

Management of the Sexually Assaulted Patient: Utilization of the “Forensic Survey”

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Abstract

Hospitals, doctor's offices, and urgent care centers are often where sexual assault survivors find themselves when seeking medical services. Too often are these facilities ill-equipped to care for the unique needs these patients possess. As a greater number of victims surface in search of care, medical providers and facilities necessitate more preparedness to meet these client requirements. The sexually assaulted patient is a trauma patient and should be treated equally utilizing the well-accepted primary and secondary surveys as endorsed by the Emergency Nurses Association. Following the primary and secondary surveys, the forensic survey should also be considered by healthcare providers to ensure vigilant forensic considerations are made leading to both proper evidence collection and referrals to community resources.

Keywords: Sexual assault; Domestic violence; Trauma; Forensic; Survey

Introduction

Non-consensual intimate violence is a worldwide problem which affects both women and men across the spectrum of age and race. Statistical data show the number of those affected by this type of injustice to be as prevalent as one in every three [1]. Most often the perpetrator of sexual offense is someone known, trusted, or even related to the victim. Personal victimization predisposes an elevated emotional traumatization of the victim subsequent from both physical intrusion and loss of trust. Health care providers have opportunities to support sufferers of such crimes in numerous ways. Just as the patient experiencing a stroke needs comprehensive care, so does the sexually assaulted patient. Healthcare professionals have long recognized the need for specialized care for those patients and conditions labeled “high risk”. Fortunately, sexually assaulted clients seldom require immediate life-saving measures. Conversely, they do often require one or more various forms of long term medical or therapeutic care. Early recognition and support to patients following a sexual assault provides the best opportunity for long term mental survival. When healthcare systems fail to identify and treat these clients appropriately, the long term outcome for patients can be devastating [2]. The following two cases occurred within two months' time, and the differences in care were evident. In these two cases the patients sought the services of their local rape crisis centers who shared the outcomes of the women in the case histories. No violations in patient confidentiality were made as the patient names, situations, and any other key elements were appropriately changed to protect their privacy.

Case One

03:00 on Sunday morning, and the typical Saturday night crowd is beginning to stream in as clubs and bars in the area are closing. A nurse is triaging various inebriated and unruly clients when Susan walks in. She is outfitted in skinny jeans, an embellished tank top, and brightly colored high heels suited for the runway. She has a slight aroma of alcohol on her. Quietly she stands there as her companion, Amy, approaches the triage window asking if her friend can get “checked out”. The nurse looks her over asking through the speaker, “What seems to be the problem?” Now with her arm around Susan's shoulder, Amy says, “Could we talk somewhere private?” The nurse opens the door letting both women enter the triage room. Placing the blood

pressure cuff on her arm, the nurse notices a leaf stuck to her upper arm and a slight reddish color to her neck. Quickly brushing off the leaf, the nurse continues with a full set of vitals. Returning to the earlier question, she asks, “What brings you to the emergency department this morning?” “She thinks she was raped,” Amy says in reply to her. Instantly the nurse feels an upsurge of emotion feeling both dread and sympathy simultaneously. The nurse dreads the process that is to come while feeling sympathetic to her patient Susan. Without hesitation the nurse notifies the charge nurse that she has just screened a sexual assault victim. He makes his way to triage and looks in. He then notifies the nurse that a trauma patient is coming in, so the new admission will have to wait until things settle down. The girls are then sent back into the waiting area by the nurse who also instructs Susan not to use the restroom and not to eat or drink. Even though Susan is shivering and requests a blanket, she also tells her not to put anything on staling, “You're a crime scene, and nothing should be disturbed.” In addition, the social worker is paged to come to the emergency department per the hospital's policy.

It is now 07:00 and time for shift change. Patient reports are passed on to the on-coming triage nurse. The out-going nurse tells her that the rape victim has not been brought back yet, social service was called in, and she has a friend with her. The relief nurse looks into the waiting area, and calls Susan's name for a re-assessment. There is no response. The nurse walks out further into the waiting area for a better look, but she is unable to locate Susan or Amy. She notifies the new charge nurse and pages social services. Once contact has been made with the social worker she advises the nurses that she thought she was there for the major trauma that was brought in a while ago and has spent the last three hours with that patient's family. No one had seen the sexually assaulted patient since she was triaged and led back into the waiting

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room. Amy is then discharged by the receptionist as a "left without being seen".

The victim, Susan, left the emergency department at 06:30 a.m., exhausted, thirsty, cold, and with a very full bladder. Her friend, Amy, needed to get to work, and after witnessing many other patients with what seemed like minor problems get called back for treatment became increasingly impatient. Susan also felt uncomfortable feeling like everyone was looking at her in the waiting area, so eventually she went home and showered, and showered, and showered. She went to bed and tried to put the night's trauma away. She was not successful.

Case Two

In another hospital emergency department a similar scene is played out. Janet presents to the triage window and asks to be seen by a doctor. The triage nurse brings her in and asks "How can I help you tonight?" Janet tells the nurse that she was raped a few hours earlier. A call is made to the charge nurse stating that there is a patient for room 21 who will need an escort. Refraining from taking any vitals, the nurse asks, "Are you presently having any pain?" Janet replies, "Not really pain but I am sore down there". The triage nurse provides a brief face-to-face report to the nurse taking Janet back to the exam room designated for sexual assault cases and offers a blanket. The nurse then continues with her assessment keeping in mind "Patient first, evidence second". She performs a primary survey consisting of A, B, C and D (Airway, Breathing, Circulation, and Disability), and when she is confident that the patient has no obvious life-threatening conditions, she continues with a modified assessment [3]. She asks the Janet about past medical history, allergies, time of assault, and location. The nurse then notifies the Sexual Assault Nurse Examiner (SANE) and Crisis Center Advocate on call and has them report to the hospital. She then offers to notify the appropriate law enforcement agency based on where the assault took place. Janet states that she is not sure that she wants to do that right now. Janet's nurse then educates her on her reporting options explaining that since she is a competent adult seeking treatment within 96 hours of the assault, she can have evidence collected even if she does not want the police involved at this time. Continuing to explain, the nurse informs Janet she has the right, under federal law, to have evidence collected on her behalf, and that it will be stored for a period of time so that she can make a fully informed decision at a later time. Janet decides she wants to be examined, have the evidence collected, and decide later about filing a police report. The emergency department physician provides a medical screening and signs the patient over to the SANE on her arrival. After a short while the advocate from the crisis center arrives and is introduced to the patient by her nurse. The advocate explains her role and offers to stay with Janet as long as she would like. While waiting for the SANE to arrive, the advocate provides Janet with information regarding her rights as well as counseling and resources available to her.

When the SANE arrives, she makes introductions. She then explains a little about what a SANE is and what she does in addition to a typical medical examination. Janet consents to the examination and requests to have the advocate present throughout the process. After the consent process is completed, the SANE proceeds with the secondary survey E, F, G, H and I (Expose/ Environment, Full set of vitals, Get tools and equipment, Interventions) which includes a head to toe examination looking for both trauma and any possible evidence for collection and/or documentation [3]. In addition to the secondary survey, the SANE also completes a "forensic survey" which includes: K, L, M, N, O and P [4]. K: Keep/package evidence, L: Limit contact (with clothing, patient's body), M: Maintain integrity (keep non-essential staff out of

the room when possible), N: No talk or sharing of information outside the treatment team and law enforcement, O: Observe and document (document patient's demeanor, appearance, and body language), and P: Photograph as much of the patient as they will allow (Take photo before, during, and after treatment if possible. Photographs are very important in criminal and civil trials). Three hours later the SANE is concluding the examination process, and she and the advocate have spent high quality, uninterrupted time with Janet during the first key hours following her trauma. Janet is discharged to home with prescriptions for antibiotics, as needed, nausea medication, Plan B, and an updated tetanus immunization. Later that evening the advocate makes a follow up call to Janet seeing if she needs anything. Janet voices how grateful she is for all the care she received. Four days later, Janet decides to report the crime to law enforcement. The evidence is processed and foreign DNA is found. The case is able to be set for trial.

Conclusion

Historically, victims of sexual assault have been categorized with a low acuity. They are labeled lowly at a Level 4 or 5 having to wait hours for treatment. Typically, any person presenting with a history of an assault is categorized much higher until proven otherwise. That is based on mechanism of injury. MOI is a good indicator in most assault cases, but it is not as reliable in sexual assault cases. In some instances the patient will not be aware of a serious injury due to co-existing conditions such as drug or alcohol ingestion. The patient may also be reluctant to report forced oral or anal assaults due to embarrassment. A trained SANE can use knowledge, experience, and compassion to help patients move to the next step in healing. Just like a patient recovering from a heart attack or cancer, the sexual assault victim will always carry the scars from their assault but with appropriate assessment, intervention, and on-going treatment they can move from victim to survivor. The approach emergency department staff takes when providing care to victims of sexual assault should be foremost to assess the patient's medical needs. It is unreasonable and neglectful to push victims out into waiting rooms or fail to provide the needed comprehensive care. If the hospital does not have a SANE or SAFE (Sexual Assault Forensic Examiner) available, health care providers must offer to transfer that patient to an appropriate SANE/SAFE supported hospital. Licensed hospitals and Joint Commission Accredited Hospitals are required to maintain a policy that addresses the needs of sexual assault victims, and in most communities hospitals may participate as members of the Sexual Assault Response Team (SART). Everyone on the team focuses on the victim; keeping that focus helps to create a program that helps victims of sexual assault begin to heal both physically and emotionally.

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