Management of Acute Child and Adolescent Sexual Abuse and Assault

SCAN Team Sexual Assault/Abuse Medical Evaluation Clinical Care Pathway

ED or clinic triage assessment determines suspected or confirmed Sexual abuse or assault concerns

ED to gather brief summary of abuse or assault from most appropriate source i.e. police, Children's Aid Society (CAS), parent or caregiver. Avoid collecting information from child or adolescent

Prior to ED medical assessment SCAN clinician on call to provide recommended course of action and communicate with ED MRP

SCAN clinician initiates the Sexual Abuse and Assault Medical Evaluation clinical care pathway if 9am-5 pm – in SCAN clinic; before 9 am and after 5pm in ED by SCAN team

SCAN clinician to gather following information not in the presence of the child from caregiver/police or CAS for child or adolescent with caution:
- History related to abuse/assault
- Determine type of contact
- Determine symptoms

Was Sexual Assault within 72 hours?

ED to medical assessment Triage RN to call SCAN team prior to medical assessment

ED RN
ED MD
SCAN Team

SCAN clinician to assess in ED immediately or next day

Child or adolescent has medical and/or psychological symptoms

No symptoms and non urgent needs

If indicated and within 120 hours of assault as per PEP protocol, consider prophylactic treatment as per order set.

Report to CAS

Complete written documentation and photodocumentation (Policy)

If indicated, collect forensic evidence using SAEK

Complete HIV Post Exposure Prophylaxis (PEP) Assessment

If indicated and within 120 hours of assault, consider Emergency Contraception

Discuss follow-up plan (PEP, STI testing)

Discharge Planning

- Assess Safety
- Follow-up appointments
- Explain findings to patient/caregiver/CAS and if consent Police
- Discuss follow-up plan (PEP, STI testing)

Mental Health Assessment

Complete STI testing

If indicated, administer STI presumptive treatment

No

Yes

Yes

Is patient under 16 and/or is there a child protection concern?

Discuss reporting to police with consent

Report to CAS

Complete Physical/Genital Examination (Techniques)

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1.0 Introduction

Children and adolescents who have been acutely sexually abused/ assaulted regularly come to SickKids for a medical evaluation. These patients are often assessed in different clinical settings by medical providers with varying levels of training and experience. Given the medical legal nature of the evaluation of children and adolescents with suspected and/or confirmed sexual abuse/assault including the potential child protection and criminal justice implications, there is a need for a consistent, evidence based approach to assessment and managing these patients.

The purpose of this clinical practice guideline (CPG) is to articulate a standard of care for the emergency department (ED) and the SCAN Program Clinic when providing care to children and adolescents who have experience acute sexual abuse/assault.

Target Population

This guideline is intended for use with children and adolescents who have experienced acute sexual abuse/assault and their families who:

- are between the ages of 0 to 18 years; and
- present to ED or the SCAN Program clinic within 72 hours following a sexual abuse/assault event.

Target Users

The target users of this CPG are healthcare providers caring for children or adolescents who have been sexually abused or assaulted, or with whom there is a suspicion of sexual abuse or assault. These health care providers include:

- Nurses, Sexual Assault Nurse Examiners, Nurse Practitioners at SickKids;
- Staff Physicians, Residents, Fellows at SickKids;
- Providers who provide consultation to other organizations caring for or involved with this population; and
- External partners outside of SickKids.
2.0 Definitions

- **Sexual abuse**: occurs when a child under the age of 16 is used for sexual purposes by an adult or adolescent. It is inherently emotionally abusive and is a betrayal of trust and an abuse of power over the child. Sexual abuse is often accompanied by other forms of mistreatment. Child sexual abuse involves exposing a child to any sexual activity or behavior, whether direct or indirect[1].

- **Sexual assault**: any form of unwanted sexual activity that is forced upon a person without that person’s consent. Sexual assault can range from unwanted sexual touching to forced intercourse. While most sexual assaults are perpetrated against women, both women and men can and are sexually assaulted[1].

- **Child**: for the purposes of this CPG a child is typically under the age of 12 and has not entered the stages of puberty.

- **Adolescent**: for the purposes of this CPG an adolescent is over the age of 12 and has entered stages of puberty.

3.0 Clinical Practice Recommendations

*Refer to Appendix A for Grades of Recommendation for each of the Clinical Practice Recommendations*

3.1 ED Management of Sexual Assault/ Abuse

3.1.1 Triage Timing

- All patients presenting to the ED with a reported history of sexual abuse/assault must be triaged immediately[2-5]

- Click for: [ED to SCAN Patient Flow Process](#)
3.1.2 Components of initial triage assessment

- Obtain a brief summary of abuse or assault concern from most appropriate source. The source may be police, the Children’s Aid Society (CAS), caregiver or patient. If possible, information should not be collected directly from the child or adolescent [6].
- If known, the summary should include the following:
  - When the abuse/assault occurred or last contact with the alleged offender.
  - Type of contact (genital-genital, oral-to-genital, genital-anal, digital-genital/anal etc.).
  - Physical and mental health symptoms (ano-genital pain/bleeding/discharge, suicidality etc.).
  - Involvement of CAS and/or police.[6]
- Triage RN to call the SCAN program to determine an appropriate plan.
- The SCAN clinician and the ED Managing Physician will determine a plan collaboratively prior to the child or adolescent being seen.

3.2 Timing of Examination in ED

- The timing of the examination depends on several variables [3, 7, 8].
- It is recommended that when possible, children/adolescents and families be seen in a coordinated manner, and the least intrusive environment.
- When possible, children and adolescents should be interviewed by police/CAS prior to the medical examination.
- The following are indications for an emergency evaluation:
  1. Medical concerns such as acute pain, bleeding or discharge. The nature of the symptoms will influence how emergently an examination is needed [8].
  2. Psychological or safety concerns [9]
  3. Alleged assault that may have occurred within 72 hours for pre-pubescent children and 298 hours (12 days) for adolescents (see forensic evidence section for further details) [10-12]
4. Need for emergency contraception up to 120 hours (5 days) after alleged assault\textsuperscript{13, 14}

5. Need for HIV post-exposure prophylaxis (HIV PEP) up to 72 hours \textsuperscript{15, 16}

6. Need for post-exposure prophylaxis for other sexually transmitted infections (STI) and/or STI testing \textsuperscript{15, 17}

**Practice Point:**
If a child/youth does not fit any of the above indications, and does not need to be seen in the ER, arrangement with the SCAN program should be made immediately for follow-up. Please call before sending a child to the clinic 416-813-6275 or 416-813-1500 after hours.

### 3.3 Medical Evaluation

The medical evaluation in the ED or SCAN Program clinic should be completed by a member of the SCAN team (NP, MD, MD fellow) unless there is an emergent medical need to be addressed.

#### 3.3.1 Medical History

- Objective of the medical history is to gather information necessary to guide medical decision-making and forensic evidence collection\textsuperscript{18, 19}.
- History related to the abuse/assault should be gathered from the caregiver and/or police/CAS whenever possible \textsuperscript{6, 14, 16, 18}
- Pre-pubescent children: further required history and a medical history should be gathered from the caregiver and not in the presence of the child.
- Adolescents: further required history pertaining to the abuse/assault and a medical history may be gathered from the adolescent with caution using open ended questions.
• Children and adolescents should not have a forensic interview by a health care professional. A forensic interview is conducted by child protection and/or police officers as a part of the investigation of the sexual abuse/assault allegations.
• Please refer to the Sexual Assault Nurse Examiner Documentation Form for specific elements to include in the medical history

3.3.2 Ano-genital Examination

• The ano-genital examination should be performed by a healthcare provider with experience and expertise in the area of sexual abuse. Please refer to the Guidelines for Examination of Genitalia in Children.
• A complete head to toe examination including genitalia should be offered. The following principles should be considered when performing a physical examination in the context of sexual abuse/assault:
  ▪ Ensure patient comfort and privacy
  ▪ Never restrain, sedate, force or coerce a child into an examination
  ▪ The examination should be tailored to the child or adolescent and he/she should be given as much control over the examination as possible \[16\]
  ▪ Examiners should be aware that a genital examination may be difficult for a child or adolescent in the context of sexual abuse/assault and provide appropriate support
  ▪ Examiners should explain the examination and procedures in a developmentally appropriate manner \[16\]

• There are several different positions that will optimize the examination with regards to visualization and specimen collection. See Adams, 2016 – examination techniques

3.3.3 Ano-genital Examination Techniques

• For specific examination techniques, see Adams, 2016 – examination techniques
• The following should also be considered:
- An internal speculum examination must not be done on pre-pubertal children [18]. A speculum examination is rarely indicated in the adolescent patient in the context of sexual abuse/assault. Indications for a speculum examination in adolescents include:
  - Ongoing bleeding (no external source)
  - Collection of cervical specimens including cervical NAAT sample if indicated
  - Suspected foreign body
- Measurement of the hymenal opening should not be performed [20]
- Examination under anesthesia is rarely indicated in the context of sexual abuse/assault.
- Forensic evidence collection is not an indication for an examination under anesthesia
- Consider examination under anesthesia only when medical signs and symptoms indicate the need. These may include:
  - Ongoing bleeding (no external source)
  - Suspected foreign body
  - Suspected STI when appropriate samples are not able to be collected
  - Need for surgical intervention

3.3.4 Determining sexual maturation rating (SMR)

- Sexual maturity rating is a standard system used to assess child/adolescent physical development, using five stages (from preadolescent to adult) based on degree of maturation of secondary sexual characteristics during puberty which permits the healthcare professional to gauge the degree of pubertal maturation that has occurred [21]
- Refer to Sexual Maturation Rating Guide for further information.

3.3.5 Interpretation of Findings

- To ensure that accurate and relevant opinions are generated, an evidence based approach to interpreting the results of the ano-genital examination is required [22]. Findings should fall into one of three of the following categories:
1. Findings documented in newborns or commonly seen in non-abused children;
2. Findings with no expert consensus on interpretation with respect to sexual contact or trauma; and
3. Findings caused by trauma and/or sexual contact (if findings fall under category #3 photos should be taken and immediately reviewed by a peer for a second opinion)

* Further description of all findings and categories can be found in Adams, 2016

3.3.6 Documentation

- Document who is in the room for the examination and positioning techniques
- For both female and male patients, all parts of the genitalia should be described.
- Genital and non-genital injury or findings should be noted for type, appearance, location and measurement.
- Use the face of a clock to document the location of genital findings with 12 o’clock at the anterior portion of the hymen and 6 o’clock at the posterior portion when child/adolescent is in the supine position [6]

* Photodocumentation is a standard of care (especially for examinations with abnormal findings), with either a colposcope or a hand held camera. Diagnostic quality images allow for peer/expert review for quality assurance, teaching and legal proceedings. A detailed written description of the examination findings should always accompany photographs [6, 23, 24]

- Photographic images are considered Personal Health Information under the Personal Health Information Protection Act 2004.
- Specific consent for photography must be obtained from the caregiver and/or patient as appropriate. Children and caregivers always have the right to decline photographs being taken.
- Photographs should be taken, stored, transferred and retained according to hospital policy (Taking Photographic Images of Patients)
3.4 Forensic Evidence Collection

- Decisions to collect forensic evidence should be based on the case history of the abuse/assault and the age of the victim, including the time interval between the assault and presentation to a medical facility as well as certain factors that may reduce the likelihood of forensic evidence recovery (i.e. bathe/shower, voiding).
- See hospital instructions included in the Sexual Assault Evidence Kit (SAEK) for further details.

3.4.1 Timing of evidence collection

- Forensic evidence collection is recommended for sexual contact that may have resulted in the exchange of biologic material up to 72 hours in pre-pubertal children and 12 days in adolescents depending on the type of contact \[^{[11, 12, 16, 23]}\].
- Penile penetration of the rectum (regardless of shower /condom use). Evidence collection up to 72 hours.
- Oral-genital contact of the patient (has not showered). Evidence collection up to 72 hours.
- Oral-genital contact by the patient. Evidence collection up to 24 hours.
- Digital penetration of the vagina and/or rectum (regardless of shower) evidence collection up to 72 hours.
- Penile penetration of vagina (regardless of shower/condom use) evidence collection up to 12 days in the case of adolescents.

3.4.2 Consent for Evidence Collection

- There is no age of consent to collect and release the SAEK to law enforcement. In order to give consent, the patient must be able to understand the information that is relevant to making a decision about the use of the SAEK and be able to appreciate the reasonably foreseeable consequences of a decision or lack of decision. If the patient is not capable of consenting, then consent from a guardian must be obtained.
• The option exists for patients to have evidence collected and stored in a secure manner if they are unsure whether they wish to involve the police. Releasing the SAEK to the police requires written consent from the patient and/or guardian.

3.5 Sexually Transmitted Infection Testing

3.5.1 Indications for Testing

• Each child/adolescent should be assessed individually with regards to testing for sexually transmitted infections (STI).
• The following situations put the child at higher risk for STIs and are indications for testing [6, 17]
  - The child has symptoms or signs of an STI (e.g. vaginal discharge or pain, genital itching or odor, urinary symptoms, genital ulcers or lesions).
  - The suspected assailant is known to have an STI or to be at risk for an STI
  - Another child or adult in the household is known to have an STI
  - The prevalence of STIs in the community is high
  - There is information to suggest evidence of genital, oral or anal contact.

3.5.2 Testing Methods [15, 25-27]

• Specimen sampling sites should be established based on the point of sexual contact from the history, timing of potential exposures or if symptoms are present.
• If there is no point of contact identified, consider risk and intrusive nature of testing.
• If potential exposure was recent; to avoid potential false-positives and/or false-negatives, the specific STI window periods should be considered and STI testing may have to be delayed/repeated at follow-up.
• As stated in Public Health Agency of Canada (PHAC) STI Guidelines, in pre-pubescent children, cultures have been the preferred method for medical-legal purposes, but Nucleic amplification acid tests (NAATs) may be acceptable if positive results are confirmed by a second set of primers or, in some cases a second test sent to another laboratory. [17]
Please refer to the SCAN STI testing protocol.

3.5.3 STI Prophylaxis treatment

- Prophylaxis for gonorrhea and chlamydia prophylaxis is not recommended in prepubescent children\(^\text{[17]}\). However, it can be considered in patients, including adolescents, where follow-up may be difficult to ensure.
- If follow-up cannot be guaranteed to conduct proper testing, prophylaxis and testing should be considered.
- Prophylaxis should not be provided if the samples for STI testing are being collected and followed up of any positive results can be ensured.
- If the patient has not received the Hepatitis B vaccine, provide the first dose of the vaccine. If Hepatitis B vaccine status is unknown, consider serology to determine Hepatitis B antibody titers.
- If the patient is unvaccinated and the alleged perpetrator is known to have Hepatitis B, provide Hepatitis B Immunoglobulin (HBIG).
- For more information, including current medication recommendations refer to the Public Health Agency of Canada guidelines.

3.6 HIV Post Exposure Prophylaxis

- Human Immunodeficiency Virus (HIV) Post-Exposure Prophylaxis (PEP) should be offered to all children and adolescents who are considered at risk for HIV infection and who present within 72 hours of a sexual assault or the last incident of sexual abuse\(^\text{[15]}\).
- The sooner HIV PEP is initiated, the greater the likelihood that it will prevent transmission\(^\text{[6, 14, 15]}\).
- Refer to the HIV PEP protocol and HIV order-set for assessment of risk, medication dosages, and follow-up procedures.
3.7 Emergency Contraception \[13, 14, 16\]
- Offer emergency contraception to pubertal patients who report vaginal-penile penetration.
- Offer the emergency contraceptive pill (ECP) to patients presenting within 120 hours (5 days) of exposure; ideally as soon as possible.
- A pregnancy test must be done prior to providing ECP.
- When applicable, patients should be counseled that ECP is less effective in women weighing 75-80 kg and not effective in women over 80 kg. If over 80kg, insertion of IUD can be considered as an alternative (consider consultation with Gynecology or Adolescent medicine).
- Refer to the SCAN Order set for dosing information.
- Position Statement on Emergency Contraception.

3.8 Reporting to the Children’s Aid Society
- In Ontario, the criteria for reporting child abuse and/or neglect are governed by the Child and Family Services Act.
- Professionals and members of the public are obligated to report concerns forthwith to a Children's Aid Society where there are reasonable grounds to suspect that a child (under 16yrs of age) has suffered or there is a risk that a child is likely to suffer, abuse or neglect”. This report must be made by phone immediately by the person receiving the information upon which the concern is based. It cannot be delayed or delegated to another individual. Health care providers must share relevant patient information with the child protection agency. For further information refer to the Child and Family Services Act or call the appropriate Children’s Aid Society. In most cases, a report should be made to the Children’s Aid Society located in the area in which the child or adolescent resides.
- Child Abuse and Neglect Reporting.

3.9 Reporting to Police
- Health care providers must obtain formal consent in order to share information with the police.
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- According to the [Criminal Code of Canada](#), the age of consent for sexual activity is 16 years of age. Refer to the Criminal Code for further detail.
- A report may be made to police on behalf of the child/guardian or adolescent provided they have given consent.
- Once the Children's Aid Society has formally launched a joint investigation with police health care providers can share information about the reported concerns directly with police.
- [Guidelines for Police Investigations](#)

### 3.10 Crisis Intervention and Mental Health Assessment

- Appropriate psychosocial support is integral to the care provided to sexual abuse and assault patients and their families. The following should be considered:
  
  - Trauma symptom screen [28]
  - Suicide and/or self-harm risk assessment [29]
  - Psycho-education around coping.
  - Psycho-education for non-offending caregivers around responding to and supporting their child as well as their own coping [30].
  - Any additional concerns raised by patients and/or caregivers.
  - Follow-up in the SCAN clinic and/or connection with appropriate community resources.

### 3.11 Discharge & Follow-up [18]

- Health care providers should address the following issues with patients prior to discharge:
  
  1. Ensure the patient’s medical and mental health needs related to the assault have been addressed.
  2. Arrange a follow-up appointment based on the patient’s medical and psychosocial needs.
  3. Ensure that a plan is in place to address the patient’s safety and well-being after leaving the hospital. This should be done in collaboration with the Children’s Aid Society and police when applicable.

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4. Provide the child/adolescent and/or caregiver/CAS with discharge instructions including the following:

- A summary of the visit (evidence collected, tests conducted, medication prescribed or provided and treatment received);
- Information on medications to be taken;
- Follow-up appointment date(s) and time(s);
- Information on any referrals made; and
- Provide patient with contact information for the SCAN Program

4.0 References


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**Version: 1**


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Appendix A

Statement of Evidence

Search Strategy:
- A systematic search for existing Clinical Practice Guidelines was conducted in October 2009 using the Internet and the OVID database (MEDLINE, Embase) to search for CPGs. To be included as a potential CPG to adapt for use at SickKids, the CPG must have met the following criteria:
  - Published or updated within the past 5 years (2005 or after);
  - Included clearly articulated and directive recommendation statements (i.e. easily extracted for practice)
  - Included pediatric specific recommendations
  - Included at least one section relevant to:
    - Assessment/Diagnosis
    - Pharmacological/Non-Pharmacological Treatments
    - General Management
    - Referral/follow-up

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CPG Selection:

- This CPG has been adapted from the following current guidelines: The U.S. Department of Justice, A National Protocol for Sexual Assault Medical Forensic Examinations: Adults/Adolescents (2013); the World Health Organization (2013 & 2003 respectively): Responding to intimate partner violence and sexual violence against women; and the Guidelines for medico-legal care for victims of sexual violence. The ADAPTE Framework was used to assess the applicability of these guidelines.
- Not all recommendations from the above noted guidelines were adopted for the SickKids Management of Acute Child and Adolescent Sexual Assault and Abuse Clinical Practice Guideline. Recommendations that were relevant to pediatrics and the care offered within SickKids for the acute management of sexual assault or abuse were either (i) adopted (taken directly) or (ii) adapted (with minor modifications for use at SickKids).
- If a recommendation was adapted, the changes are noted in parentheses. Where these guidelines were lacking in addressing specific procedures related to pre-pubertal children and/or adolescents, additional research/literature was used to supplement the recommendations.
- Some SickKids consensus recommendations are included that were not taken from the guidelines and these are clearly identified by "SickKids Consensus" in parentheses throughout the guideline text. The research considered when developing the recommendations is discussed in the original publication of the guidelines or in the case of recommendations not adapted or adopted from a current guideline, the research considered is indicated within the CPG. Please click on each link to access the original guideline publications for more detailed information.

Grades of recommendation

A
Recommendation supported by at least one randomized controlled trial, systematic review or meta-analysis.

B
Recommendation supported by at least one cohort comparison, case study or other experimental study.

C
Recommendation supported by expert opinion or experience of a consensus panel.

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Appendix B

Implementation Plan

Facilitators:
- Standardized evaluation and management process
- Standardized tools: HIV PEP order set and protocol; STI testing protocol, SCAN team documentation tool; and SEAK
- ED staff engagement
- SCAN team orientation for medical trainees
- 24/7 SCAN team responder

Barriers:
- High staff turn-over rate; mitigate by providing standardized education to new staff in ED and SCAN team

Measurement Plan

Metrics:
- Retrospective chart audit to include:
  - Appropriate use of HIV order set
  - Appropriate STI testing and/or treatment
  - Frequency of use of Sexual Assault Documentation
  - Appropriate use of emergency contraception
  - Frequency and appropriateness of forensic evidence collection
  - Appropriate CAS or Police involvement
  - Appropriate mental health assessment completed
- Assess usability of pathway
- Frequency: monthly for 6 months following implementation and quarterly thereafter

Attachments:

Emergency Department SCAN Patient Flow.pdf

SCAN PEP orderset Final Feb 15 2017.pdf

HIV PEP Protocol December 2016.pdf

Guidelines for Medical Assessment and Care of Children who may have been Sexually Assaulted.pdf

Sexual Maturation Rating.pptx

SCAN Documentation Template.pdf
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STI Testing Protocol.pdf