Documentation

-Use different letters for each finding (A, B, C..)
-Use numbers for sub-categories within same area (A.1, A.2, A.3)
-Describe finding: location, description, measurement, shape
-Mark areas dry stains are collected from and + or – fluorescence/contrast
-Never leave assessment area blank – "no visible findings or reports of pain"
-Be sure to document pain to area: pain scale, w or w/o palpation, etc
-Use quotation marks for direct patient statements
-Attempt to link findings with forensic narrative, doc on diagram when +
-Sign/date each page of entire chart
-Document declined on any exam steps not performed by pt request
-Write times/date on envelopes for each step
-Avoid biased language (discharge, refused, happy, sad, etc)

Jurisdiction / Chain of Custody (COC)

-Location of assault is jurisdiction who takes custody of evidence
-If unclear on which jurisdiction, call the county agency to assist determining
-If patient is unsure of where assault occurred, call county/agency where exam done
-Contact admin for out of state/far distance PDs to assist in kit handoff
-Document everyone you report felony to (PD, CP Cover letter, pages 1-4S, APS, ODH)
-Chain of custody times must match exactly on all forms
-Complete an extended COC for kits given to security at hospital

Mandated Reporting

-Report to agencies where crime occurred (may not be where exam done)
-Report to law enforcement where crime occurred
-APS: 65 years of age or older when NOT a resident of skilled nursing facility
-CPS: 17 years of age or younger
-ODH: when assault occurs in any skilled nursing facility (NH, Hospital)

On Call Procedures

-Answering Service will text/page examiner when case occurs
-Confirm receipt of page within 5 minutes
-Call facility back if advised to do so in page
-Obtain age of patient (must be 13 yrs of age or older for Adult/Adolescent)
-If 12 yrs of age or younger, advise to transfer to pediatric facility
-Obtain when assault occurred (must be within 96 hours for forensic exam)
-Response to facility must be within 60minutes (90 for farther facilities)
-Provide ETA to facility when returning call

Securing Evidence

-Tape all sides of every box and bag (no open seams)
-Initial and date must overlap evidence tape onto the box on each side
-Describe each clothing item on the corresponding bag (bra, pants, shirt, etc)
-Assure all items are included on Chain of Custody

Paperwork Sorting After Case

-Admin gets copies of <u>everything</u> sent via Forcura
-PD gets copies of everything (may omit d/c, plan B docs)
-Inside kit: consent and pages 1-4 (questionnaire, narrative, diagrams)
-Inside DFSA: consent, DFSA screening copy
-ODH: Cover letter, pages 1-4, ODH complaint form – sent via EFax
-CPS: Cover letter, pages 1-4 – sent via EFax
-APS: Cover letter, pages 1-4 – sent via EFax

ALS and Photography

-Never use flash photography
-Align camera parallel with body part for photo
-In all photos use measuring device, ID label, injury number/letter
-Check to assure all photos are clear and focused prior to completed exam
-Photograph clothing if + ALS observed during exam
-Photograph rips/tears in clothing if present
-Keep memory card/camera in a secured area when not in use (not vehicle)
-Facial photo and internal genitalia are only photos without measuring/ID

Clothing Collection

-Collect one article at a time
-Articles not worn during assault do not have to be collected (excluding any article touching genitalia)
-Only collect items that are worn by the patient, do not secure items via COC that were removed prior to your arrival by hospital staff (document)
-If patient declines clothing collection mark each bag "patient declined"
-If patient declines clothing collection, swab pertinent clothing areas and place inside clothing bag

MD / RN Report Post Exam

-Assault characteristics, exam findings, photography, injuries
-Plan B (if candidate and SANE must obtain consent AND baseline preg test)
-Review CDC recommendations for treatment medications
-Place all physician information on d/c paperwork for patient
-Review recommended follow up requirements with MD and patient

Quick Reference Guide