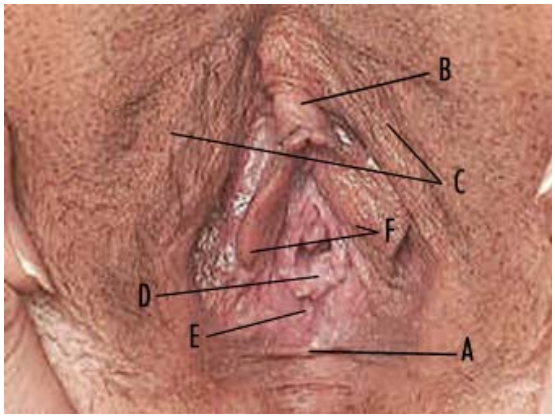
Use the image below to answer question 11.



11. Select the answer with the correct anatomical locations identified by letters A through E.

    a. Fossa novicularis (A); Clitoral Hood (B); Labia Majora (C); Hymen (D); Posterior Fourchette (E); Labia Minora (F)
    b. Posterior Fourchette (A); Clitoral Hood (B); Labia Majora (C); Hymen (D); Fossa novicularis (E); Labia Minora (F)
    c. Fossa novicularis (A); Clitoral Hood (B); Labia Majora (C); Posterior Fourchette (D); Hymen (E); Labia Minora (F)
    d. Posterior Fourchette (A); Clitoral Hood (B); Labia Minora (C); Hymen (D); Fossa novicularis (E); Labia Majora (F)

12. _____ is the most common place to find a genital injury in a sexual assault patient.

    a. Labia majora
    b. Hymen
    c. Clitoris
    d. Posterior fourchette

13. When completing an assault history the SANE should:

    a. Briefly document the patient's story or it could be too long.
    b. Interview by starting with general questions and moving to more specific questions.
    c. Avoid repeating any of the offensive terms used by the patient.
    d. Press the patient for answers if she is reluctant to provide details.

14. The extent of an injury from blunt force trauma depends on:

    a. The amount of force applied
    b. The location of the injury on the body
    c. The physiologic status of the patient
    d. All of the above

15. All of the following can be considered temporary incapacities inhibiting consent except:

    a. An intoxicated patient
    b. A drug-facilitated assault patient
    c. A developmentally delayed patient
    d. An actively psychotic patient

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16. Consent for a forensic exam can best be explained as:

    a. The same as consent for medical treatment
    b. Can be obtained from a minor
    c. Is implied consent for an unconscious patient
    d. Cannot be obtained from a patient with reported alcohol consumption.

17. In the case of a sexually assaulted minor patient who does not want a sexual assault examination, the sexual assault examination may be performed by the SANE with the consent of a parent.

    a. True
    b. False

18. Blunt force traumas include all of the following except:

    a. Cuts
    b. Abrasions
    c. Bruises or contusions
    d. Lacerations

19. A 30-year-old patient reports she was assaulted multiple times during a 36 hour period. This information is important to note because:

    a. It proves the intercourse was not consensual.
    b. It eliminates a possible “rough sex” defense.
    c. It could account for genital injuries seen during the genital exam.
    d. It negatively influences the decision to offer emergency contraception.

20. The majority of sexual assault patients have genital injury.

    a. True
    b. False

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