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Inside

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Are sexual assault victims getting the proper treatment in your ED?

These patients require biological, psychological, and social services

ED nurses play a major role in the healing process of sexual assault victims, says **Patricia Speck**, MSN, RN, FNP, CS, nurse coordinator for Memphis (TN) Sexual Assault Resource Center.

"In many communities, the ED is the only resource for these patients," she explains. "His or her needs are biological, psychological, and social. ED nurses are in the best position to evaluate the patient holistically on all three levels."

Every sexual assault victim has at least five needs, says **Linda Ledray**, PhD, RN, FAAN, director of the Sexual Assault Resource Service in Minneapolis.

"These include documentation of and caring for any injuries, collection of forensic evidence, dealing with STD and pregnancy concerns, crisis intervention, and follow-up services," she stresses. "These must be addressed for every rape victim who comes into the ED."

More than 95% of all sexual assault victims do not sustain physical injuries requiring emergent medical attention, says **Eileen Allen**, RN, coordinator of the Monmouth County Sexual Assault Nurse Examiner (SANE) program in Freehold, NJ. However, these patients are in need of a full range of assessment,

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Sexual assault victims require careful emotional and physical treatment, including confidentiality, privacy, thorough evidence collection, and referral to counseling from ED nurses.

- Five key needs of rape victims in the ED include: documentation and caring for any injuries, collection of forensic evidence, dealing with STDs and pregnancy, crisis intervention, and follow-up services.
- During the exam, ask victims if they want anyone present, explain evidence collection procedures, encourage questions, and obtain consent for every step of the procedure.
- Research shows that victims who receive therapeutic care in the hours and weeks after the assault have a 50% reduced incidence of post-traumatic stress disorder.

treatment, and follow-up services, she stresses.

Often victims feel they have been stripped of any sense of control. "It is important for the ED nurse to recognize a rape victim's needs and ensure the patient's dignity and confidentiality throughout the exam and treatment process," emphasizes Allen. Offer the victim as many opportunities as possible to regain control, by informing him or her about choices regarding treatment and services, she advises.

Meeting the victim's needs

Biased, poor, or negligent care in the ED by the nurse or physician can have a lifelong effect on health-seeking behaviors in the victim, notes Speck.

"Research has shown that victims who receive therapeutic care in the hours and weeks following the assault have a reduced incidence of post-traumatic stress disorder by 50%," she reports.[1]

Here are ways to meet the unique needs of sexual assault victims in the ED:

• **Expect a wide range of behaviors.** "A victim's demeanor can range from agitated and angry to very calm and composed," notes Allen. "There is no one correct way for a victim to react or behave. Most of the time, he or she is not physically injured, but may react in any manner of ways. Be ready to deal with any type of reaction."

• **Ensure the privacy of victims.** "There are stories of victims being left waiting in the main ED waiting room in the company of a police officer for hours, making them vulnerable to questions from friends or acquaintances who may happen to walk through the area," says Allen.

If your ED does not have a private waiting area that is separate from the main ED waiting room, find another space, Allen recommends. "Utilize an area already designated as a family waiting room for trauma patients, or find another private, underutilized space, such as a conference room," she says.

• **Know local and state laws regarding sexual assault reporting.** "The victims should be asked if they have notified police or if they wish to do so. In New Jersey, reporting rape is not mandatory. As an ED nurse, I am not allowed to report it without the victim's permission," says Allen. "However, in other states, it is mandatory [to report the crime to authorities]."

• **Involve victims in the decision-making process.** Advises Allen, "Say, 'Have you notified the police? In our state, it's up to you. Have you reached out for any support services?'"

• **Offer victims options throughout the assessment and treatment process.** "Ask them if they would like to have anyone present while you document the history of the assault," says Allen. "Explain the evidence collection procedures, and assure the victim that he or she can ask questions throughout the procedure."

• **Explain that the patient can refuse any steps in the procedure that he or she doesn't wish to undergo.** "I briefly explain why we do this, and how we do it, and then I ask the victim if it's okay if we go ahead and do that. I never assume that an initial consent for treatment is a blanket consent for all steps in the procedure." Allen says.

• **Provide privacy.** "Whenever possible, patients should be assessed and treated behind closed doors instead of behind a pulled curtain," says Allen. "During the assessment and information gathering, the examiner will be asking very specific questions about the details of the assault itself. It's very stressful, both for the examiner and for the victim, to try and carry on this conversation with patients and visitors in the cubicle next door."

Paperwork should also be kept private, stresses **Suzanne Brown**, RN, CEN, sexual assault nurse examiner at Inova Fairfax Hospital in Falls Church, VA. "I am appalled when I hear stories of patients getting seen after a sexual assault, and as soon as they leave everyone looks at the medical record. Patient confidentiality includes that record," she says. "In our program, the patient's medical record goes, in a sealed envelope, from the nurse who is seeing the patient to medical records."

• **Be willing to testify.** "Nurses need to know how to be a competent witness in court, and have a responsibility to do that," Ledray emphasizes. "One study found that out of 97 kits collected, 14 had absolutely no identifying information as to who collected it, which is suspicious.[2] It's an understandable concern that it's a time commitment to be called to testify, but it's an important part of the nursing role."

• **Know policies on victims' rights.** "Victims may be afraid to report the crime because their name will be in the paper. You need to know if that's true so you

can let them make an educated decision," says Ledray. "You also need to know if prosecutors will force the victim to testify if he or she changes his or her mind later, or if he or she can just report [the crime] and make the decision about prosecuting later."

• **Don't worry about saying the wrong thing.** "It's not so crucial what you say, because it's highly unlikely you're going to say the wrong thing," says Ledray. "A study showed that just having a caring nurse in the room, who said nothing through the rest of the exam, was very beneficial and helpful to the patient. Nonverbal communication can make a significant difference."[3]

• **Don't be afraid of talking to the victim about the assault.** "The stigma is diminished the more they talk about it," says Speck.

• **Start with less-invasive procedures.** "Do the oral first, then perianal, anal, and vaginal specimens," recommends Ledray. "If your routine is to draw blood first, change it, because it's not the best way to deal with a rape victim. Draw blood last because it's most painful and invasive."

• **Work with law enforcement.** "You need to work with police, prosecutors, advocates, and sexual assault response teams. You will be able to accomplish a lot more if you know what evidence is useful in court," says Ledray. **(See story on evidence collection tips on p. 106.)**

ED Representatives met with the local sex crimes unit to discuss evidence collection, says Ledray. "For instance, our crime lab kit doesn't ask for additional blood for drugs and alcohol. But we are still drawing an extra tube that can be held and used, because assailants were claiming the victim had exchanged sex for drugs. With that extra tube of blood, we can prove it wasn't true," she explains.

Remain professional with patients

• **Don't sound accusatory.** At triage, avoid questions that sound like accusations, says Brown. "Stay away from 'why' questions, such as, 'Why were you walking down that street at midnight?' or 'Why were you drinking?'" she advises. "Instead, say something like, 'I understand you were drinking tonight, we all go out for drinks, about how much did you have?'"

• **Be conscious of your own prejudices.** "You need to deal with your own issues about sexual assault. If you feel you'll be judgmental about drinking, then you shouldn't be taking care of that patient," says Brown. "If you can't offer the patient the morning after pill, your judgmental feelings will come across. Check your attitude at the door."

• **Don't get too personal.** "If you have been a victim of sexual assault, don't talk to the patient about that. You need to remain professional," advises Brown. "Otherwise, your comments will be brought up in court against you to show bias. Be empathetic, instead of sympathetic."

• **Know which equipment is needed.** In most non-SANE programs, the exam is done visually, which doesn't pick up all the injuries the patient has, says Brown. "Most SANE programs use a colposcope or med scope," she notes. "These are devices which aid in visualization, to magnify and photograph the area. This is starting to become a standard of care for a rape victim. You can also [use this to] photograph physical injuries from child abuse or domestic violence, or even to look at edges of wounds."

Toluidine blue dye adheres to injuries that have occurred within approximately three days, says Brown. "The dye highlights injuries you don't see with your naked eye," she explains. "The naked eye picks up about 10% of injuries, with the dye you pick up about 50%. The dye only adheres while that injury is fresh so, once [the injury] starts to heal, it won't adhere. If the victim claims an injury happened two days ago, and the dye adheres, it shows that it's likely it did happen in that time frame."

• **Put all instructions in writing.** "Everything needs to be written down for a patient. You may have told her 10 times during an exam, but she won't remember most of what you say. Victims are often in a state of shock," says Brown. "Provide detailed, written instructions, such as, 'Take this medicine at this time. Call me at this number if you have questions. Follow up with this doctor on this date.'"

• **Know resources.** Ask victims about their need for support services, advises Allen. "Include services from a rape care advocate or someone from the social services department," she says. "The triage nurse needs to be educated as to what services are available in his or her facility and community."

Victims need a counselor who is comfortable dealing with sexual assault issues, Brown advises. "Hospital social workers know what resources are out there. You can also put together a sexual assault resource book with names and numbers, so you are not reinventing the wheel every time a patient comes in."

• **Be sensitive to needs of male sexual assault patients.** Male victims of sexual assault usually have more trauma associated with their assault and may require the care of a surgeon, says **Susan McDaniel Hohenhaus**, RN, CEN, FNE, coordinator, Emergency Medical Services for Children at the North Carolina Office of Emergency Medical Services in Raleigh, NC. "The most common form of sexual assault reported by males is forced anal intercourse," she notes.

Only about 12% percent of men report sexual

assault to the police and another 12% report it to medical personnel, more often in a primary care setting than in an ED setting, Hohenhaus reports.

"If a male patient presents with signs of physical assault, especially by multiple assailants, the clinician should suspect sexual assault," she says. "Unfortunately, men report rape even less frequently than women, especially teenagers," she notes.

Boys tend to be victimized by a known assailant, particularly a family member, and report that victimization occurs most often around age 11, Hohenhaus notes. "Clinicians should question children in this age range regarding unwanted sexual contact," she advises.

Men may experience anxiety over their physical response to the assault, notes Brown. "A male does not have to be sexually aroused to have an erection. Some men do have an erection and even ejaculation, but these are both considered to be involuntary reactions," she explains.

Medical attention should be a priority

• **Don't overlook immediate medical needs.** "At triage, ask the patient, 'Are you hurt anywhere physically that I need to look at right now?' Because the majority of sexual assault victims don't have physical injuries that require immediate medical attention, there is a tendency to overlook this possibility. Medical stability is always the No. 1 priority," says Brown.

In some cases, medical injuries were completely overlooked, reports Speck. "Victims were put in rooms for privacy and never checked on by the nursing or medical staff until the SANE nurse arrived, and then it was nearly too late for some," she says. "In one case, the patient's vagina was traumatically lacerated and punctured her abdominal cavity following the rape. By the time the I was called, the patient had a rigid abdomen and was spiking a 104° F temp."

The delay resulted in a bad outcome, Speck recalls. "I went to surgery to collect evidence (a successful collection), but the patient lost one-third of her vagina and her female reproductive organs," she says. "Before she was released, she had two other surgeries to remove the infection in her peritoneal space. That may have been prevented if she had been appropriately triaged for bleeding and subsequent hypovolemia."

• **Make patients feel safe.** "Safety is a big issue with victims. Let patients know we are here to help them, that they are safe with us," says Brown. "At triage, tell the patient, 'We commend you for coming in here; it's a big step for you to take, and we will keep you safe while you are here. We'll also try and help you with your emotional trauma.'"

• **Ask where the rape occurred.** "It needs to be investigated in the jurisdiction where it happened," says Brown. "For example, in northern Virginia we have 22 jurisdictions, so we need to know which county to call to report the rape."

• **Ask patients what would make them more comfortable.** "One woman was sexually assaulted over a couple of days. When she came in, she wasn't sure if she could go through with the exam," recalls Brown. "I asked her, 'Is there something I can do to make this experience easier for you?' She said, 'If I'm home and get stressed, I usually have a cup of tea.' So I said, 'Let me do a couple of swabs from mouth and then we'll get you a cup of tea, then we'll do the rest of the exam.' And she was fine."

• **Don't always take what patients say at face value.** "They have just been through a life-threatening ordeal, so the way they're saying things may not be what they really mean," Brown says. "Ask, 'How can I help you with this?' instead of just taking it as a refusal of the exam."

During the exam, patients may become distressed due to a specific concern, Brown reports. "You need to be aware of subtle movements or body language. If you notice a patient is becoming upset, say, 'Obviously something is bothering you.' The patient may tell you, 'I just thought about pregnancy.' Address it right then and there, so you decrease the anxiety at that moment."

• **Establish a good rapport with the patient.** "You need a good rapport with the patient to get the best evidence collected. If you go in the room and go right to the vaginal swabs, the patient might not tell you there was also contact with the breast," Brown explains. "Anywhere that there has been any type of transfer of any type of body fluids, we swab."

• **Tell patients that their account of the rape is essential to conducting a thorough exam.** Brown says, "I joke with patients a lot by saying, 'You're fortunate because you got the best nurse, but I'm only as good as the information you give me. I know it's hard to bring up these issues, but I need your help.'"

• **Address self-blame and shame of the patient.** "Provide a statement of sympathy, such as, 'I'm sorry that happened to you,' and dispel myths voiced by the victim," advises Speck. "Assess the assimilation of the trauma both psychologically and socially, then plan for medical evaluation of post-trauma syndromes such as pelvic pain syndrome."

• **Word questions so that it doesn't sound as if the victim is at fault.** "Instead of saying, 'Did you put your mouth on him anywhere?' ask, 'Did he make you put your mouth on him anywhere?' This is a way to give control back to the victim, and can make a big difference," Brown explains.

• **Address STDs and pregnancy.** Patients should be offered both medication to prevent STDs and emergency contraceptives, recommends Brown. "It's a patient's choice; he or she can also have one and not the other," she says. "In our program, all meds are available so the patient doesn't need to go to the drugstore. That gives you more compliance, but it also provides more confidentiality. This way, she doesn't have to deal with the pharmacist looking at her and thinking, she must have been raped."

Sexual assault patients should be treated prophylactically for STDs, not tested, Hohenhaus recommends. "What you are testing at this time is the victim. If they are positive at the time of the exam, this may be discovered at court and may be used against her," she says. "By the time a search warrant is obtained for the assailant to be tested, he can have been tested and treated confidentially."

Instead, refer patients to a private doctor or the health department for further testing, Hohenhaus advises. "The CDC still does not recommend HIV prophylaxis for victims of sexual assault unless there is a known infected perpetrator," she notes. "This applies to adult victims."

• **Emergency contraception is offered to all patients, and all are tested for pregnancy.** "Generally speaking, we offer two tablets of Ovral at the exam with two to be taken 12 hours later," says Hohenhaus. "We also give them something to keep them from vomiting, as we have had women tell us they often can't keep the second dose down, especially after all of the meds we give for STD prophylaxis." ■

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3. Ledray L. November 1984 dissertation. The impact of rape and the relative efficacy of guide to goals and supportive counseling as treatment models for rape victims.

Stay informed about date rape drugs

Learn to recognize the reactions they can cause

Several date rape drugs have been widely publicized, but there are many more commonly used substances, says **Patty C. Feneski**, RN, ENP, prehospital coordinator at Desert Samaritan Medical Center in Mesa, AZ. "The three drugs you usually hear about are gamma hydroxybutyrate (GHB), Rohypnol, and ketamine, but they certainly aren't the most common ones," she says.

Any drug that causes central nervous system depression can be used to facilitate rape, says Feneski. "You can put any drug in a drink. This includes benzodiazepenes, opiates, amphetamines, barbiturates, and cocaine. Chlorohydrate is a drug that's been around since the 19th century, and is still used as a knockout pill."

Alcohol is by far the most common drug used in sexual assault, says Feneski. "Alcohol is a central nervous system depressant, and the drug I've found most often in victims of sexual assault," she notes. "There are four stages of depression. The first stage is sedation, with decreased mental and physical response to stimuli. The second stage is disinhibition, where rapes can occur, and there is impaired judgment and loss of control. The third stage is sleep, and the fourth is anesthesia."

There actually have been very few cases of Rohypnol use in sexual assaults, reports Feneski. "Rohypnol certainly can be used, but it's not common. It's not marketed in this country, but you can get it in Mexico. However, Hoffman La Roche has reduced the number of pharmacies that have it," she adds.

Here are some things to consider when managing patients who may have been victims of drug-facilitated sexual assault:

• **Know signs of date rape drugs.** Some signs a patient may have been a victim of drug-facilitated rape include:

— **inability to remember details of the assault;**
— **confusion;**
— **impaired judgment;**
— **dizziness;**
— **drowsiness and impaired coordination;**
— **appearance of intoxication, despite lack of alcohol consumption, or out of proportion to the amount of alcohol consumed.**

• **Patients may say they think they've been raped, but aren't sure.** "They might have awakened in a strange place with their clothes off, or been redressed with their clothes on backward," Feneski says.

• **Victims may not have full memory of the assault.** "For example, ketamine is used as a veterinary anesthetic, but it also has amnesiac qualities. So patients will have spotty memory, seem disoriented, and won't have all the details," Feneski notes. "If the history is vague, say, 'You seem fuzzy on details; are

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- Gamma hydroxybutyrate (GHB), Rohypnol, and ketamine have been widely publicized as date rape drugs, but any drug that causes central nervous system depression can be used to facilitate sexual assault.
- If you suspect a sexual assault was drug-facilitated, a urine sample should be obtained as quickly as possible.
- Victims of drug-facilitated rape exhibit a wide range of behaviors, but potential signs and symptoms include spotty memory, disorientation, and delayed reporting.
- A free drug testing service, that follows strict chain-of-custody procedures, is available for EDs.

you having trouble remembering?' If they say yes, ask if there is any potential that they have been drugged."

• **Victims of date rape drugs can have a wide spectrum of behavior.** "They may come in crying hysterically because they think something's happened and don't remember, or they may be very calm and controlled and not talk much," explains Feneski.

• **Suggest to police and physicians that a urine sample be sent to a federally certified forensic toxicology lab.** "They can test for some specific things that our tests in hospitals and routine crime labs don't usually pick up," says Fenseski. "We don't screen quite as carefully, and some of our tests aren't as sensitive as ones they use."

A free drug testing service is available to EDs at the ElSohly Laboratories in Oxford, MS, whose cost is underwritten by Hoffman La Roche. The testing program can be accessed by calling a toll-free hotline, and a strict chain-of-custody procedures is followed.

"They will fax you a form to complete and give you a FedEx number to send the urine sample," says Feneski. "The results are sent back confidentially in about a week." **(See list on p. 108 for contact information.)**

As of this year, 1,598 samples were tested at the lab, says Feneski. "Six hundred sixteen of the tests didn't find any drugs at all; and several of the tests were positive for more than one substance, including 649 for alcohol, 292 for marijuana, 218 for a benzodiazepene other than Rohypnol, 137 for cocaine, 115 for amphetamines, 59 for GHB, 47 for opiates, 21 for propoxyphene, 18 for barbiturates, seven for Rohypnol, and one for PCP," she reports.

• **Don't be suspicious of delayed reports.** "Many of these reports are delayed, because the victim will be asleep for awhile. It may be the next morning before they come in," she says. "People tend to question the delayed report more. However, a study of false allegations found they were all reported in a timely manner, so that refutes that old myth."[1]

• **Obtain a urine sample promptly.** "If patients call before coming to the ED, tell them if they have to void, to save the urine and bring it in with them in a sealed jar," says **Linda Ledray**, PhD, RN, FAAN, director of the Sexual Assault Resource Service in Minneapolis. "This is something new that we're just learning."

If it was a potentially drug-facilitated rape, the urine sample should be obtained as quickly as possible, says Ledray. "Substances are metabolized so quickly out of the system, that if there is a delay, the likelihood of positive results goes down dramatically," she explains. "We have collected samples up to 36 hours later, but never got positive results beyond 27 hours. The best results come from samples taken within six, seven, or eight hours of the incident." ■

Reference

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Do's and don'ts of evidence collection

Applicable tips for a faultless exam

Evidence collected in the ED from a sexual assault is often later used as an integral part of the victim's case. Errors made in documentation on the part of medical personnel during this important step may hinder the victim's credibility. It is imperative to remember the correct procedures to avoid contaminating the evidence or misrepresenting the victim's statements.

Errors are commonly made when collecting evidence from a sexual assault, says **Suzanne Brown**, RN, CEN, sexual assault nurse examiner at Inova Fairfax Hospital in Falls Church, VA.

"When you are examining a sexual assault victim, it becomes not just a medical exam, but also a legal exam," she notes. "If you do not collect evidence properly, it can hurt the victim's case."

Here are tips for collecting evidence of sexual assault:

• **Don't put clothing evidence in plastic bags.** "Always use paper bags, because the plastic tends to seal in moisture. While the evidence is being stored, you can get overgrowth of bacteria or fungus [which may

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Errors are commonly made in chain of custody and forensic issues during examinations of sexual assault victims.

- Avoid subjective comments like "hymen not intact." Instead, use fact-based language such as "blunt trauma to the hymen and vestibule."
- Use paper bags to store clothing evidence; plastic bags seal in moisture and may cause overgrowth of fungus or bacteria.
- All evidence should be labeled to include the name of the patient, the date of collection, and the name of the person who collected it.
- Use the victim's words instead of medical jargon when documenting the exam.

contaminate the evidence]," says **Eileen Allen**, RN, coordinator of the Monmouth County Sexual Assault Nurse Examiner (SANE) program in Freehold, NJ.

• **Don't alter damage to clothing evidence.** "If you have to cut clothing evidence, cut along the seams, not through holes caused by rips or use of weapons," Allen says.

• **Do dry specimens before packaging them.** "If swabs are used to collect oral, vaginal, or anal samples, they can be dried by being stood upright in a test tube rack or by pushing the shaft of the swab through the top of a tissue box so the cotton tip is in the air," advises Allen.

• **Do package evidence correctly.** "You can collect the best evidence in the world, but if you don't have everything signed and sealed, it can't be used in court," says Brown. "If a box had no seal on it, someone may have tampered with it, so it can't be used."

• **Do put evidence in separate paper bags.** "For example, put underpants in one bag and a shirt in another. This prevents cross-contamination of evidence. If the victim says her assailant ejaculated on the outside of her shorts, and there is now seminal fluid on the shoulder of her shirt, you will have to explain how it got there," says Brown. "That creates a little hole, so maybe it didn't happen the way the victim said it did. If you collect things separately, it prevents those kinds of issues."

• **Do label all evidence.** "All evidence should be labeled to include the name of the person you collected it from, the date of collection, and the name of the person who collected it. That begins the chain of custody of evidence," says Allen.

• **Don't break the chain of custody.** "Once evidence is labeled and sealed, it must be turned over to law enforcement immediately or stored under lock and key until it can be turned over to police," says Allen. "You can't leave it sitting on the counter and turn your back on it, because if anyone else might have access to it, the chain of custody might be broken."

Once you start collecting evidence, you can never leave the room for any reason, stresses **Linda Ledray**, PhD, RN, FAAN, director of the Sexual Assault Resource Service in Minneapolis. "If you forgot something or if you leave to care for another patient, you're breaking the chain of custody," she says. "You need to put the evidence in a locked refrigerator until you turn it over to the police."

• **Do use the victim's own words.** "The history of the assault should include a brief description in the victim's own words of exactly what happened to them, specifically including the position of both the victim's and assailant's bodies when the assault occurred, as well as any specific acts of physical contact or penetration," says Allen.

Avoid using medical jargon in the patient's chart, except in the description of medical findings, advises **Patricia Speck**, MSN, RN, FNP, CS, nurse coordinator for Memphis (TN) Sexual Assault Resource Center. "Drawings with objective descriptions of color, temperature, size, depth, and sensitivity are good court evidence and meet the criteria for fact-based evidence," she says.

The details of which acts occurred and in which sequence may become important, says Allen. "For example, if the victim reports she was assaulted in the front seat of an automobile, and was forced up against the door, it might cue the examiner to look closely at the skin surface on the victim's back, where pressure marks or bruising might be noted," she explains.

• **Don't include subjective comments.** "Opinions, like 'hymen not intact,' or 'patient appears drunk' are discouraged," says Speck. "In addition, legal terms like rape and sexual assault or abuse on the record are discouraged. In at least one case in Memphis, the judge disallowed a physician's ED record because the documentation was biased."

Instead, use descriptions that provide the reader with a fact-based picture of the evaluation. "For instance, 'The hymen was annular with two acute lacerations at 4 and 8 o'clock. Blue-black hematomas present at the capillary ring adjacent to the lacerations. Red bruising of the posterior fourchette. Edema present in the surrounding vestibular tissue'" Speck suggests.

By using fact-based descriptions, nursing diagnoses will also remain objective. "For example, 'Blunt trauma to the hymen and vestibule,' may result in nursing diagnoses such as, 'Rape trauma syndrome-acute stage,' 'Alterations in intimacy,' 'Alteration in elimination,' 'Pain syndromes associated with genital trauma,' or

SOURCES

For more information about managing sexual assault victims in the ED, contact:

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- ***The Sexual Assault Nurse Examiner Development and Operation Guide*** (DOJ-OVC, 1999) is available free through the Department of Justice's Office for Victims of Crime. To obtain a copy, contact the Office for Victims of Crime Resource Center at P.O. Box 6000, Rockville, MD 20849. Telephone: (800) 627-6872 or (202) 307-5983. Fax: (301) 519-5212. .
- **A free drug testing service** is available for EDs investigating sexual assault cases. The test is a series of three assays designed to detect certain drugs in the urine, including alcohol, amphetamines, barbiturates, benzodiazepines, cocaine, GHB, marijuana, and opiates. For more information, contact El Sohly Laboratories, Inc., 5 Industrial Park Drive, Oxford, MS 38655. Telephone: (601) 236-2609. Fax: (601) 234-0253. For testing, call (800) 608-6540. For general information about drugs and assault, call (800) 608-6540.

other client-driven and identified problems," says Speck. "Opinions are not valuable in this scenario." ■

MedicAlert jewelry can speed assessment

Emblems identify patients' medical conditions fast

If a patient has potentially life-threatening conditions such as hemophilia, diabetes, asthma, or allergies to medications, MedicAlert ID jewelry can speed assessment and avoid bad outcomes. "As part of your initial evaluation, you should always look for the bracelet," recommends **Charlotte Yeh**, MD, FACEP, medical director of Medicare policy at the National Heritage Insurance Company in Hingham, MA. "If it's not part of your routine, it should be, because it can be invaluable."

When a patient with Alzheimer's disease came to the ED with a complex medical problem, the MedicAlert emblem she was wearing made it possible to avoid hospitalization, recalls Yeh. "I was able to review her existing condition, find out who her primary care provider was, and contact that person. As a result, I was able to care for her in the ED, which shortened her stay," she says.

Nurses should encourage patients to be members of MedicAlert. "If you encounter patients with chronic conditions or who may have problems with communication, recommend this to them at discharge," Yeh advises. "Offer patients membership applications, or at least provide the 800 number." Here are some benefits of MedicAlert:

• **Information is attached to patient (on a bracelet or necklace).** "This is the one program where personalized information is attached to the patient," Yeh explains. "Other medical ID programs usually involve cards carried in the patient's wallet. Those aren't as useful, because they can be separated from the patient."

• **The emblem lists medical conditions that could affect care.** "This tells us immediately if a patient is allergic to insect stings and can immediately go into anaphylactic shock, or has implants such as a pacemaker or heart valve that could affect treatment," explains Yeh. "You can go to any drugstore and buy bracelets saying you are allergic to penicillin, but those are preprinted and don't have detailed contact information."

• **MedicAlert is also recognized internationally by the medical community**. She notes,"In this day and age of global travel, it's important that information be accessible at any time."

EXECUTIVE SUMMARY

- MedicAlert emblems can identify potentially life-threatening conditions.
- The emblem adds to information provided by caregivers about a child's medical condition.
- A 24-hour emergency response center can be called to obtain the patient's name, address, phone number, family contacts, and primary care provider.
- MedicAlert is an approved identifier in six states for "do not resuscitate" orders (DNR): Arkansas, Kansas, New Mexico, Maryland, West Virginia, and California.

• **The emblem adds to information provided by caregivers.** One study revealed that caregivers often can't adequately inform health care providers about children's special needs, reports **Alfred Sacchetti**, MD, FACEP, an emergency physician at Our Lady of Lourdes Medical Center in Camden, NJ.[1] "In the study, parents were interviewed when they brought their children to specialty clinics. They looked at whether they had enough knowledge to explain the child's medical condition," he explains. "By and large, we found the majority of parents could not, in a consistent fashion, explain to a health care provider unfamiliar with the child what was going wrong with them."

One child had a complex cardiac problem, and the patient's mother didn't adequately explain the condition, Sacchetti recalls. "The mom didn't know enough to explain that oxygen would make the child's condition worse," he says. "Of course, everybody starts out getting oxygen, and it wasn't until we got hold of a consultant that we were able to get that information."

Medical ID jewelry can be lifesaving in those situations, says Sacchetti. "It's true that parents know more than most specialists do. But no matter how much parents are educated about their child's problem, they can't tell us everything we need to know. And if the parent isn't there, the child can still be identified to all health care providers."

• **A 24-hour medical database is available.** A 24-hour emergency response center can be called to obtain additional information, which can be immediately faxed over or shared over the telephone. (For more information, call (800) 825-3785.)

"MedicAlert is not only for preliminary information. You also have access to the patient's medical history and contact information for that individual," explains Yeh.

Nurses should use this medical database, urges Yeh. "MedicAlert is a two-part service. First, nurses should look at the emblem, and second, they should access the medical database," she says. "It's not widely known that there is a national medical database available."

The 24-hour hotline number can be dialed collect from anywhere in the world. When ED staff call the number, they reach the MedicAlert Emergency Response Center. Within seconds, operators dispatch computerized medical information by voice or fax. Information includes the patient's medical conditions, allergies, special needs, and the names of personal physicians and family members, and can be updated an unlimited number of times by members at no charge.

Like any data, however, they are only as good as the input, notes Yeh. "The process is when somebody signs up, he or she is given a detailed medical sheet to complete. If the person does not keep it updated, then the information can be outdated," she says. "However since contacts are listed, you will at least have information on who to contact to get the latest information."

• **The emblem confirms identification of the patient.** MedicAlert can also provide identification for patients who are unconscious, disoriented, or unable to speak when they arrive at the ED. "We've all had the embarrassing situation of having a critically ill or injured person and contacting the wrong family or misidentifying the patient, because his or her [personal items] did not accompany him or her to the ED," says Yeh.

• **Identification of do not resuscitate (DNR) patients.** "MedicAlert is an approved identifier in six states for DNR, which are Arkansas, Kansas, New Mexico, Maryland, West Virginia, and California," says **Rose Marie Tantillo**, JD, RN, advance directive DNR program manager at MedecAlert Foundation, based in Turlock, CA.

Upon receipt of DNR forms approved by the state, the MedicAlert emblem is engraved according to state requirements. "We keep a copy of the patient's DNR order on file, which is in our database. When a health care worker sees that, they know there is a DNR order in effect. That emblem, in effect, acts as a DNR order, and they can withdraw or withhold resuscitative measures," Tantillo says.

• **A copy of the patient's DNR form can be faxed as needed.** "Whether that is valid in their state or not depends on state guidelines," says Tantillo. "Some states require that they see the original, but anything can be used to show the intent of the person."

In Arizona, a patient had a DNR on file with Medic-Alert. "The ED nurse contacted MedicAlert and asked us to pull the order and read it over the phone. The physician verified it and called the code at that point," Tantillo reports. "In that case, the bracelet indicated the wish for DNR, and we verified that we had the order." ■

SOURCES

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- **A new training program** for ED personnel is available from MedicAlert to enhance awareness and use of its emergency medical information service. The program includes a student participation manual, visual aids including PowerPoint presentation, CD, slides, case studies, and an explanation of how the MedicAlert identification emblem works as a DNR order. To order, contact MedicAlert, 2323 Colorado Ave., Turlock, CA 95382. Telephone: (800) 825-3785 or (209) 669-2436. Fax: (209) 669-2457.

Reference

1. Carraccio C, et al. Family member knowledge of children's medical problems: The need for universal application of an emergency data set. *Pediatrics* 1998;102:367-370.

Cutting-edge concepts for airway management

Advances provide options for critical intubation

When you're faced with a patient with a difficult airway, you need as many options as possible. "There are a number of new approaches in airway management which ED nurses must be aware of," emphasizes **Ron M. Walls**, MD, FRCPC, FACEP, chair of the department of Emergency Medicine at Brigham and Women's Hospital in Boston. "It's extremely important for nurses to keep up to date with these changes."

Here are updates on the latest in airway techniques, equipment, and medications:

• **Techniques.** The biggest change in airway management over the past 10 years has been the advent and widespread use of neuromuscular blocking agents, especially succinylcholine, to facilitate ED intubation, notes Walls. "Physicians have received additional training in this important technique, either in residency training programs or in special continuing medical education courses," he says.

This permits safer, faster, and more successful intubation using a technique called rapid sequence intubation (RSI). "Emergency nurses should be aware of the principles of RSI, including the application of the Sellick maneuver, which is a posterior displacement of the cricoid cartilage against the interior surface of the sixth cervical vertebral body, compressing the esophagus and, thus, preventing passive regurgitation of gastric contents," says Walls.

Know the drugs used for RSI, the expected sequence, and recommended doses of these drugs, and the monitoring used for rapid sequence intubation, including blood pressure, pulse, oximetry, and end-tidal CO_2, recommends Walls.

New devices are emerging

Rapid sequence intubation involves the simultaneous administration of a potent sedative agent, such as etomidate or midazolam, with a neuromuscular blocking agent, usually succinylcholine, to render a patient unconscious and paralyzed for rapid tracheal intubation.

The technique involves pre-oxygenation and other specific steps to achieve tracheal intubation rapidly and safely, with minimal risk of aspiration of gastric contents, Walls says. "This is a technique that ED nurses should be familiar with," he stresses.

Other techniques, such as cricothyrotomy, are not new to ED airway management, but are vitally important, Walls explains. "Cricothyrotomy occurs in about 1% of all ED cases of airway management," he says. "New devices are just coming on-line and ED practitioners can expect to see more of them as time goes on."

• **Equipment.** New devices are emerging that are useful in the difficult and failed intubation scenario, Walls notes. "The intubating fiberoptic bronchoscope is becoming more widely used in EDs by emergency physicians," he says. "New laryngoscopes, such as the Bullard rigid fiberoptic scope, and new devices, such as the Intubating Laryngeal Mask Airway (ILM) and the lighted stylet, are expanding emergency airway management."

It's possible to intubate through the Laryngeal Mask Airway (LMA), notes **Robert Schneider**, MD, FACS, FACEP, residency director of the department of emergency medicine at Carolinas Medical Center in Charlotte, NC. "You can take up to a nine endotracheal tube and pass it through the aperture of the fast track, and right into the glottic opening, [or] use a fiberoptic bronchoscope or pharyngoscope and do direct endoscopy

EXECUTIVE SUMMARY

Rapid sequence intubation (RSI) involves the administration of a potent sedative agent with a neuromuscular blocking agent to render a patient unconscious and paralyzed for rapid tracheal intubation.

- Monitoring used for rapid sequence intubation includes blood pressure, pulse, oximetry, and end-tidal CO_2.
- Rocuronium is a new airway medication that can be used in place of succinylcholine to achieve rapid tracheal intubation.
- New devices are being used for difficult and failed intubation scenarios, including the intubating fiberoptic bronchoscope, laryngoscopes, and devices such as the Intubating Laryngeal Mask Airway (ILM), Combitube, and the lighted stylet.

through the LMA or intubate over it," he explains.

The fast track LMA consists of a mask around the glottic opening, Schneider says. "It's like having a mask around the face, except it's a mask (the diaphragm portion of the fast track) that fits around the glottic opening, as opposed to fitted securely around the airway. You have an opportunity to oxygenate the patient and then intubate them right through the fenestrations of the device."

Combitubes are another rescue device that EMS personnel might be using, says Schneider. "It's like the old esophageal obturator airway (EOA) tubes, except you are able to oxygenate the patient with the Combitube even if you inadvertently place it into the airway. With the EOA, you didn't have an opening at the distal end of the tube. If you were unfortunate enough to place the tube into the airway instead of the esophagus, you were stuck,"

The Combitube may be used in the prehospital setting for patients whose airway reflexes are depressed. "Otherwise, the patient won't tolerate the tube," Schneider notes. "Some prehospital providers are using the Combitube instead of rapid sequence intubation to oxygenate the patient until they can get them to a primary treatment facility where the patient can then undergo definitive endotracheal intubation."

The Combitube is also used in the ED as a rescue device. "If you have a patient you are unable to intubate, you can put a Combitube in there and continue oxygenation until you can figure out an alternative way of intubating the patient," says Schneider. "But the Combitube doesn't substitute for having a cuffed endotracheal tube beneath the cords."

Know the basic mechanics of the tube and the principles behind it, Schneider advises. "You have two balloons on the Combitube. The larger one, which is inflated first, is in the hypopharnyx, and that balloon usually takes 100 cc of air. It's important to blow that up first so it takes on the anatomy of the pharynx, and then inflate the esophageal balloon," he explains.

The oxygenation port of the Combitube differs from the LMA in that it oxygenates by approximation rather than sitting over the glottic aperture like the LMA does, Schneider notes. "The LMA simulates the standard bag that we use, whereas the Combitube is a series of holes placed circumferentially around the tube. You've got an obstruction above (hypopharyngeal balloon) and below (esophageal balloon), and you insufflate oxygen, hoping that enough oxygen finds its way into the patient's airway."

Both are easy devices to pass, says Schneider. "The Combitube is like passing an NG tube. It's not that difficult, you just need to understand and follow the anatomy," he says. "The fast track LMA is also extremely easy to pass."

In addition, end-tidal CO_2 detectors are now so readily available that they should be used for all ED intubations to ensure that the tube has been placed in

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the trachea and not in the esophagus, Walls reports.

• **Medications.** "The most important new airway medication may be Rocuronium, a relatively new, more rapidly-acting agent in the same class as pancuronium and vecuronium," says Walls. "This drug can be used in place of succinylcholine, when succinylcholine is contraindicated, to achieve rapid tracheal intubation."

As with all neuromuscular blocking agents, Rocuronium does not sedate the patient, Walls notes. "Concomitant use of a potent sedative or induction agent is necessary, as it is with succinylcholine," he says.

Etomidate is an older induction agent that is finding new life in the ED, Walls reports. "This drug causes rapid loss of consciousness and is more hemodynamically stable than most other available induction agents," he says. "It is commonly used with succinylcholine for RSI."

It is also key to understand the pharmacology of RSI, and know the milligram-per-cc dose is of every agent you're administering, warns Schneider.

"Ketamine is a perfect example of an agent that comes in two different concentrations. If you think you're giving the weaker one but you're actually giving the stronger one, you're obviously going to get a result that you weren't anticipating," he says. ■

CE Objectives

After reading this issue of *ED Nursing*, the CE participant should be able to:

1. Identify clinical, regulatory, or social issues relating to ED nursing.
2. Describe how those issues affect nursing service delivery.
3. Cite practical solutions to problems and integrate information into the ED nurse's daily practices, according to advice from nationally recognized experts. ■