5

DOCUMENTATION

5. DOCUMENTATION

OBJECTIVES

PREPARATION AND MATERIALS

- Know how to document in a safe, confidential manner
- Explain the importance of correct documentation.
- Understand how to correctly fill out the medical history and examination form.

AVAILABLE TRAINING RESOURCES

Presentation
5. Documentation

Facilitator guide
5. Documentation

Video
5. Documentation guidelines

Activities
5. Documentation

Participant handouts
5.1 Documenting the Examination
5.2 Describing features of physical injuries
5.3 Sample history and examination form

REQUIRED SUPPLIES & MATERIALS

- Projector, Laptop
- Pen and blank paper workbook for each participant
- Printouts of sample medical history and examination forms and pictograms for the activity

KEY MESSAGES

- Document the description of the incident in a clear, objective, non-judgmental way
- Document injuries clearly, precisely and systematically
- Documentation must be safely, securely stored

FURTHER RESOURCES FOR FACILITATORS (OPTIONAL)

- WHO 2020 Clinical management of rape and intimate partner violence survivors Developing protocols for use in humanitarian settings, pg 20-21

DOCUMENTATION FACILITATOR GUIDE

SLIDES 1-14

Slide 3 notes
- It is **not** the health care provider's responsibility to determine whether or not someone has been raped or experienced violence, or to prove or disprove that rape or violence occurred.
- Your responsibility is to **document** your medical findings and observations in a **thorough and objective way.**
- Document your findings without stating conclusions about the rape. Note that in many cases of rape there are no clinical findings.
- Your responsibility is to provide non-judgmental support and to listen and believe.
- The clinic record is sometimes the only documentation of the assault. It may be subpoenaed by the court. It can give information on the approximate timing of the assault. For this reason it should include descriptions of any pre- existing injuries.

Slide 4 notes
- Tell the survivor what you would like to write down and why. Ask if this is okay. Follow the survivors wishes. Offer a survivor a choice of what and how things are documented. If there is anything she does not want written down, do not record it.
- Do not interrupt or stop survivors from speaking while recording the history. While listening, write down relevant details they are describing
- Address any confidentiality concerns the survivor has about who has access to any written records and how they are stored.

Slide 6 notes
- **Record the interview** in a clear, complete, objective, non-judgemental way.
- Document verbatim/**in the survivors own words.** Use quotations to identify the patient's own words. Write the incident in a chronological order
- Do not reformulate the verbal account of the patient.
- Make sure to write their exact words of the most important details
- Record precisely, in the survivor's own words, important statements made by her, such as reports of threats made by the assailant such as "He said he'll break my neck if I shout out." There is no need to write everything the survivor says, but make sure not to miss relevant details
- Do not be afraid to include the name of the assailant, but use qualifying statements, such as "patient states" or "patient reports".
- Avoid the use of the term "alleged" or presumptive, as it can be interpreted as meaning that the survivor exaggerated or lied and gives the message we do not believe survivors.

Slide 7 notes
- **Document injuries** clearly, completely, objectively, precisely, systematically
- Document all injuries using standard terminology and describing the characteristics of the wounds.
- Record all your findings and observations clearly and fully on the examination form and the pictograms
- Document and record the type, size, colour, location and form of any bruises, lacerations, injuries, ecchymoses and petechiae.
- Health-care providers who have not been trained in injury interpretation should limit their role to describing injuries in as much detail as possible, without speculating about the cause, as this can have profound consequences.
- If you are trained, you may write the possible cause of injuries – but do not speculate. It may be helpful to note the cause or suspected cause of these injuries or other conditions, including who injured her.
- It is not the health care provider's responsibility to determine whether or not someone has been raped. Document your findings without stating conclusions about the rape. Note that in many cases of rape there are no clinical findings.

Slide 8 notes
Again, record your findings at the examination in a clear, complete, objective, non-judgemental way.
- Do not document anything regarding virginity. Virginity testing is a harmful practice and not recommended.
- If there are no injuries, simply write "no injuries seen". The absence of injuries should not lead to the conclusion that no sexual violence took place.

Slide 9 notes
- The medical history and examination form will guide you in what to ask and document.

Slide 10 notes
- Document the injuries on pictograms as well.

Slide 11 notes
- Document the injuries on pictograms as well.

Activity 5 Documentation

Video 5 Documentation guidelines