# INTERNATIONAL ASSOCIATION OF FORENSIC NURSES

## Educational Planning Table – Live/Enduring Material

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

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

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

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

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

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

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

**Select all that apply:** ☒ **Nursing Professional Development** ☐ **Patient Outcome** ☐ **Other: Describe** Click here to enter text.

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| *Provide an outline of the content* | *Approximate time required for content delivery and/or participation in the activity* | *List the name/credentials* | *Select the learner engagement strategies to be used by Faculty, Presenters, Authors (note: PowerPoint and lecture by themselves are not learner engagement strategies) (select all that apply)* |
| **I. Overview of Forensic Nursing and Sexual Violence**<br>A. Forensic Nursing Overview<br>1. History and evolution of forensic nursing<br>2. Role of the adult/adolescent SANE in caring for adult and adolescent sexual assault patient populations<br>3. Role of the adult/adolescent SANE and sexual violence education and prevention<br>4. Role of the International Association of Forensic Nurses in establishing the scope and standards of forensic nursing practice | 405 minutes | Must be a SANE-A or SANE-P certified professional | ☐ Lecture/PowerPoint<br>**(select at least one additional strategy below):**<br>☐ Integrating opportunities for dialogue or question/answer<br>☐ Including time for self-check or reflection<br>☐ Audience Response System<br>☐ Analyzing case studies<br>☐ Providing opportunities for problem-based learning<br>☐ Pre/Post Test<br>☐ Other: _____ |

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| 5. Key aspects of *Forensic Nursing: Scope and Standards of Practice*<br>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-malfeasance, veracity, confidentiality, and justice<br>7. Nursing resources, locally and globally, that contribute to current and competent adult/adolescent SANE practice<br>8. Vicarious trauma<br>9. Methods for preventing vicarious trauma associated with adult/adolescent SANE practice<br>10. Key concepts associated with the use of evidence-based practice in the care of adult and adolescent sexual assault patient populations<br>B. Sexual Violence<br>1. Types of sexual violence<br>2. Types of intimate partner violence (IPV)<br>3. Global incidence and prevalence rates for sexual violence and IPV in the female | | | |

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| and male adult and adolescent populations<br>a. Risk factors for sexual violence and abuse<br>4. Health consequences of sexual violence and abuse and co-occurring violence, to include physical, psychosocial, cultural, and socioeconomic sequelae<br>5. Unique healthcare challenges to underserved sexual assault and abuse populations and associated prevalence rates, including but not limited to:<br>a. Men<br>b. Inmates<br>c. GLBTQIA (gay, lesbian, bisexual, transgender, questioning/queer, intersex, agender/asexual)<br>d. Patients with disabilities<br>e. Culturally diverse populations<br>f. Mental health populations<br>g. Patients with language/communication barriers<br>h. People who are trafficked<br>i. Patients who are in the military<br>6. Best practices for improving forensic nursing care provided to underserved or vulnerable patient populations | | | |

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| 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)<br>8. Biases and deeply held beliefs regarding sexual violence, abuse, and co-occurring violence in adult and adolescent patient populations<br>9. Key concepts of offender behavior and the effect on sexual assault patient populations<br>10. Differences between the minor and adult patient populations as related to adult and adolescent sexual violence<br>11. Delayed disclosure and recantation as common presentations in sexual violence and abuse | | | |
| **II. Victim Responses and Crisis Intervention**<br>A. Common psychosocial responses to sexual violence, abuse, and co-occurring violence in adult and adolescent populations | 150 minutes | | ☐ Lecture/PowerPoint<br>**(select at least one additional strategy below):**<br>☐ Integrating opportunities for dialogue or question/answer<br>☐ Including time for self-check or reflection<br>☐ Audience Response System<br>☐ Analyzing case studies |

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| B. Acute and long-term psychosocial ramifications associated with sexual violence, abuse, and co-occurring violence<br>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<br>1. Key components of a suicide risk assessment<br>2. Key components of a safety risk assessment<br>D. Diverse reactions that can be manifested in the patient after sexual violence<br>E. Risk factors for acute and chronic psychosocial sequelae in adult and adolescent patients following sexual violence, abuse, and co-occurring violence<br>F. Common concerns regarding reporting to law enforcement following sexual violence, abuse, and co-occurring violence and potential psychosocial ramifications associated with this decision<br>G. Culturally competent, holistic care of adult and adolescent patients who have experienced sexual assault, based on | | | ☐ Providing opportunities for problem-based learning<br>☐ Pre/Post Test<br>☐ Other: _____ |

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| objective and subjective assessment data, patient-centered outcomes, and patient tolerance<br>H. Risk factors for nonadherence in adult and adolescent patient populations following sexual violence<br>I. Diverse psychosocial issues associated with underserved sexual violence patient populations, such as:<br>1. Males<br>2. Inmates<br>3. GLBTQIA (gay, lesbian, bisexual, transgender, questioning/queer, intersex, agender/asexual)<br>4. Adolescents<br>5. Patients with disabilities<br>6. Culturally diverse populations<br>7. Mental health populations<br>8. Patients with language/communication barriers<br>9. People who are trafficked<br>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 | | | |

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| 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<br>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:<br>1. Empathetic and reflective listening<br>2. Maintaining dignity and privacy<br>3. Facilitating participation and control<br>4. Respecting autonomy<br>5. Maintaining examiner objectivity and professionalism | | | |
| **III. Collaborating with Community Agencies**<br><br>A. Sexual assault response team (SART), including:<br>1. Overview of roles and responsibilities<br>2. SART models<br>3. Strategies for implementing and sustaining a SART<br>4. Benefits and challenges | 240 minutes | Must minimally include the following:<br>• Community-based crisis center advocate<br>• Systems-based advocate<br>• SANE-A or SANE-P certified nurse<br>• Law enforcement<br>• Prosecutor<br>• Crime lab analyst | ☐ Lecture/PowerPoint<br>**(select at least one additional strategy below):**<br>☐ Integrating opportunities for dialogue or question/answer<br>☐ Including time for self-check or reflection<br>☐ Audience Response System<br>☐ Analyzing case studies<br>☐ Providing opportunities for problem-based learning<br>☐ Pre/Post Test |

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| B. Roles and responsibilities of the following multidisciplinary SART members as they relate to adult and adolescent sexual violence:<br>1. Victim advocates (community- and system-based)<br>2. Medical forensic examiners (adult/adolescent SANEs, death investigators, coroners, medical examiners, forensic nurse consultants)<br>3. Law enforcement personnel<br>4. Prosecuting attorneys<br>5. Defense attorneys<br>6. Forensic scientists<br>7. Social service agencies<br>C. Key strategies to initiate and maintain effective communication and collaboration among multidisciplinary SART members while maintaining patient privacy and confidentiality | | Child protection (in peds courses) | ☐ Other: _____ |
| **IV. Medical Forensic History Taking**<br><br>A. Key components of obtaining a comprehensive, developmentally appropriate patient history, including a focused review of systems with an | 120 minutes | | |

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| adult/adolescent patient, which can provide context for appropriate healthcare decisions and potential forensic implications, to include:<br>1. Past medical history<br>2. Allergies<br>3. Medications<br>4. Recreational drug use<br>5. Medical/surgical history<br>6. Vaccination status<br>7. Anogenital-urinary history<br>8. Last consensual intercourse<br>9. Pregnancy history<br>10. Contraception usage<br>11. Last menstrual period<br>12. Event history<br>a. Actual/attempted acts<br>b. Date and time of event<br>c. Location of event<br>d. Assailant information<br>e. Use of weapons/restraints/threats<br>f. Use of recording devices (photographs or videos of the event)<br>g. Suspected drug-facilitated sexual assault<br>h. Condom use<br>i. Ejaculation | | | |

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

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| **V. Observing and Assessing Physical Examination Findings**<br>A. Importance of obtaining informed consent and assent throughout the medical forensic examination process<br>B. Importance of addressing patient concerns related to examiner gender and other preferences<br>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:<br>1. Patient's general appearance, demeanor, cognition, and mental status<br>2. Clothing and other personal possessions<br>3. Body surfaces for physical findings<br>4. Anogenital structures<br>5. Sexual maturation<br>6. Impact of estrogen on anogenital structures<br>D. Mechanical and physical trauma and identification of each type<br>1. Blunt force<br>2. Sharp force<br>3. Gunshot wounds<br>4. Strangulation | 240 minutes | | |

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| E. Comprehensive strangulation assessment for the patient with known or suspected strangulation as a part of the history and/or physical findings<br>F. Terminology related to mechanical and physical trauma findings, including:<br>1. Abrasion<br>2. Laceration/tear<br>3. Cut/incision<br>4. Bruise/contusion<br>5. Hematoma<br>6. Swelling/edema<br>7. Redness/erythema<br>8. Petechiae<br>G. Anogenital anatomy and physiology, including:<br>1. Normal anatomical variants<br>2. Types and patterns of injury that are potentially associated with sexual assault<br>3. Physical findings and medical conditions or non-assault-related trauma that can be misinterpreted as resulting from a sexual assault<br>H. Multimethod approach for identifying and confirming physical findings, which may include: | | | |

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| 1. Positioning<br>2. Labial separation/traction<br>3. Sterile water irrigation<br>4. Colposcopic or photographic visualization with magnification<br>5. Anoscopic visualization, if indicated and within the scope of practice in the jurisdiction's Nurse Practice Act<br>6. Toluidine blue dye application and removal<br>7. Urinary (Foley) catheter, swab, or other technique for visualization of the hymen<br>8. Peer review/expert consultation<br>I. Current evidence-based references and healthcare practice guidelines for the care of the adult and adolescent patient who has experienced sexual assault<br>J. Circumstances that may necessitate referral and/or consultation<br>K. Planning care using current evidence-based practice for adult and adolescent sexual assault patient populations<br>L. Using clinical judgment to determine care<br>M. Individualized short- and long-term goals based on the physiological, psychological, sociocultural, spiritual, and economic needs | | | |

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| of the adult and adolescent patient who has experienced sexual assault<br>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<br>O. Care prioritization based on assessment data and patient-centered goals<br>P. When to employ medical consultation and trauma intervention | | | |
| **VI. Medical Forensic Specimen Collection**<br>A. Patient (Victim)-Centered Care<br>1. Importance of patient participation, consent, and ongoing assent during specimen collection procedures as a means of recovering from sexual violence<br>2. Sexual assault evidence collection kit<br>3. Integration of obtaining and preserving forensic samples into the medical forensic examination<br>4. Specimen collection options within the community available to adult and adolescent patients who have experienced sexual assault, including: | 165 minutes | | |

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| a. Reporting to law enforcement<br>b. Non-reporting/anonymous evidence collection<br>c. Medical evaluation and treatment<br>5. Recommendations for collection time limits of biological specimens following a sexual assault<br>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:<br>a. DNA<br>b. Trace/non-biologic<br>c. History documentation<br>d. Physical findings, identification, and documentation<br>e. Medical forensic photography<br>f. Toxicology<br>7. Chain of custody and principles and procedures for maintaining<br>8. Drug-facilitated sexual assault (DFSA), current trends, criteria associated with a risk assessment for DFSA, and when specimen collection procedures are indicated | | | |

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| 9. Patient concerns and common misconceptions patients may have regarding specimen collection<br>10. Potential risks and benefits for the patient related to evidence collection<br>11. Adjunctive tools and methods used in specimen identification and collection and associated risks and benefits, including but not limited to:<br>a. Alternate light sources<br>b. Swab collection techniques<br>c. Speculum examination<br>d. Colposcopic visualization or magnification with a digital camera<br>e. Anoscopic visualization, if indicated and within the scope of practice in the Nurse Practice Act<br>12. Appraisal of data regarding the assault details to facilitate complete and comprehensive medical forensic examination and evidence collection<br>13. Evidence-based practice guidelines for the identification, collection, preservation, handling, and transfer of biologic and trace evidence specimens following a sexual assault | | | |

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| 14. Evidence-based practice when planning evidentiary procedures<br>15. Materials and equipment needed for biologic and trace evidence collection<br>16. Techniques to support the patient and minimize the potential for additional trauma during specimen collection procedures<br>17. Techniques to facilitate patient participation in specimen collection procedures<br>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<br>B. Patient (Suspect)-Centered Care<br>1. Differences in victim and suspect medical forensic examination and specimen collection following a sexual assault<br>2. Legal authorization needed to obtain evidentiary specimens and examine a suspect, including:<br>a. Written consent<br>b. Search warrant<br>c. Court order | | | |

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| 3. Components of a suspect medical forensic examination<br>4. Recommendations for time limits of collection of biologic evidence in the suspect of a sexual assault<br>5. Types of evidence that can be collected in the medical forensic examination of a suspect following sexual assault, such as:<br>a. DNA evidence<br>b. Trace/non-biologic evidence<br>c. Physical findings, identification, and documentation<br>d. Medical forensic photography<br>e. Toxicology<br>f. Variables in specimen collection, packaging, preservation, and transportation issues for items, including:<br>i. Products of conception<br>ii. Foreign bodies<br>iii. Tampons<br>iv. Diapers<br>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 | | | |

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| 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<br>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**<br>A. Importance of obtaining informed consent and assent for photography<br>B. Impact of abuse involving photography/images on a patient's experience with photodocumentation<br>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)<br>D. Physical findings that warrant medical forensic photographic documentation | 120 minutes | | |

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| E. Biologic and/or trace evidentiary findings that warrant photographic documentation<br>F. Physiological, psychological, sociocultural, and spiritual needs of adult/adolescent patients that warrant medical forensic photography following a sexual assault<br>G. Options for obtaining medical forensic photographs, including colposcope images and digital imaging equipment<br>H. Variables affecting the clarity and quality of photographic images, including skin color, type and location of finding, lighting, aperture, and film speed<br>I. Key photography principles, including consent, obtaining images that are relevant, a true and accurate representation of the subject matter, and noninflammatory<br>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 | | | |

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| K. Photography prioritization based on assessment data and patient-centered goals<br>L. Adapting photography to accommodate patient needs and preferences<br>M. Selecting the correct media for obtaining photographs based on the type of physical or evidentiary finding warranting photographic documentation<br>N. Situations that may warrant follow-up photographs and options for securing<br>O. Consent, storage, confidentiality, and the appropriate release and use of photographs taken during the medical forensic examination<br>P. Legal and confidentiality issues that are pertinent to photographic documentation<br>Q. Consistent peer review of photographs to ensure quality and accurate interpretation of photographic findings | | | |
| **VIII. Sexually Transmitted Infection Testing and Prophylaxis**<br>A. Outline prevalence/incidence and morbidity and risk factors related to sexually transmitted infections after sexual assault and abuse | | | |

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| B. Recognize symptoms associated with sexually transmitted diseases<br>C. Recognize the STIs are commonly asymptomatic<br>D. Differentiate symptoms and findings that may mimic sexually transmitted infections<br>E. Describe key concepts associated with screening for the risk of transmission of select sexually transmitted infections based on the specifics of the patient's provided history<br>F. Identify patient concerns and myths regarding the transmission, treatment, and prophylaxis of select sexually transmitted infections<br>G. Collect and analyze data regarding the physiological, psychological, sociocultural, spiritual, and economic needs of adult/adolescent patients following sexual assault who are at risk for an actual or potential sexually transmitted infection(s)<br>H. Identify current evidence-based national and/or international guidelines for the testing and prophylaxis/treatment of sexually transmitted infections when planning care for adult/adolescent patients following sexual assault who are at risk for | | | |

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| an actual or potential sexually transmitted infection(s)<br>I. Apply, analyze, and synthesize current evidence-based practice when planning care for adult/adolescent patients following sexual assault who are at risk for an actual or potential sexually transmitted infection(s)<br>J. Compare the risks and benefits of testing for sexually transmitted infection(s) during the acute evaluation versus at the time of initial follow-up after prophylaxis<br>K. Modify testing methodologies appropriately based on site of collection, pubertal status, and patient tolerance for select sexually transmitted infections<br>L. Distinguish between screening and confirmatory testing methodologies for select sexually transmitted infections<br>M. Describe the appropriate approach to HIV risk assessment and prophylaxis decision making, based on current guidelines, local epidemiology and available resources<br>N. Establish, communicate, evaluate, and revise individualized short- and long-term goals based on the physiological, psychological, sociocultural, spiritual, and economic needs of adult/adolescent patients following sexual | | | |

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| assault who are at risk for an actual or potential sexually transmitted infection(s)<br>O. Prioritize care based on assessment data and patient-centered goals<br>P. Discuss appropriate sexually transmitted infection(s) testing and prophylaxis based on current evidence-based practice, risk factors for transmission, and symptomology<br>Q. Adapt sexually transmitted infection(s) testing and prophylaxis based on patient tolerance, adherence, and contraindications<br>R. Describe circumstances that indicate the need for specialty consultation when indicated<br>S. Summarize collection, preservation, and transport of testing medias for select sexually transmitted infections(s) | | | |
| **IX. Pregnancy Risk Evaluation and Care**<br>A. Prevalence rates for pregnancy following a sexual assault<br>B. Risk evaluation for pregnancy following a sexual assault based on the specifics of the patient's provided history and developmental age<br>C. Testing methods (e.g., blood versus urine; quantitative versus qualitative) | | | |

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| D. Effectiveness of available pregnancy prevention methods<br>E. Patient education key concepts regarding emergency contraception, including:<br>1. Mechanism of action<br>2. Baseline testing<br>3. Side effects<br>4. Administration<br>5. Failure rate<br>6. Follow-up requirements<br>F. Patient concerns, belief systems, and misconceptions related to reproduction, pregnancy, and pregnancy prophylaxis<br>G. Physiological, psychological, sociocultural, spiritual, and economic needs of adult and adolescent patients at risk for an unwanted pregnancy following a sexual assault<br>H. Evidence-based guidelines for pregnancy prophylaxis when planning care for adult and adolescent patients at risk for unwanted pregnancy following a sexual assault<br>I. Prioritizing care based on assessment data and patient-centered goals<br>J. Situations warranting medical or specialty consultation<br>K. Evaluating the effectiveness of the established plan of care and adapting the | | | |

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| care based on changes in data collected throughout the nursing process<br>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**<br>1. Roles and responsibilities of the forensic nurse in documenting the adult and adolescent medical forensic examination<br>2. Steps of the nursing process, including patient-centered care, needs, and goals<br>3. Differentiating and documenting sources of information provided<br>4. Documentation of sources/sites of evidence collection<br>5. Documentation of event history by quoting the patient's statements as much as possible<br>6. Documentation of outcry statement made during the medical forensic examination<br>7. Differentiation between objective and subjective data; Using language to document that is free of judgment or bias<br>8. Processes related to medical forensic documentation that include quality | | | |

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| improvement, peer review, and research/evidence-based practice<br>9. Legal considerations, including:<br>1. Regulatory or other accreditation requirements (see legal considerations section)<br>2. Legal, regulatory, or other confidentiality requirements (see legal considerations section)<br>3. Mandated reporting requirements (see legal considerations section)<br>4. Informed consent and assent (see legal considerations section)<br>5. Continuity of care<br>10. Judicial considerations, including:<br>1. True and accurate representation<br>2. Objective and unbiased evaluation<br>3. Chain of custody<br>11. Key principles related to consent, access, storage, archiving, and retention of documentation for:<br>1. Written/electronic medical records<br>2. Body maps/anatomic diagrams<br>3. Forms<br>4. Photographs (see medical forensic photography section) | | | |

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| 12. 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)<br>13. Sharing medical forensic documentation with other treatment providers<br>14. Patient access to the medical forensic record<br>15. Release, distribution, and duplication of medical forensic records, including photographic and video images and evidentiary material<br>1. Any potential cross-jurisdictional issues<br>2. Procedures to safeguard patient privacy and the transfer of evidence/information to external agencies according to institutional protocol<br>3. Explanation of laws and institutional policy that have domain over the protection of patient records and information<br>4. Applicable facility/examiner program policies (e.g., restricted access to medical records related to the medical forensic examination, response to | | | |

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| subpoenas and procedures for image release) | | | |
| **XI. Discharge and Follow-Up Planning**<br>A. Identify appropriate resources that address the specific safety, medical, and forensic needs of adult and adolescent patients following a sexual assault<br>B. Recognize the need to structure individualized discharge planning and follow-up care based on medical, forensic, and patient priorities<br>C. Facilitate access to appropriate multidisciplinary collaborative agencies<br>D. Identify evidence-based guidelines for discharge and follow-up care following an adult and adolescent sexual assault<br>E. Apply, analyze, and synthesize current evidence-based practice when planning and prioritizing discharge and follow-up care associated with safety, psychological, forensic, or medical issues, including the prevention and/or treatment of sexually transmitted infections and pregnancy<br>i. Modify and facilitate plans for treatment, referrals, and follow-up based on patient needs and concerns | 195 minutes | Must include a SANE-A or SANE-P certified nurse | |

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| ii. Generate, communicate, evaluate, and revise individualized short- and long-term goals related to discharge and follow-up needs<br>iii. Determine and discuss appropriate follow-up and discharge needs based on current evidence-based practice, recognizing differences related to age, developmental level, cultural diversity, and geographic differences | | | |
| **XIII. Legal Considerations and Judicial Proceedings**<br>A. Legal Considerations<br>1. Consent<br>a. Key concepts associated with obtaining informed consent and assent<br>b. Methodology for obtaining consent to perform a medical forensic examination in adult and adolescent patient populations<br>c. Differences between legal requirements associated with consent or declination of medical care versus consent or declination of evidence collection and release<br>d. Impact of age, developmental level, and physical and mental | 330 minutes | Must minimally include a prosecutor and a SANE-A or SANE-P certified nurse | |

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| incapacitation on consent procedures and the appropriate methodology for securing consent in each instance<br>e. Legal exceptions to obtaining consent as applicable to the practice area<br>f. Potential consequences of reporting options and assisting the patient with informed decision-making<br>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<br>h. Coordinating with other providers to support patient choices for medical forensic examination and consent<br>i. Procedures to follow when the patient is unable to consent<br>j. The critical importance of never performing the medical forensic examination against the will of the patient<br>k. Physiological, psychological, sociocultural, spiritual, and economic needs of adult and | | | |

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| adolescent patients following a sexual assault that may affect informed consent procedures<br>B. Reimbursement<br>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<br>2. Reimbursement procedures and options for adult and adolescent patient populations<br>C. Confidentiality<br>1. Legal requirements associated with patient confidentiality and their impact on the provision of protected health information to patients, families, and multidisciplinary agencies, including:<br>a. Health Insurance Portability and Accountability Act (HIPAA) or other applicable confidentiality legislation<br>b. Key concepts associated with informed consent and the release of protected health information | | | |

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| c. Physiological, psychological, sociocultural, spiritual, and economic needs of adult and adolescent patients following a sexual assault that may impact confidentiality procedures<br>D. Medical screening examinations<br>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:<br>a. Emergency Medical Treatment and Active Labor Act (EMTALA) or other applicable legislation<br>b. Required procedures to secure informed consent and informed declination in accordance with applicable legislation<br>c. Required procedures to transfer or discharge/refer a patient in accordance with applicable legislation | | | |

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| d. Prioritizing and securing medical treatment as indicated by specific presenting chief complaints<br>e. Physiological, psychological, sociocultural, spiritual, and economic needs of adult and adolescent patients following a sexual assault that may affect medical procedures<br>E. Mandated reporting requirements<br>1. Legal requirements associated with mandated reporting requirements in adult and adolescent patient populations<br>2. Mandatory reporting requirement procedures and options for adult and adolescent patient populations<br>3. Differentiating between reported and restricted/anonymous medical forensic evaluations following sexual violence<br>4. Modifying medical forensic examination procedures in non-reported/anonymous cases<br>5. Physiological, psychological, sociocultural, spiritual, and economic needs of adult and adolescent patients following a sexual assault that may | | | |

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| affect mandated reporting requirement procedures<br>F. Judicial proceedings<br>A. Role of the SANE in judicial and administrative proceedings, including:<br>1. Civil versus criminal court proceedings<br>2. Family court proceedings<br>3. Administrative/university proceedings<br>4. Title IX hearings<br>5. Military and court martial proceedings<br>6. Matrimonial/divorce hearings<br>7. Child custody proceedings<br>B. Legal definitions associated with sexual violence<br>C. Case law and judicial precedence that affect the provision of testimony in judicial proceedings, such as:<br>1. Admissibility or other applicable laws specific to the area of practice<br>2. Rules of evidence or other applicable laws specific to the area of practice<br>3. Hearsay or other applicable laws specific to the area of practice | | | |

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| *Provide an outline of the content* | *Approximate time required for content delivery and/or participation in the activity* | *List the name/credentials* | *Select the learner engagement strategies to be used by Faculty, Presenters, Authors (note: PowerPoint and lecture by themselves are not learner engagement strategies) (select all that apply)* |
| D. Differences between civil and criminal judicial proceedings, including applicable rules of evidence<br>E. Differences between the roles and responsibilities of fact versus expert witnesses in judicial proceedings<br>F. Differences between judge versus jury trials<br>G. Judicial processes:<br>1. Indictment<br>2. Arraignment<br>3. Plea agreement<br>4. Sentencing<br>5. Deposition<br>6. Subpoena<br>7. Direct examination<br>8. Cross-examination<br>9. Objections<br>H. Forensic nurse's role in judicial proceedings, including:<br>1. Educating the trier of fact<br>2. Providing effective testimony<br>3. Demeanor and appearance<br>4. Objectivity<br>5. Accuracy<br>6. Evidence-based testimony<br>7. Professionalism | | | |

## Educational Planning Table – Live/Enduring Material

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

**Select all that apply:** ☒ **Nursing Professional Development** ☐ **Patient Outcome** ☐ **Other: Describe** Click here to enter text.

| **CONTENT (Topics)** | **TIME FRAME (if live)** | **PRESENTER/AUTHOR** | **TEACHING METHODS/LEARNER ENGAGEMENT STRATEGIES** |
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| I. Key processes associated with pretrial preparation | | | |
| | **TOTAL REQUIRED MINUTES MUST = at minimum 2400**<br><br>**TOTAL ACTUAL MINUTES =** 2400<br><br>**TOTAL ACTUAL MINUTES/60 minutes=** 40 **Contact hours.** | | |

List the full citations of **at least three (3)** evidence-based references/resources used for developing this educational activity:

Adams, J., Kellogg, N., & Moles, R. (2016). Medical care for children who may have been sexually abused: An update for 2016. *Clinical Emergency Pediatric Medicine, 17(4)*, 255–263.

Agency for Healthcare Research and Quality. (2016, April). *Trauma-Informed Care*. Retrieved from Prevention and Chronic Care: https://www.ahrq.gov/professionals/prevention-chronic-care/healthier-pregnancy/preventive/trauma.html

American Nurses Association. (2015). *Nursing: scope and standards of practice* (3rd ed.). Silver Spring, MD: Nursesbooks.org.

Barnes, J., Putnam, F., & Trickett, P. (2009). Sexual and physical revictimizationamong victims of severe childhood sexual abuse. *Child Abuse and Neglect, 33(7)*, 412–420.

Benner, P. (1982). From novice to expert. *American Journal of Nursing, 82*(3), 402–407.

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Benner, P. (1984). *From novice to expert: Excellence and power in clinical nursing practice.* Menlo Park, CA: Addison-Wesley Publishing.

Center for Health Care Strategies. (2017, August). *What is trauma-informed care?* Center for Health Care Strategies webinar presentation. Available at https://www.chcs.org/resource/key-ingredients-trauma-informed-care/

Culatta, R. (. (2018). *Learning Theories: Andragogy (Malcolm Knowles)*. Retrieved July 27, 2018, from Instructional Design: http://www.instructionaldesign.org/theories/andragogy/

Dreyfus, S. E. (1980). *A five-stage model of the mental activities involved in directed skill acquisition.* Berkley, CA: University of California.

Duffy, J. R. (1992). The impact of nurse caring on patient outcomes. In D. A. Gaut (Ed.), *The presence of caring in nursing* (pp. 113–136). New York, NY: National League for Nursing Press.

Duffy, J. R. (2009). Caring assessment tools and the CAT-admin. In J. Watson (Ed.), *Instruments for assessing and measuring caring in nursing and health sciences* (2nd ed., pp. 131–148). New York, NY: Springer.

Duffy, J. R. (2009). *Quality caring in nursing: Applying theory to clinical practice, education, and leadership.* New York, NY: Springer.

Duffy, J. R. (2013). *Quality caring: In nursing and health systems.* New York, NY: Springer.

Duffy, J. R., & Hoskins, L. M. (2003). The Quality Caring Model: Blending dual paradigms. *Advances in Nursing Science, 26*(1), 77–88.

Duffy, J., Hoskins, L. M., & Seifert, R. F. (2007). Dimensions of caring: Psychometric properties of the caring assessment tool. *Advances in Nursing Science, 30*(3), 235–245.

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ERC. (2017, January 23). *3 Reasons Why Traditional Classroom Learning Is Still King*. Retrieved from HR Insights Blog: https://www.yourerc.com/blog/post/3-reasons-why-traditional-classroom-based-learning-is-still-king.aspx

Felitti, V., Anda, R., Nordenberg, D., Williamson, D., Spitz, A., Edwards, V., . . . Marks, J. (1998). Relationship of childhood abuse and household dysfunction to many of the leading causes of death in adults: The Adverse Childhood Experiences (ACE) Study. *American Journal of Preventitive Medicine, 14(4)*, 245-258.

Finkelhor, D., Shattuck, A., Turner, H., & Hamby, S. L. (2014). The lifetime prevalence of child sexual abuse and sexual assault assessed in late adolescence. *Journal of Adolescent Health, 55(3)*, 329-333.

Godbout, N., Briere, J., Sabourin, S., & Lussier, Y. (2014). Child sexual abuse and subsequent relational and personal functioning: The role of parental support . *Child Abuse and Neglect, 38(2)*, 317-325.

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Hockenberry, M., & Wilson, D. (2015). Wong's essentials of pediatric nursing. St. Louis, MO: Elsevier Mosby.

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McElvaney, R. (2015). Disclosure of child sexual abuse: Delays, non-disclosure and partial disclosure. What the research tells us and implications for practice. *Child Abuse Review, 24(3)*, 159–169.

McElvaney, R., Greene, S., & Hogan, D. (2014). To tell or not to tell? Factors influencing young people's informal disclosures of child sexual abuse. *Journal of Interpersonal Violence, 29(5)*, 928–947.

Meakim, C., Boese, T., Decker, S., Franklin, A., Gloe, D., & Lioce, L. (2013, June). Standards of Best Practice: Simulation; Standard I: Terminology. *Clinical Simulationin Nursing, 9*(6 Supplement), S3–S11.

Noll, J., Shenk, C., & Putnam, K. (2009). Childhood sexual abuse and adolescent pregnancy: A meta-analysis of the published research on the effects of child sexual abuse. *Journal of Psychology, 135(1)*, 17–36.

Petiprin, A. (2016). *Nursing theory: Roy adaptation model*. Retrieved April 26, 2018, from Nursing Theory: http://nursing-theory.org/theories-and-models/roy-adaptation-model.php

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Rothman, E., Exner, D., & Baughman, A. (2011). The prevalence of sexual assault against people who identify as gay, lesbian, or bisexual in the United States: A systematic review. *Trauma, Violence & Abuse, 12*(2), 55–66.

Ruiz, J. G. (2006). The impact of e-learning in medical education. *Academic Medicine, 81*(3), 207–212.

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Watson, J. (1979). *Nursing: The Philosophy and Science of Caring.* Boston: Little, Brown, & Co.

## INTERNATIONAL ASSOCIATION OF FORENSIC NURSES

Educational Planning Table – Live/Enduring Material

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**Select all that apply: ☒ Nursing Professional Development ☐ Patient Outcome ☐ Other: Describe** Click here to enter text.

| CONTENT (Topics) | TIME FRAME (if live) | PRESENTER/AUTHOR | TEACHING METHODS/LEARNER ENGAGEMENT STRATEGIES |
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Watson, J. (1985). *The theory of human care: a theory of nursing.* Connecticut: Appleton-Century Crofts.

World Health Organization. (2013). Responding to intimate partner violence and sexual violence against women: WHO clinical and policy guidelines. *World Health Organization*.

World Health Organization. (2017). Responding to children and adolescents who have been sexually abused: WHO clinical guidelines. Geneva, Switzerland.

Yuen, A. (2011). Exploring teaching approaches in blended learning. *Research & Practice in Technology Enhanced Learning, 6*(1), 3–23.


**If Live:**

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

**Total minutes 2400 divided by 60= 40 contact hour(s)**

**If Enduring:**

**Method of calculating contact hours:**

☐ **Pilot Study** ☐ **Mergener formula** ☐ **Historical Data** ☐ **Complexity of Content** ☐ **Other: Describe** Click here to enter text.

**Criteria for Awarding Contact Hours**

Criteria for awarding contact hours for live and enduring material activities include:

(Check all that apply)

- ☒ Attendance for a specified period of time (e.g., 100% of activity, or miss no more than 10 minutes of activity)
- ☐ Credit awarded commensurate with participation
- ☐ Attendance at 1 or more sessions
- ☒ Completion/submission of evaluation form
- ☐ Successful completion of a post-test (e.g., attendee must score _____% or higher)
- ☐ Successful completion of a return demonstration

☐ Other - Describe: _____

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

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

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

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

**QUESTIONS? Phone: 410.626.7805 ext. 116**
**Please return the completed Educational Planning Table Form to IAFN at:**
**EMAIL: CE@forensicnurses.org**