**Title of Activity: Combined SANE Adult/Adolescent and Pediatric Course Date/Location of Activity:** Click here to enter text.

**Please use the provided gap analysis tool to answer the following questions**

**Description of current state:** Only 17% of Emergency Departments have Sexual Assault Nurse Examiner (SANE) Programs due to the lack of trained Registered Nurses (RNs) who can function as SANEs

**Description of desired/achievable state:** All RNs who serve patients with a presenting complaint of sexual violence have the competency to provide a comprehensive Sexual Assault Examination (SAE)

**Identified Gap(s):** Lack of trained RNs to function as a SANE

**Gap to be addressed by this activity:**  **Knowledge**  **Skills**  **Practice**  **Other: Describe** Click here to enter text.

| **Learning Outcome(s) as a result of participating in the activity:**  The overall learning outcome for basic SANE education is to provide registered nurses and advanced practice nurses with the knowledge, and skills, and judgement to provide competent, comprehensive, patient-centered, coordinated care to patients being evaluated for sexual assault, or suspected of having been sexually assaulted.  **Select all that apply:  Nursing Professional Development  Patient Outcome  Other: ­­­­­­­­­­­­­­­­­­­­­­Describe** Click here to enter text. | | | |
| --- | --- | --- | --- |
| **CONTENT (Topics)** | **TIME FRAME (if live)** | **PRESENTER/ AUTHOR** | **TEACHING METHODS/LEARNER ENGAGEMENT STRATEGIES** |
| *Provide an outline of the content* | *Approximate time required for content delivery and/or participation in the activity* | *List the name and credentials* | *Select the learner engagement strategies to be used by Faculty, Presenters, Authors (note: PowerPoint and lecture by themselves are not learner engagement strategies)*  *(select all that apply)* |
| **Overview of Forensic Nursing and Sexual Violence and Child Sexual Assault/Abuse**  A.Forensic Nursing Overview   1. History and evolution of forensic nursing 2. Role of the adult/adolescent/pediatric SANE in caring for adult/adolescent/ pediatric sexual abuse/assault patient populations | minutes | Must include a SANE-A and SANE-P certified professional. This can be a dual certified nurse or 2 separately certified nurses.  Click or tap here to enter text. | Lecture/PowerPoint **(select at least one additional strategy below):**  Integrating opportunities for dialogue or question/answer  Including time for self-check or reflection  Audience Response System  Analyzing case studies |

| **Learning Outcome(s) as a result of participating in the activity:**  The overall learning outcome for basic SANE education is to provide registered nurses and advanced practice nurses with the knowledge, and skills, and judgement to provide competent, comprehensive, patient-centered, coordinated care to patients being evaluated for sexual assault, or suspected of having been sexually assaulted.  **Select all that apply:  Nursing Professional Development  Patient Outcome  Other: ­­­­­­­­­­­­­­­­­­­­­­Describe** Click here to enter text. | | | | |
| --- | --- | --- | --- | --- |
| **CONTENT (Topics)** | **TIME FRAME (if live)** | **PRESENTER/ AUTHOR** | **TEACHING METHODS/LEARNER ENGAGEMENT STRATEGIES** |
| *Provide an outline of the content* | *Approximate time required for content delivery and/or participation in the activity* | *List the name and credentials* | *Select the learner engagement strategies to be used by Faculty, Presenters, Authors (note: PowerPoint and lecture by themselves are not learner engagement strategies)*  *(select all that apply)* |
| 1. Role of the adult/adolescent/pediatric SANE and sexual abuse/assault education and prevention 2. Role of the International Association of Forensic Nurses in establishing the scope and standards of forensic nursing practice 3. Key aspects of *Forensic Nursing: Scope and Standards of Practice* 4. Professional and ethical conduct related to adult/adolescent/pediatric SANE practice and the care of adult/adolescent/pediatric sexual abuse/assault patient populations, through the ethical principles of autonomy, beneficence, non-malfeasance, veracity, confidentiality, and justice 5. Nursing resources, locally and globally, that contribute to current and competent adult/adolescent/pediatric SANE practice 6. Vicarious trauma 7. Methods for preventing vicarious trauma associated with adult/adolescent/pediatric SANE practice 8. Key concepts associated with the use of evidence-based practice in the care of adult/adolescent/pediatric sexual abuse/assault patient populations   B. Sexual Violence and Child Abuse   1. Types of adult/adolescent/pediatric sexual abuse/assault 2. Types of physical child maltreatment 3. Global incidence and prevalence rates for sexual violence and abuse in the female and male adult/adolescent/pediatric populations    1. Risk factors for adult/adolescent/pediatric sexual abuse/assault    2. Fundamentals of growth and development in the context of understanding child/adolescent sexual abuse/assault 4. Health consequences of sexual abuse/assault, to include physical, psychosocial, cultural, and socioeconomic sequelae 5. Unique healthcare challenges to underserved or vulnerable sexual abuse and assault populations and associated prevalence rates, including but not limited to: 6. Boys/men 7. Patients with developmental challenges 8. GLBTQIA (gay, lesbian, bisexual, transgender, questioning/queer, intersex, agender/asexual) 9. Patients in emergent or long-term foster care placement 10. Patients with disabilities 11. Culturally diverse populations 12. Mental health populations 13. Patients with language/communication barriers 14. People who are trafficked 15. Patients who are in the military 16. Best practices for improving forensic nursing care to underserved or vulnerable patient populations 17. Factors that impact the vulnerability of patients being targeted for sexual abuse/assault (i.e., adverse childhood experiences [ACEs], generational violence, and people who were raised in the foster care system) 18. Biases and deeply held beliefs regarding sexual abuse/assault in adult/adolescent/pediatric patient populations 19. Key concepts of offender typology and related impact on sexual abuse/assault patient populations 20. Differences in typology of offenders targeting adult/adolescent/pediatric populations 21. Grooming or accommodation syndrome with child sexual abuse victims and their families 22. Dynamics of familial sexual abuse (incest) and the impact on the child and non-offending caregiver(s) 23. Children’s disclosure of sexual abuse and the factors related to disclosure |  |  | Providing opportunities for problem-based   learning  Pre/Post Test  Other: Click or tap here to enter text. |
| **. Victim Responses and Crisis Intervention**   * 1. Common psychosocial responses to sexual abuse/assault and child maltreatment in pediatric and adolescent populations   2. Acute and long-term psychosocial ramifications associated with sexual abuse/assault and child maltreatment   3. Emotional and psychological responses and sequelae following sexual abuse/assault, including familiarity with traumatic and stress-related disorders applicable to adult/adolescent/pediatric sexual abuse/assault and child maltreatment patient populations      + 1. Key components of a suicide risk assessment        2. Key components of a safety risk assessment   4. Diverse reactions that can be manifested in the patient after sexual violence   5. Risk factors for acute and chronic psychosocial sequelae in adult/adolescent/pediatric patients following sexual abuse/assault and child maltreatment   6. Risk factors for acute and chronic health conditions related to or exacerbated by sexual abuse/assault and child maltreatment, such as asthma, hypertension, and gastrointestinal issues   7. Common concerns regarding reporting to law enforcement following sexual abuse/assault and child maltreatment and potential psychosocial ramifications associated with this decision   8. Culturally competent, holistic care of pediatric and adolescent patients who have experienced sexual abuse/assault, based on objective and subjective assessment data, patient-centered outcomes, and patient tolerance   9. Risk factors for non-adherence in adult/adolescent/pediatric patient populations following sexual abuse/assault   10. Diverse psychosocial issues associated with underserved sexual violence patient populations, such as:  1. Males 2. Inmates/juvenile detainees 3. GLBTQIA (gay, lesbian, bisexual, transgender, questioning/queer, intersex, agender/asexual) 4. Familial perpetration (sibling, parent/guardian, etc.) 5. Patients with disabilities 6. Culturally diverse populations 7. People with mental illness 8. Patients with language/communication barriers 9. People who are trafficked    1. Prioritizing crisis intervention strategies for pediatric and adolescent patients following sexual abuse/assault 10. Factors related to the patient’s capacity to consent to services, such as age, cognitive ability, mental state, limited English proficiency, intoxication, and level of consciousness 11. Patient outcomes, interventions, and evaluation criteria designed to address actual or potential psychosocial problems, based on the patient’s chronological age, developmental status, identified priorities, and tolerance 12. Techniques and strategies for interacting with adult/adolescent/pediatric patients and their families following a disclosure of or a concern regarding sexual abuse/assault, including but not limited to:     * + 1. Empathetic and reflective listening         2. Maintaining dignity and privacy         3. Facilitating participation and control         4. Respecting autonomy         5. Maintaining examiner objectivity and professionalism | minutes | Click or tap here to enter text. | Lecture/PowerPoint **(select at least one additional strategy below):**  Integrating opportunities for dialogue or question/answer  Including time for self-check or reflection  Audience Response System  Analyzing case studies  Providing opportunities for problem-based   learning  Pre/Post Test  Other: Click or tap here to enter text. |
| **Collaborating with Community Agencies**   * 1. Multidisciplinary (MDT) Sexual assault response team (SART), including:      1. Overview of roles and responsibilities      2. MDT/SART models      3. Child advocacy centers      4. Family justice centers      5. Sexual assault response/resource teams (SART)      6. Strategies for implementing and sustaining a MDT/SART      7. Benefits and challenges   2. Roles and responsibilities of the following MDT members as they relate to adult/adolescent/pediatric sexual abuse/assault:      1. Victim advocates (community- and system-based)      2. Medical forensic examiners (adult/adolescent/pediatric SANEs, death investigators, coroners, medical examiners, forensic nurse consultants)      3. Law enforcement personnel      4. Prosecuting attorneys      5. Defense attorneys      6. Forensic scientists      7. Forensic interviewers      8. Child protection agencies      9. Other social service agencies   3. Key strategies for initiating and maintaining effective communication and collaboration among MDT/SART members while maintaining patient privacy and confidentiality | minutes | Must minimally include the following:   * Community-based crisis center advocate * Systems-based advocate * SANE-A or SANE-P certified nurse * Law enforcement * Prosecutor * Crime lab analyst * CPS representative   Click or tap here to enter text. | ☐ Lecture/PowerPoint **(select at least one additional strategy below):**  ☐ Integrating opportunities for dialogue or question/answer  ☐ Including time for self-check or reflection  ☐ Audience Response System  ☐ Analyzing case studies  ☐ Providing opportunities for problem-based   learning  ☐ Pre/Post Test  ☐ Other: |
| **Medical Forensic History Taking**   * + - 1. Key components of obtaining a comprehensive, developmentally appropriate patient history, including a focused review of systems with a pediatric/adolescent patient, which can provide context for appropriate healthcare decisions and potential forensic implications, to include:     1. Past medical history     2. Allergies     3. Medications     4. Recreational drug use     5. Medical/surgical history     6. Vaccination status     7. Social history     8. Parent/caretaker     9. Other information, as needed     10. Developmental history  1. Milestones 2. Physical development 3. Sexual development 4. Intellectual development 5. Social development 6. Emotional development 7. Moral development    * 1. Anogenital-urinary history         1. Urinary tract development and disorders         2. Reproductive tract development and disorders         3. Last consensual intercourse, if applicable         4. Pregnancy history, if applicable         5. Contraception usage, if applicable         6. Menarche and last menstrual period      2. Gastrointestinal history   a. Gastrointestinal tract development and disorders  b. Constipation and diarrhea history and treatments   * + 1. Event history        1. Actual/attempted acts        2. Date and time of event        3. Location of event        4. Assailant information        5. Use of weapons/restraints/threats/grooming/manipulation        6. Use of recording devices (photographs or videos of the event)        7. Suspected drug-facilitated sexual assault        8. Condom use        9. Ejaculation        10. Pain or bleeding associated with acts        11. Physical assault        12. Strangulation        13. Potential destruction of evidence  1. Difference between obtaining a medical forensic history and conducting a forensic interview, and the purpose of each 2. Techniques for establishing rapport and facilitating disclosure while considering the patient’s age, developmental level, tolerance, gender identity, and cultural differences 3. Obtaining a child's history independent of other parties 4. Obtaining a caregiver (parent, guardian, etc.) history independent from the child 5. Obtaining a medical forensic history from a child and identifying when doing so would be inappropriate 6. Difference between leading and non-leading questions 7. Importance of using the medical forensic history to guide the physical assessment of the patient and evidence collection   B. Poly-victimization or co-occurrence of violence using the medical forensic history   1. Importance of accurate and unbiased documentation of the medical forensic history 2. Coordination between law enforcement representatives and SAFEs regarding the logistics and boundaries of medical forensic history taking and investigative intent | minutes | Click or tap here to enter text. | Lecture/PowerPoint **(select at least one additional strategy below):**  Integrating opportunities for dialogue or question/answer  Including time for self-check or reflection  Audience Response System  Analyzing case studies  Providing opportunities for problem-based   learning  Pre/Post Test  Other: Click or tap here to enter text. |
| **Observing and Assessing Physical Examination Findings**   1. Acute and non-acute medical forensic examination process for the pediatric/adolescent patient 2. Role of the SANE within the child advocacy center model 3. Developmentally appropriate communication skills and techniques with respect to cognitive and linguistic development 4. Prioritizing a comprehensive health history and review of systems data 5. History, including health issues and immunization status 6. History of alleged or suspicious event 7. Patient 8. Family/caregiver/guardian 9. Law enforcement 10. Child protection agency 11. Psychosocial assessment of the child/adolescent related to the event 12. Crisis intervention for acute presentations 13. Behavioral/psychological implications of long-term abuse in the prepubescent, pediatric, and adolescent child 14. Suicide and safety assessment and planning 15. Impact of substance abuse issues 16. Guidance for child, family, and caregivers 17. Referrals 18. Comprehensive head-to-toe physical assessment that is age, gender identity, developmentally, and culturally appropriate, as well as mindful of the patient’s tolerance, including assessment of: 19. Patient’s general appearance, demeanor, cognition, and mental status 20. Clothing and other personal possessions 21. Body surfaces for physical findings 22. Patient’s growth and development level 23. Patient’s sexual maturation 24. Patient utilizing a head-to-toe evaluation approach 25. Anogenital structures, including the effect of estrogen/testosterone on anogenital structures 26. Identification of findings that are: 27. Documented in newborns or commonly seen in non-abused children     1. Normal variants     2. Findings commonly caused by other medical conditions     3. Conditions that may be misinterpreted as resulting from abuse 28. Indeterminate 29. Diagnostic of trauma and/or sexual contact     1. Acute trauma to external genital/anal tissues     2. Residual (healing) injuries     3. Injuries indicative of blunt force penetrating trauma     4. Sexually transmitted disease(s)     5. Pregnancy     6. Sperm identified in specimens taken directly from a child’s body (Adams, Kellogg, & Moles, 2016) 30. Mechanical and physical trauma and identification of each type 31. Blunt force 32. Sharp force 33. Gunshot wounds 34. Strangulation 35. Comprehensive strangulation assessment for the patient with known or suspected strangulation as a part of the history and/or physical findings 36. Terminology related to mechanical and physical trauma findings, including: 37. Abrasion 38. Laceration/tear 39. Cut/incision 40. Bruise/contusion 41. Hematoma 42. Swelling/edema 43. Redness/erythema 44. Petechiae 45. Anogenital anatomy and physiology, including: 46. Normal anatomical variants 47. Types and patterns of injury that are potentially associated with sexual abuse/assault 48. Physical findings and medical conditions associated with non-assault-related trauma that can be misinterpreted as resulting from sexual abuse/assault 49. Significance of a normal examination 50. Examination positions and methods, including: 51. Labial separation/traction 52. Supine/prone knee-chest 53. Assistive techniques and equipment for evidence collection where appropriate, including but not limited to: 54. Alternate light source 55. Toluidine blue dye application and interpretation 56. Colposcope versus camera with macro lens for photographs 57. Urinary (Foley) catheter, swab, or other technique for visualization of the hymen 58. Water flushing 59. Use of cotton swabs 60. Physical evidence collection through use of: 61. Current evidence-based forensic standards and references 62. Appropriate identification, collection, and preservation of evidence 63. Appropriate chain of custody procedures 64. Recognized variations in practice, following local recommendations and guidelines   M. Circumstances that may necessitate referral and/or consultation   1. Using clinical judgment to determine care 2. Individualized short- and long-term goals based on the physiological, psychological, sociocultural, spiritual, and economic needs of the adult and adolescent patient who has experienced sexual assault 3. Critical thinking and decision-making to correlate potential mechanisms of injury for anogenital and non-anogenital findings, including recognizing findings that may result from a culturally specific practice, medical condition, or disease processes   1. Medical consultation and trauma intervention when indicated 2. Documenting history, findings, and interventions   1. Injury/trauma findings 2. Normal variations 3. Disease processes 4. Diagrams and trauma grams that accurately reflect photographic and visualized image documentation 5. Unbiased and objective evaluations 6. Importance of peer review/expert consultation 7. Local and legal maintenance and release of records policies | minutes | Click or tap here to enter text. | Lecture/PowerPoint **(select at least one additional strategy below):**  Integrating opportunities for dialogue or question/answer  Including time for self-check or reflection  Audience Response System  Analyzing case studies  Providing opportunities for problem-based   learning  Pre/Post Test  Other: Click or tap here to enter text. |
| **Medical Forensic Evidence Collection**   * 1. Patient (Victim)-Centered Care      1. Importance of patient participation, consent, ongoing assent, and collaboration in specimen/collection procedures as a means of recovering from sexual abuse/assault (as appropriate)      2. Elements of consent and the procedures required for specimen collection with respect to age and capacity      3. Basic growth and development stages in the context of building rapport and tailoring the approach to the patient      4. Integration of obtaining and preserving forensic samples into the medical forensic examination      5. Specimen collection options within the community available to adult/adolescent/pediatric patients who have experienced sexual abuse/assault, including:         1. Mandatory reporting requirements         2. Reporting to law enforcement         3. Non-reporting/anonymous evidence collection, if applicable (based on the age of the patient and local statutes)         4. Medical evaluation and treatment  1. Recommendations for collection time limits of biological specimens following sexual abuse/assault, including the differences in time frames for prepubertal victims 2. Differences in approach to evidence collection in the prepubertal population (i.e., external versus internal samples) 3. Types of specimens and methods of collection in the adult/adolescent/pediatric patient following a sexual abuse/assault, based on the event history, including but not limited to:    * + 1. DNA        2. Trace/non-biologic        3. History documentation        4. Physical findings, identification, and documentation        5. Clothing/linen evidence        6. Medical forensic photography        7. Toxicology 4. Chain of custody principles and procedures for maintaining 5. Drug-facilitated sexual abuse/assault (DFSA), current trends, criteria associated with a risk assessment for DFSA, and when specimen collection procedures are indicated 6. Patient/guardian’s concerns and common misconceptions that patient/guardian’s may have regarding specimen collection 7. Potential risks and benefits for the patient/guardian associated with evidence collection 8. Adjunctive tools and methods used in specimen identification and collection and associated risks and benefits, 90 minutes: including but not limited to:    * + 1. Alternate light sources        2. Swab collection techniques        3. Speculum examination (adult/adolescent/pubertal population)        4. Colposcopic visualization or magnification with a digital camera        5. Anoscopic visualization, if indicated and within the scope of practice in the Nurse Practice Act 9. Appraisal of data regarding the abuse/assault details to facilitate complete and comprehensive medical forensic examination and evidence collection 10. Evidence-based practice guidelines for the identification, collection, preservation, handling, and transfer of biologic and trace evidence specimens following adult/adolescent/pediatric sexual abuse/assault 11. Evidence-based practice when planning evidentiary procedures 12. Materials and equipment needed for biologic and trace evidence collection 13. Modification of evidence collection based on the patient’s age, developmental/cognitive level, and tolerance 14. Techniques to support the patient/guardian and minimize the potential for additional trauma during specimen collection procedures 15. Techniques to facilitate patient participation during specimen collection procedures (as appropriate) 16. Evaluating the effectiveness of the established plan of care and associated evidentiary procedures and adapting the plan based on changes in data collected throughout the nursing process 17. Patient (Suspect)-Centered Care     * 1. Differences in victim and suspect medical forensic examination and specimen collection following sexual abuse/assault       2. Legal authorization needed to obtain evidentiary specimens and examine a suspect, including:          1. Written consent 18. Search warrant 19. Court order 20. Components of a suspect medical forensic examination 21. Recommendations for time limits of collection of biologic evidence in the suspect of sexual abuse/assault 22. Types of evidence that can be collected in the medical forensic examination of a suspect following sexual abuse/assault, such as:     * + 1. DNA evidence         2. Trace/non-biologic evidence         3. Physical findings, identification, and documentation         4. Medical forensic photography         5. Toxicology         6. Variables in specimen collection, packaging, preservation, and transportation issues for items, including:     1. Products of conception     2. Foreign bodies     3. Tampons     4. Diapers 23. Synthesizing data from reported abuse/assault to facilitate complete and comprehensive medical forensic examination and evidence collection in the suspect of a sexual abuse/assault 24. Preventing cross-contamination if the medical forensic examination and/or evidence collections of the victim and suspect are performed in the same facility or by the same examiner 25. Evaluating the effectiveness of the established plan of care and adapting the care based on changes in data collected throughout the nursing process | minutes | Click or tap here to enter text. | Lecture/PowerPoint **(select at least one additional strategy below):**  Integrating opportunities for dialogue or question/answer  Including time for self-check or reflection  Audience Response System  Analyzing case studies  Providing opportunities for problem-based   learning  Pre/Post Test  Other: Click or tap here to enter text. |
| **Medical Forensic Photography**   1. Importance of obtaining informed consent and assent for photography 2. Impact of abuse involving photography/images on a patient’s experience with photodocumentation 3. Potential legal issues related to photography (e.g., use of filters, alterations to images, use of unauthorized camera equipment, such as personal cell phones or law enforcement’s camera) 4. Physical findings that warrant photographic documentation 5. Biologic and/or trace evidentiary findings that warrant photographic documentation 6. Physiological, psychological, sociocultural, and spiritual needs of pediatric/adolescent patients that warrant/involve photography following sexual abuse/assault 7. Options for obtaining medical forensic photographs, including colposcopic images and digital imaging equipment 8. Variables affecting the clarity and quality of photographic images, including skin color, type and location of finding, lighting, aperture, and film speed 9. Key photography principles, including consent, obtaining images that are relevant, a true and accurate representation of the subject matter, and noninflammatory 10. Images obtained by the examiner as part of the medical/health record versus those obtained by other agencies or even the offender 11. Photography principles as they relate to the types of images required by judicial proceedings, including overall, orientation, close-up, and close-up with scale photographs 12. Photography prioritization based on assessment data and patient-centered goals 13. Adapting photography needs based on patient tolerance, needs, and preferences 14. Selecting the correct media for obtaining photographs based on the type of physical or evidentiary finding warranting photographic documentation 15. Overall, orientation, close-up, and close-up with scale photographs that provide a true and accurate reflection of the subject matter 16. Situations that may warrant follow-up photographs and options for securing     * 1. Consent, storage, confidentiality, and the appropriate release and use of photographs taken during the medical forensic examination 17. Legal and confidentiality issues that are pertinent to photographic documentation 18. Consistent peer review of photographs to ensure quality and accurate interpretation of photographic findings 19. Need for anogenital photography in the pediatric population as related to quality assurance, confirmation of the presence or absence of findings, and decreasing the necessity of repeat examinations | minutes | Click or tap here to enter text. | Lecture/PowerPoint **(select at least one additional strategy below):**  Integrating opportunities for dialogue or question/answer  Including time for self-check or reflection  Audience Response System  Analyzing case studies  Providing opportunities for problem-based   learning  Pre/Post Test  Other: Click or tap here to enter text. |
| **Sexually Transmitted Disease Testing and Prophylaxis**   * + - * 1. Prevalence/incidence and morbidity and risk factors related to sexually transmitted diseases after sexual abuse and assault         2. Symptoms associated with sexually transmitted diseases         3. Sexually transmitted diseases that are commonly asymptomatic         4. Symptoms and findings that may mimic sexually transmitted diseases         5. Key concepts associated with screening for the risk of transmission of select sexually transmitted diseases based on the specifics of the patient’s provided history         6. Probability of maternal transmission versus community-acquired infection         7. Presence of sexually transmitted disease may be evidence of sexual abuse/assault in the pediatric/adolescent patient (see Adams’s classification)         8. Patient and/or guardian concerns and myths regarding transmission, treatment, and prophylaxis of select sexually transmitted diseases         9. Physiological, psychological, sociocultural, spiritual, and economic needs of adult/adolescent/pediatric patients who are at risk for an actual or potential sexually transmitted disease(s) following sexual abuse/assault         10. Evidence-based national and/or international guidelines for the testing and prophylaxis/treatment of sexually transmitted diseases when planning care for adult/adolescent/pediatric patients who are at risk for an actual or potential sexually transmitted disease(s) following sexual abuse/assault         11. Evidence-based practice when planning care for adult/adolescent/pediatric t patients who are at risk for an actual or potential sexually transmitted disease(s) following sexual abuse/assault  1. Risks versus benefits of testing for select sexually transmitted disease(s) during the acute medical forensic evaluation versus at the time of initial follow-up after prophylaxis 2. Risks versus benefits of testing for select sexually transmitted disease(s) during the acute medical forensic evaluation versus at the time of initial follow-up after prophylaxis 3. Testing methodologies based on site of collection, pubertal status, and patient tolerance for select sexually transmitted diseases (nucleic acid amplification testing (NAAT) versus culture versus serum) 4. Screening versus confirmatory testing methodologies for select sexually transmitted diseases 5. Prophylaxis options, common side effects, routes of administration, contraindications, necessary baseline laboratory specimens when applicable (e.g., HIV), dosing, and follow-up requirements for select sexually transmitted disease(s) 6. Referrals for follow-up testing (e.g., HIV nPEP) 7. Approach to HIV risk assessment and prophylaxis decision-making based on current guidelines, local epidemiology, and available resources 8. Individualizing short- and long-term goals based on the physiological, psychological, sociocultural, spiritual, and economic needs of adult/adolescent/pediatric patients who are at risk for an actual or potential sexually transmitted disease(s) following sexual abuse/assault 9. Prioritizing care based on assessment data and patient-centered goals 10. Sexually transmitted disease(s) testing and prophylaxis based on current evidence-based practice, risk factors for transmission, and symptomology 11. Sexually transmitted disease(s) testing and prophylaxis based on patient tolerance, adherence, and contraindications 12. Indications for seeking medical consultation 13. Collection, preservation, and transport of testing medias for select sexually transmitted disease(s) 14. Follow-up care and discharge instructions associated with select sexually transmitted disease(s) | minutes | Click or tap here to enter text. | Lecture/PowerPoint **(select at least one additional strategy below):**  Integrating opportunities for dialogue or question/answer  Including time for self-check or reflection  Audience Response System  Analyzing case studies  Providing opportunities for problem-based   learning  Pre/Post Test  Other: Click or tap here to enter text. |
| **Pregnancy Risk Evaluation and Care**   1. Prevalence rates for pregnancy following sexual abuse/assault 2. Risk evaluation for pregnancy following sexual abuse/assault based on the specifics of the patient’s provided history and pubertal status 3. Testing methods (e.g., blood versus urine; quantitative versus qualitative) 4. Effectiveness of available pregnancy prevention methods 5. Patient education key concepts regarding emergency contraception, including: 6. Mechanism of action 7. Baseline testing 8. Side effects 9. Administration 10. Failure rate 11. Follow-up requirements 12. Patient and guardian concerns, belief systems, and misconceptions related to reproduction, pregnancy, and pregnancy prophylaxis 13. Physiological, psychological, sociocultural, spiritual, and economic needs of adult/adolescent/pediatric who are at risk for an unwanted pregnancy following sexual abuse/assault 14. Evidence-based guidelines for pregnancy prophylaxis when planning care for p adult/adolescent/pediatric patients at risk for unwanted pregnancy following sexual abuse/assault 15. Prioritizing care based on assessment data and patient-centered goals 16. Situations warranting medical or specialty consultation 17. Evaluating the effectiveness of the established plan of care and adapting the care based on changes in data collected throughout the nursing process 18. Demonstrating the ability to identify and explain necessary follow-up care, discharge instructions, and referral sources associated with emergency contraception and/or pregnancy termination options | minutes | Click or tap here to enter text. | Lecture/PowerPoint **(select at least one additional strategy below):**  Integrating opportunities for dialogue or question/answer  Including time for self-check or reflection  Audience Response System  Analyzing case studies  Providing opportunities for problem-based   learning  Pre/Post Test  Other: Click or tap here to enter text. |
| **Medical Forensic Documentation**   1. Roles and responsibilities of the forensic nurse in documenting the adult/adolescent/pediatric sexual abuse/assault medical forensic examination 2. Steps of the nursing process, including patient/family-centered care, needs, and goals 3. Differentiating and documenting sources of information provided 4. Documentation of event history by using patient/guardian’s words verbatim as much as possible 5. Including questions asked by the guardian and/or the SANE in the history 6. Objective versus subjective data    * 1. Documentation of event history by quoting the patient’s statements as much as possible      2. Documentation of outcry statement made during the medical forensic examination      3. Differentiation between objective and subjective data; Using language to document that is free of judgment or bias 7. Processes related to medical forensic documentation that include quality improvement, peer review, and research/evidence-based practice 8. Legal considerations, including: 9. Regulatory or other accreditation requirements (see legal considerations section) 10. Legal, regulatory, or other confidentiality requirements (see legal considerations section) 11. Mandated reporting requirements (see legal considerations section) 12. Informed consent and assent (see legal considerations section) 13. Continuity of care 14. Judicial considerations including: 15. True and accurate representation 16. Objective and unbiased evaluation 17. Chain of custody 18. Key principles related to consent, access, storage, archiving, and retention of documentation for:   Written/electronic medical records  Body maps/anatomic diagrams  Forms  Photographs (see medical-forensic photography section)   1. Terminology related to pediatric/adolescent sexual abuse/assault 2. Storage and retention policies for medical forensic records (including the importance of adhering to criminal justice standards for maintaining records, such as statutes of limitations) Sharing medical forensic documentation with other treatment providers:   1. Communication   1. Accountability 2. Quality improvement 3. Peer review 4. Research 5. Documentation elements of the case: 6. Demographic data 7. Consent 8. History of abuse/assault 9. Patient presentation 10. Medical history 11. Physical examination and findings 12. Genital examination and findings 13. Impression/opinion 14. Treatment 15. Interventions 16. Mandatory reporting requirements 17. Discharge plan and follow-up 18. Release, distribution, and duplication of medical forensic records, including photographic and video images and evidentiary material     * 1. Any potential cross-jurisdictional issues       2. Procedures to safeguard patient privacy and the transfer of evidence/information to external agencies according to institutional protocol       3. Explanation of laws and institutional policy that have domain over the protection of patient records and information       4. Applicable facility/examiner program policies (e.g., restricted access to medical records related to the medical forensic examination, response to subpoenas and procedures for image release) | minutes | Click or tap here to enter text. | Lecture/PowerPoint **(select at least one additional strategy below):**  Integrating opportunities for dialogue or question/answer  Including time for self-check or reflection  Audience Response System  Analyzing case studies  Providing opportunities for problem-based   learning  Pre/Post Test  Other: Click or tap here to enter text. |
| **Discharge and Follow-Up Planning**   1. Resources that address the specific safety, medical, and forensic needs of adult/adolescent/pediatric patients following sexual abuse/assault 2. Individualizing the discharge plan and follow-up care based on medical, forensic, and patient priorities 3. Facilitation of access to multidisciplinary collaborative agencies 4. Differences in discharge and follow-up concerns related to age, developmental level, cultural diversity, family dynamics, and geographic differences 5. Evidence-based guidelines for discharge and follow-up care following sexual abuse/assault of adult/adolescent/pediatric patient 6. Evidence-based practice when planning and prioritizing discharge and follow-up care associated with safety, and psychological, forensic, or medical issues, including the prevention and/or treatment of sexually transmitted disease(s) and pregnancy 7. Modifying and facilitating plans for treatment, referrals, and follow-up care based upon patient/family needs and concerns 8. Generating, communicating, evaluating, and revising individualized short- and long-term goals related to discharge and follow-up needs 9. Determining and communicating follow-up care and discharge needs based on evidence-based practice, recognizing differences related to age, developmental level, cultural diversity, and geography | minutes | Must include a SANE-A or SANE-P certified nurse  Click or tap here to enter text. | Lecture/PowerPoint **(select at least one additional strategy below):**  Integrating opportunities for dialogue or question/answer  Including time for self-check or reflection  Audience Response System  Analyzing case studies  Providing opportunities for problem-based   learning  Pre/Post Test  Other: Click or tap here to enter text. |
| **Legal Considerations and Judicial Proceedings**   1. Legal Considerations 2. Consent    * 1. Key concepts associated with obtaining informed consent and assent      2. Methodology for obtaining consent to perform a medical forensic evaluation in adult/adolescent/pediatric patient populations      3. Difference between legal requirements associated with consent or declination of medical care versus consent or declination of evidence collection and release      4. Impact of age, developmental level, and physical and mental incapacitation on consent procedures and the appropriate methodology for securing consent in each instance      5. Legal exceptions to obtaining consent as applicable to the practice area      6. Communicating consent procedures and options to pediatric and adolescent patient populations         + 1. Potential consequences of withdrawal of consent and/or assent and the need to explain this to the patient while respecting and supporting their decisions           2. Coordinating with other providers to support patient choices for medical forensic examination and consent           3. Procedures to follow when the patient is unable to consent           4. The critical importance of never performing the medical forensic examination against the will of the patient      7. Physiological, psychological, sociocultural, spiritual, and economic needs of pediatric and adolescent patients following sexual abuse/assault that may affect informed consent procedures 3. Reimbursement    * 1. Crime Victim Compensation/reimbursement options that are associated with the provision of a medical forensic evaluation in cases of adult/adolescent/pediatric sexual abuse/assault and intimate partner violence      2. Reimbursement procedures and options for adult/adolescent/pediatric patient populations 4. Confidentiality    * 1. Legal requirements associated with patient confidentiality and their impact on the provision of protected health information to patients, families, and multidisciplinary agencies, including:    1. Health Insurance Portability and Accountability Act (HIPAA) or other applicable confidentiality legislation    2. Key concepts associated with informed consent and the release of protected health information 5. Explaining procedures associated with confidentiality to adult/adolescent/pediatric patient populations 6. Physiological, psychological, sociocultural, spiritual, safety, and economic needs of adult/adolescent/pediatric patients following sexual abuse/assault that may impact confidentiality procedures 7. Medical screening examinations 8. Legal requirements associated with the provision of a medical screening examination and its impact on the provision of medical forensic care in adult/adolescent/pediatric patients following sexual abuse/assault, including:    1. Emergency Medical Treatment and Active Labor Act (EMTALA) or other applicable legislation 9. Required procedures to secure informed consent and informed declination in accordance with applicable legislation 10. Required procedures to transfer or discharge/refer a patient in accordance with applicable legislation 11. Prioritizing and securing appropriate medical treatment as indicated by specific presenting chief complaints 12. Explaining medical screening procedures and options to pediatric and adolescent patient populations 13. Physiological, psychological, sociocultural, spiritual, and economic needs of pediatric and adolescent patients following sexual abuse/assault that may affect medical procedures 14. Mandated reporting requirements     * + 1. Legal requirements associated with mandated reporting requirements in pediatric/adolescent patient populations         2. Mandatory reporting requirement procedures and options for adult/adolescent/pediatric patient populations         3. Differentiating between reported and restricted/anonymous medical forensic evaluations following sexual abuse/assault, if applicable (based on age of patient and local statutes)         4. Modifying medical forensic evaluation procedures in non-reported/anonymous cases         5. Physiological, psychological, sociocultural, spiritual, and economic needs of adult and adolescent patients following sexual abuse/assault that may affect mandated reporting requirement procedures 15. Judicial proceedings 16. Role of the SANE in judicial and administrative proceedings, including:     1. Civil versus criminal court proceedings     2. Family court proceedings     3. Administrative/university proceedings     4. Title IX hearings     5. Military and court martial proceedings     6. Matrimonial/divorce proceedings     7. Child custody proceedings 17. Legal definitions associated with adult/adolescent/pediatric sexual abuse/assault 18. Case law and judicial precedence that affect the provision of testimony in judicial proceedings, including but not limited to:     * 1. Admissibility or other applicable laws specific to the area of practice       2. Rules of evidence or other applicable laws specific to the area of practice       3. Hearsay or other applicable laws specific to the area of practice 19. Differences among family, civil, and criminal judicial proceedings, including applicable rules of evidence 20. Differences between the roles and responsibilities of fact versus expert witnesses in judicial proceedings 21. Differences between judge versus jury trials 22. Judicial processes: 23. Indictment 24. Arraignment 25. Plea agreement 26. Sentencing 27. Deposition 28. Subpoena 29. Direct examination 30. Cross-examination 31. Objections 32. Forensic nurse’s role in judicial proceedings, including:     * 1. Educating the trier of fact       2. Providing effective testimony       3. Demeanor and appearance       4. Objectivity       5. Accuracy       6. Evidence-based testimony       7. Professionalism 33. Key processes associated with pretrial preparation | minutes | Must minimally include a prosecutor and a SANE-A or SANE-P certified nurse  Click or tap here to enter text. | Lecture/PowerPoint **(select at least one additional strategy below):**  Integrating opportunities for dialogue or question/answer  Including time for self-check or reflection  Audience Response System  Analyzing case studies  Providing opportunities for problem-based   learning  Pre/Post Test  Other: Click or tap here to enter text. |

**TOTAL REQUIRED MINUTES MUST = at minimum 3480**

**TOTAL ACTUAL MINUTES =** Click or tap here to enter text.

**TOTAL ACTUAL MINUTES** Click or tap here to enter text. **Divided by 60 = TOTAL CONTACT HOURS** Click or tap here to enter text.

|  |
| --- |
| List the full citations of **at least three (3)** evidence-based references/resources used for developing this educational activity:  Click or tap here to enter text.  Adams, J., Kellogg, N., & Moles, R. (2016). Medical care for children who may have been sexually abused: An update for 2016. *Clinical Emergency Pediatric Medicine, 17(4)*, 255–263.  Agency for Healthcare Research and Quality. (2016, April). *Trauma-Informed Care*. Retrieved from Prevention and Chronic Care: https://www.ahrq.gov/professionals/prevention-chronic-care/healthier-pregnancy/preventive/trauma.html  American Nurses Association. (2015). *Nursing: scope and standards of practice* (3rd ed.). Silver Spring, MD: Nursesbooks.org.  Barnes, J., Putnam, F., & Trickett, P. (2009). Sexual and physical revictimizationamong victims of severe childhood sexual abuse. *Child Abuse and Neglect, 33(7)*, 412–420.  Benner, P. (1982). From novice to expert. *American Journal of Nursing, 82*(3), 402–407.  Benner, P. (1984). *From novice to expert: Excellence and power in clinical nursing practice.* Menlo Park, CA: Addison-Wesley Publishing.  Center for Health Care Strategies. (2017, August). *What is trauma-informed care?* Center for Health Care Strategies webinar presentation. Available at https://www.chcs.org/resource/key-ingredients-trauma-informed-care/  Culatta, R. (. (2018). *Learning Theories: Andragogy (Malcolm Knowles)*. Retrieved July 27, 2018, from Instructional Design: http://www.instructionaldesign.org/theories/andragogy/  Dreyfus, S. E. (1980). *A five-stage model of the mental activities involved in directed skill acquisition.* Berkley, CA: University of California.  Duffy, J. R. (1992). The impact of nurse caring on patient outcomes. In D. A. Gaut (Ed.), *The presence of caring in nursing* (pp. 113–136). New York, NY: National League for Nursing Press.  Duffy, J. R. (2009). Caring assessment tools and the CAT-admin. In J. Watson (Ed.), *Instruments for assessing and measuring caring in nursing and health sciences* (2nd ed., pp. 131–148). New York, NY: Springer.  Duffy, J. R. (2009). *Quality caring in nursing: Applying theory to clinical practice, education, and leadership.* New York, NY: Springer.  Duffy, J. R. (2013). *Quality caring: In nursing and health systems.* New York, NY: Springer.  Duffy, J. R., & Hoskins, L. M. (2003). The Quality Caring Model: Blending dual paradigms. *Advances in Nursing Science, 26*(1), 77–88.  Duffy, J., Hoskins, L. M., & Seifert, R. F. (2007). Dimensions of caring: Psychometric properties of the caring assessment tool. *Advances in Nursing Science, 30*(3), 235–245.  ERC. (2017, January 23). *3 Reasons Why Traditional Classroom Learning Is Still King*. Retrieved from HR Insights Blog: https://www.yourerc.com/blog/post/3-reasons-why-traditional-classroom-based-learning-is-still-king.aspx  Felitti, V., Anda, R., Nordenberg, D., Williamson, D., Spitz, A., Edwards, V., . . . Marks, J. (1998). Relationship of childhood abuse and household dysfunction to many of the leading causes of death in adults: The Adverse Childhood Experiences (ACE) Study. *American Journal of Preventitive Medicine, 14(4)*, 245-258.  Finkelhor, D., Shattuck, A., Turner, H., & Hamby, S. L. (2014). The lifetime prevalence of child sexual abuse and sexual assault assessed in late adolescence. *Journal of Adolescent Health, 55(3)*, 329-333.  Godbout, N., Briere, J., Sabourin, S., & Lussier, Y. (2014). Child sexual abuse and subsequent relational and personal functioning: The role of parental support . *Child Abuse and Neglect, 38(2)*, 317-325.  Hayden, J., Smiley, R. A., & Kardong-Edgren, S. J. (2014). The NCSBN National Simulation Study: A Longitudinal, Randomized, Controlled Study Replacing Clinical Hours with Simulation in Prelicensure Nursing Educaiton. *Journal of Nursing Regulation, 5*(2 Supplement).  Hockenberry, M., & Wilson, D. (2015). Wong’s essentials of pediatric nursing. St. Louis, MO: Elsevier Mosby.  Krishnan, D., Keloth, A., & Ubedulla, S. (2017, June). Pros and cons of simulation in medical education: A review. *International Journal of Medical and Health Research, 3*(6), 84–87.  Malloy, L., Mugno, A., Rivard, J., Lyon, T., & Quas, J. (2016). Familial influences on recantation in substantiated child sexual abuse cases. *Child Maltreatment, 21(3)*, 256–261.  McElvaney, R. (2015). Disclosure of child sexual abuse: Delays, non-disclosure and partial disclosure. What the research tells us and implications for practice. *Child Abuse Review, 24(3)*, 159–169.  McElvaney, R., Greene, S., & Hogan, D. (2014). To tell or not to tell? Factors influencing young people's informal disclosures of child sexual abuse. *Journal of Interpersonal Violence, 29(5)*, 928–947.  Meakim, C., Boese, T., Decker, S., Franklin, A., Gloe, D., & Lioce, L. (2013, June). Standards of Best Practice: Simulation; Standard I: Terminology. *Clinical Simulationin Nursing, 9*(6 Supplement), S3–S11.  Noll, J., Shenk, C., & Putnam, K. (2009). Childhood sexual abuse and adolescent pregnancy: A meta-analysis of the published research on the effects of child sexual abuse. *Journal of Psychology, 135(1)*, 17–36.  Petiprin, A. (2016). *Nursing theory: Roy adaptation model*. Retrieved April 26, 2018, from Nursing Theory: http://nursing-theory.org/theories-and-models/roy-adaptation-model.php  Raja, S. H.-Y. (2015). Trauma Informed Care in Medicine: Current Knowledge and Future Research. *Community Health*, 216–226.  Rothman, E., Exner, D., & Baughman, A. (2011). The prevalence of sexual assault against people who identify as gay, lesbian, or bisexual in the United States: A systematic review. *Trauma, Violence & Abuse, 12*(2), 55–66.  Ruiz, J. G. (2006). The impact of e-learning in medical education. *Academic Medicine, 81*(3), 207–212.  Sumner, S., Mercy, J., Saul, J., Motsa-Nzuza, N., Kwesigabo, G., & Buluma, R. (2015). Prevalence of sexual violence against children and use of social services - seven countries, 2007–2013. *Morbidity and Mortality Weekly Report, 64*(21), pp. 565–569.  Watson, J. (1979). *Nursing: The Philosophy and Science of Caring.* Boston: Little, Brown, & Co.  Watson, J. (1985). *The theory of human care: a theory of nursing.* Connecticut: Appleton-Century Crofts.  World Health Organization. (2013). Responding to intimate partner violence and sexual violence against women: WHO clinical and policy guidelines. *World Health Organization*.  World Health Organization. (2017). Responding to children and adolescents who have been sexually abused: WHO clinical guidelines. Geneva, Switzerland.  Yuen, A. (2011). Exploring teaching approaches in blended learning. *Research & Practice in Technology Enhanced Learning, 6*(1), 3–23. |

**Calculating Contact Hours**

**Note: Time spent evaluating the learning activity may be included in the total time when calculating contact hours.**

|  |  |
| --- | --- |
| **Live Activity** | Click or tap here to enter text.**Total Minutes divided by 60 =** Click or tap here to enter text.**contact hour(s)** |
| **Enduring Activity** | **Select your method of calculating contact hours:**  **Pilot Study**  **Mergener formula**  **Historical Data**  **Complexity of Content**   **Other:** Click here to enter text. |

**Criteria for Awarding Contact Hours**

Criteria for awarding contact hours for live and enduring material activities include: **(Check all that apply)**

Attendance for a specified period of time (e.g., 100% of activity, or miss no more than 10 minutes of activity)

Credit awarded commensurate with participation

Attendance at 1 or more sessions

Completion/submission of evaluation form

Successful completion of a post-test (e.g., attendee must score      % or higher)

Successful completion of a return demonstration

Other - Click or tap here to enter text.

**Estimated Number of Contact Hours to Be Awarded:** Click here to enter text.

**Description of evaluation method: How will the change in knowledge, skills, and/or practices of target audience be assessed at the end of the activity? (Relate this to identified practice gap and educational need):**

|  |  |
| --- | --- |
| **Short-term evaluation options:**  Intent to change practice  Active participation in learning activity  Post-test  Return demonstration  Case study analysis  Role-play  Other –Click or tap here to enter text. | **Long-term evaluation options:**  Self-reported change in practice  Change in quality outcome measure  Return on Investment (ROI)  Observation of performance  Other – Click or tap here to enter text. |

**Completed By (name/credentials):** Click or tap here to enter text. **Date:** Click or tap to enter a date.

**QUESTIONS? Phone: 410.626.7805 ext. 116 EMAIL: CE@forensicnurses.org**