

SEXUAL ASSAULT KIT INSTRUCTIONS

INFORMATION REGARDING SEXUAL ASSAULT EXAM/EVIDENCE COLLECTION PROCEDURES

- The information provided for the exam/evidence collection is for medical providers. The role of the medical provider is to provide medical care for a patient that states they have been sexually assaulted. The evidence collection is a courtesy that is offered within the care of the patient. The medical provider is neutral and should not make a judgment regarding the history of the patient.
- The information regarding evidence collection/form instructions is merely a guide. Every event of sexual assault is individualized. The patient history is the guide for the exam procedure and evidence collection. There is no way to address every possible scenario that can present from the patient history.
- Paper bags are used to facilitate drying and decrease the likelihood of damage to DNA. The kit includes all paper containers with the exception of the blood collection container.
- Once the kit is open it is within the chain of custody. The medical provider can not leave the kit unattended. If another medical provider is left in charge of the kit, this must be documented. The patient, advocate, law enforcement and/or any other ancillary person can not be in charge of the kit.
- Please keep in mind the patient will not be familiar with the exam process or evidence collection procedures. It is important to have ongoing communication and education with the patient throughout the process.
- Be respectful of the patient during this process. Provide modesty for the patient during the exam/evidence collection.
- Be aware of exam techniques/evidence collection steps that could be uncomfortable for the patient. Example: swab collection techniques that may seem forceful or uncomfortable for the patient. Ask the patient throughout the exam process/evidence collection to give feedback for anything that is painful and uncomfortable.

- Allow the patient to “set the pace” for the exam/evidence collection process. There is no “right or wrong way” to respond to a traumatic event. Every case is individualized and every patient has a mechanism of coping with trauma.
- Be thorough. Be compassionate. Be the medical provider **you** would want to provide **your** care.

BEFORE BEGINNING THE EXAM/EVIDENCE COLLECTION

- If the kit is “expired” based on the expiration date on the back of the kit, this indicates the purple top, blood collection tube will need to be replaced by hospital stock. The kit can still be used for evidence collection.
- Inventory the kit once opened. It should include a MS CHILD/ADOLESCENT Form, a MS ADOLESCENT/ADULT Form, a blue FDA Inspection indicator form, a four page generic instruction form, a small plastic bag with red evidence tape stickers and a bio-hazard sticker for the front of the kit package and 21 collection envelopes. Some kits may have a small, square paper with a number indicating an inspection number.
- Discard the form that will not be used for the patient. (Example: If the patient is 17 years old, the ADOLESCENT/ADULT Form will be used and the CHILD/ADOLESCENT form will be discarded)
- Place all other items back inside the evidence kit prior to or during the exam/evidence collection. The kit will be inventoried by the Crime Lab. The Crime Lab has requested that every collection envelope be placed back inside the kit whether the step is collected or not. This will let the Crime Lab know the kit was complete and the medical examiner addressed all the steps within the kit. Example: If the patient shaves the pubic hair region, there will be no need to comb through or pull pubic hair. On the envelope, beside the question “IF NO, WHY NOT?” The medical examiner could document “Patient shaves pubic hair”

TITLE PAGE

- This page will be completed at the end of the collection process

PAGE 1

- It is best to get a copy of the patients face sheet/demographic sheet from admissions. This will have the patients information that can be transferred to page 1 of the form. Ask the patient to verify the information is correct.
- Ask the patient to read ***EACH LINE OF THE CONSENT PRIOR TO PLACING INITIALS ON THE FORM AND SIGNING THE FORM.*** Be prepared to answer any questions regarding the consent and clarify any information in the consent. (Read the form prior to the exam and be familiar with the content)
- Assure the patient that even though they are signing consent for the exam/ process of evidence collection they can withdraw consent at any time for any step. Adolescent patients have the right to refuse evidence collection even if the care giver of the adolescent signs the consent form.
- Remember, there is nothing “medical” the examiner will determine with evidence collection. The evidence collection is a courtesy that is offered to the patient. The evidence will be turned over to law enforcement for either processing by the Crime Lab, or stored by an investigating entity until the patient makes the decision to have the assault investigated.
- Each page of the exam form will need to have patient information in the upper right corner. It is easier to have patient stickers (if this is the facility practice) placed in this area. Another use of patient stickers can be on each collection envelope and blood tube in STEP 19.

PAGE 2

- Ask the patient the questions from each section. Most of the questions can be answered on the form with yes/no check box.
- Page 2, Section F, Number 3 ask the name of the alleged perpetrator, age, gender, ethnicity and relationship to the patient. Under “known”, document how the patient knows the alleged assailant. (Example: Ex-boyfriend). If unknown, this will be indicated by a check/”X”.
- Keep in mind that “body weight” can be used as a restraint by an assailant during an assault.

PAGE 3

- Ask the patient questions from each section
- Some patients may not understand all of the terminology on the form. Be prepared to explain the terminology.
- Use the check boxes as you ask the questions. However, if the patient gives an explanation/description of the activity lines have been provided for patient direct quotes.

PAGE 4

- Indicate the date/time of the exam and beginning of evidence collection. You will need to return to this page at the end of the exam/evidence collection to document the date/time of the end of the exam.
- Address each section on this page
- Assess the patients body for any findings. Ask the patient the source of each finding. Every finding on the patient is significant even if it is not related to the assault.
- Document the finding on the body gram with a “mark” (either an X, or draw the finding). Draw a line from the “mark” and give the finding a legend indicator (either number or letter) Example: Bruise noted on patients right anterior thigh, mark an “X” on the right anterior thigh of the body gram, draw a line from the “X”, at the end of the line assign the letter “A”, write “A” on the first line of the legend chart, under “Type” write EC (Ecchymosis/Contusion), under “Description” document a description of the bruise including size/color.
- Document the indicator in the legend at the bottom of the page. Document the type of finding from the legend.
- Document YES/NO as to whether or not there is photography of the finding. (It is not necessary to indicate a photo number)
- Each page of the form can be done as the evidence is collected.

PAGE 5

- Address each section on this page.
- Assess the head, neck and oral cavity for any findings even if the finding is not related to the assault.

- Document the finding on the body gram as previously instructed.
- Complete the legend chart.
- Incorporate evidence collection in the exam process.

PAGE 6 (FEMALE)/PAGE 7 (MALE)

- Address each section on this page.
- Assess all areas of the genitalia/anal region.
- Document the finding on the body gram as previously instructed
- Complete the legend chart.
- Incorporate evidence collection in the exam process.
- Draw a “line” through the page that is not utilized for the patient. (Example: if the patient is male, draw a line through page 7 as an indicator that these steps were not indicated for this patient)

PAGE 8

- Section L: Check either “yes” or “no” as to each step of evidence collection. If the evidence indicated was collected, the collecting examiner must sign beside the step collected.
- Section M: Toxicology Samples. Document if blood or urine toxicology was collected. To collect urine toxicology, have the patient urinate in hospital stock collection cup. The Crime Lab has requested a minimum of 30 ml of urine be collected but recommends 100 ml be collected. Once the urine is collected, place a patient identifying sticker on the collection cup, place a signed/dated evidence tape over the top of the collection cup of urine, place the cup in a hospital stock bio-hazard bag, seal the bag with signed/dated evidence tape, place this bag in another hospital stock bio-hazard bag, seal the second bag with signed/dated evidence tape and place a patient identifying sticker on the second/outer bag. This will be given to the investigating agency separately with the evidence collection kit.

- Section N: Photo Documentation. Indicate if a colposcope was used and if so the setting of the magnification. Indicate if photos were taken, the type of camera and number of photos. Document the photo number and what the photo is that was taken. (Example: Photo 1- Orientation of patient, Photo 2- Patient armband/sticker for identification, Photo 3-Bruise top of right thigh, Photo 4-Close up bruise top of right thigh, Photo 5-Close up of bruise top of right thigh with scale, etc....)
- Section O: Document the role of each person in the room with the patient.
- If the SANE/Nurse assessed the patient and collects the evidence this is indicative of being the examiner.
- If the Advanced Practice Clinician assessed the patient and collects the evidence they are the examiner.
- If the Advanced Practice Clinician does not do the exam/evidence collection, they are the assistant to the examiner.
- If the Advanced Practice Clinician performs the speculum insertion/evidence collection of the patient and the SANE/nurse does the remaining evidence collection/exam, the SANE/Nurse is the examiner and the Advanced Practice Clinician is the assistant.
- If the nurse has completed the 40 hour Sexual Assault Nurse Examiner Course (SANE) they can sign SANE after their name/nurse title. If the examiner has passed the Certification exam they can sign SANE-A after their name/title.
- Section P: Document how many pieces of evidence will be distributed to the investigating entity. The sexual assault evidence collection kit envelope, the bags of extra evidence (such as clothing) and the urine drug screen are examples of separate pieces of evidence. Document the name of the entity under "Given To"
- Section Q: Document if prophylactic medication was provided.
- Section R: Summarize the findings from the exam. If there were no abnormal findings this will need to be documented. If there are abnormal findings, summarize the findings.

- This area can be used as documentation of the history the patient provided. Place any pertinent information from the patient/provider in quotes.
- This area can be used for a continuation from any page in the form.
- This area can be used to document the time the patient presented to the facility, the time the patient was received by the medical provider, the time the kit/exam was started/completed, the time the advanced practice clinician assessed the patient, the time medications were provided to the patient (including meds, route and patient response), the time the patient was discharged, suicide risk/safety assessment, and who the patient was with when discharged.
- Any information the examiner feels is pertinent can be documented in this area.
- ***DO NOT USE THIS AREA TO INVESTIGATE A CASE! THE ASSESSMENT OF THE PATIENT IS FOR MEDICAL PLAN OF CARE, NOT INVESTIGATION OF A CRIME!***

UPON COMPLETION OF THE EXAM/EVIDENCE COLLECTION/FORM

- ***THE ORIGINAL FORM STAYS WITH THE MEDICAL FACILITY***
- Document on the title page each copy of the form and its placement.
- A copy of the form will be placed in the sexual assault evidence collection kit for the Crime Lab Staff.
- A copy of the form will be placed in the manila envelope on the outside of the kit collection envelope for law enforcement.
- A copy of the form will be sent to facility billing with a copy of the patient face sheet/demographic sheet to be sent to the MS Attorney General Office for reimbursement. (Address to the MS Attorney General Office is on the title page)
- A copy of the form may be provided to Department of Human Services as indicated.

CHAIN OF CUSTODY FORM ON THE FRONT OF THE EVIDENCE COLLECTION KIT ENVELOPE

- Moisten the glue on the flap of the envelope to seal the evidence kit package
- Seal the flap with signed/dated evidence tape at the top and bottom of the kit package
- Document across the front side top of the kit package the number of items. (Example: 1 bag of clothing including steps 2-5, urine toxicology, evidence kit)
- Place the bio-hazard sticker included in the kit on the area indicated on the front of the kit package
- Complete the documentation sections on the front of the kit package
- If the kit is to be stored until received by the investigating entity, place the evidence in a locked, refrigerated area. If there is no locked, refrigerated area a chain of custody log must be created to indicate security of the evidence. When the evidence is turned over to the investigating entity, the facility should keep a copy of the chain of custody log with the original permanent medical record.
- Once the investigating entity receives the evidence, complete the “CHAIN OF CUSTODY” form.
- Document in the original patient permanent record the receiving entity and who received the evidence package.