



INTERNATIONAL  
ASSOCIATION OF  
**Forensic  
Nurses**

# Sexual Assault Nurse Examiner (SANE)

## EDUCATION GUIDELINES



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# International Association of Forensic Nurses

## Sexual Assault Nurse Examiner (SANE) Education Guidelines

### INTRODUCTION

The primary purpose of the International Association of Forensic Nurses *Sexual Assault Nurse Examiner (SANE) Education Guidelines* is to help the sexual assault nurse examiner meet the medical forensic needs of those who have been affected by sexual violence, including individual patients, families, communities, and systems. Registered nurses who perform medical forensic evaluations must receive additional and specific didactic and clinical preparation to care for adult, adolescent, and pediatric patients following sexual violence or assault. The sexual assault nurse examiner practicing within recommendations set forth in the *Sexual Assault Nurse Examiner (SANE) Education Guidelines* uses the nursing process and applies established evidence-based standards of forensic nursing practice to ensure that all patients reporting sexual violence and victimization receive a competent medical forensic examination, taking into consideration developmental, cultural, racial, ethnic, gender identity, sexual, and socioeconomic diversity.

Given the prevalence of trauma among patient populations, the IAFN recognizes the criticality of the caregiver's use of a trauma-informed approach to care, regardless of the patient's presentation or demeanor. One in six women has been the victim of an attempted or completed sexual assault in her lifetime, and one in five girls by the age of 13 has been sexually abused (Agency for Healthcare Research and Quality, 2016). According to Raja et al. (2015), the four underlying principles of providing trauma-informed care (TIC) are: 1) realizing the prevalence of traumatic events and the widespread impact of trauma; 2) recognizing the signs and symptoms of trauma; 3) responding by integrating knowledge about trauma into policies, procedures, and practices; and 4) seeking to actively resist re-traumatization. The Center for Healthcare Strategies (2017) finds that small changes in physical and emotional aspects of the care environment (e.g., involving patients in their own care) and the attitudes of caregivers (e.g., including patients in decisions) yield positive results in fostering safety and trust. The concept of TIC must be considered in all aspects of education related to the care provided to patients who have experienced sexual assault. Although not explicitly listed

in the course outline as a stand-alone topic, the concept of TIC is intended to be interwoven throughout the didactic course in its entirety and to serve as a foundational element of the care that SANEs provide.

The nursing process is a critical thinking model that includes assessment, diagnosis, outcomes identification, planning, implementation, and evaluation, and is fundamental to the practice of SANEs. According to the American Nurses Association's *Nursing: Scope and Standards of Practice*, diagnosis is a clinical judgment about the healthcare consumer's response to actual or potential health conditions or needs. The diagnosis provides the basis for determination of a plan to achieve expected outcomes. Registered nurses utilize nursing and medical diagnoses depending upon educational and clinical preparation and legal authority (American Nurses Association, 2015). In 2015, the American Nurses Credentialing Center's Commission on Accreditation revised its guidelines to direct that each continuing nursing education activity reflect a learning outcome (American Nurses Credentialing Center, 2015). The learning outcome is a written statement of the expected result of participation in a learning activity. Learning objectives may be used as stepping stones or stair steps toward achieving a learning outcome for an activity (Dickerson, 2017).

The overall learning outcome for basic SANE education is to provide registered nurses and advanced practice nurses with the knowledge and skills to provide competent, comprehensive, patient-centered, coordinated care to patients being evaluated for sexual assault, or suspected of having been sexually assaulted. A competent SANE will assess patients for acute healthcare needs, provide consultation, and provide for the stabilization and treatment of the patient. Successful completion of the didactic SANE course and the clinical skills training will provide sexual assault nurse examiners with the knowledge and skills to perform the medical forensic examination, obtain a medical forensic history, demonstrate critical thinking in the collection and documentation of specimens obtained during the examination, and document pertinent physical findings from the examination. Competent SANEs will also possess the knowledge and skills to offer information, treatment, and referrals for sexually transmitted diseases<sup>1</sup> (STDs) and other nonacute healthcare concerns; assess pregnancy risk and discuss treatment options with the patient, including reproductive health services; and testify in court to the findings of the medical forensic examination and/or an opinion about the findings. SANEs will also have the knowledge and skills to work collaboratively with the interdisciplinary sexual assault response or resource team (SART), which may include advocates, law enforcement personnel, attorneys, and others.

The *Sexual Assault Nurse Examiner (SANE) Education Guidelines* set forth the *minimum* level of instruction for each key target learning topic in the adult/adolescent and/or pediatric/adolescent populations, while allowing for flexibility to meet the

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<sup>1</sup> Although sexually transmitted disease (STD) and sexually transmitted infection (STI) may be used interchangeably, STD has been chosen for use in this document as it reflects the language used by the Centers for Disease Control and Prevention (CDC).

educational needs of registered nurses in diverse practice settings and communities. At this time, most sexual assault nurse examiners are trained and practice within the United States; therefore, some of the content included in these guidelines is limited to application in the United States. A registered nurse who acts in the specialized role of a sexual assault nurse examiner by providing care to adult/adolescent and or pediatric/adolescent patients should complete a minimum 40-hour didactic curriculum that addresses the content outlined in these guidelines. This course is intended for registered and advanced practice nurses. The minimum licensing recommendation to practice as a SANE is the registered nurse due to the scope and practice related to assessment, patient education, and level of care planning. Although physician assistants and physicians may also receive SANE training, this document is limited in scope to the practice of nursing as it applies to SANE education.

In 2002, the International Association of Forensic Nurses developed and awarded the first international board certification for SANEs caring for the adult/adolescent population (e.g., the SANE-A<sup>®</sup>). In 2007, board certification SANEs caring for the pediatric/adolescent population become available (e.g., the SANE-P<sup>®</sup>).

Certification recognizes the SANE-trained registered nurse who has been practicing in the role of a SANE and has successfully met all requirements to become board certified. IAFN wants to support SANEs in becoming board certified. Successful completion of a SANE training course that meets the current *SANE Education Guidelines* does not result in certification, but is a requisite for applying to sit for the certification examination. Certification recognizes nurses who demonstrate the highest standards of forensic nursing practice and validates their knowledge about the care required for a unique patient population. Certification reflects expertise and dedication to quality patient care and the commitment to excellence is recognized, trusted, and appreciated. Once a SANE is certified, they are able to include their certification in their credentials as SANE-A and/or SANE-P. The American Nurses Credentialing Center (ANCC) provides guidance on how nurses should designate credentials, including board certifications and academic degrees, after their names. SANE certification is not required for practice, but is highly recommended.

Each training course outlined within this document stands alone as a minimum recommended requirement of training for each forensic nursing role. For example, the SANE Adult/Adolescent course prepares the registered nurse to function as a sexual assault nurse examiner for adult/adolescent patients. The SANE Pediatric/Adolescent course prepares the registered nurse to function as a sexual assault nurse examiner for pediatric/adolescent patients. The combination course prepares the registered nurse to provide care for pediatric, adolescent, and adult patients.

## **PURPOSE OF THE GUIDELINES**

The purpose of the *Sexual Assault Nurse Examiner (SANE) Education Guidelines* is to:

1. Identify the standardized, evidence-based body of scientific knowledge necessary for the comprehensive medical forensic examination of the patient who has experienced sexual assault or abuse;
2. Summarize the concept, development, function, and collaboration of the multidisciplinary team as it relates to sexual violence response; and
3. Summarize sexual assault nurse examiner professional practice issues.

## DEFINING PATIENT POPULATIONS

For the purpose of this document, the term *sexual assault nurse examiner* (SANE) refers to a forensic nurse who has specialized training in caring for adult/adolescent and/or pediatric/adolescent patients following a sexual assault.

Whether trained as an adult/adolescent SANE, a pediatric/adolescent SANE, or both, the nurse should have a clear understanding of factors that influence the nursing process and the subsequent provision of care to individuals following sexual violence, including:

1. Age
2. Gender identity
3. Language aptitude
4. Physiologic development
5. Sexual maturation
6. Psychosocial capacity
7. Cognitive ability
8. Sexual orientation
9. Moral, ethical, and legal considerations
10. Spiritual beliefs and practices
11. Cultural experience
12. Health priorities
13. Support systems
14. Trauma history

For the purpose of this document, developmental age periods are defined in Table 1.0. The adult/adolescent didactic and clinical guidelines provide key target learning topics regarding postpubertal patients (defined as the onset of menses in females and the advent of secondary sex characteristics in males) and postmenopausal and other older adult patients. The pediatric/adolescent didactic and clinical guidelines provide key



target learning topics regarding prepubertal and adolescent patients up to 18 years of age.

**Table 1.0 Developmental Age Periods**

Each child grows at his or her own unique and personal way. Great individual variation exists in the age at which developmental milestones are reached. The sequence is predictable; the exact timing is not. Adolescence, which literally means to “grow into maturity,” is generally regarded as the psychologic, social, and maturational process initiated by the pubertal changes (Hockenberry & Wilson, 2015, p. 39).

· Prenatal	Conception to birth
· Infancy	Birth to 12 months <i>Neonate – Birth to 28 days</i> <i>Infant – 1 to 12 months</i>
· Early Childhood	1 to 6 years <i>Toddler – 1 to 3 years</i> <i>Preschool – 3 to 6 years</i>
· Middle Childhood	6 to 11 or 12 years <i>School age</i>
· Later Childhood	11 to 18 years <i>Prepubertal – 10 to 13 years</i> <i>Adolescence – 13 to 18 years</i>
· Adult	18 years and over

(Hockenberry & Wilson, 2015)

## THEORETICAL FRAMEWORK

The International Association of Forensic Nurses Education Guidelines Task Force discussed several nursing theories upon which to base the *Sexual Assault Nurse Examiner (SANE) Education Guidelines*. Consensus was reached to use three theoretical frameworks: Sister Callista Roy’s Adaptation Model of Nursing, Dr. Patricia Benner’s From Novice to Expert Theory, and Joanne Duffy’s Quality Caring Model. Each theory is summarized below along with its application to the *Sexual Assault Nurse Examiner (SANE) Education Guidelines*.

### ROY’S ADAPTATION MODEL OF NURSING

The Task Force found Sister Callista Roy’s Adaptation Model of Nursing to most accurately depict the forensic nursing process. According to Roy’s model, the individual

is a “bio-psycho-social being in constant interaction with a changing environment” (Petiprin, 2016). Viewing people as individuals and in groups, such as communities and families, is a major component of the model. SANE educational courses identify the patient as an individual and as part of a family or community system, which is affected by all forms of violence. Roy focuses on the nursing process as a way to identify the patient’s needs and formulate a plan of care. The nursing process is the foundation for SANE practice. The nurse assesses the patient’s needs and responses, identifies nursing diagnoses with clear steps for behavioral outcomes (Petiprin, 2016), formulates a plan of care, performs interventions based on the patient’s risks and assessment findings, and evaluates patient outcomes and responses.

The *Sexual Assault Nurse Examiner (SANE) Education Guidelines* incorporate the nursing process as the framework for teaching. This specialized training prepares the SANE to provide holistic care and determine appropriate nursing diagnoses, planning, and interventions based on the individual patient’s needs as well as the needs of the patient’s family and community. Roy’s key concepts of person, environment, health, and nursing form the basis of the care that SANEs provide to their patients (Petiprin, 2016). Each concept influences the other and nursing practice serves as the overarching component for facilitating the healing process.

#### **BENNER’S FROM NOVICE TO EXPERT THEORY**

Dr. Patricia Benner conceptualized how expert nurses develop skills and understanding of patient care not only through education but also through experiences. Her seminal 1984 work, *From Novice to Expert; Excellence and Power in Clinical Nursing Practice*, outlines the process by which a nurse progresses from novice to expert. Benner’s theory proposes an approach to the learning process that highlights the importance of clinical experience as an extension of practical knowledge. Experience is a prerequisite for expertise. Benner uses the theory to describe how nurses progress through five levels: novice, advanced beginner, competent, proficient, and expert (Benner, *From novice to expert: Excellence and power in clinical nursing practice*, 1984).

An expert nurse is able to integrate a variety of information and practical nursing skills related to patient care into a meaningful whole. To apply this theory to SANE education, expert nurse mentors or preceptors develop the training and curriculum of the novice SANE and identify implications for teaching and learning at each level.

SANEs use substantial analytical and critical thinking skills as well as expert knowledge and judgement in the clinical care of patients following a sexual assault. SANEs must identify, analyze, and intervene in a variety of complex situations and patient conditions that may be new to the novice SANE. It is impossible to teach every condition and circumstance that a SANE may encounter. The development of critical thinking skills is what supplements technical knowledge. Preceptor roles must be developed to convey this experiential knowledge to novice SANEs. Real-life scenarios or clinical narratives may also convey this knowledge and can be used to deepen the understanding of clinical practice that cannot be otherwise quantified.

Not all of the knowledge embedded in expertise can be captured in theoretical propositions or with analytic strategies that depend on identifying all the elements that comprise a decision. However, the intentions, expectations, meanings, and outcomes of expert practice can be captured by interpretive descriptions of actual practice (Benner, 1984, p. 4).

Developing expert SANE practice is essential for providing quality care to patients following a sexual assault. The skills of an expert nurse are best imparted through clinical experience, whereby the expert shares complex and critical nursing decisions and communication abilities. A novice nurse initially will rely on the technical knowledge gained through textbooks and training. Only with experience will the nurse move through all three domains of competence: technical, interpersonal, and critical thinking, which are requisite when caring for patients who have experienced sexual assault. As the SANE develops professionally, he or she moves from mastery of technical skills, such as conducting the physical examination and obtaining and preserving forensic specimens, to mastery of interpersonal competencies, such as developing a strong therapeutic relationship, understanding and managing psychological reactions and mental health concerns, to employing critical thinking competencies, such as integrating complex and numerous sources of information (medical, forensic, psychological, legal, social, political), to provide a holistic view of the patient.

The *SANE Education Guidelines* capitalize on the process of experiential learning and support and sustain expert clinicians as preceptors who will tailor their teaching to the learning abilities of the novice SANE and his or her unique needs.

#### **DUFFY'S QUALITY CARING MODEL®**

The *SANE Education Guidelines* describe patient-centered nursing interventions that characterize the SANE's relationship with the patient. The dynamic between the SANE and the patient is a caring relationship, which encompasses patient participation, consent and mutuality, teaching, and a warm and open environment. The goal is to improve the health and welfare of patients, families, and communities.

Joanne Duffy's Quality Caring Model® offers a framework to support the interventions and actions of the caring relationship that exists between the SANE and the patient, family, and community. A number of nursing theorists contributed to the creation of the Quality Caring Model—most notably, Watson, who spoke about caring as the essence of nursing (1979, 1985). Later, Duffy noted, "The relationship, therefore, becomes the base that the nurse and the patient use to share information, thoughts, feelings, and concerns. As this relationship is forged, caring is developed and quality outcomes are achieved" (Duffy, 2009).

Duffy, Hoskins, and Seifert (2007) identified eight factors that are present in a caring relationship. These factors include mutual problem-solving, attentive reassurance, human respect, an encouraging manner, appreciation of unique meanings, a healing

environment, affiliation needs, and basic human needs (Duffy, Hoskins, & Seifert, 2007). The SANE's interventions, as outlined in the *SANE Education Guidelines*, demonstrate each of these factors. For instance, the SANE exhibits mutual problem-solving when discussing options of care with the patient, empowering the patient to make their own decisions while providing the information necessary to make an informed choice. Attentive reassurance is the active listening that the SANE provides when taking a patient history. The SANE reflects human respect when asks how the patient prefers to be addressed and then treating that person with dignity. The SANE demonstrates an encouraging manner when posing open-ended questions and allowing time and space for the patient to express themselves. Appreciation of unique meanings is the action of inquiry, seeking to understand the patient's history and trauma through reflection and active listening. This also involves the SANE's assessment of their personal attitudes, privilege, and style of verbal and nonverbal communication. The healing environment is the space that the SANE creates by offering examination rooms that are private, confidential, warm, and ideally removed from the often-chaotic emergency department. Affiliation needs are the SANE's actions in involving families and community collaborators, according to the patient's consent and request. Basic human needs are the actions that the SANE provides in performing safety checks and ensuring that the patient's immediate physical and safety needs are being met. Important to Duffy's model is that "evaluation leads to intervention and action with more subsequent evaluation" (Duffy, 2009).

## **INSTRUCTIONAL METHODOLOGIES**

Nurses attending continuing education courses learn in a variety of ways. Knowles's theory informs the process of adult learners. This theory states that active involvement is key to the learning process. The active learner retains more information, more readily sees the applicability of that information, and learns more quickly. Knowles assumes that the learner must be self-directed, knows the reason that he or she needs to acquire the information, and brings a different type and quality of experience (Culatta, 2018).

Participants in sexual assault nurse examiner education courses are generally motivated learners. They have decided to expand their knowledge base to become educated in providing specialized care to patients who have experienced sexual violence. However, not all adults learn in the same manner. Instructors may use a variety of mediums to design and deliver a curriculum to the students.

Key to developing SANE education based on these guidelines is the course planner's understanding that didactic training involves lecture and textbook instruction regarding the specific content areas rather than demonstration or laboratory study. Demonstration and simulation-based learning is a critical component to educating the SANE as well, but should be used for the clinical course rather than the didactic course.

### **Classroom Education**

Traditionally, basic SANE education content has been delivered in the classroom setting. Students attend the didactic portion whereby an instructor presents information. This method offers several advantages. First, many participants are comfortable with the traditional classroom setting. It affords an active conversational setting; instructors and peers have the opportunity to network and learn from each other (ERC, 2017). Questions are answered immediately and the instructor clarifies content so the attendees benefit from the explanation. Another advantage is the structure provided by the classroom (ERC, 2017). The course is delivered on specific dates at predetermined times. Finally, few technology demands exist in the classroom setting. Computer skills are rarely required. The main disadvantage to this approach is that the instructor may not be able to accommodate the learning style of each participant (Michael, 2009) or the attendee may have difficulty securing the time off necessary for live attendance. Each person learns and retains information in a different manner: by listening, seeing, or doing. This consideration should be noted when delivering the curriculum in this format.

### **Web-Based Education**

A growing trend in education has been the development of web-based programs or courses that are available on the Internet. Evidence has shown the effectiveness of Internet learning as documented in medical education (Ruiz, 2006). Message boards, teleconferencing, and chats make collaborative learning more readily available. Ruiz (2006) writes that studies in collaborative learning have shown higher levels of learning satisfaction; improvements in knowledge and self-awareness; and an enhanced understanding of concepts, course learning outcomes, and changes in practice. This type of curriculum delivery allows large numbers of participants to benefit from the learning opportunity. Students complete course requirements at their own pace within a given time frame. The major disadvantage is that the face-to-face interaction with instructors and peers is lost because of a separation of time and space (ERC, 2017). Effective time management skills are required for this type of learning, which may discourage some from excelling.

### **Simulation**

Simulation has become an increasingly popular teaching method in nursing education. The use of simulation includes high fidelity mechanical simulators, role playing with standardized patients, scenario setting, and case studies. This type of learning has shown to increase patient safety and decrease errors, improve clinical judgment, and is useful for evaluating specific skills (Hayden, Smiley, & Kardong-Edgren, 2014). Disadvantages to using simulation include the amount of time required to set up a simulation laboratory, create scenarios, and plan for role plays (Krishnan, Keloth, & Ubedulla, 2017). When mechanical simulators are used, patient reactions to procedures are lost (Krishnan, Keloth, & Ubedulla, 2017). The use of simulation to teach and evaluate skills associated with conducting the medical forensic examination may be incorporated into the curriculum, but may not replace the expected hours of didactic content. The simulation must be structured. Clear learning goals with set scenarios and methods for evaluating student performance, based upon the established standards (competency validation

tools), are essential. A process for providing feedback to the student must be developed and consistently used (Meakim et al., 2013). To address the student's action or inaction in the simulation environment, the instructors should be thoroughly familiar with the scenarios. Successful simulation sessions require much preparation and cannot be loosely organized. Consultation with educators who use various methods of simulation is highly recommended.

# SEXUAL ASSAULT NURSE EXAMINER (SANE) EDUCATION REQUIREMENTS (OVERVIEW)

## Coursework Content

The coursework requirements identified in this section provide the minimum course hours necessary to meet the SANE education eligibility requirements to apply to sit for the Commission for Forensic Nursing Certification examinations. Programs should be designed as basic courses for those who are new to the field of forensic nursing and to the specialized role of the Sexual Assault Nurse Examiner in caring for patients who have experienced sexual assault. Regardless of the didactic course delivery method (live, online, etc.) or type (Adult/Adolescent, Pediatric/Adolescent, or Combined Pediatric/Adolescent/Adult), the course in its entirety must be one educational offering that is developed by one accredited provider and should not take longer than 15 weeks to complete. Participants should receive a certificate of completion expressly stating the attendee's name, the date(s) of the training, the number of continuing nursing education contact hours awarded (or the academic equivalent)<sup>2</sup>, and the provider's accreditation statement. Additionally, the final course certificate should clearly state that the participant completed a Sexual Assault Nurse Examiner or Sexual Assault Forensic Examiner program and the appropriate population addressed (Adult/Adolescent, Pediatric/Adolescent, or Combined Pediatric/Adolescent/Adult). Detailed components of the didactic and clinical training can be found later in this document.

### I. Adult/Adolescent

- A minimum of 40 hours of didactic coursework that yields a minimum of 40 continuing nursing education contact hours from an accredited provider of nursing education, or academic credit or the national equivalent from an accredited educational institution; and
- Clinical components, including simulated clinical experiences, that are completed in addition to the coursework and are not calculated as a part of the 40-hour didactic course.

### II. Pediatric/Adolescent

- A minimum of 40 hours of didactic coursework that yields a minimum of 40 continuing nursing education contact hours from an accredited provider of nursing education, or academic credit or the national equivalent from an accredited educational institution; and
- Clinical components, including simulated clinical experiences, that are completed in addition to the coursework and are not calculated as a part of the 40-hour didactic course.

### III. Combination Adult/Adolescent and Pediatric/Adolescent

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<sup>2</sup> 1 semester hour = 15 contact hours; 1 quarter hour = 12.5 contact hours  
<https://www.nursingworld.org>



- A minimum of 64 hours of didactic coursework that yields a minimum of 64 continuing nursing education contact hours from an accredited provider of nursing education, or academic credit or the national equivalent from an accredited educational institution; and
- Clinical components, including simulated clinical experiences, that are completed in addition to the coursework and are not calculated as a part of the 64-hour didactic course.

Each course must provide nursing contact hours, nursing academic credits, or a national equivalent that demonstrates proof of hours and course content.

## RECOMMENDATIONS FOR INSTRUCTORS

Sexual assault nurse examiner course instructors are challenged with designing and teaching a high-quality course that meets all established learning outcomes. It is recommended that various mediums be used when presenting course material. Blended learning involves using multiple forms of instruction to meet the needs of the students (Yuen, 2011). For example, instructors could present lectures, but have students prepare for the course in advance by completing some lessons via a web-based connection. Classroom didactics should ideally use a combination of slide presentations, videos, discussion, case studies, and lecture. Students should be encouraged to discuss the concepts as they apply to actual cases involving forensic health care.

Simulation may be used to teach and reinforce skills associated with the medical forensic examination, such as anogenital inspection, speculum insertion, evidence packaging, etc. The medical forensic examination may be simulated with either live models or mechanical simulators. Care should be given to the development and evaluation of the scenario content with established learning outcomes for each scenario.

Simulated medical forensic examinations should not be used exclusively for teaching or evaluating clinical skills. Precepted medical forensic examinations are an essential component to ensure that the student is ready to perform an adequate medical forensic examination independently. Limited information is available regarding how much simulation should be used in relation to actual precepted patient care. The study by the National Council of State Boards of Nursing (NCSBN) documents that the use of simulation as a teaching method translates to the clinical environment as evidenced by high competency rankings (Hayden, Smiley, & Kardong-Edgren, 2014). The NCSBN study recommends using a blend to evaluate student mastery of clinical skills. This is also a recommendation for sexual assault nurse examiner education.

Students may best master basic technical skills under structured guidance during simulation. Skill at interacting with a patient in a clinical setting, particularly establishing competence in gathering a medical forensic history, may be enhanced through actual precepted medical forensic examinations on patients affected by sexual assault.

Regardless how the courses are conveyed, instructors must consider the variables associated with teaching the adult learner and develop content designed to overcome



challenges associated with different styles of learning (seeing, doing, and reading). By using a variety of methods, the instructor will engage students and enhance the learning experience.

## **INSTRUCTORS FOR ADULT/ADOLESCENT PATIENT POPULATIONS**

The IAFN recognizes the importance of having both core faculty members and multidisciplinary content experts provide instructional content during an adult/adolescent SANE educational program. Core faculty members are defined as those individuals who are primarily responsible for structuring, providing, and evaluating the content associated with the educational offering. Multidisciplinary content experts are individuals who provide specific educational content in their respective area of expertise and may include but are not limited to ancillary experts in nursing, other healthcare disciplines, law enforcement, forensic science, social services, advocacy, or the judicial community. Listed below are the guidelines for the core faculty member(s) and the multidisciplinary content expert(s):

### **I. Core faculty member(s) recommendations**

- A. Holds current, active, and unrestricted registered nursing licensure with his or her respective Board of Nursing or other appropriate governing body
- B. Has successfully completed the didactic and clinical requirements associated with an adult/adolescent SANE education program
- C. Demonstrates active participation in continuing education relevant to caring for adult/adolescent sexual assault patient populations
- D. At least one core faculty member holds a current IAFN SANE-A<sup>®</sup> certification
- E. At least one core faculty member demonstrates expert clinical competency by:
  1. Engaging in active clinical practice in the care of adult/adolescent sexual assault patient populations, and
  2. Having at least five years of experience in caring for adult/adolescent sexual assault patient populations (Benner, 1984)
    - a. At least one core faculty member demonstrates expertise in providing instructional content to the adult learner

### **II. Multidisciplinary content expert(s) recommendations**

- A. Demonstrates the ability to present instructional content effectively (ANCC, 2015)
- B. Demonstrates content expertise as indicated by:
  1. Recent experience in the specialty area (ANCC, 2015)
  2. Advanced professional development that signifies expertise in the specific content area (ANCC, 2015) and/or
  3. Certification in the specialty area (ANCC, 2015) and/or
  4. Academic preparation in the specialty area (ANCC, 2015)

## **INSTRUCTORS FOR PEDIATRIC/ADOLESCENT PATIENT POPULATIONS**

The IAFN recognizes the importance of having both core faculty members and multidisciplinary content experts provide instructional content during a pediatric/adolescent SANE educational program. Core faculty members are defined as those individuals who are primarily responsible for structuring, providing, and evaluating the content associated with the educational offering. Multidisciplinary content experts are individuals who provide specific educational content in their respective area of expertise and may include but are not limited to ancillary experts in nursing, other healthcare disciplines, law enforcement, forensic science, social services, advocacy, or the judicial community. Listed below are the guidelines for the core faculty member(s) and the multidisciplinary content expert(s):

### **I. Core faculty member(s) recommendations:**

- A. Holds current, active, and unrestricted registered nursing licensure with his or her respective Board of Nursing or other appropriate governing body
- B. Has successfully completed the didactic and clinical requirements associated with a pediatric/adolescent SANE education program
- C. Demonstrates active participation in continuing education relevant to caring for pediatric/adolescent sexual assault patient populations
- D. At least one core faculty member holds a current IAFN SANE-P certification
- E. At least one core faculty member demonstrates expert clinical competency by:
  1. Engaging in active clinical practice in the care of pediatric/adolescent sexual assault patient populations, and
  2. Having at least five years of experience in caring for pediatric/adolescent sexual assault patient populations (Benner, 1984)
    - a. At least one core faculty member demonstrates expertise in providing instructional content to the adult learner

### **II. Multidisciplinary content expert(s) recommendations**

- A. Demonstrates the ability to present instructional content effectively (ANCC, 2015)
- B. Demonstrates content expertise as indicated by:
  1. Recent experience in the specialty area (ANCC, 2015)
  2. Advanced professional development that signifies expertise in the specific content area (ANCC, 2015) and/or
  3. Certification in the specialty area (ANCC, 2015) and/or
  4. Academic preparation in the specialty area (ANCC, 2015)

## SETTING UP YOUR COURSE (AT-A-GLANCE)

Course Type	Didactic	Clinical*
<b>Adult/Adolescent</b>	<ul style="list-style-type: none"> <li>• Final issued certificate equals at least 40 contact hours in nursing or the academic course equivalent</li> <li>• Designed as one educational offering by one accredited provider</li> </ul>	<p>Demonstration of clinical skill to establish validated clinical competence at the local level (or “in a simulated or practice setting”) in adult/ adolescent clinical learning outcomes</p>
<b>Pediatric/Adolescent</b>	<ul style="list-style-type: none"> <li>• Final issued certificate equals at least 40 contact hours in nursing or the academic course equivalent</li> <li>• Designed as one educational offering by one accredited provider</li> </ul>	<p>Demonstration of clinical skill to establish validated clinical competence at the local level (or “in a simulated or practice setting”) in pediatric/adolescent clinical learning outcomes</p>
<b>Combined Pediatric/Adolescent/Adult</b>	<ul style="list-style-type: none"> <li>• Final issued certificate equals at least 64 contact hours in nursing or the academic course equivalent</li> <li>• Designed as one educational offering by one accredited provider</li> </ul>	<p>Demonstration of clinical skill to establish validated clinical competence at the local level (or “in a simulated or practice setting”) in adult/ adolescent/pediatric clinical learning outcomes</p>

\* The Clinical Skill component may take place in a variety of ways. Some communities offer the 16-hour Clinical Skills Lab, a program created by the IAFN. Additionally, programs may offer their own clinical skills lab, precepted experience with an established clinician, or integrated clinical orientation offered by the employer.

# Section I

## Adult/Adolescent Sexual Assault Nurse Examiner (SANE)

### EDUCATION GUIDELINES

#### ADULT/ADOLESCENT DIDACTIC CONTENT

##### Sexual Violence

The World Health Organization (WHO) (2013) defines *sexual violence* as “any sexual act, attempt to obtain a sexual act, unwanted sexual comments or advances or acts to traffic, or otherwise directed against a person’s sexuality using coercion, by any person regardless of their relationship to the victim, in any setting including but not limited to home and work” (p. 11). Worldwide sexual violence takes many forms and may include but is not limited to rape, sexual harassment, sexual abuse/assault, forced or coerced marriage or cohabitation, genital mutilation and forced prostitution, or trafficking for the purpose of sexual exploitation (World Health Organization, 2013). Sexual violence may include intimate partner violence. The WHO (2013) defines *intimate partner violence* as “behavior within an intimate relationship that causes physical, sexual or psychological harm, including acts of physical aggression, sexual coercion, psychological abuse and controlling behaviors” (p. vii).

In a multi-country study conducted by the WHO, the prevalence rate of sexual violence by a partner ranged from 6% to 59% and by a non-partner from 0.3% to 11.5% in subjects up to 49 years of age. In the same study, 3% to 24% of the subjects reported that their first sexual experience was forced and occurred during adolescence. Among women, prevalence rates for sexual and/or physical violence involving an intimate partner across the lifespan range from 15% to 71% of women. Although limited in number, other studies support similar or higher prevalence rates for physical and sexual intimate partner violence in same-sex relationships (World Health Organization, 2013). In a systematic review of 75 studies, the prevalence rate of sexual violence across the lifespan for lesbian or bisexual women ranged from 15.6% to 85% and for gay or bisexual men from 11.8% to 54% (Rothman, Exner, & Baughman, 2011). Limited studies address the prevalence rates of intimate partner and sexual violence in adult males; those that exist are problematic given that most experts believe available statistics drastically underrepresent the number of male rape victims. In studies from developed countries,

5% to 10% of men report a history of male child sexual abuse (World Health Organization, 2013).

Numerous consequences are associated with sexual violence. Sexual violence in childhood and adolescence is significantly associated with higher rates of health risks and health-risk behaviors in both males and females. In adulthood, intimate partner and sexual violence is associated with higher prevalence rates of unintended pregnancies, abortions and pregnancy complications, sexually transmitted diseases, mental health disorders, and suicide. In addition, children of women who experience intimate partner or sexual violence are more likely to have poorer overall health and educational outcomes and behavioral and emotional disturbances associated with perpetrating or experiencing violence themselves later in life (World Health Organization, 2013).

Risk factors associated with intimate partner or sexual violence victimization include but are not limited to young age, lower socioeconomic status, exposure to maltreatment as a child, mental health disorders, alcohol and/or illicit drug use, weak or absent support systems within the community, and societal support of violence (World Health Organization, 2013).

### **Adult/Adolescent Didactic Content Target Learning Topics**

The following content framework is designed to provide the adult/adolescent SANE with the *minimum* target learning topics to demonstrate the cognitive, affective, and psychomotor skills needed to use the nursing process in caring for adult and adolescent patients following sexual violence. The target learning topics provide adult/adolescent SANEs from a variety of professional practice backgrounds with the foundational knowledge and critical thinking skills necessary to provide holistic, comprehensive, trauma-informed care to adult and adolescent sexual assault patient populations. Each key target learning topic contains measurable outcome criteria that follow the steps of the nursing process, including assessment, diagnosis, outcome identification, planning, implementation, and evaluation.

**Learning Outcome:** The overall learning outcome for basic SANE education is to provide registered nurses and advanced practice nurses with the knowledge, and skills, and judgment to provide competent, comprehensive, patient-centered, coordinated care to patients being evaluated for sexual assault, or suspected of having been sexually assaulted.

### **Key Target Didactic Learning Topics**

- I. Overview of Forensic Nursing and Sexual Violence
- II. Victim Responses and Crisis Intervention
- III. Collaborating with Community Agencies
- IV. Medical Forensic History-Taking

- V. Observing and Assessing Physical Examination Findings
- VI. Medical Forensic Specimen Collection
- VII. Medical Forensic Photography
- VIII. Sexually Transmitted Disease Testing and Prophylaxis
- IX. Pregnancy Risk Evaluation and Care
- X. Medical Forensic Documentation
- XI. Discharge and Follow-Up Planning
- XII. Courtroom Testimony and Legal Considerations

## I. Overview of Forensic Nursing and Sexual Violence

Learning Objective: Upon completing instruction in the following topics, the participant will have the knowledge required by the adult/adolescent SANE to incorporate fundamental forensic principles and practices into the nursing process when providing care for adult and adolescent patients following a sexual assault.

### A. Forensic Nursing Overview

1. History and evolution of forensic nursing
2. Role of the adult/adolescent SANE in caring for adult and adolescent sexual assault patient populations
3. Role of the adult/adolescent SANE and sexual violence education and prevention
4. Role of the International Association of Forensic Nurses in establishing the scope and standards of forensic nursing practice
5. Key aspects of *Forensic Nursing: Scope and Standards of Practice*
6. Professional and ethical conduct related to adult/adolescent SANE practice and care of adult and adolescent sexual assault patient populations through the ethical principles of autonomy, beneficence, non-maleficence, veracity, confidentiality, and justice
7. Nursing resources, locally and globally, that contribute to current and competent adult/adolescent SANE practice
8. Vicarious trauma
9. Methods for preventing vicarious trauma associated with adult/adolescent SANE practice

## 10. Key concepts associated with the use of evidence-based practice in the care of adult and adolescent sexual assault patient populations

Learning Objective: Upon completing instruction in the following topics, the participant will have the knowledge required to recognize the dynamics of sexual violence, which provide context for the care of adult and adolescent patients following a sexual assault. The adult/adolescent SANE uses this knowledge to educate patients about the connection between violence and health, and to collaborate with patients in identifying appropriate interventions and community referrals.

### B. Sexual Violence

1. Types of sexual violence
2. Types of intimate partner violence (IPV)
3. Global incidence and prevalence rates for sexual violence and IPV in the female and male adult and adolescent populations
  - a. Risk factors for sexual violence and abuse
4. Health consequences of sexual violence and abuse and co-occurring violence, to include physical, psychosocial, cultural, and socioeconomic sequelae
5. Unique healthcare challenges to underserved sexual assault and abuse populations and associated prevalence rates, including but not limited to:
  - a. Men
  - b. Inmates
  - c. GLBTQIA (gay, lesbian, bisexual, transgender, questioning/queer, intersex, agender/asexual)
  - d. Patients with disabilities
  - e. Culturally diverse populations
  - f. Mental health populations
  - g. Patients with language/communication barriers
  - h. People who are trafficked
  - i. Patients who are in the military
6. Best practices for improving forensic nursing care provided to underserved or vulnerable patient populations
7. Factors that impact the vulnerability of patients being targeted for sexual assault and abuse (i.e., adverse childhood experiences [ACEs], generational violence, and people who were raised in the foster care system)
8. Biases and deeply held beliefs regarding sexual violence, abuse, and co-occurring violence in adult and adolescent patient populations
9. Key concepts of offender behavior and the effect on sexual assault patient populations





10. Differences between the minor and adult patient populations as related to adult and adolescent sexual violence
11. Delayed disclosure and recantation as common presentations in sexual violence and abuse

## II. Victim Responses and Crisis Intervention

Learning Objective: Upon completing instruction in the following topics, the participant will have the knowledge required to identify the psychosocial impact of sexual violence on adult and adolescent patient populations. These topics underpin the foundational knowledge of the adult/adolescent SANE to appropriately assess, plan, implement, and evaluate care as well as to collaborate with patients in identifying appropriate care goals and community care referrals.

- A. Common psychosocial responses to sexual violence, abuse, and co-occurring violence in adult and adolescent populations
- B. Acute and long-term psychosocial ramifications associated with sexual violence, abuse, and co-occurring violence
- C. Emotional and psychological responses and sequelae following sexual violence, including the impact of trauma on memory, cognitive functioning, and communication applicable to adult and adolescent sexual violence patient populations
  1. Key components of a suicide risk assessment
  2. Key components of a safety risk assessment
- D. Diverse reactions that can be manifested in the patient after sexual violence
- E. Risk factors for acute and chronic psychosocial sequelae in adult and adolescent patients following sexual violence, abuse, and co-occurring violence
- F. Common concerns regarding reporting to law enforcement following sexual violence, abuse, and co-occurring violence and potential psychosocial ramifications associated with this decision
- G. Culturally competent, holistic care of adult and adolescent patients who have experienced sexual assault, based on objective and subjective assessment data, patient-centered outcomes, and patient tolerance
- H. Risk factors for nonadherence in adult and adolescent patient populations following sexual violence
- I. Diverse psychosocial issues associated with underserved sexual violence patient populations, such as:
  1. Males
  2. Inmates

3. GLBTQIA (gay, lesbian, bisexual, transgender, questioning/queer, intersex, agender/asexual)
  4. Adolescents
  5. Patients with disabilities
  6. Culturally diverse populations
  7. Mental health populations
  8. Patients with language/communication barriers
  9. People who are trafficked
- J. 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
- K. 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
- L. Techniques and strategies for interacting with adult and adolescent patients and their families following a disclosure of sexual violence, 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

### **III. Collaborating with Community Agencies**

Learning Objective: Upon completing instruction in the following topics, the participant will have the foundational knowledge to effectively interact and collaborate with multidisciplinary team members involved in the care of adult and adolescent patients following sexual violence.

- A. Sexual assault response team (SART), including:
1. Overview of roles and responsibilities
  2. SART models
  3. Strategies for implementing and sustaining a SART
  4. Benefits and challenges
- B. Roles and responsibilities of the following multidisciplinary SART members as they relate to adult and adolescent sexual violence:
1. Victim advocates (community- and system-based)

2. Medical forensic examiners (adult/adolescent SANEs, death investigators, coroners, medical examiners, forensic nurse consultants)
  3. Law enforcement personnel
  4. Prosecuting attorneys
  5. Defense attorneys
  6. Forensic scientists
  7. Social service agencies
- C. Key strategies to initiate and maintain effective communication and collaboration among multidisciplinary SART members while maintaining patient privacy and confidentiality

#### **IV. Medical Forensic History Taking**

Learning Objective: Upon completing instruction in the following topics, the participant will have the necessary knowledge required to accurately, objectively, and concisely obtain medical forensic information associated with a sexual assault involving an adult or adolescent patient.

- A. Key components of obtaining a comprehensive, developmentally appropriate patient history, including a focused review of systems with an adult/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. Anogenital-urinary history
  8. Last consensual intercourse
  9. Pregnancy history
  10. Contraception usage
  11. Last menstrual period
  12. Event history
    - a. Actual/attempted acts
    - b. Date and time of event
    - c. Location of event
    - d. Assailant information
    - e. Use of weapons/restraints/threats
    - f. Use of recording devices (photographs or videos of the event)
    - g. Suspected drug-facilitated sexual assault

- h. Condom use
  - i. Ejaculation
  - j. Pain or bleeding associated with acts
  - k. Physical assault
  - l. Strangulation
  - m. Potential destruction of evidence
- B. Difference between obtaining a medical forensic history and conducting a forensic interview, and the purpose of each
  - C. Techniques for establishing rapport and facilitating disclosure while considering the patient's age, developmental level, tolerance, gender identity, and cultural differences
  - D. Importance of using the medical forensic history to guide the physical assessment of the patient and evidence collection
  - E. Poly-victimization or co-occurrence of violence using the medical forensic history
  - F. Importance of accurate and unbiased documentation of the medical forensic history
  - G. Coordination between law enforcement representatives and SAFEs regarding the logistics and boundaries of medical forensic history taking and investigative intent

## V. Observing and Assessing Physical Examination Findings

Learning Objective: Upon completing instruction in the following topics, the participant will have the knowledge required to perform in the role of the adult/adolescent SANE in assessing and identifying physical findings in the patient, including potential mechanisms of injury following a sexual assault. The adult/adolescent SANE is responsible for using evidence-based practice as a framework for identifying and interpreting physical findings and for ensuring that adult and adolescent patients receive holistic, comprehensive, trauma-informed, patient-centered care that focuses on the nursing process, including evidentiary considerations and healthcare priorities and practices.

- A. Importance of obtaining informed consent and assent throughout the medical forensic examination process
- B. Importance of addressing patient concerns related to examiner gender and other preferences
- C. Comprehensive head-to-toe physical assessment that is age, gender identity, developmentally, and culturally appropriate, while considering the patient's tolerance, including assessment of:
  1. Patient's general appearance, demeanor, cognition, and mental status
  2. Clothing and other personal possessions
  3. Body surfaces for physical findings

4. Anogenital structures
  5. Sexual maturation
  6. Impact of estrogen on anogenital structures
- D. Mechanical and physical trauma and identification of each type
1. Blunt force
  2. Sharp force
  3. Gunshot wounds
  4. Strangulation
- E. Comprehensive strangulation assessment for the patient with known or suspected strangulation as a part of the history and/or physical findings
- F. Terminology related to mechanical and physical trauma findings, including:
1. Abrasion
  2. Laceration/tear
  3. Cut/incision
  4. Bruise/contusion
  5. Hematoma
  6. Swelling/edema
  7. Redness/erythema
  8. Petechiae
- G. Anogenital anatomy and physiology, including:
1. Normal anatomical variants
  2. Types and patterns of injury that are potentially associated with sexual assault
  3. Physical findings and medical conditions or non-assault-related trauma that can be misinterpreted as resulting from a sexual assault
- H. Multimethod approach for identifying and confirming physical findings, which may include:
1. Positioning
  2. Labial separation/traction
  3. Sterile water irrigation
  4. Colposcopic or photographic visualization with magnification
  5. Anoscopic visualization, if indicated and within the scope of practice in the jurisdiction's Nurse Practice Act
  6. Toluidine blue dye application and removal
  7. Urinary (Foley) catheter, swab, or other technique for visualization of the hymen
  8. Peer review/expert consultation
- I. Current evidence-based references and healthcare practice guidelines for the care of the adult and adolescent patient who has experienced sexual assault

- J. Circumstances that may necessitate referral and/or consultation
- K. Planning care using current evidence-based practice for adult and adolescent sexual assault patient populations
- L. Using clinical judgment to determine care
- M. 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
- N. Critical thinking elements and evidence-based practice needed to correlate potential mechanisms of injury of anogenital and non-anogenital findings, including recognizing findings that may be the result of medical conditions or disease processes
- O. Care prioritization based on assessment data and patient-centered goals
- P. When to employ medical consultation and trauma intervention

## **VI. Medical Forensic Specimen Collection**

Learning Objective: Upon completing instruction in the following topics, the participant will have the knowledge required to perform in the role of the adult/adolescent SANE in employing a patient-centered approach to obtaining and preserving the biologic and trace specimens from adult and adolescent victims and suspects using forensic nursing principles.

### **A. Patient (Victim)-Centered Care**

1. Importance of patient participation, consent, and ongoing assent during specimen collection procedures as a means of recovering from sexual violence
2. Sexual assault evidence collection kit
3. Integration of obtaining and preserving forensic samples into the medical forensic examination
4. Specimen collection options within the community available to adult and adolescent patients who have experienced sexual assault, including:
  - a. Reporting to law enforcement
  - b. Non-reporting/anonymous evidence collection
  - c. Medical evaluation and treatment
5. Recommendations for collection time limits of biological specimens following a sexual assault
6. Types of specimens and methods of collection in the adult and adolescent patient following a sexual assault, based on the event history, including but not limited to:
  - a. DNA
  - b. Trace/non-biologic

- c. History documentation
  - d. Physical findings, identification, and documentation
  - e. Medical forensic photography
  - f. Toxicology
7. Chain of custody and principles and procedures for maintaining
  8. Drug-facilitated sexual assault (DFSA), current trends, criteria associated with a risk assessment for DFSA, and when specimen collection procedures are indicated
  9. Patient concerns and common misconceptions patients may have regarding specimen collection
  10. Potential risks and benefits for the patient related to evidence collection
  11. Adjunctive tools and methods used in specimen identification and collection and associated risks and benefits, including but not limited to:
    - a. Alternate light sources
    - b. Swab collection techniques
    - c. Speculum examination
    - d. Colposcopic visualization or magnification with a digital camera
    - e. Anoscopic visualization, if indicated and within the scope of practice in the Nurse Practice Act
  12. Appraisal of data regarding the assault details to facilitate complete and comprehensive medical forensic examination and evidence collection
  13. Evidence-based practice guidelines for the identification, collection, preservation, handling, and transfer of biologic and trace evidence specimens following a sexual assault
  14. Evidence-based practice when planning evidentiary procedures
  15. Materials and equipment needed for biologic and trace evidence collection
  16. Techniques to support the patient and minimize the potential for additional trauma during specimen collection procedures
  17. Techniques to facilitate patient participation in specimen collection procedures
  18. 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
- B. Patient (Suspect)-Centered Care**
1. Differences in victim and suspect medical forensic examination and specimen collection following a sexual assault
  2. Legal authorization needed to obtain evidentiary specimens and examine a suspect, including:
    - a. Written consent
    - b. Search warrant
    - c. Court order

3. Components of a suspect medical forensic examination
4. Recommendations for time limits of collection of biologic evidence in the suspect of a sexual assault
5. Types of evidence that can be collected in the medical forensic examination of a suspect following sexual assault, such as:
  - a. DNA evidence
  - b. Trace/non-biologic evidence
  - c. Physical findings, identification, and documentation
  - d. Medical forensic photography
  - e. Toxicology
  - f. Variables in specimen collection, packaging, preservation, and transportation issues for items, including:
    - i. Products of conception
    - ii. Foreign bodies
    - iii. Tampons
    - iv. Diapers
6. Synthesizing data from a reported sexual assault to inform a complete and comprehensive medical forensic examination and evidence collection in the suspect of a sexual assault
7. Preventing cross-contamination if the medical forensic examinations and/or evidence collections of the victim and suspect are performed in the same facility or by the same examiner
8. Evaluating the effectiveness of the established plan of care and adapting the care based on changes in data collected throughout the nursing process

## **VII. Medical Forensic Photography**

Learning Objective: Upon completing instruction in the following topics, the participant will have the knowledge required to accurately and objectively document physical and evidentiary findings in adult and adolescent sexual assault patient populations through the use of medical forensic photography.

- A. Importance of obtaining informed consent and assent for photography
- B. Impact of abuse involving photography/images on a patient's experience with photodocumentation
- C. 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)
- D. Physical findings that warrant medical forensic photographic documentation
- E. Biologic and/or trace evidentiary findings that warrant photographic documentation



- F. Physiological, psychological, sociocultural, and spiritual needs of adult/adolescent patients that warrant medical forensic photography following a sexual assault
- G. Options for obtaining medical forensic photographs, including colposcope images and digital imaging equipment
- H. Variables affecting the clarity and quality of photographic images, including skin color, type and location of finding, lighting, aperture, and film speed
- I. Key photography principles, including consent, obtaining images that are relevant, a true and accurate representation of the subject matter, and noninflammatory
- J. 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
- K. Photography prioritization based on assessment data and patient-centered goals
- L. Adapting photography to accommodate patient needs and preferences
- M. Selecting the correct media for obtaining photographs based on the type of physical or evidentiary finding warranting photographic documentation
- N. Situations that may warrant follow-up photographs and options for securing
- O. Consent, storage, confidentiality, and the appropriate release and use of photographs taken during the medical forensic examination
- P. Legal and confidentiality issues that are pertinent to photographic documentation
- Q. Consistent peer review of photographs to ensure quality and accurate interpretation of photographic findings

## **VIII. Sexually Transmitted Disease Testing and Prophylaxis**

Learning Objective: Upon completing instruction in the following topics, the participant will have the knowledge required to use the nursing process when caring for and communicating with adult and adolescent patients who are at risk for an actual or potential sexually transmitted disease following a sexual assault. Sexually transmitted diseases may include gonorrhea, chlamydia, trichomoniasis, human immunodeficiency virus (HIV), syphilis, herpes, human papillomavirus, and hepatitis B and C.

- A. Prevalence/incidence and morbidity and risk factors related to sexually transmitted diseases after sexual assault and abuse
- B. Symptoms associated with sexually transmitted diseases
- C. Sexually transmitted diseases that are commonly asymptomatic
- D. Symptoms and findings that may mimic sexually transmitted diseases

- E. 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
- F. Patient concerns and myths regarding transmission, treatment, and prophylaxis of select sexually transmitted diseases
- G. Physiological, psychological, sociocultural, spiritual, and economic needs of adult/adolescent patients who are at risk for an actual or potential sexually transmitted disease(s) following a sexual assault
- H. Evidence-based national and/or international guidelines for the testing and prophylaxis/treatment of sexually transmitted diseases when planning care for adult/adolescent patients who are at risk for an actual or potential sexually transmitted disease(s) following a sexual assault
- I. Evidence-based practice when planning care for adult/adolescent patients who are at risk for an actual or potential sexually transmitted disease(s) following a sexual assault
- J. Risks versus benefits of testing for sexually transmitted disease(s) during the acute medical forensic evaluation versus at the time of initial follow-up after prophylaxis
- K. Testing methodologies based on site of collection, pubertal status, and patient tolerance for select sexually transmitted diseases
- L. Screening versus confirmatory testing methodologies for select sexually transmitted diseases
- M. Approach to HIV risk assessment and prophylaxis decision-making based on current guidelines, local epidemiology, and available resources
- N. Individualizing short- and long-term goals based on the physiological, psychological, sociocultural, spiritual, and economic needs of adult/adolescent patients who are at risk for an actual or potential sexually transmitted disease(s) following a sexual assault
- O. Prioritizing care based on assessment data and patient-centered goals
- P. Sexually transmitted disease(s) testing and prophylaxis based on current evidence-based practice, risk factors for transmission, and symptomology
- Q. Sexually transmitted disease(s) testing and prophylaxis based on patient tolerance, adherence, and contraindications
- R. Indications for seeking medical consultation
- S. Collection, preservation, and transport of testing medias for select sexually transmitted disease(s)
- T. Follow-up care and discharge instructions associated with select sexually transmitted disease(s)

## IX. Pregnancy Risk Evaluation and Care

Learning Objective: Upon completing instruction in the following topics, the participant will have the knowledge required to accurately assess the risk of pregnancy following a sexual assault and to provide the adult and adolescent patient with options for care, including information for receiving emergency contraception.

- A. Prevalence rates for pregnancy following a sexual assault
- B. Risk evaluation for pregnancy following a sexual assault based on the specifics of the patient's provided history and developmental age
- C. Testing methods (e.g., blood versus urine; quantitative versus qualitative)
- D. Effectiveness of available pregnancy prevention methods
- E. Patient education key concepts regarding emergency contraception, including:
  - 1. Mechanism of action
  - 2. Baseline testing
  - 3. Side effects
  - 4. Administration
  - 5. Failure rate
  - 6. Follow-up requirements
- F. Patient concerns, belief systems, and misconceptions related to reproduction, pregnancy, and pregnancy prophylaxis
- G. Physiological, psychological, sociocultural, spiritual, and economic needs of adult and adolescent patients at risk for an unwanted pregnancy following a sexual assault
- H. Evidence-based guidelines for pregnancy prophylaxis when planning care for adult and adolescent patients at risk for unwanted pregnancy following a sexual assault
- I. Prioritizing care based on assessment data and patient-centered goals
- J. Situations warranting medical or specialty consultation
- K. Evaluating the effectiveness of the established plan of care and adapting the care based on changes in data collected throughout the nursing process
- L. 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

## **X. Medical Forensic Documentation**

Learning Objective: Upon completing instruction in the following topics, the participant will have the knowledge to accurately, objectively, and concisely document

findings and evidentiary specimens associated with an adult and adolescent sexual assault.

- A. Roles and responsibilities of the forensic nurse in documenting the adult and adolescent medical forensic examination
- B. Steps of the nursing process, including patient-centered care, needs, and goals
- C. Differentiating and documenting sources of information provided
- D. Documentation of sources/sites of evidence collection
- E. Documentation of event history by quoting the patient's statements as much as possible
- F. Documentation of outcry statement made during the medical forensic examination
- G. Differentiation between objective and subjective data; Using language to document that is free of judgment or bias
- H. Processes related to medical forensic documentation that include quality improvement, peer review, and research/evidence-based practice
- I. Legal considerations, including:
  - 1. Regulatory or other accreditation requirements (see legal considerations section)
  - 2. Legal, regulatory, or other confidentiality requirements (see legal considerations section)
  - 3. Mandated reporting requirements (see legal considerations section)
  - 4. Informed consent and assent (see legal considerations section)
  - 5. Continuity of care
- J. Judicial considerations, including:
  - 1. True and accurate representation
  - 2. Objective and unbiased evaluation
  - 3. Chain of custody
- K. Key principles related to consent, access, storage, archiving, and retention of documentation for:
  - 1. Written/electronic medical records
  - 2. Body maps/anatomic diagrams
  - 3. Forms
  - 4. Photographs (see medical forensic photography section)
- L. 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)
  - 1. Sharing medical forensic documentation with other treatment providers

2. Patient access to the medical forensic record
- M. 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)

## **XI. Discharge and Follow-Up Planning**

Learning Objective: Upon completing instruction in the following topics, the participant will have the knowledge to develop, prioritize, and facilitate appropriate discharge and follow-up plans of care for adult and adolescent sexual assault patient populations based on the individual needs of each patient and the consideration of age, developmental level, cultural values, and geographic differences.

- A. Resources that address the specific safety, medical, and forensic needs of adult and adolescent patients following a sexual assault
- B. Individualizing the discharge plan and follow-up care based on medical, forensic, and patient priorities
- C. Facilitation of access to multidisciplinary collaborative agencies
- D. Evidence-based guidelines for discharge and follow-up care following a sexual assault of an adult or adolescent patient
- E. 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 diseases and pregnancy
- F. Modifying and facilitating plans for treatment, referrals, and follow-up care based on patient needs and concerns
- G. Generating, communicating, evaluating, and revising individualized short- and long-term goals related to discharge and follow-up needs
- H. Determining and communicating follow-up and discharge needs based on evidence-based practice, recognizing differences related to age, developmental level, cultural diversity, and geography

## **XII. Legal Considerations and Judicial Proceedings**

Learning Objective: Upon completing instruction in the following topics, the participant will have the foundational knowledge required to effectively consider legal requirements that affect the provision of care to adult and adolescent patients following intimate partner or sexual violence and to provide objective, accurate, evidence-based testimony in judicial proceedings.

### **A. Legal Considerations**

#### **1. Consent**

- a. Key concepts associated with obtaining informed consent and assent
- b. Methodology for obtaining consent to perform a medical forensic examination in adult and adolescent patient populations
- c. Differences between legal requirements associated with consent or declination of medical care versus consent or declination of evidence collection and release
- d. Impact of age, developmental level, and physical and mental incapacitation on consent procedures and the appropriate methodology for securing consent in each instance
- e. Legal exceptions to obtaining consent as applicable to the practice area
- f. Potential consequences of reporting options and assisting the patient with informed decision-making
- g. Potential consequences of withdrawal of consent and/or assent and the need to explain this to the patient while respecting and supporting their decisions
- h. Coordinating with other providers to support patient choices for medical forensic examination and consent
- i. Procedures to follow when the patient is unable to consent
- j. The critical importance of never performing the medical forensic examination against the will of the patient
- k. Physiological, psychological, sociocultural, spiritual, and economic needs of adult and adolescent patients following a sexual assault that may affect informed consent procedures

### **B. Reimbursement**

1. Crime Victim Compensation/reimbursement options that are associated with the provision of a medical forensic examination in cases of adult and adolescent intimate partner and sexual violence as applicable
2. Reimbursement procedures and options for adult and adolescent patient populations

### **C. 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:
  - a. Health Insurance Portability and Accountability Act (HIPAA) or other applicable confidentiality legislation
  - b. Key concepts associated with informed consent and the release of protected health information
  - c. Physiological, psychological, sociocultural, spiritual, and economic needs of adult and adolescent patients following a sexual assault that may impact confidentiality procedures

D. Medical screening examinations

1. Legal requirements associated with the provision of a medical screening examination and its impact on the provision of medical forensic care in adult and adolescent patients following intimate partner or sexual violence, including:
  - a. Emergency Medical Treatment and Active Labor Act (EMTALA) or other applicable legislation
  - b. Required procedures to secure informed consent and informed declination in accordance with applicable legislation
  - c. Required procedures to transfer or discharge/refer a patient in accordance with applicable legislation
  - d. Prioritizing and securing medical treatment as indicated by specific presenting chief complaints
  - e. Physiological, psychological, sociocultural, spiritual, and economic needs of adult and adolescent patients following a sexual assault that may affect medical procedures

E. Mandated reporting requirements

1. Legal requirements associated with mandated reporting requirements in adult and adolescent patient populations
2. Mandatory reporting requirement procedures and options for adult and adolescent patient populations
3. Differentiating between reported and restricted/anonymous medical forensic evaluations following sexual violence
4. Modifying medical forensic examination procedures in non-reported/anonymous cases
5. Physiological, psychological, sociocultural, spiritual, and economic needs of adult and adolescent patients following a sexual assault that may affect mandated reporting requirement procedures

F. Judicial proceedings

1. Role of the SANE in judicial and administrative proceedings, must include:

- a. Civil versus criminal court proceedings
2. Role of the SANE in judicial and administrative proceedings, may include:
  - a. Family court proceedings
  - b. Administrative/university proceedings
  - c. Title IX hearings
  - d. Military and court martial proceedings
  - e. Matrimonial/divorce hearings
  - f. Child custody proceedings
3. Legal definitions associated with sexual violence
4. Case law and judicial precedence that affect the provision of testimony in judicial proceedings, such as:
  - a. Admissibility or other applicable laws specific to the area of practice
  - b. Rules of evidence or other applicable laws specific to the area of practice
  - c. Hearsay or other applicable laws specific to the area of practice
5. Differences between civil and criminal judicial proceedings, including applicable rules of evidence
6. Differences between the roles and responsibilities of fact versus expert witnesses in judicial proceedings
7. Differences between judge versus jury trials
8. Judicial processes:
  - a. Indictment
  - b. Arraignment
  - c. Plea agreement
  - d. Sentencing
  - e. Deposition
  - f. Subpoena
  - g. Direct examination
  - h. Cross-examination
  - i. Objections
9. Forensic nurse's role in judicial proceedings, including:
  - a. Educating the trier of fact
  - b. Providing effective testimony
  - c. Demeanor and appearance
  - d. Objectivity
  - e. Accuracy
  - f. Evidence-based testimony
  - g. Professionalism
10. Key processes associated with pretrial preparation



# ADULT/ADOLESCENT CLINICAL PRECEPTORSHIP CONTENT

## Clinical Education Component

The clinical preceptorship is designed to complement the classroom educational experience and allow the SANE to apply information and skills obtained during the classroom experience. The required clinical experience is in addition to the 40-hour didactic course. It is recommended that this preceptorship be completed with the guidance of a physician, advanced practice nurse, or a forensically experienced registered nurse.

Clinical preceptor experiences should be completed in a time frame that ensures competency and maximum retention of knowledge and skills, typically within six months of completion of the didactic training. Required clinical skills shall be performed until the nurse demonstrates competence, and competency is determined by the professional assessing the required clinical skills.

The Dreyfus Model of Skills Acquisition proposes that any skill training procedure must be based on some model of skill acquisition to address, at each stage of training, the appropriate issues involved in facilitating advancement. This model moves adult learners through five levels of development: 1) Novice; 2) Advanced; Beginner; 3) Competent; 4) Proficient; and 5) Expert (Dreyfus, 1980). Benner (1982) used this same model to publish a study regarding how nurses develop clinically. Benner proposed that the novice has no practical experience and little understanding of contextual meaning; the advanced beginner has enough patient care experience to recognize and discriminate priorities; the competent nurse has practiced in the same population for two or three years, is efficient, organized, and capable of developing plans of care; the proficient nurse sees the whole picture and can anticipate patient needs based on experience with that population; and the expert nurse has a comprehensive grasp of patient care situations and can focus on problems and address them with flexibility and proficiency.

In the majority of cases, the newly trained SANE will begin her or his practice at the novice or advanced beginner stages of skill acquisition because both the patient population and the role are new to the nurse. For this reason, and in recognition of Benner's description of clinical nursing development, it is recommended that a minimum of two years in clinical practice as a registered nurse occur prior to practicing as a SANE.

Given the diversity of communities and the different challenges facing rural, low-volume versus urban, high-volume communities, multiple options for clinical skill attainment must be recognized. Clinical skills acquisition may be obtained using any of the following approaches:

### **Approach 1:**

- A. Clinical experience with a non-sexual assault patient population, while the nurse is being precepted by a physician, physician assistant, advanced practice nurse or a forensically experienced registered nurse who adheres to the clinical content described below until competency is achieved; and
- B. Clinical experience with patients who have experienced sexual assault, while the nurse is being precepted by a physician, advanced practice nurse, or a forensically experienced registered nurse who adheres to the clinical content described below until competency is achieved at the local program level.

### **Approach 2:**

- A. Simulated patient experiences using live models, while the nurse is being precepted by a physician, physician assistant, advanced practice nurse, or a forensically experienced registered nurse who adheres to the clinical content described below until competency is achieved.
- B. Clinical experience with patients who have experienced sexual assault, while the nurse is being precepted by a physician, advanced practice nurse, or a forensically experienced registered nurse who adheres to the clinical content described below until competency is achieved at the local program level.

### **Approach 3:**

- A. Simulated patient experiences using medical simulation models, while the nurse is being precepted by a physician, physician assistant, advanced practice nurse, or a forensically experienced registered nurse who adheres to the clinical content described below; and
- B. Clinical experience with patients who have experienced sexual assault, while the nurse is being precepted by a physician, advanced practice nurse, or a forensically experienced registered nurse who adheres to the clinical content described below until competency is achieved at the local program level.

The following clinical education content identifies the framework for the SANE who cares for the adult/adolescent sexual assault patient population. These target learning topics outline the minimum level of instruction required during the clinical preceptorship experience. As with the didactic portion of training, the clinical learning topics are grounded in the nursing process of assessment, diagnosis, outcome identification, planning, implementation, and evaluation.

**Learning Outcome for Clinical Education:** Upon completing the clinical learning experience, the participant will possess the foundational knowledge and skills

required to perform as a sexual assault nurse examiner who provides care for adult/adolescent patients who have experienced sexual assault.

1. Presenting examination options and developmentally appropriate patient–nurse dialogue necessary for obtaining informed consent from adult and adolescent patient populations
2. Evaluating the effectiveness of the established plan of care regarding consent and modifying or adapting the care based on assessment of the patient’s capacity and developmental level from data collected throughout the nursing process
3. Explaining procedures associated with confidentiality to adult and adolescent patient populations
4. Identifying circumstances where mandatory reporting is necessary and explaining the procedures associated with mandatory reporting to adult and adolescent patient populations
5. Evaluating the effectiveness of the established plan of care regarding confidentiality and modifying or adapting the care based on the patient’s developmental level or capacity and data collected throughout the nursing process
6. Explaining medical screening procedures and options to adult and adolescent patient populations
7. Evaluating the effectiveness of the established plan of care regarding medical evaluation/nursing assessment/treatment and modifying or adapting to meet the patient’s needs based on changes in data collected throughout the nursing process
8. Evaluating the effectiveness of the established plan of care regarding mandatory reporting requirements and modifying or adapting based on changes in data collected throughout the nursing process
9. Identifying critical elements in the medical forensic history and review of systems and demonstrating effective history taking, skills
10. Demonstrating a complete head-to-toe assessment
11. Preparing the adult and/or adolescent patient for the anogenital examination
12. Differentiating normal anogenital anatomy from normal variants and abnormal findings
13. Demonstrating anogenital visualization techniques:
  - a. Labial separation
  - b. Labial traction
  - c. Hymenal assessment (urinary [Foley] catheter, swab, or other technique)

- d. Speculum assessment of the vagina and cervix
- 14. Collecting specimens for testing for sexually transmitted disease(s)
- 15. Articulating rationales for specific tests for sexually transmitted disease(s) and collection techniques
- 16. Collecting and preserving evidence (dependent on local practice and indications by history), including:
  - a. Buccal swabs
  - b. Oral swabs
  - c. Bite mark swabbing
  - d. Other body surface swabbing
  - e. Fingernail clippings/swabbings
  - f. Anal swabs
  - g. Rectal swabs
  - h. Vaginal swabs
  - i. Cervical swabs
  - j. Head hair combing/collection
  - k. Pubic hair combing/collection
  - l. Clothing
  - m. Toxicology
- 17. Articulating rationales for the specific type and manner of evidentiary specimen collection
- 18. Packaging evidentiary materials
- 19. Sealing evidentiary materials
- 20. Articulating rationales for the packaging and sealing of evidentiary material
- 21. Maintaining chain of custody for evidentiary materials
- 22. Articulating the rationale for maintaining proper chain of custody
- 23. Modifying evidence collection techniques based on the patient's age, developmental/cognitive level, and tolerance
- 24. Demonstrating knowledge of consent, storage, confidentiality, and the appropriate release and use of photographs taken during the medical forensic examination
- 25. Obtaining overall orientation, close-up, and close-up with scale for medical forensic photodocumentation to provide a true and accurate reflection of the subject matter
- 26. Evaluating the effectiveness of the established plan of care and modifying or adapting care based on changes in data collected throughout the nursing process

27. Demonstrating patient–nurse dialogue establishing follow-up care and discharge instructions associated with emergency contraception and/or pregnancy termination options
28. Demonstrating patient–nurse dialogue establishing follow-up care and discharge instructions associated with select sexually transmitted disease(s)
29. Identifying discharge and follow-up concerns related to age, developmental level, cultural diversity, and geographic differences
30. Evaluating the effectiveness of established discharge and follow-up plans of care, and revising the established plan of care while adhering to current evidence-based practice guidelines
31. Prioritizing the need for and implementation of crisis intervention strategies in adult and adolescent patients based on assessment findings following sexual violence
32. Demonstrating the nursing process as a foundation of the nurse’s decision-making, including:
  - a. Assessment—collects data pertinent to the patient’s health and situation;
  - b. Diagnosis—analyzes the data to determine diagnoses or issues;
  - c. Outcome Identification—identifies individualized patient outcomes based on patient need;
  - d. Planning—develops a plan that prescribes strategies to attain the expected outcomes;
  - e. Implementation—implements the plan, including any coordination of care, patient teaching, consultation, prescriptive authority, and treatment; and
  - f. Evaluation—evaluates progress toward outcome attainment (ANA, 2010)

Participation in chart review, peer review, ongoing education, supervision, and mentoring is essential to prepare and sustain the registered nurse for the adult/adolescent SANE role. It is recommended that every SANE, novice through expert, regularly participate in these activities. Ongoing involvement in skill development will promote standardized practice, quality outcomes, and proficiency.

### **Optional Preceptorship Content**

Optional preceptorship content describes areas that instructors may choose to include in the overall program expectation, but that IAFN does not deem to be expected as part of the SANE’s training as these items may not be readily available in all communities.

1. Demonstrating additional visualization techniques:
  - a. Anogenital toluidine blue dye application and removal as applicable to local practice
  - b. Specialized equipment commonly used in practice, such as magnification

tools, colposcopes, alternate light sources (ALS), etc.

2. Photodocumenting medical forensic examination findings using the above techniques

# Section II

## Pediatric/Adolescent Sexual Assault Nurse Examiner (SANE)

### EDUCATION GUIDELINES

#### PEDIATRIC/ADOLESCENT DIDACTIC CONTENT

##### Child Sexual Abuse

The World Health Organization (2017) define *child sexual abuse* (CSA) as the involvement of a child in sexual activity that he or she does not fully comprehend, is unable to give informed consent to, or for which the child is not developmentally prepared and cannot give consent, or that violates the laws or social taboos of society. Child sexual abuse is evidenced by this activity between a child and an adult or another child who by age or development is in a relationship of responsibility, trust or power, the activity being intended to gratify or satisfy the needs of the other person. This may include but is not limited to: the inducement or coercion of a child to engage in any unlawful sexual activity; the exploitative use of a child in prostitution or other unlawful sexual practices; the exploitative use of children in pornographic performance and materials (p. vii).

The sexual activity may involve touching or fondling, oral-genital, genital, and/or anal contact which may or may not include penetration of the vagina or anus. In many cases, sexual abuse differs from sexual assault in that the sexual contact is progressive and longitudinal. The perpetrator of child sexual abuse is more often a known and trusted caregiver or a family member.

Given the prevalence of trauma among patient populations, the IAFN recognizes the criticality of the caregiver's use of a trauma-informed approach to care, regardless of the patient's presentation or demeanor. The statistics in the previous paragraphs speak to the overwhelming presence of trauma in pediatric and adolescent populations. According to Raja et al. (2015), the four underlying principles of providing trauma-informed care (TIC) are 1) realizing the prevalence of traumatic events and the widespread impact of trauma; 2) recognizing the signs and symptoms of trauma; 3) responding by integrating knowledge about trauma into policies, procedures, and practices; and 4) seeking to actively resist re-traumatization. The Center for Healthcare Strategies (2017) finds that small changes in physical and emotional aspects of the care environment (e.g., involving

patients in their own care) and the attitudes of caregivers (e.g., including patients in decisions) yield positive results in fostering safety and trust. The concept of TIC must be considered in all aspects of education related to the care provided to patients who have experienced sexual assault. Although not listed in the course outline as a stand-alone topic, the concept of TIC is intended to be interwoven throughout the didactic course in its entirety and to serve as a foundational element of the care that SANEs provide.

Typically, a child does not disclose sexual abuse for days, weeks, months, or even years. Child sexual abuse often occurs within the context of secrecy and shame and may involve coercion and manipulation or “grooming” behavior, sometimes referred to as “accommodation syndrome.” Studies have shown that child disclosures are often delayed and as few as 25 percent of child victims are thought to disclose immediately following CSA (McElvaney, 2015). Children may provide disclosure incrementally over time and may minimize or deny the abuse, even when questioned. Some children may subsequently recant their disclosure during an investigation (Malloy, Mugno, Rivard, Lyon, & Quas, 2016). Many factors contribute to nondisclosure, including but not limited to feelings of embarrassment or shame; feelings of responsibility or self-blame; lack of understanding of the abuse; limited communication abilities; use of threats, manipulation, or requests for secrecy by the offender or other family member; fear of negative consequences (whether real or imagined) for themselves or family members; and anticipation of disbelief or an unsupportive response members; anticipation of disbelief or an unsupportive response (McElvaney, Greene, & Hogan, 2014).

An accurate accounting of CSA statistics is difficult because of the significant amount of underreporting. Historically, most prevalence data derived from surveys of adults about their childhood experiences. In recent years, however, researchers have turned to youth studies in an effort to obtain more contemporaneous data. A recent survey of 2,293 15- to 17-year-old children in the United States found that lifetime experience of 17-year-old respondents with sexual abuse and sexual assault was 26.6% for girls and 5.1% for boys (Finkelhor, Shattuck, Turner, & Hamby, 2014). A review of studies from 9 low- and middle-income nations showed that the global reported rates of CSA are 4.4% to 37.6% for girls and 5.6% to 21.2% for boys (Sumner et al., 2015). Due to variations in definition, cultural meaning, levels of surveillance, and awareness, countries that provide CSA data show considerable variability in prevalence.

The consequences of CSA may be significant and long-term and may include physical and psychological factors that adversely affect health. In a study of adults reporting adverse childhood experiences, CSA was associated with several physical and mental disorders (Felitti et al., 1998). Although not all children who have experienced sexual abuse exhibit psychological or behavioral symptoms at the time of the medical assessment, children who have experienced repeated episodes or prolonged abuse may develop behavioral and psychological sequelae, such as posttraumatic stress disorder and other trauma-related symptoms, depression, eating disorder behavior, delinquent behavior, and higher rates of suicide (Godbout, Briere, Sabourin, & Lussier, 2014). Evidence also



suggests that female adolescents who have experienced childhood sexual abuse engage in their first voluntary sexual experience at a younger age,



engage in sexual risk behavior, have increased rates of pregnancy and illicit drug use, and experience more physical abuse and sexual revictimization (Barnes, Putnam, & Trickett, 2009; Noll, Shenk, & Putnam, 2009).

## **Pediatric/Adolescent Didactic Content Target Learning Topics**

The following content framework is designed to provide the pediatric/adolescent SANE with the *minimum* target learning topics to demonstrate the cognitive, affective, and psychomotor skills needed to use the nursing process when caring for pediatric and adolescent patients following sexual abuse/assault. The target learning topics provide pediatric/adolescent SANEs from a variety of professional practice backgrounds with the foundational knowledge and critical thinking skills necessary to provide holistic, comprehensive, trauma-informed care to pediatric and adolescent sexual abuse/assault patient populations. Each key target learning topic contains measurable outcome criteria that follow the steps of the nursing process, including assessment, diagnosis, outcome identification, planning, implementation, and evaluation.

**Learning Outcome:** The overall learning outcome for basic SANE education is to provide registered nurses and advanced practice nurses with the knowledge, and skills, and judgment to provide competent, comprehensive, patient-centered, coordinated care to patients being evaluated for sexual assault, or suspected of having been sexually assaulted.

### **Key Target Didactic Learning Topics**

- I. Overview of Forensic Nursing and Child Sexual Abuse
- II. Victim Responses and Crisis Intervention
- III. Collaborating with Community Agencies
- IV. Medical Forensic History Taking
- V. Observing and Assessing Physical Examination Findings
- VI. Medical Forensic Specimen Collection
- VII. Medical Forensic Photography
- VIII. Sexually Transmitted Disease Testing and Prophylaxis
- IX. Pregnancy Risk Evaluation and Care
- X. Medical Forensic Documentation
- XI. Discharge and-Follow-Up Planning
- XII. Courtroom Testimony and Legal Considerations

## I. Overview of Forensic Nursing and Child Sexual Abuse

Learning Objective: Upon completing instruction in the following topics, the participant will have the knowledge required by the pediatric/adolescent SANE to incorporate fundamental forensic principles and practices into the nursing process when caring for pediatric and adolescent patients following sexual abuse/assault.

### A. Forensic Nursing Overview

1. History and evolution of forensic nursing
2. Role of the pediatric/adolescent SANE in caring for pediatric and adolescent sexual abuse/assault patient populations
3. Role of the pediatric/adolescent SANE and sexual abuse/assault education and prevention
4. Role of the International Association of Forensic Nurses in establishing the scope and standards of forensic nursing practice
5. Key aspects of *Forensic Nursing: Scope and Standards of Practice*
6. Professional and ethical conduct related to pediatric/adolescent SANE practice and the care of pediatric and adolescent sexual abuse/assault patient populations, through the ethical principles of autonomy, beneficence, non-maleficence, veracity, confidentiality, and justice
7. Nursing resources, locally and globally, that contribute to current and competent pediatric/adolescent SANE practice
8. Vicarious trauma
9. Methods for preventing vicarious trauma associated with pediatric/adolescent SANE practice
10. Key concepts associated with the use of evidence-based practice in the care of pediatric and adolescent sexual abuse/assault patient populations

Learning Objective: Upon completing instruction in the following topics, the participant will have knowledge required to recognize the dynamics of sexual violence, which provide the context for the care of pediatric and adolescent patients following sexual abuse/assault. The pediatric/adolescent SANE uses this knowledge to educate patients and families about the connection between child and adolescent sexual abuse/assault and health, and to collaborate with patients and families in identifying appropriate interventions and community referrals.

### B. Child Sexual Abuse

1. Types of child/adolescent 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 pediatric and adolescent populations
  - a. Risk factors for pediatric/adolescent sexual abuse/assault
  - b. 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:
  - a. Boys/men
  - b. Patients with developmental challenges
  - c. GLBTQIA (gay, lesbian, bisexual, transgender, questioning/queer, intersex, agender/asexual)
  - d. Patients in emergent or long-term foster care placement
  - e. Patients with disabilities
  - f. Culturally diverse populations
  - g. Mental health populations
  - h. Patients with language/communication barriers
  - i. People who are trafficked
6. Best practices for improving forensic nursing care to underserved or vulnerable patient populations
7. 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)
8. Biases and deeply held beliefs regarding sexual abuse/assault in pediatric and adolescent patient populations
9. Key concepts of offender typology and related impact on sexual abuse/assault patient populations
10. Differences in typology of offenders targeting pediatric populations
11. Grooming or accommodation syndrome with child sexual abuse victims and their families
12. Dynamics of familial sexual abuse (incest) and the impact on the child and non-offending caregiver(s)
13. Children's disclosure of sexual abuse and the factors related to disclosure

## II. Victim Responses and Crisis Intervention

**Learning Objective:** Upon completing instruction in the following topics, the participant will have the knowledge required to understand the psychosocial impact

of sexual abuse/assault on pediatric and adolescent patient populations. These topics underpin the foundational knowledge of the pediatric/adolescent SANE to appropriately assess, plan, implement, and evaluate care as well as to collaborate with patients in identifying appropriate care goals and community care referrals.

- A. Common psychosocial responses to sexual abuse/assault and child maltreatment in pediatric and adolescent populations
- B. Acute and long-term psychosocial ramifications associated with sexual abuse/assault and child maltreatment
- C. Emotional and psychological responses and sequelae following sexual abuse/assault, including familiarity with traumatic and stress-related disorders applicable to pediatric and adolescent sexual abuse/assault and child maltreatment patient populations
  - 1. Key components of a suicide risk assessment
  - 2. Key components of a safety risk assessment
- D. Diverse reactions that can be manifested in the patient after sexual violence
- E. Risk factors for acute and chronic psychosocial sequelae in pediatric and adolescent patients following sexual abuse/assault and child maltreatment
- F. 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
- G. Common concerns regarding reporting to law enforcement following sexual abuse/assault and child maltreatment and potential psychosocial ramifications associated with this decision
- H. 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
- I. Risk factors for non-adherence in pediatric and adolescent patient populations following sexual abuse/assault
- J. 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
- K. Prioritizing crisis intervention strategies for pediatric and adolescent patients following sexual abuse/assault
- L. 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
- M. Techniques and strategies for interacting with pediatric and adolescent 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

### III. Collaborating with Community Agencies

Learning Objective: Upon completing instruction in the following topics, the participant will have the foundational knowledge to effectively interact and collaborate with multidisciplinary team members involved in the care of pediatric and adolescent patients following sexual abuse/assault.

#### A. Multidisciplinary team (MDT), including:

1. Overview of roles and responsibilities
2. MDT models
3. Child advocacy centers
4. Family justice centers
5. Sexual assault response/resource teams (SART)
6. Strategies for implementing and sustaining an MDT/SART
7. Benefits and challenges

#### B. Roles and responsibilities of the following MDT members as they relate to pediatric and adolescent sexual abuse/assault:

1. Victim advocates (community- and system-based)
2. Medical forensic examiners (pediatric/adolescent 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
- C. Key strategies for initiating and maintaining effective communication and collaboration among MDT members while maintaining patient privacy and confidentiality

#### IV. Medical Forensic History Taking

Learning Objective: Upon completing instruction in the following topics, the participant will have the foundational knowledge to accurately, objectively, and concisely obtain medical forensic information associated with sexual abuse/assault involving a pediatric or adolescent patient.

- A. 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
    - a. Parent/caretaker
    - b. Other information, as needed
  8. Developmental history
    - a. Milestones
    - b. Physical development
    - c. Sexual development
    - d. Intellectual development
    - e. Social development
    - f. Emotional development
    - g. Moral development
  9. Genitourinary history
    - a. Urinary tract development and disorders
    - b. Reproductive tract development and disorders
    - c. Last consensual intercourse, if applicable
    - d. Pregnancy history, if applicable



- e. Contraception usage, if applicable
  - f. Menarche and last menstrual period
10. Gastrointestinal history
    - a. Gastrointestinal tract development and disorders
    - b. Constipation and diarrhea history and treatments
  11. Event history
    - a. Actual/attempted acts
    - b. Date and time of event
    - c. Location of event
    - d. Assailant information
    - e. Use of weapons/restraints/threats/grooming/manipulation
    - f. Use of recording devices (photographs or videos of the event)
    - g. Suspected drug-facilitated sexual assault
    - h. Condom use
    - i. Ejaculation
    - j. Pain or bleeding associated with acts
    - k. Physical assault
    - l. Strangulation
    - m. Potential destruction of evidence
  12. Difference between obtaining a medical forensic history and conducting a forensic interview, and the purpose of each
  13. Techniques for establishing rapport and facilitating disclosure while considering the patient's age, developmental level, tolerance, gender identity, and cultural differences
  14. Obtaining a child's history independent of other parties
  15. Obtaining a caregiver (parent, guardian, etc.) history independent from the child
  16. Obtaining a medical forensic history from a child and identifying when doing so would be inappropriate
  17. Difference between leading and non-leading questions
  18. Importance of using the medical forensic history to guide the physical assessment of the patient and evidence collection
  19. Importance of accurate and unbiased documentation of the medical forensic history
  20. Coordination between law enforcement representatives and SAFEs regarding the logistics and boundaries of medical forensic history taking and investigative intent

## V. Observing and Assessing Physical Examination Findings

Learning Objective: Upon completing instruction in the following topics, the participant will have the knowledge to perform in the role of the pediatric/adolescent

SANE in assessing and identifying physical findings in the patient, including potential mechanisms of injury following sexual abuse/assault. The pediatric/adolescent SANE is responsible for using evidence-based practice as a framework for identifying and interpreting physical findings and for ensuring that pediatric and adolescent patients receive holistic, comprehensive, trauma-informed, patient-centered care that focuses on the nursing process, including evidentiary considerations and healthcare priorities and practice.

- A. Acute and non-acute medical forensic examination process for the pediatric/adolescent patient
- B. Role of the SANE within the child advocacy center model
  - 1. Developmentally appropriate communication skills and techniques with respect to cognitive and linguistic development
- C. Prioritizing a comprehensive health history and review of systems data
  - 1. History, including health issues and immunization status
  - 2. History of alleged or suspicious event
  - 3. Patient
  - 4. Family/caregiver/guardian
  - 5. Law enforcement
  - 6. Child protection agency
- D. Psychosocial assessment of the child/adolescent related to the event
  - 1. Crisis intervention for acute presentations
  - 2. Behavioral/psychological implications of long-term abuse in the prepubescent, pediatric, and adolescent child
  - 3. Suicide and safety assessment and planning
  - 4. Impact of substance abuse issues
  - 5. Guidance for child, family, and caregivers
  - 6. Referrals
- E. 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:
  - 1. Patient's general appearance, demeanor, cognition, and mental status
  - 2. Clothing and other personal possessions
  - 3. Body surfaces for physical findings
  - 4. Patient's growth and development level
  - 5. Patient's sexual maturation
  - 6. Patient utilizing a head-to-toe evaluation approach
  - 7. Anogenital structures, including the effect of estrogen/testosterone on anogenital structures

8. Identification of findings that are:
  - a. Documented in newborns or commonly seen in non-abused children
    - i. Normal variants
    - ii. Findings commonly caused by other medical conditions
    - iii. Conditions that may be misinterpreted as resulting from abuse
  - b. Indeterminate
  - c. Diagnostic of trauma and/or sexual contact
    - i. Acute trauma to external genital/anal tissues
    - ii. Residual (healing) injuries
    - iii. Injuries indicative of blunt force penetrating trauma
    - iv. Sexually transmitted disease(s)
    - v. Pregnancy
    - vi. Sperm identified in specimens taken directly from a child's body  
(Adams, Kellogg, & Moles, 2016)
- F. Mechanical and physical trauma and identification of each type
  1. Blunt force
  2. Sharp force
  3. Gunshot wounds
  4. Strangulation
- G. Comprehensive strangulation assessment for the patient with known or suspected strangulation as a part of the history and/or physical findings
- H. Terminology related to mechanical and physical trauma findings, including:
  1. Abrasion
  2. Laceration/tear
  3. Cut/incision
  4. Bruise/contusion
  5. Hematoma
  6. Swelling/edema
  7. Redness/erythema
  8. Petechiae
- I. Anogenital anatomy and physiology, including:
  1. Normal anatomical variants
  2. Types and patterns of injury that are potentially associated with sexual abuse/assault
  3. Physical findings and medical conditions associated with non-assault-related trauma that can be misinterpreted as resulting from sexual abuse/assault
- J. Significance of a normal examination
- K. Examination positions and methods, including:
  1. Labial separation/traction

2. Supine/prone knee-chest
3. Assistive techniques and equipment for evidence collection where appropriate, including but not limited to:
  - a. Alternate light source
  - b. Toluidine blue dye application and interpretation
  - c. Colposcope versus camera with macro lens for photographs
  - d. Urinary (Foley) catheter, swab, or other technique for visualization of the hymen
  - e. Water flushing
  - f. Use of cotton swabs
- L. Sound 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
    - a. Injury/trauma findings
    - b. Normal variations
    - c. Disease processes
    - d. Diagrams and trauma grams that accurately reflect photographic and visualized image documentation
    - e. Unbiased and objective evaluations
- M. Importance of peer review/expert consultation
- N. Local and legal maintenance and release of records policies

## VI. Medical Forensic Evidence Collection

Learning Objective: Upon completing instruction in the following topics, the participant will have the knowledge required to perform in the role of the pediatric/adolescent SANE in employing a patient/family-centered approach to obtaining and preserving the biologic and trace specimens from pediatric and adolescent victims and suspects using forensic nursing principles.

- A. Patient (Victim)-Centered Care
  1. Importance of patient participation and collaboration in evidence collection procedures as a means of recovering from sexual abuse/assault (as appropriate)
  2. Elements of consent and the procedures required for evidence 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. Specimen collection options within the community available to pediatric and adolescent patients who have experienced sexual abuse/assault, including:
  - a. Mandatory reporting requirements
  - b. Non-reporting/anonymous evidence collection, if applicable (based on the age of the patient and local statutes)
  - c. Medical evaluation and treatment
5. Recommendations for collection time limits of biological specimens following sexual abuse/assault, including the differences in time frames for prepubertal victims
6. Differences in approach to evidence collection in the prepubertal population (i.e., external versus internal samples)
7. Types of specimens and methods of collection in the pediatric and adolescent patient following a sexual abuse/assault, based on the event history, including but not limited to:
  - a. DNA
  - b. Trace/non-biologic
  - c. History documentation
  - d. Physical findings, identification, and documentation
  - e. Clothing/linen evidence
  - f. Medical forensic photography
  - g. Toxicology
8. Physical evidence collection through use of:
  - a. Current evidence-based forensic standards and references
  - b. Current evidence-based forensic standards and references
  - c. Appropriate identification, collection, and preservation of evidence
  - d. Appropriate chain of custody procedures
  - e. Recognized variations in practice, following local recommendations and guidelines
9. Chain of custody principles and procedures for maintaining
10. Drug-facilitated sexual abuse/assault (DFSA), current trends, criteria associated with a risk assessment for DFSA, and when specimen collection procedures are indicated
11. Patient/guardian's concerns and common misconceptions that patient/guardians may have regarding specimen collection
12. Potential risks and benefits for the patient/guardian associated with evidence collection
13. Adjunctive tools and methods used in specimen identification and collection and associated risks and benefits, including but not limited to:
  - a. Alternate light sources
  - b. Swab collection techniques
  - c. Speculum examination (adolescent/pubertal population)
  - d. Colposcopic visualization or magnification with a digital camera

- e. Anoscopic visualization, if indicated and within the scope of practice in the Nurse Practice Act
  - 7. Appraisal of data regarding the abuse/assault details to facilitate complete and comprehensive medical forensic examination and evidence collection
  - 8. Evidence-based practice guidelines for the identification, collection, preservation, handling, and transfer of biologic and trace evidence specimens following pediatric and adolescent sexual abuse/assault
  - 9. Evidence-based practice when planning evidentiary procedures
  - 10. Materials and equipment needed for biologic and trace evidence collection
  - 11. Modification of evidence collection based on the patient's age, developmental/cognitive level, and tolerance
  - 12. Techniques to support the patient/guardian and minimize the potential for additional trauma during specimen collection procedures
  - 13. Techniques to facilitate patient participation during specimen collection procedures (as appropriate)
  - 14. 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
- B. Patient (Suspect)-Centered Care**
- 1. Differences in victim and suspect medical forensic examination and evidence collection following sexual abuse/assault
  - 2. Legal authorization needed to obtain evidentiary specimens and examine a suspect, including:
    - a. Written consent
    - b. Search warrant
    - c. Court order
  - 3. Components of a suspect medical forensic examination
  - 4. Recommendations for time limits of collection of biologic evidence in the suspect of sexual abuse/assault
  - 5. Types of evidence that can be collected in the medical forensic examination of a suspect following sexual abuse/assault, such as:
    - a. DNA evidence
    - b. Trace/non-biologic evidence
    - c. Physical findings, identification, and documentation
    - d. Medical forensic photography
    - e. Toxicology
    - f. Variables in specimen collection, packaging, preservation, and transportation issues for items, including:
      - i. Products of conception
      - ii. Foreign bodies
      - iii. Tampons
      - iv. Diapers

6. 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
7. 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
8. Evaluating the effectiveness of the established plan of care and adapting the care based on changes in data collected throughout the nursing process

## VII. Medical Forensic Photography

Learning Objective: Upon completing instruction in the following topics, the participant will have the knowledge required to accurately and objectively document physical and evidentiary findings in pediatric and adolescent sexual abuse/assault patient populations through the use of medical forensic photography.

- A. Consent, storage, confidentiality, and the appropriate release and use of photographs taken during the medical forensic examination
- B. Physical findings that warrant photographic documentation
- C. Biologic and/or trace evidentiary findings that warrant photographic documentation
- D. Physiological, psychological, sociocultural, and spiritual needs of pediatric/adolescent patients that warrant/involve photography following sexual abuse/assault
- E. Options for obtaining medical forensic photographs, including colposcopic images and digital imaging equipment
- F. Variables affecting the clarity and quality of photographic images, including skin color, type and location of finding, lighting, aperture, and film speed
- G. Key photography principles, including consent, obtaining images that are relevant, a true and accurate representation of the subject matter, and noninflammatory
- H. Images obtained by the examiner as part of the medical/health record versus those obtained by other agencies or even the offender
- I. 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
- J. Photography prioritization based on assessment data and patient-centered goals
- K. Adapting photography needs based on patient tolerance
- L. Selecting the correct media for obtaining photographs based on the type of physical or evidentiary finding warranting photographic documentation

- M. Overall, orientation, close-up, and close-up with scale photographs that provide a true and accurate reflection of the subject matter
- N. Situations that may warrant follow-up photographs and options for securing
- O. Consistent peer review of photographs to ensure quality and accurate interpretation of photographic findings
- P. 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

## VIII. Sexually Transmitted Disease Testing and Prophylaxis

Learning Objective: Upon completing instruction in the following topics, the participant will have the knowledge required to use the nursing process when caring for and communicating with pediatric and adolescent patients who are at risk for an actual or potential sexually transmitted disease following sexual abuse/assault. Sexually transmitted diseases may include gonorrhea, chlamydia, trichomoniasis, human immunodeficiency virus (HIV), syphilis, herpes, human papillomavirus, and hepatitis B and C.

- A. Prevalence/incidence and morbidity and risk factors related to sexually transmitted diseases after sexual abuse and assault
- B. Symptoms associated with sexually transmitted diseases
- C. Sexually transmitted diseases that are commonly asymptomatic
- D. Symptoms and findings that may mimic sexually transmitted diseases
- E. 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
- F. Probability of maternal transmission versus community-acquired infection
- G. Presence of sexually transmitted disease may be evidence of sexual abuse/assault in the pediatric/adolescent patient (see Adams's classification)
- H. Patient and/or guardian concerns and myths regarding transmission, treatment, and prophylaxis of select sexually transmitted diseases
- I. Physiological, psychological, sociocultural, spiritual, and economic needs of pediatric/adolescent patients who are at risk for an actual or potential sexually transmitted disease(s) following sexual abuse/assault
- J. Evidence-based national and/or international guidelines for the testing and prophylaxis/treatment of sexually transmitted diseases when planning care for pediatric/adolescent patients who are at risk for an actual or potential sexually transmitted disease(s) following sexual abuse/assault



- K. Evidence-based practice when planning care for pediatric/adolescent patients who are at risk for an actual or potential sexually transmitted disease(s) following sexual abuse/assault
- L. 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
- M. 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
- N. 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)
- O. Screening versus confirmatory testing methodologies for select sexually transmitted diseases
- P. 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)
- Q. Referrals for follow-up testing (e.g., HIV nPEP)
- R. Individualizing short- and long-term goals based on the physiological, psychological, sociocultural, spiritual, and economic needs of pediatric/adolescent patients who are at risk for an actual or potential sexually transmitted disease(s) following sexual abuse/assault
- S. Prioritizing care based on assessment data and patient-centered goals
- T. Sexually transmitted disease(s) testing and prophylaxis based on current evidence-based practice, risk factors for transmission, and symptomology
- U. Sexually transmitted disease(s) testing and prophylaxis based on patient tolerance, adherence, and contraindications
- V. Indications for seeking medical consultation
- W. Collection, preservation, and transport of testing medias for select sexually transmitted diseases(s)
- X. Follow-up care and discharge instructions associated with select sexually transmitted disease(s)

## IX. Pregnancy Risk Evaluation and Care

Learning Objective: Upon completing instruction in the following topics, the participant will have the knowledge required to accurately assess the risk of pregnancy

following sexual abuse/assault and to provide the pediatric and adolescent patient with options for care, including information for receiving emergency contraception.

- A. Prevalence rates for pregnancy following sexual abuse/assault
- B. Risk evaluation for pregnancy following sexual abuse/assault based on the specifics of the patient's provided history and pubertal status
- C. Testing methods (e.g., blood versus urine; quantitative versus qualitative)
- D. Effectiveness of available pregnancy prevention methods
- E. Patient education key concepts regarding emergency contraception, including:
  - 1. Mechanism of action
  - 2. Baseline testing
  - 3. Side effects
  - 4. Administration
  - 5. Failure rate
  - 6. Follow-up requirements
- F. Patient and guardian concerns, belief systems, and misconceptions related to reproduction, pregnancy, and pregnancy prophylaxis
- G. Physiological, psychological, sociocultural, spiritual, and economic needs of pediatric and adolescent patients who are at risk for an unwanted pregnancy following sexual abuse/assault
- H. Evidence-based guidelines for pregnancy prophylaxis when planning care for pediatric and adolescent patients at risk for unwanted pregnancy following sexual abuse/assault
- I. Prioritizing care based on assessment data and patient-centered goals
- J. Situations warranting medical or specialty consultation
- K. Evaluating the effectiveness of the established plan of care and adapting the care based on changes in data collected throughout the nursing process
- L. 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

## **X. Medical Forensic Documentation**

**Learning Objective:** Upon completing instruction in the following topics, the participant will have the knowledge to accurately, objectively, and concisely document findings and evidentiary specimens associated with a pediatric/adolescent sexual abuse/assault.

- A. Roles and responsibilities of the forensic nurse in documenting the pediatric and adolescent sexual abuse/assault medical forensic examination
- B. Steps of the nursing process, including patient/family-centered care, needs, and goals
- C. Differentiating and documenting sources of information provided
- D. Documentation of event history by using patient/guardian's words verbatim as much as possible
- E. Including questions asked by the guardian and/or the SANE in the history
- F. Objective versus subjective data
- G. Processes related to medical forensic documentation that include quality improvement, peer review, and research/evidence-based practice
- H. Legal considerations, including:
  - 1. Regulatory or other accreditation requirements (see legal considerations section)
  - 2. Legal, regulatory, or other confidentiality requirements (see legal considerations section)
  - 3. Mandated reporting requirements (see legal considerations section)
  - 4. Informed consent and assent (see legal considerations section)
- I. Judicial considerations including:
  - 1. True and accurate representation
  - 2. Objective and unbiased evaluation
  - 3. Chain of custody
- J. Key principles related to consent, access, storage, archiving, and retention of documentation for:
  - 1. Written/electronic medical records
  - 2. Body diagrams
  - 3. Photographs (see medical-forensic photography section)
- K. Terminology related to pediatric/adolescent sexual abuse/assault
- L. Purpose of professional medical-forensic documentation, including:
  - 1. Communication
  - 2. Accountability
  - 3. Quality improvement
  - 4. Peer review
  - 5. Research
- M. Documentation elements of the case:
  - 1. Demographic data

2. Consent
  3. History of abuse/assault
  4. Patient presentation
  5. Medical history
  6. Physical examination and findings
  7. Genital examination and findings
  8. Impression/opinion
  9. Treatment
  10. Interventions
  11. Mandatory reporting requirements
  12. Discharge plan and follow-up
- N. 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)
1. Sharing medical forensic documentation with other treatment providers
  2. Patient/parental access to the medical forensic record
- O. 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)

## **XI. Discharge and Follow-Up Planning**

Learning Objective: Upon completing instruction in the following topics, the participant will have the knowledge to develop, prioritize, and facilitate appropriate discharge and follow-up plans of care for the pediatric/adolescent sexual abuse/assault patient populations, based on the individual needs of each patient and the consideration of age, developmental level, cultural values, and geographic differences.

- A. Resources that address the specific safety, medical, and forensic needs of pediatric/adolescent patients following sexual abuse/assault

- B. Individualizing the discharge plan and follow-up care based on medical, forensic, and patient priorities
- C. Facilitation of access to multidisciplinary collaborative agencies
- D. Differences in discharge and follow-up concerns related to age, developmental level, cultural diversity, family dynamics, and geographic differences
- E. Evidence-based guidelines for discharge and follow-up care following sexual abuse/assault of a pediatric/adolescent patient
- F. 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
- G. Modifying and facilitating plans for treatment, referrals, and follow-up care based upon patient/family needs and concerns
- H. Generating, communicating, evaluating, and revising individualized short- and long-term goals related to discharge and follow-up needs
- I. 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

## XII. Legal Considerations and Judicial Proceedings

Learning Objective: Upon completing instruction in the following topics, the participant will have the foundational knowledge required to effectively consider legal requirements that affect the provision of care to child and adolescent patients following sexual abuse/assault and to provide objective, accurate, evidence-based testimony in judicial proceedings.

### A. Legal Considerations

#### 1. Consent

- a. Key concepts associated with obtaining informed consent and assent
- b. Methodology for obtaining consent to perform a medical forensic evaluation in pediatric/adolescent patient populations
- c. Difference between legal requirements associated with consent or declination of medical care versus consent or declination of evidence collection and release
- d. Impact of age, developmental level, and physical and mental incapacitation on consent procedures and the appropriate methodology for securing consent in each instance
- e. Legal exceptions to obtaining consent as applicable to the practice area
- f. Communicating consent procedures and options to pediatric and adolescent patient populations

- g. Physiological, psychological, sociocultural, spiritual, and economic needs of pediatric and adolescent patients following sexual abuse/assault that may affect informed consent procedures
- B. Reimbursement
1. Crime Victim Compensation/reimbursement options that are associated with the provision of a medical forensic evaluation in cases of pediatric/adolescent sexual abuse/assault
  2. Reimbursement procedures and options for pediatric and adolescent patient populations
- C. 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:
    - a. Health Insurance Portability and Accountability Act (HIPAA) or other applicable confidentiality legislation
    - b. Key concepts associated with informed consent and the release of protected health information
  2. Explaining procedures associated with confidentiality to pediatric and adolescent patient populations
  3. Physiological, psychological, sociocultural, spiritual, safety, and economic needs of pediatric and adolescent patients following sexual abuse/assault that may impact confidentiality procedures
- D. Medical screening examinations
1. Legal requirements associated with the provision of a medical screening examination and its impact on the provision of medical forensic care in pediatric and adolescent patients following sexual abuse/assault, including:
    - a. Emergency Medical Treatment and Active Labor Act (EMTALA) or other applicable legislation
  2. Required procedures to secure informed consent and informed declination in accordance with applicable legislation
  3. Required procedures to transfer or discharge/refer a patient in accordance with applicable legislation
  4. Prioritizing and securing appropriate medical treatment as indicated by specific presenting chief complaints
  5. Explaining medical screening procedures and options to pediatric and adolescent patient populations
  6. Physiological, psychological, sociocultural, spiritual, and economic needs of pediatric and adolescent patients following sexual abuse/assault that may affect medical procedures
- E. Mandated reporting requirements

1. Legal requirements associated with mandated reporting requirements in pediatric/adolescent patient populations
  2. Mandatory reporting requirement procedures and options for pediatric/adolescent 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
- F. Judicial proceedings
1. Role of the SANE in judicial and administrative proceedings must include:
    - a. Civil versus criminal court proceedings
  2. Role of the SANE in judicial and administrative proceedings may include:
    - b. Family court proceedings (may)
    - c. Administrative/university proceedings
    - d. Title IX hearings
    - e. Military and court martial proceedings
    - f. Matrimonial/divorce proceedings
    - g. Child custody proceedings
- G. Legal definitions associated with child/adolescent sexual abuse/assault
- H. 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
- I. Differences among family, civil, and criminal judicial proceedings, including applicable rules of evidence
- J. Differences between the roles and responsibilities of fact versus expert witnesses in judicial proceedings
- K. Differences between judge versus jury trials
- L. Judicial processes:
1. Indictment
  2. Arraignment
  3. Plea agreement
  4. Sentencing
  5. Deposition
  6. Subpoena

7. Direct examination
  8. Cross-examination
  9. Objections
- M. 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
- N. Key processes associated with pretrial preparation

## **PEDIATRIC/ADOLESCENT CLINICAL PRECEPTORSHIP CONTENT**

### **Clinical Education Component**

The clinical preceptorship is designed to complement the classroom educational experience and allow the SANE to apply information and skills obtained during the classroom experience. The required clinical experience is in addition to the 40-hour didactic course. It is recommended that this preceptorship be completed with the guidance of a physician, advanced practice nurse, or a forensically experienced registered nurse.

Clinical preceptor experiences should be completed in a time frame that ensures competency and maximum retention of knowledge and skills, typically within six months of completion of the didactic training. Required clinical skills shall be performed until the nurse demonstrates competence, and competency is determined by the professional assessing the required clinical skills.

The Dreyfus Model of Skills Acquisition proposes that any skill training procedure must be based on some model of skill acquisition to address, at each stage of training, the appropriate issues involved in facilitating advancement. This model moves adult learners through five levels of development: 1) Novice 2) Advanced Beginner 3) Competent 4) Proficient and 5) Expert (Dreyfus, 1980). Benner (1982) used this same model to publish a study regarding how nurses develop clinically. Benner proposed that the novice has no practical experience and little understanding of contextual meaning; the advanced beginner has enough patient care experience to recognize and discriminate priorities; the competent nurse has practiced in the same population for two or three years, is efficient, organized, and capable of developing plans of care; the proficient nurse sees



the whole picture and can anticipate patient needs based on experience with that population; and the expert nurse has a comprehensive grasp of patient care situations and can focus on problems and address them with flexibility and proficiency.

In the majority of cases, the newly trained SANE will begin her or his practice at the novice or advanced beginner stages of skill acquisition because both the patient population and the role are new to the nurse. For this reason, and in recognition of Benner's description of clinical nursing development, it is recommended that a minimum of two years in clinical practice as a registered nurse occur prior to practicing as a SANE.

Given the diversity of communities and the different challenges facing rural, low-volume versus urban, high-volume communities, multiple options for clinical skill attainment must be recognized. Clinical skills acquisition may be obtained using any of the following approaches:

#### **Approach 1:**

- A. Clinical experience with a non-sexual assault patient population, while the nurse is being precepted by a physician, physician assistant, advanced practice nurse or a forensically experienced registered nurse who adheres to the clinical content described below until competency is achieved; and
- B. Clinical experience with patients who have experienced sexual assault, while the nurse is being precepted by a physician, advanced practice nurse, or a forensically experienced registered nurse who adheres to the clinical content described below until competency is achieved at the local program level.

#### **Approach 2:**

- A. Simulated patient experiences using live models, while the nurse is being precepted by a physician, physician assistant, advanced practice nurse, or a forensically experienced registered nurse who adheres to the clinical content described below until competency is achieved.
- B. Clinical experience with patients who have experienced sexual assault, while the nurse is being precepted by a physician, advanced practice nurse, or a forensically experienced registered nurse who adheres to the clinical content described below until competency is achieved at the local program level.

#### **Approach 3:**

- A. Simulated patient experiences using medical simulation models, while the nurse is being precepted by a physician, physician assistant, advanced practice nurse, or

- a forensically experienced registered nurse who adheres to the clinical content described below; and
- B. Clinical experience with patients who have experienced sexual assault, while the nurse is being precepted by a physician, advanced practice nurse, or a forensically experienced registered nurse who adheres to the clinical content described below until competency is achieved at the local program level.

The following clinical education content identifies the framework for the SANE who cares for the pediatric/adolescent sexual abuse/assault patient population. These target learning topics outline the minimum level of instruction required during the clinical preceptorship experience. As with the didactic portion of training, the clinical learning topics are grounded in the nursing process of assessment, diagnosis, outcome identification, planning, implementation, and evaluation.

Learning Outcome for Clinical Education: Upon completing the clinical learning experience, the participant will possess the foundational knowledge and skills required to perform as a sexual assault nurse examiner who provides care for pediatric/adolescent patients who have experienced sexual abuse/assault.

1. Explaining the rationale for history taking and demonstrate effective history-taking skills
2. Prioritizing a comprehensive health history and review of systems, including:
  - a. Health history and immunization status
  - b. History of the event
3. Differentiating between histories obtained from the following sources:
  - a. Patient
  - b. Family/caregiver/guardian
  - c. Law enforcement
  - d. Child protection agency
4. Demonstrating knowledge related to the psychosocial assessment of the child/adolescent related to the event
5. Explaining the rationale for head-to-toe assessment and demonstrating the complete head-to-toe assessment
6. Preparing the child/adolescent for the anogenital examination
7. Differentiating normal anogenital anatomy from normal variants and abnormal findings
8. Using appropriate examination positions and methods, including:
  - a. Labial separation/traction
  - b. Supine frog leg
  - c. Supine and prone knee-chest
9. Implementing appropriate physical evidence collection through use of:
  - a. Current evidence-based forensic standards and references

- b. Appropriate identification, collection, and preservation of evidence
  - c. Appropriate chain of custody procedures
  - d. Recognized variations in practice, following local recommendations and guidelines
10. Articulating the rationale for and demonstrating the following visualization techniques:
    - a. Labial separation
    - b. Labial traction
    - c. Hymenal assessment (urinary [Foley] catheter, swab, other technique)
    - d. Speculum assessment of the vagina and cervix in the adolescent
  11. Demonstrating the proper collection of specimens for testing for sexually transmitted disease
  12. Explaining the rationale for specific tests for sexually transmitted diseases and collection techniques
  13. Demonstrating the proper collection of evidence (dependent on local practice and indications by history), including:
    - a. Buccal swabs
    - b. Oral swabs
    - c. Bite mark swabbing
    - d. Other body surface swabbing
    - e. Fingernail clippings/swabbings
    - f. Anal swabs
    - g. Rectal swabs
    - h. Vaginal swabs
    - i. Cervical swabs
    - j. Head hair combing/collection
    - k. Pubic hair combing/collection
    - l. Clothing
    - m. Toxicology
  14. Articulating rationales for a specific type and manner of evidentiary specimen collection
  15. Packaging evidentiary materials
  16. Sealing evidentiary materials
  17. Articulating a rationale for the packaging and sealing of evidentiary material
  18. Maintaining the chain of custody for evidentiary materials
  19. Articulating the rationale for maintaining proper chain of custody
  20. Identifying differences in approach to evidence collection in the prepubertal population (i.e., external versus internal samples)
  21. Modifying evidence collection based on the patient's age, developmental/cognitive level, and tolerance

22. Evaluating the effectiveness of established discharge and follow-up plans of care, and revising the established plan of care while adhering to current evidence-based practice guidelines
23. Evaluating the effectiveness of the established plan of care and modifying/adapting care based on changes in data collection, using the nursing process
24. Utilizing the nursing process as a foundation of the nurses' decision-making, including:
  - a. Assessment—collects data pertinent to the patient's health and situation;
  - b. Diagnosis—analyzes the data to determine diagnoses: or issues;
  - c. Outcome Identification—identifies individualized patient outcomes based on patient need;
  - d. Planning—develops a plan that prescribes strategies to attain the expected outcomes;
  - e. Implementation—implements the plan, including any coordination of care, patient teaching, consultation, prescriptive authority and treatment; and
  - f. Evaluation—evaluates progress toward outcome attainment (ANA, 2010)

Participation in chart review, peer review, ongoing education, supervision, and mentoring is essential to prepare and sustain the registered nurse for the pediatric/adolescent SANE role. It is recommended that every SANE, novice through expert, regularly participate in these activities. Ongoing involvement in skill development will promote standardized practice, quality outcomes, and proficiency.

### **Optional Preceptorship Content**

Optional preceptorship content describes areas that instructors may choose to include in the overall program expectation, but that IAFN does not deem to be expected as part of the SANE's training as these items may not be readily available in all communities.

1. Demonstrating additional visualization techniques:
  - a. Anogenital toluidine blue dye application and removal as applicable to local practice
  - b. Specialized equipment commonly used in practice, such as magnification tools, colposcopes, alternate light sources (ALS), etc.
2. Photodocumenting examination findings using the above techniques

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# APPENDIX 1: ADULT/ADOLESCENT SEXUAL ASSAULT NURSE EXAMINER INITIAL COMPETENCY VALIDATION FORM

Learning Outcome for Clinical Education: Upon completing the clinical learning experience, participants will possess the foundational knowledge and skill required to perform as a sexual assault nurse examiner for adult/adolescent populations within their community.

Competence	Satisfactory Performance (initial/date)	Unsatisfactory Performance (initial/date)	Notes
1. Presents examination options and developmentally appropriate patient-nurse dialogue necessary to obtaining informed consent from adult and adolescent patient populations			
2. Evaluates the effectiveness of the established plan of care regarding consent and modifying or adapting based on assessment of the patient's capacity and developmental level from data collected throughout the nursing process			
3. Explains procedures associated with confidentiality to adult and adolescent patient populations			
4. Describes circumstances where mandatory reporting is necessary and explains the procedures associated with mandatory reporting to adult and adolescent patient populations			
5. Evaluates the effectiveness of the established plan of care regarding confidentiality and modifying or adapting based on the patient's developmental or level of capacity in data collected throughout the nursing process			
6. Explains medical screening			



Competence	Satisfactory Performance (initial/date)	Unsatisfactory Performance (initial/date)	Notes
procedures and options to adult and adolescent patient populations			
7. Evaluates the effectiveness of the established plan of care regarding medical evaluation/nursing assessment/treatment and modifying or adapting to meet the patient's needs based on changes in data collected throughout the nursing process			
8. Evaluates the effectiveness of the established plan of care regarding mandatory reporting requirements and modifying or adapting based on changes in data collected throughout the nursing process			
9. Identifies critical elements in the medical forensic history and review of systems and demonstrating effective history-taking, skills			
10. Demonstrates a complete head-to-toe assessment			
11. Prepares the adolescent and adult for the anogenital examination			
12. Differentiates a normal anogenital anatomy from normal variants and abnormal findings			
13. Demonstrates anogenital visualization techniques:			
a. Labial separation			
b. Labial traction			
c. Hymenal assessment (Foley catheter, swab, or other technique)			

Competence	Satisfactory Performance (initial/date)	Unsatisfactory Performance (initial/date)	Notes
d. Speculum assessment of the vagina and cervix			
14. Collects specimens for testing for sexually transmitted disease			
15. Explains rationales for specific STI tests and collection techniques			
16. Collects and preserves specimens as evidence (dependent on local practice and indications by history), including:			
a. Buccal swabs			
b. Oral swabs			
c. Bite mark swabbing			
d. Other body surface swabbing			
e. Fingernail clippings/swabbings			
f. Anal swabs			
g. Rectal swabs			
h. Vaginal swabs			
i. Cervical swabs			
j. Head hair combing/collection			

Competence	Satisfactory Performance (initial/date)	Unsatisfactory Performance (initial/date)	Notes
k. Pubic hair combing/collection			
l. Clothing			
m. Toxicology			
17. Explains rationales behind the specific type and manner of evidentiary specimen collection			
18. Packages evidentiary materials			
19. Seals evidentiary materials			
20. Explains rationales for the packaging and sealing of evidentiary material			
21. Explains how to maintain chain of custody for evidentiary materials			
22. Explains rationale for maintaining proper chain of custody			
23. Demonstrates how to modify evidence collection techniques based on the patient's age, developmental/cognitive level, and tolerance			
24. Takes appropriate actions related to consent, storage, confidentiality, and the appropriate release and use of photographs taken during the medical-forensic examination			

Competence	Satisfactory Performance (initial/date)	Unsatisfactory Performance (initial/date)	Notes
25. Obtains overall, orientation, close-up and close-up with scale for medical-forensic photodocumentation to provide a true and accurate reflection of the subject matter			
26. Evaluates the effectiveness of the established plan of care and modifying or adapting care based on changes in data collected throughout the nursing process			
27. Demonstrates effective patient-nurse dialogue establishing follow-up care and discharge instructions associated with emergency contraception and/or pregnancy termination options			
28. Demonstrates effective patient-nurse dialogue establishing follow-up care and discharge instructions associated with select sexually transmitted disease(s)			
29. Plans for discharge and follow-up concerns related to age, developmental level, cultural diversity and geographic differences			
30. Evaluates the effectiveness of established discharge and follow-up plans of care, and revises the established plan of care while adhering to current evidence-based practice guidelines			

Competence	Satisfactory Performance (initial/date)	Unsatisfactory Performance (initial/date)	Notes
31. Prioritizes the need for and implementation of crisis intervention strategies in adult and adolescent patients following sexual violence based on assessment findings			
32. Incorporates nursing process as a foundation of the nurses' decision-making, including:			
a. Assessment-collecting data pertinent to the patient's health and situation;			
b. Diagnosis-analyzing the data to determine diagnosis or issues;			
c. Outcome Identification-identifies individualized patient outcomes based on patient need;			
d. Planning-develops a plan that prescribes strategies to attain the expected outcomes;			
e. Implementation-implements the plan, including any coordination of care, patient teaching, consultation, prescriptive authority and treatment; and			
f. Evaluation-evaluates progress toward outcome attainment. (ANA, 2010)			

Name of SANE (Print)		Name of Preceptor #1 & Credentials (Print/Initials)	
Name of Preceptor #2 & Credentials (Print/Initials)		Name of Preceptor #3 & Credentials (Print/Initials)	
Name of Preceptor #4 & Credentials (Print/Initials)		Name of Preceptor #5 & Credentials (Print/Initials)	

## APPENDIX 2: PEDIATRIC/ADOLESCENT SEXUAL ASSAULT NURSE EXAMINER INITIAL COMPETENCY VALIDATION FORM

Competence	Satisfactory Performance (initial/date)	Unsatisfactory Performance (initial/date)	Notes
1. Explaining the rationale for history taking and demonstrate effective history-taking skills			
2. Prioritizing a comprehensive health history and review of systems, including:			
a. Health history and immunization status			
b. History of the event			
3. Differentiating between histories obtained from the following sources:			
a. Patient			
b. Family/caregiver/guardian			
c. Law enforcement			
d. Child protection agency			
4. Demonstrating knowledge related to the psychosocial assessment of the child/adolescent related to the event demonstrate knowledge related to the psychosocial assessment of the child/adolescent related to the event			
5. Explaining the rationale for head-to-toe assessment and demonstrate the complete head-to-toe assessment			
6. Preparing the child/adolescent for the anogenital examination			
7. Differentiating normal anogenital anatomy from			

Competence	Satisfactory Performance (initial/date)	Unsatisfactory Performance (initial/date)	Notes
normal variants and abnormal findings			
8. Using appropriate examination positions and methods, including:			
a. Labial separation/ traction			
b. Supine frog leg			
c. Supine and prone knee-chest			
9. Implementing appropriate physical evidence collection through use of:			
a. Current evidence-based forensic standards and references			
b. Appropriate chain of custody procedures			
c. Recognized variations in practice, following local recommendations and guidelines			
10. Rationale for and demonstrate the following visualization techniques:			
a. Labial separation			
b. Labial traction			
c. Hymenal assessment (Foley catheter, swab, other technique)			



Competence	Satisfactory Performance (initial/date)	Unsatisfactory Performance (initial/date)	Notes
d. Speculum assessment of the vagina and cervix in the adolescent			
11. Demonstrating the proper collection of specimens for testing for sexually transmitted disease			
12. Explaining the rationale for specific STI tests and collection techniques			
13. Demonstrating proper collection of evidence (dependent on local practice and indications by history) including:			
a. Buccal swabs			
b. Oral swabs			
c. Bite mark swabbing			
d. Other body surface swabbing			
e. Fingernail clippings/swabbings			
f. Anal swabs			
g. Rectal swabs			
h. Vaginal swabs			
i. Cervical swabs			

Competence	Satisfactory Performance (initial/date)	Unsatisfactory Performance (initial/date)	Notes
j. Head hair combing/collection			
k. Pubic hair combing/collection			
l. Clothing			
m. Toxicology			
14. Rationales behind a specific type and manner of evidentiary specimen collection			
15. Packaging of evidentiary materials			
16. Sealing of evidentiary materials			
17. Rationale for the packaging and sealing of evidentiary material			
18. Maintenance of the chain of custody for evidentiary materials			
19. Rationale for maintaining proper chain of custody			
20. Differences in approach to evidence collection in the prepubertal population (i.e., external versus internal samples)			
21. Modifying evidence collection based on the patient's age,			

Competence	Satisfactory Performance (initial/date)	Unsatisfactory Performance (initial/date)	Notes
developmental/cognitive level, and tolerance			
22. Evaluating the effectiveness of established discharge and follow-up plans of care, and revise the established plan of care while adhering to current evidence-based practice guidelines			
23. Evaluating the effectiveness of the established plan of care and modifying/adapting care based on changes in data collection, using the nursing process			
24. Nursing process as a foundation of the nurses' decision-making, including:			
a. Assessment-collecting data pertinent to the patient's health and situation;			
b. Diagnosis-analyzing the data to determine diagnosis or issues;			
c. Outcome Identification-identifies individualized patient outcomes based on patient need;			
d. Planning-develops a plan that prescribes strategies to attain the expected outcomes;			
e. Implementation-implements the plan,			

Competence	Satisfactory Performance (initial/date)	Unsatisfactory Performance (initial/date)	Notes
including any coordination of care, patient teaching, consultation, prescriptive authority and treatment; and			
f. Evaluation-evaluates progress toward outcome attainment. (ANA, 2010)			

Name of SANE (Print)		Name of Preceptor #1 & Credentials (Print/Initials)	
Name of Preceptor #2 & Credentials (Print/Initials)		Name of Preceptor #3 & Credentials (Print/Initials)	
Name of Preceptor #4 & Credentials (Print/Initials)		Name of Preceptor #5 & Credentials (Print/Initials)	

## APPENDIX 3: SANE DIDACTIC COURSE EDUCATIONAL PLANNING TABLES

Adult/Adolescent: <https://www.forensicnurses.org/adultplanningtable>

Pediatric/Adolescent: <https://www.forensicnurses.org/pediatricplanningtable>

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