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Clinical Judgment Development: Six Steps to Establish Professional Identity and Role-Specific Competencies in Caring for a Sexual Assault Survivor

Rose Eva Constantino[1*], Larissa C. Allen[2], Vivian Hui[2], Kelly M. Nitowski[2], Brayden Kameg[2], Amy S. Bowser[2], Rebecca Burkart[2], Betty Braxter[2]

[1]Department of Health and Community Systems, School of Nursing, University of Pittsburgh, Pittsburgh, Pennsylvania, USA
[2]School of Nursing, University of Pittsburgh, Pittsburgh, Pennsylvania, USA
Email: *rco100@pitt.edu, lca16@pitt.edu, CHH168@pitt.edu, KMN64@pitt.edu, bnk13@pitt.edu, amybowser@pitt.edu, REB166@pitt.edu, Bjbst32@pitt.edu

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Abstract

Background: Clinical judgment is a specific role that establishes a professional identity. The purpose of this paper is to prepare nursing students to make better judgments in the clinical setting and realign learning and teaching. **Methods:** We used six steps to arrive at a competent clinical judgment suggested by the National Council State Board of Nursing (NSCBN) as a clinical judgment model 1) recognizing cues, 2) analyzing cues, 3) prioritizing hypotheses, 4) generating solutions, 5) taking an action, and 6) evaluating outcomes during the head-to-toe examination of the patient. **Results:** The primary outcomes are stabilization of the hemodynamics of the patient and prevention of further blood loss. Fluids are being given to help keep the vascular volume from being depleted, but they cannot solve the underlying problem. Continued assessment, intervention, and monitoring of vital signs through the course of the hospital stay ending with the patient's discharge. **Discussion:** Survivors of sexual assault are unique for a nurse to provide care. The nurse needs to assess, intervene, monitor, and pay attention to detail of the 6 steps to clinical judgment, resulting in positive outcomes for their patient. **Conclusions:** Forensic nursing is a field of nursing that focuses on sexual assault survivor care and works to make the aftermath of their tragic situation easier to cope with. Strengthening clinical judgment skills could remedy significant mistakes made by novice forensic nurses. Critical thinking and clinical ethical reasoning are the building blocks of clinical judgment.

Keywords

Analyze Cues, Clinical Judgment, Evaluate Outcomes, Generate Solutions, Prioritize Hypotheses, Recognize Cues

1. Background

Clinical judgment is a specific role that establishes a professional identity. As a BSN, MSN, DNP, and/or PhD student, and educator, preparing to make better judgments in the clinical setting is essential in establishing the contours of professional practice [1]. The American Association of Colleges of Nursing identifies knowledge for nursing practice including integration, translation, and application of established and evolving disciplinary nursing knowledge and ways of knowing that distinguishes the practice of professional nursing and forms the basis for clinical judgment and innovation in nursing practice [2]. In 2019, the National Council State Board of Nursing (NSCBN) published newsletters describing the clinical judgment model [3]. This model shows the clinical judgment process occurring in six steps. These six steps to arriving at a competent clinical judgment include, 1) recognizing cues, 2) analyzing cues, 3) prioritizing hypotheses, 4) generating solutions, 5) taking an action, and 6) evaluating outcomes. Below is a case study that demonstrates how students develop clinical judgment thinking alongside developing skills to support clients experiencing intimate partner violence (IPV).

2. Methods

We used six steps to arrive at a competent clinical judgment suggested by the National Council State Board of Nursing (NSCBN) as a clinical judgment model 1) recognizing cues, 2) analyzing cues 3) prioritizing hypotheses, 4) generating solutions, 5) taking an action, and 6) evaluate outcomes during the head-to-toe examination of the patient.

2.1. Case Scenario

A forensic nurse working in the Emergency Department (ED) on a night shift was assigned to a patient whose chief complaint is abdominal pain. The patient is a 24-year-old Asian-American female who reports throbbing bilateral lower quadrant abdominal pain. She reports that the pain started about three hours ago and was mild, but continuously worsened so she decided to come to the ED. She reports that she is unsure of what event could have caused the pain. She denies taking any analgesics before presentation to the ED. She has asthma diagnosed as a child, denies any other previous medical history. The patient also tells the nurse that her menstrual period came earlier and the flow is much heavier than normal. When asked about any possible emergency contact with family members or support persons, she reports that she has no one to call to inform

that she is in the hospital. The patient also mentions that she has recently ended a long-term relationship. The patient seems to feel uncomfortable being in the hospital and is not making direct eye contact with you as she speaks. The nurse takes the patient's vital signs, as shown in Table 1 with results before treatment, and performs a full head-to-toe assessment.

2.2. Head to Toe Assessment

Neuro: The patient is conscious and aware of her surroundings, has no reports of numbness/tingling sensations, seems distracted/unfocused during the assessment.

Respiratory: The lungs sound clear on both sides, with no crackles or wheezing, respiratory rate is noted to be faster than normal.

Cardiac: Heart sounds are clear with no extra sounds noted, pulses are regular and equal on all four extremities, the capillary refill is less than three seconds, no chest pain was noted.

GI: Pt has bowel sounds in all four quadrants, the stomach is soft, tender, and non-distended, the patient is moving their bowels, and has flatus.

GU: Pt has normal urine output, noted to be clear and light-yellow characteristics.

Skin: Pink and warm, with bruises on arms, legs, and abdomen, in different stages on different parts of the body. The patient has bilateral irregular forearm bruises, both purple. The left forearm has a bruise that measures approximately 4 cm × 4 cm, right forearm has a bruise that measures approximately 3.5 cm × 4 cm. The patient has a yellow-green bruise on the medial aspect of the left thigh measuring approximately 5 cm × 5 cm. The patient also has several purple bruises on the lower abdomen measuring approximately 5 cm × 4 cm in total surface area. When asked if she was aware where these bruises came from, the patient states that she is just a very clumsy person and they sometimes "just appear." When asked specifically about how the bruises on the abdomen came about, the patient states she ran into her counter and the bruises appeared later.

Psychosocial: The patient is cooperative with care, but is very timid; was hesitant about removing clothing to fully assess even when in a private corner bay area.

Reproductive History: Peri pad saturated upon exam and patient states she is

Table 1. Vital signs before treatment.

Vital Signs	5 minutes ago	30 minutes ago	On admission
Temp	36.6	36.8	36.7
Pulse	120	112	104
Heart Rate	26	22	18
Blood Pressure	92/71	98/68	105/65
Pain	8/10	7/10	8/10

saturating approximately one pad per hour. Absence of clots or a foul-smelling odor. The patient uses a condom as a method of birth control. On pelvic speculum exam by the APP, STI cultures and wet prep slides were collected. Wet prep slides showed no acute findings. The exam showed active bleeding from the cervix. The nurse orders laboratory blood works on the patient. Table 2 shows the results of the laboratory blood values before the treatment.

After completing the physical assessment, the nurse noted recognizable cues. The patient has several bruises over her body that seemed to have appeared at different points in time, indicating possible trauma. Her blood pressure (BP) is also trending downward, with systolic decreasing from 105 to 92 millimeters of mercury (mmHg) since admission, while her heart rate (HR) is trending upwards, from 104 to 120 beats per minute (bp/m), indicating that the patient is becoming increasingly hypovolemic. The early, irregular, and heavy vaginal bleeding is also problematic and could be related to the patient's noted hypovolemia. Based on these findings, a Computerized Tomography (CT) scan of the abdomen and pelvis is ordered to look at any internal injuries that could be an explanation for what is causing the abdominal pain. The CT scan shows intrauterine trauma and intrauterine bleeding with surrounding organs intact. No free fluid was found in the abdominal cavity.

3. Six Steps to Clinical Judgment

3.1. Step I. Recognize Cues

The nurse recognizes cues that would lead to other differential diagnoses. Clues include the patient's hesitation about removing clothing to fully assess even when in a private corner bay area and limited information by the patient on what could have caused the pain and injuries. Additionally, a long-term relationship

Table 2. Results of laboratory blood values before the treatment.

On Admission Blood Tests	Value	On Admission Blood Tests	Value
White Blood Cells	15,000	Glucose	95
Red Blood Cells	3.0	Albumin	3.2
Hemoglobin	10.5	Prothrombin Time	11.4
Hematocrit	32	Partial Thromboplastin Time	27
Platelets	10,000	International Normalized Ratio	1.0
Sodium	137	Aspartate Aminotransferase	35
Potassium	4.2	Alanine Aminotransferase	22
Chloride	104	Alkaline Phosphorus	70
Bicarbonate	23	Bilirubin	1.2
Blood Urea Nitrogen	15	Calcium	8.7
Creatinine	0.9	Magnesium	2.3

has recently ended for the patient. This patient's most prevalent cue is intrauterine bleeding which seems to have been caused by some type of trauma. The patient claims that her bruising came from accidentally walking into the counter, but the internal injuries are not consistent with this. The patient's bruising patterns do not correctly match the reasons for their appearance. The bruising also appears to be at different stages which indicate that these injuries happened on more than one occasion. The patient claims that she is clumsy, but this explanation may not identify the true mechanism and cause of injury. When examining this patient, it is important to note the details that might not have been spoken or identified subjectively or objectively, but what might be inferred.

3.2. Step II. Analyze Cues

From the initial examination, she was most likely to have some type of internal bleeding as evidenced by the clinical signs of hypovolemia. Her pain score also started increasing, from 8/10 on admission to 8/10 currently, where 10 is the highest. Once her labs had returned, it could be inferred that there was some type of bleeding problem due to a Red Blood Cells (RBC) level of 3.0, low hemoglobin and hematocrit of 10.5 and 32, and high platelet and White Blood Cells (WBC) levels of 15,000 and 10,000, respectively. Heavy vaginal bleeding was already observed, and bleeding from the cervix was observed on the exam. Furthermore, a CT scan showed intrauterine bleeding. These cues indicate that the patient is not hemodynamically stable.

Many different signs throughout the initial assessment can lead the nurse to believe that there is something else happening in the patient's life not verbalized but is vital to her care. She has several cues that tell the nurse that she might be uncomfortable in the hospital situation especially being evaluated. One cue is the lack of the ability for the patient to be able to focus while the nurse assesses her with the inability to make eye contact. There is also the clue of the patient not knowing where all the bruises on her body had come from with no real explanation behind them. The patient was timid with the nurse observing her even though she was in a private place with a female nurse assessing her. The patient also reports that she has no one to call as a support person while she is in the hospital which is not expected for most patients especially her age. These signs can be indicative of abuse. The nurse should assess for a history of trauma and current safety concerns after building rapport with the patient. This patient also has risk factors that would put her at a higher risk to be a victim of sexual assault.

3.3. Step III. Prioritize Hypotheses

Now that this patient has been in the Emergency Department for 40 to 45 minutes, the nurse should have a good idea of the situation and what should be prioritized. This patient's most life-threatening problem is intrauterine bleeding which seems to have been caused by some type of intrauterine trauma and is

hypothesis 1. Another hypothesis is bleeding from the genital tract due to trauma. The patient claims that her bruising came from accidentally walking into the counter, but the internal injuries are not consistent with this. The patient's bruising patterns do not correctly match the reasons she claims their appearance. The bruising also appears to be at different stages which indicate that there was more than one injury that caused these bruises to form. The patient does claim that they are clumsy, but this explanation may not identify the true mechanism and cause of injury. When examining this patient, it is important to note the details that might not have been spoken or identified subjectively or objectively, but what might be inferred. Once her labs had returned, the nurse notes the patient's hemoglobin and hematocrit levels of 10.5 and 32. While these levels do not warrant a blood transfusion, the patient's increasing tachycardia and persistent hypotension indicate that the patient is hypovolemic, making the patient hemodynamically unstable. Treating the patient's hypovolemia is the highest priority to stabilize the patient so other issues can be addressed.

3.4. Step IV. Generate Solutions

Next, the nurse gathers data using the Situation-Background-Assessment-Recommendation (SBAR) model before calling the provider. The data shared with the provider aligns with Hypothesis 1 (intrauterine bleeding due to trauma). The nurse develops the following plan. This patient will most likely need some form of surgery to repair the internal bleeding. However, before the patient goes to surgery there are actions the nurse can implement to help improve the patient's status [4]. Crystalloid fluid, such as normal saline or Lactated Ringer's, should be initiated before the patient's arrival to the operating room (OR) to aid in fluid stabilization. The nurse should also request that the provider orders some form of pain medication to help control the abdominal pain until the surgery. The nurse should recheck with the patient to assure that she did not take any medication that could induce bleeding. In addition, the nurse should hold any possible medication prescribed that could cause more bleeding, including nonsteroidal anti-inflammatory drugs.

3.5. Step V. Take Action

The action steps of an Advanced Practice Nurse (APN) in a full practice State will differ from the action steps of a staff nurse. The initial step will focus on a staff nurse is on the conduct of the Situation-Background-Assessment-Recommendation (SBAR). The SBAR report to the provider after review of the CT scan results from the SBAR report is given, the staff nurse will probably begin intravenous fluid therapy to maintain vascular volume. The staff nurse will also continue to assess vital signs and the patient's level of pain and continue with the pad count to assess blood loss. Whatever the treatment choice is selected, the staff nurse will help to prepare the patient for the procedure, answer questions about the procedure, and provide support. With a patient who is internally bleeding, they

can deteriorate quickly especially if the duration of bleeding is unknown. This patient thought that her bleeding was just her period, so she could have been slowly bleeding for hours and even days before presenting to the hospital with abdominal pain. The body can compensate for blood loss up until a certain point and a patient can present as stable while in this compensation stage. The nurse should also initiate a pad count and monitor the amount of blood being absorbed on the pad. The action steps of an Advanced Practice Nurse (APN) in a full practice, are as follows:

3.5.1. Action 1

The APN orders an abdominal CT scan. An abdominal CT scan is ordered to look at any internal injuries that could be an explanation for what is causing the abdominal pain. The CT scan would also be able to detect any possible bleeding from the bruising sites that are on the patient's body. Table 3 shows CT scans showing trauma to the uterus and intrauterine bleeding.

3.5.2. Action 2

The APN shares with the patient 2 choices of treatments to prevent further blood loss: 1) surgery-laparoscopy or 2) the use of an intrauterine balloon tamponade. The APN shares the pros and cons of each treatment choice and answers the patient's questions. The APN also collaborates and refers the patient to a medical provider if the patient decides on surgery. If the intrauterine balloon tamponade is the treatment selected, the APN may also collaborate with a medical provider and dependent on the state's practice regulations may or may not insert the tamponade. The APN explains and shows the patient the balloon that will be inserted into the vagina and through the cervix into the uterus. After the balloon is inserted into the uterus, it will be inflated to achieve a tamponade effect. Action 3 listed below should occur before the surgery or insertion of the uterine balloon tamponade.

3.5.3. Action 3

Perform an evidentiary examination and collection of specimens. Before this patient goes for intrauterine tamponade, the nurse is going to have to speak to the patient to determine if the patient came to the hospital with these injuries after being a victim of a sexual assault. The patient has red flags in her physical, and psychosocial presentation leading the nurse to believe that she might have been a victim of assault. The bruising and the bleeding from the uterus are both very

Table 3. Results of the CT scan of the abdomen.

Diagnostic Tests	Preparation	Results
CT scan of the abdomen with contrast	Explain to the patient what the procedure is and what the results of the test will allow us to determine	CT scan shows trauma to the uterus and intrauterine bleeding

telling signs of trauma. The reason that the nurse must have this conversation before the surgery occurs is that if the patient is a victim who came to the hospital after a sexual assault, the patient has the option to collect evidence from their body as a result of the sexual assault. Collecting evidence from a sexual assault is colloquially known as performing a "rape kit" examination, not to identify the perpetrator because she knows him, but to memorialize the time and the trauma he has done to the patient [5]. These kits can help to provide evidence if the patient would want to someday report the perpetrator of the assault and prove the identity of the perpetrator. However, if a patient needs to be taken into surgery, their body will likely get washed off with most of the evidence being gone or degraded. It is important to have this conversation with sexual assault survivors to offer them a chance to collect evidence to be used if they are ever in need of it. If this patient would like the evidentiary exam completed but deteriorates rapidly, requiring immediate attention in the OR, evidence can also be collected in this setting. It is important to explain the possibility of evidence collection to the patient before being admitted to the OR so that the patient can opt in or out of the examination.

4. Step VI. Evaluate Results/Outcomes

4.1. Stabilization of the Hemodynamics

The primary outcomes are stabilization of the hemodynamics of the patient and prevention of further blood loss. The abnormal labs that the patient had are going to not see an effect until after the surgery is performed to repair the trauma. The fluids are being given to help keep the vascular volume from being depleted, but they cannot solve the underlying problem. The continued monitoring of vital signs specifically blood pressure and assessment of blood loss show a steady increase in the blood pressure beginning after surgery and continues through the course of the hospital stay ending with the patient's discharge. With the nurse also continuing to monitor blood loss on pads while evaluating lab results, the nurse records the client pad count remains about 1 moderately soaked pad every 90 minutes initially after surgery. Five hours after later, the blood loss on the pad diminishes to 1 moderately soaked pad every couple of hours. At the time of discharge, the client may still be wearing a pad, however, it is very lightly soaked and appears more like the end of a menses. **Table 4** shows the results of the laboratory blood values and **Table 5** shows the vital signs after treatment.

4.2. Evaluate Psychosocial Needs

The nurse is also going to need to evaluate the patient for any type of psychosocial needs after surgery is performed. Since it has been confirmed the patient is a sexual assault survivor, the nurse should offer services for support or refer the patient to someone who can offer services for support and advocacy. The nurse should also evaluate the patient's living situation and determine if it is safe for her to return home. If not, there needs to be a discussion of options related to

Table 4. Results of laboratory blood values after treatment.

On Admission Blood Tests	Value	On Admission Blood Tests	Value
White Blood Cells	10,000	Glucose	95
Red Blood Cells	4.0	Albumin	3.2
Hemoglobin	11.0	Prothrombin Time	11.00
Hematocrit	32.5	Partial Thromboplastin Time	30
Platelets	400	International Normalized Ratio	1.0
Sodium	137	Aspartate Aminotransferase	35
Potassium	4.2	Alanine Aminotransferase	22
Chloride	104	Alkaline Phosphorus	70
Bicarbonate	23	Bilirubin	1.2
Blood Urea Nitrogen	15	Calcium	8.7
Creatinine	0.9	Magnesium	2.3

Table 5. Vital signs after treatment.

Vital Signs	After Treatment	5 hour After Treatment	Before Discharge
Temp	36.6	36.8	36.8
Pulse	112	98	88
Respiration	24	22	18
Blood/Pressure	96/76	98/74	110/80
Pain	8/10	6/10	2/10

safety planning [6]. Based on the information gathered to date, it is not clear if this patient has experienced an isolated sexual assault or if she is experiencing intimate partner violence. If the former, the aforementioned sexual assault kit, in addition to a discussion related to police reporting is appropriate. If the latter, a more comprehensive safety planning discussion is needed. If the patient is experiencing intimate partner violence, the nurse must emphasize her autonomy. Individuals who have experienced intimate partner violence are most at risk for morbidity and mortality upon leaving the abusive partner; therefore, safety planning is paramount. The nurse should understand that the patient may not be willing to leave her partner immediately and that the process in doing so should occur on the patient's terms and as she feels ready and comfortable.

4.3. Safety Plans

From a safety planning perspective, the nurse should ask the patient about interpersonal resources, where she would go if the violence escalated, and if she has feared for her life in the past. The nurse can provide resources including

hotlines and shelters specific to intimate partner violence. In the case of intimate partner violence, mandatory reporting is not warranted as it can further diminish the survivor's autonomy and pose a safety risk; however, the nurse can offer the patient aid in reporting if she is willing. Whether this was an isolated assault by a stranger or an acquaintance or chronic in the context of intimate partner violence, the nurse should also discuss with the patient if there are any support persons they have to reach out to for support at discharge [6].

4.4. Will the APN Testify as a Fact or an Expert Witness?

The APN/forensic nurse, during the recording and collection of evidence, may let her mind wonder if the patient should decide to follow up in bringing the perpetrator to court, what kind of witness will she be, a fact witness or an expert witness. As a fact witness, the evidence of the forensic nurse's testimony will be derived from her own 5 senses, and only from her 5 senses, no more no less—seeing, hearing, smelling, tasting, and/or touching. If she is called to testify as an expert witness, the evidence of her testimony will be derived from her knowledge and understanding of the case, the theoretical and clinical explanation as well as alternative explanations for the injury and how the events may have cascaded into the injury that the survivor suffered. The forensic nurse should have knowledge of treatises, evidence-based literature, articles, and manuals to provide standards of practice [6]. It is not going to be a quick and easy process for this patient to recover and they are going to need as much support as can be provided by the APN.

5. Discussion

The burden to a sexual assault survivor, on consenting for the nurse to collect evidence of the assault is traumatic, as it is an assault over an assault. Many survivors are in a very distraught emotional state, and any mention of performing this exam to collect potential evidence to be used against their perpetrator can be emotionally triggering for them. The exam is also an invasive procedure that exposes the victim in many ways so that evidence can be properly collected. The idea of this exposure can also be very scary for the patient to endure [7]. It is a difficult decision that the patient should be allowed to make, and coercion should not occur. If the patient does agree to the examination, consent must be sought from the patient by the nurse.

5.1. Ethical Principles

The ethical principles of autonomy, justice, veracity, and fidelity must be paramount when asking for consent [8] [9]. The healthcare professional who completes the nurse will need to provide the patient support and validation throughout the entire exam. Before starting the exam, the victim should be advised on all aspects of the exam. They should be informed of the purpose for collecting the kit, how the kit can be used in the investigative process, the process and asso-

ciated time frames for the testing kit, and how the victim will be notified of the results from the kit being performed. The healthcare professional should allow the patient to set the pace of the exam. They should explain every single step before they perform it to ensure they have consented to move forward with completing each step of the exam. The steps of the exam may need to be altered to accommodate the victim. The victim needs to be aware that consent can be given or withdrawn by themselves to any individual part or the entire medical-forensic exam. According to the National Best Practices for Sexual Assault, the victim should drive the encounter, rather than the need to complete the entire exam [10].

5.2. Standards of Care

The standard of practice for states and territories for collecting, recording, and reporting sexual assault kits, includes consistency with terminology, content, the structure, and procedure of how the exam is performed. The national standards for these kits include a uniform kit packaging, unique identifier, discreet labeling to protect victim privacy, identification for type of kit, standardization of the medical-forensic documents, standardized wording and labeling, and standardization of the collection items [5]. All the states' medical-forensic examination sites and providers should have access to these kits as well as training on the components of the kits, sample collection, and the documentation that goes along with it. It has been proven that the use of Sexual Assault Nurse Examiners (SANEs) and Sexual Assault Forensic Examiners (SAFEs) to perform these kits on sexual assault survivors led to higher prosecution and conviction rates of the perpetrators who committed these crimes. Forensic DNA evidence deteriorates with time so that the evidence can be collected as soon as possible after receiving consent from the victim [11] [12]. The evidence can be collected from any sexual assault victim who seeks care and can be collected as soon as possible and up to 5 days or longer after the assault has occurred [10].

5.3. Evidence Collection

One of the largest parts of the evidence collection is the potential body fluid collection. Based on the sexual assault victim's history, the areas on the victim's body where the DNA of the possible perpetrator may have been left should be collected in the form of body fluids. Time frames of the collection time for each type of body fluid vary based on where the fluid is collected from. Vaginal fluid evidence can last the longest (up to 5 days), followed by bite marks/saliva on the skin (4 days), anal fluids (3 days), and oral fluids (24 hours). Even though some of the evidence can be collected days after, the short time frames for collection make it pertinent for the healthcare provider to collect evidence as soon as possible as permitted by the survivor. Swabs are typically used to collect the evidence from these areas, and it is recommended that the least number of swabs used is the most beneficial for each area of evidence collection. As stated, collecting

more than two swabs from an area may result in a diluted sample [11] [12]. If multiple swabs are used in one area, the best recommendation is that these swabs should be collected consistently. For areas such as the vaginal or rectal exam areas, it is acceptable to use a water-soluble non-spermicidal lubricant to promote patient comfort while collecting the sample. However, if using a lubricant to collect the sample, this must be indicated in documentation and a control sample of the lubricant may be required for distinction purposes.

While body fluids are a large portion of evidence collection in sexual assault exam kits, other types of evidence can be collected from the victim. The survivor's clothing is another form of evidence that should be separately packaged and labeled for each item of clothing the victim is wearing. The combing of pubic hair can be a beneficial form of evidence as well as clipping or swabbing the pubic hair for evidence. Swabbing under the nails as well as cutting the nails may be another form of evidence collection. Swabbing the skin is also a form of evidence collection and is used commonly in victims who have evidence of bruising or strangulation. Tampons, condoms, and other foreign objects that might have potential evidence on them should be collected if the survivor has them and swabbed for any type of DNA evidence on them. Photographs may also be a form of evidence collection to capture the images of possible bruises, lacerations, bite marks, etc., on the victim's skin for evaluation [10] [11] [12]. Photographs can help investigators look closer into the mechanism of injury to help build a story and case for this victim. As discussed in this section, DNA evidence collection can be found in all sorts of places over the body.

5.4. Law Enforcement

Survivors of sexual assault who come into a facility looking to be treated for sexual assault and have a kit of evidence collected have the option not to report or report anonymously. Law enforcement agencies are responsible for storing the sexual assault kits whether the victim reported or unreported the incident. The goal of law enforcement having control of the evidence is to preserve the evidence and maintain the proper chain of custody of the evidence, in the event the victim does not choose to report the incident now but does choose to report in the future. Victims who choose to have these sexual assault kits collected on them should not be forced to pay any out-of-pocket costs for the sexual assault medical-forensic exam to be performed [9] [10] [11]. They should also have access to having a kit performed on them regardless of their willingness to cooperate with the law enforcement or criminal justice system.

When performing a sexual assault medical-forensic exam, it takes a collaborative approach between law enforcement, and several healthcare providers to ensure that the survivor is provided with evidence-based care. The use of SANEs, SAFEs, and Sexual Assault Response Team (SART) who are professionally trained on all aspects of the exam including the physical and communicative skills that are required for the exams has produced improved outcomes in this

field. A collaborative approach has been able to enhance the quality of health care for individuals who have been sexually assaulted, improve the quality of forensic evidence, increase the law enforcement's ability to collect evidence, increase prosecution rates over time, and facilitate clinical judgment development [11] [12] for the overall improvement in survivor's outcomes post-sexual assault.

6. Conclusions

Clinical judgment is a critical shill for nursing. The National Council of State Boards of Nursing (NCSBN) identifies the six steps, clinical judgment model, for learning and teaching [1] [2] [3]. The nurse needs to be aware that the sexual assault survivor could feel marginalized. Survivors of sexual assault are difficult patients for a nurse to care but for, but the proper assessment and attention to detail of the 6 steps to clinical judgment, result in positive outcomes for their patient. Forensic nursing is a field of nursing that focuses on sexual assault survivor care and works to make the aftermath of their tragic situation easier to cope with. Strengthening clinical judgment skills could remedy most mistakes made by novice forensic nurses. Critical thinking and clinical ethical reasoning are the building blocks of clinical judgment [1]. The creation of margins is a process of creating boundaries, sections (intersectionality), and peripheralized by approximation (not proximation) of the individual. Gender, poverty, and experiencing abuse create margins, sections, and vulnerabilities [13] [14]. Vulnerabilities are a state of being exposed to, and unprepared to fight or flee from health, people, and environment's damaging circumstances that pose a physical, psychological, biological, social, and economic threat to the individual, such as IPV, and could decrease healthspan [15] [16].

Marginalization is a toxic stress that leads to maladaptive coping behaviors, poor self-esteem, lack of self-efficacy, cognitive dissonance, and increased incidence of substance abuse, posttraumatic stress, and suicide [16] as if they are in Foucault's [17] panopticon. Panopticon is a paradigmatic architectural model of modern power and control, designed as a prison so that the marginalized are separated from and invisible by others but always visible by the monitor who is powerful and controlling [15] [16] [18]. As a result, internal control is achieved by the marginalized, isolation, depression, suicide is far more tolerable than being monitored and supervised in a panopticon. Looking at the current rise of intimate partner violence, and abuse, with the courts closed, it is a pandemic within a pandemic and nowhere to seek help.

Survivors of sexual assault need to receive quality nursing care, and proper assessment, and attention to detail of the 6 steps to clinical judgment. Forensic nursing is a field of nursing that focuses on sexual assault survivor care and works to make the aftermath of their tragic situation easier to cope with. Strengthening clinical judgment is essential for all forensic nurses. In developing clinical judgment, practice is important. Students develop critical thinking and clinical judgment through clinical simulation. Autonomy, critical thinking, and justice (abil-

ity to be fair) can be rehearsed through simulation [19] [20]. Critical thinking and clinical ethical reasoning are the building blocks of clinical judgment, enhancing diversity, equity, and inclusion establishing professional identity and role-specific competencies [1] [2] in caring for a sexual assault survivor.

Conflicts of Interest

The authors declare no conflicts of interest regarding the publication of this paper.

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