BCCDC Decision Support Tool:
Dispensing Prophylactic Medications Post-Sexual Assault

Scope

Registered Nurse (RN) and Registered Psychiatric Nurse (RPN) dispensing of chemoprophylaxis post-sexual assault is a restricted activity with limits and conditions as set out in the British Columbia College of Nurses and Midwives' (BCCNM) Registered Nurses Practice Standard: Acting Within Autonomous Scope of Practice.[1]

This decision support tool (DST) is focused on dispensing medication. It does not preclude other assessments and other immediate care after sexual assault. It is used in conjunction with additional organizational specific policies that may be in place.

Context

This DST aims to assist clinicians in applying an equity lens to Sexually Transmitted Infection (STI) assessment and care. The principles below guide clinicians in considering the diversity of each individual including their body, culture, gender, sexuality, and their context-specific needs when providing services:

- care that is trauma- and violence- informed, rooted in cultural safety and humility and committed to anti-Indigenous racism and anti-racism principles
- knowledge and understanding of the profound impact of STIs in relation to the social determinants of health (SDOH) and syndemics
- creative and flexible person-led care

By adhering to these principles, this DST aims to provide more equitable, inclusive, and affirming care for all people, particularly for transgender, gender-diverse, sexually diverse, and Two-Spirit peoples. This is of particular importance as inequities are associated with negative stereotypes which may in turn be associated with higher rates of STIs and non-disclosure of information. Consequently, this may hinder relevant testing, diagnosis, treatment, and the provision of targeted education. As part of these principles, anatomy and site-specific testing language are used throughout this document to strive for safer conversations when assessing and managing STI assessment and care.

Nurses must continually work to address and dismantle the ongoing impacts of racism, colonialism, and anti-Indigenous racism prevalent in BC's health care system. Indigenous-specific racism and discrimination negatively affect Indigenous peoples' access to health care and health outcomes. All nurses should be familiar with and follow the BCCNM Indigenous Cultural Safety, Cultural Humility and Anti-Racism Practice Standard which sets clear expectations for providing culturally safe and anti-racist care for Indigenous peoples.[2] Nurses

are encouraged to work closely with First Nation communities, First Nations Health Authority (FNHA), and Indigenous partners to prevent and reduce the impact of communicable diseases in First Nations communities.

The BC Centre for Disease Control (BCCDC) Reproductive Health – Sexually Transmitted Infection Decision Support Tools were developed on the unceded, traditional and ancestral lands of the xʷməθkwəy̓əm (Musqueam), Skwxwú7mesh (Squamish), and sel̓íl̓witulh (Tsleil̓ -waututh) Nations. The authors express gratitude for the privilege of working on these lands and recognize use of these tools extend across what is colonially known as British Columbia, which includes the homelands of over 200 First Nations, seven major language families, and more than 30 dialects.

This guidance acknowledges the inherent rights of Indigenous Peoples (First Nations, Métis, and Inuit) as outlined in the BC Declaration on the Rights of Indigenous Peoples Act (Declaration Act). The Declaration Act reaffirms the right of Indigenous Peoples to self-determination and self-government.

Practice Level[1,3]

All RNs and RPNs must practice within their individual competence and organization specific policies.

Nursing roles able to autonomously follow and dispense prophylactic medications based on this DST	**Nursing roles who require a client specific order from a listed health professional* to dispense prophylactic medications post-sexual assault**
RN with BCCNM Reproductive Health – Sexually Transmitted Infection (STI) Certification	RNs and RPNs – without BCCNM certification in STI management or not trained and employed as a SANE.
RNs who have attained accredited training as a sexual assault nurse examiner (SANE) and are employed as a SANE. This practice related only when working in the role of a SANE.	

*As per BCCNM and in the context of this DST, listed health professionals are physicians, nurse practitioners and RN(C)s.

Referral to, or consultation with, a physician (MD) or nurse practitioner (NP) is required prior to dispensing prophylactic medications for the following individuals:

- all individuals 11 years old and younger
- symptomatic individuals aged 12-13 years old
- pregnant individuals

- breast/chest-feeding individuals
- presents with physical trauma post-sexual assault (e.g. recent history of strangulation, head injury, vaginal bleeding unlikely to be associated with a menstrual period)
- presents with unexplained lower abdominal pain

Confidentiality and Reporting Sexual Assault [4-7]

As with all health care, sexual assault STI testing and prophylaxis is handled in a confidential manner. RNs and RPNs safeguard personal and health information learned in the context of the nurse-client relationship.

RNs and RPNs disclose this information only:

- With the individual's consent or
- When there is a specific legal or ethical obligation to do so

Individuals have a right to confidentiality. Reporting in cases of sexual assault is often a complex process. RNs and RPNs have an ethical obligation to disclose to the appropriate authority in situations that involve a substantial risk of significant harm to the health or safety of the individual or others. RNs and RPNs have a duty to report to the Ministry of Children and Family Development (MCFD) in the cases of children if "the child has been, or likely to be, physically harmed, sexually abused, or sexually exploited by a parent or other person" per the Child, Family and Community Service Act. When working with sexual assault cases requiring a duty to report, RNs and RPNs are to abide by their organizational or agency policies and consult with their supervisor as it pertains to the legal responsibility in the matter.

Additional documents to support RN and RPN practice related to confidentiality and duty to report include:

- BCCNM (2026). Nurses: Privacy and Confidentiality Practice Standard. Pub. No. 989
- BCCNM (2026). Nurses: Consent Practice Standard. Pub. 985.

Timeframe for Presentation

Individuals Presenting Within 7 Days of Sexual Assault	Individuals Declining Referral to Specialized Sexual Assault Service or Presenting between 7-21 days Post-Sexual Assault
• Depending on community availability, offer the option of attending the nearest facility where specialized sexual assault health care and forensic sample collection is available. These sites can also offer crisis counselling,	• Offer assessment, testing, and treatment as outlined in this DST. • Individuals should be made aware that any specimens collected as part of their care are

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medical-legal options, and prepare a medical-legal report. • RN/RPN can call the emergency department or agency to inform them the individual will be attending and provide report/relevant information. • RN/RPN can help arrange transportation.	for STI diagnosis only rather than forensic specimen collection.

*Assess and treat individuals who present greater than 21 days post-sexual assault, or with symptoms of an STI, using the appropriate BCCDC STI certified or non-certified DSTs.

Assessment [3]

History relevant to dispensing prophylactic medications after a known, or suspected, sexual assault:

- Potential sites of exposure (e.g. oral, genital and/or rectal) and means of assault (e.g. digital, genital, oral and/or object)
- Date and time of sexual assault
- For individuals with the capacity for pregnancy, assess current pregnancy or risk of pregnancy:
    - Vaginal intercourse since last menstrual period
    - Current contraception use and/or issues with use (e.g., missed pills)
    - Date of last menstrual period
- Immunization history/vaccination status (hepatitis A, hepatitis B, human papillomavirus (HPV), Mpox)

It is important to be aware that depending on the situation, individuals may not be able to provide answers or full details to assessment questions. This is especially true for situations of possible drug-facilitated sexual assault or when an individual may have experienced a loss of consciousness.

Testing [3,8-12]

STI testing should be offered post-sexual assault. It is important that practitioners and those seeking care understand that testing post-sexual assault is a choice, and not mandatory. The following table outlines the types of tests that should be offered post-sexual assault.

A Medical Service Plan (MSP) practitioner number is required to order most tests. RN(C)s can autonomously order tests outlined within the Reproductive Health (STI) DSTs with their MSP practitioner number. RNs/RPNs can also autonomously order certain tests if organization/employer approval has been obtained to apply for

and use an MSP practitioner number; please refer to the BCCDC Communicable Disease Control Manual, Appendix A. RNs/RPNs without an MSP practitioner number will need to collaborate with another clinician (e.g. physician, NP or RN[C]) to order tests per organizational policies.

Practitioner Note:

Baseline testing refers to testing at time of presentation to establish a reference point before any interventions. These results can help inform clinical care outcome decisions; however, they may not accurately reflect recent potential exposures. When testing for a specific event, consider the window period required for accurate diagnostic detection.

More information on window periods for different STIs can be found here.

Recommended Baseline STI Screening	**Notes**
Serology: • HIV Ag/Ab • Anti-HCV • HBsAg • Anti-HBc Total • Anti-HBs • Syphilis EIA Specimens for collection – as per sites exposed and if indicated in sexual health/assault history: • Urine NAAT CT/GC **OR** • Vaginal specimen NAAT CT/GC	1. Advise further follow-up testing (specimen collection and serology) may be indicated given window periods of tests. 2. Offer self-collected (urine, vaginal, rectal and/or throat) specimens, as appropriate. 3. Cervical specimens for GC/CT are indicated for those who are symptomatic. Refer to the BCCDC Certified DST: Assessment and Diagnostic Guideline: Sexually Transmitted Infections for further information. 4. For those who are symptomatic, follow the appropriate BCCDC STI certified or non-certified DST(s) as per scope of RN role. 5. If HIV Post-Exposure Prophylaxis (PEP) is started, HIV serology is done at 3 weeks, 6 weeks, and 3 months post-PEP completion. 6. Timelines for testing will be altered if hepatitis B immune globulin (HBIG) or hepatitis B vaccine given, or if any results are deemed positive; see appropriate guideline or DST for follow-up parameters.

If applicable: • Urine pregnancy test **Recommended Follow-up Bloodwork (if baseline tests are negative)** Post-exposure: 3 weeks: • HIV Ag/Ab • HCV RNA (if source HCV positive or high-risk group) 6 weeks: • HIV Ag/Ab 3 months: • HIV Ag/Ab • Anti-HCV • HbsAg • Anti-HBc Total • Anti-HBs • Syphilis EIA	7. Follow-up testing for CT/GC is not required for those who are not pregnant and who have taken appropriate prophylaxis, unless there is a new risk of exposure or symptoms develop.

Management [9-10, 13-17]

Diagnosis and Clinical Evaluation

This prophylaxis does not encompass all potential STIs or syndromes. Where there are signs or symptoms of STIs, follow the appropriate STI certified or non-certified DST(s), as per RN/RN(C) scope. Further clinical evaluation may be required by an MD/NP.

Prophylactic Treatment of Choice

Treatment	Notes
First Choice	**General:**

Treatment	Notes
Ceftriaxone 500 mg IM as a single dose AND Doxycycline 100 mg orally twice a day for 7 days **Second Choice** Ceftriaxone 500 mg IM in a single dose AND Azithromycin 1 g orally in a single dose **OR** Cefixime 800 mg orally in a single dose AND Doxycycline 100 mg orally twice per day for 7 days OR Azithromycin 1 g orally in a single dose	1. Treatment covers both gonorrhea and chlamydia. 2. Retreatment is indicated if 2 consecutive doses of doxycycline are missed, or a full 5 days of treatment has not been completed. 3. Consult a physician or NP if unable to use cefixime, ceftriaxone, or azithromycin. 4. See BCCDC STI Medication Handouts for further medication reconciliation and information. 5. See Monitoring and Follow-up section for test-of-cure (TOC) requirements. 6. Future GC treatment regimens will continue to reflect national recommendations in association with local GC antimicrobial resistance (AMR) trends. Further information on antibiotic resistance can be found here for those seeking care and here for health care providers. **Allergy and Administration** 1. DO NOT USE ceftriaxone or cefixime if history of allergy or anaphylaxis to cephalosporins. 2. If history of penicillin reaction, refer to Beta-Lactam Cross Reactivity Chart, consult MD or NP if needed. 3. DO NOT USE azithromycin if history of allergy to macrolides. 4. DO NOT USE doxycycline if pregnant and/or allergic to doxycycline or other tetracyclines. 5. If an azithromycin or doxycycline allergy or contraindication exists, consult with/refer to a physician or NP for alternate treatment. 6. Azithromycin and doxycycline are sometimes associated with gastrointestinal adverse effects. Taking medication with food and plenty of water may minimize adverse effects. 7. The preferred diluent for ceftriaxone IM is 3.3 ml lidocaine 1%. 8. DO NOT USE lidocaine if history of allergy to lidocaine or other local anesthetics. Alternate diluents are available such as sterile water or 0.9% Sodium Chloride. Refer to product monograph for complete list of diluents. If no alternate diluents are available, consider cefixime administered orally for treatment. 9. For IM injections of ceftriaxone, the ventrogluteal site is preferred. 10. Advise the individual to remain in the clinic for at least 15 minutes-post IM injection in case of anaphylactic reaction to treatment. Provide anaphylaxis treatment as required, using BCCDC Communicable Disease Control

Treatment	Notes
	Manual Chapter 2: Immunization- Part 3: Management of Anaphylaxis in a Non-Hospital Setting. 11. If serious allergic reaction develops including difficulty breathing and/or severe itchiness, instruct the individual to inform clinic staff immediately. If symptoms develop after leaving the clinic, advise them to seek immediate emergency care. 12. Advise that pain, redness and swelling at the injection site may occur. If any of these effects persist or worsen advise to contact health care provider. 13. Recent data has emerged regarding azithromycin and QT prolongation. Although rare, it is more significant in older populations, those with pre-existing heart conditions, arrhythmias, or electrolyte disturbances. It is unclear how significant these findings are in young to mid-age healthy adults consuming a one-time dose of azithromycin; however, please use the following precautions: Consult with or refer to an NP or physician if the individual: • has a history of congenital or documented QT prolongation. • has a history of electrolyte disturbance in particular hypokalemia, hypomagnesaemia. • has clinically relevant bradycardia, cardiac arrhythmia, or cardiac insufficiency. • is on any of the following medications: ○ Antipsychotics: pimozide (Orap®), ziprasidone (Zeldox®) ○ Cardiac: dronedarone (Multaq®) ○ Migraine: dihydroergotamine (Migranal®), ergotamine (Cafergot®)

For Further Consideration [1, 11-12,18-23]

Treatment	Notes
Hepatitis B Immunoprophylaxis (HBIg)	1. If the sexual assault occurred within the previous 14 days, HBV prophylaxis (including hepatitis B vaccine and hepatitis B immune globulin – HBIg*) may be indicated. See table 6.1 for HBV post-exposure prophylaxis (including serology) found in the BCCDC Communicable Disease Control Manual - Chapter 1: Hepatitis B and Blood and Body Fluid Exposure Management for indications. *HBIg can be obtained from Transfusion Medicine (Blood Bank) at the nearest local hospital, order from physician or NP is required.

Treatment	Notes
HIV Post-exposure Prophylaxis (PEP)	1. PEP treatment requires prescription/order from MD/NP. 2. Offer HIV post-exposure prophylaxis (PEP) for sexual assault preferably within 2 hours and not greater than 72 hours. Refer to the BC-CfE Guidance for The Use of Post-Exposure Prophylaxis (PEP) For The Prevention of HIV in British Columbia for dispensing parameters, eligibility and subsequent serology. For further information on how to obtain medication for prevention of HIV infection following an exposure, call the St Paul's Hospital Ambulatory Pharmacy 1-888-511-6222. PEP consultation is also available at several sites in the lower mainland. Refer to the BC-CfE's HIV Post-exposure Prophylaxis webpage for Consultation Sites.
Emergency Contraception	1. Levonorgestrel should be considered for the use of emergency contraception (EC) if the sexual assault occurred within the last 5 days. May not be as effective in those who weigh more than 165lbs. More information can be found here. RNs can autonomously dispense schedule II medications as set out in the BCCNM Acting Within Autonomous Scope of Practice document and act in accordance with the BCCNM Nurses: Medication practice standard. RNs who provide emergency contraception with levonorgestrel must do so within their own organizational policy and procedure. 2. Ulipristal Acetate is another oral emergency contraceptive option. It requires a prescription from an MD/NP. It can be taken up to 5 days post event and is effective in individuals weighing up to 195 lbs. 3. Insertion of an IUD can be considered for up to 7 days post-sexual assault. Refer to physician or NP as needed. RNs certified in contraceptive management can refer to the Nurses and Nurse Practitioners of British Columbia (NNPBC) DST 803: Care and Treatment Plan: Insertion and Removal of Intrauterine Contraceptives. Further information on emergency contraceptives can be found here.

Monitoring and Follow-up [9-12]

If result is positive for STI, refer to specific DST for test of cure (TOC) recommendations.

Advise individuals:

- to return for follow-up assessment if symptoms occur or recur.
- who receive prophylactic treatment to return for repeat testing, as indicated.
- who decline prophylactic treatment to return in 7 to 14 days for repeat testing (GC and CT).
- to return for required follow-up serology, as indicated.
- have received immunoglobulin (HBIG) and/or have been immunized (hepatitis B, HPV, hepatitis A, Mpox) to return for follow-up according to the respective immunization schedule.

Partner Notification [8]

RNs discussing sexual activity post-sexual assault need to be sensitive to the initial and ongoing impacts that the assault may have on individuals and their sexual partner(s).

It is important to include discussion of window periods and ways of reducing potential infection transmission to sexual partner(s). Refer to Smart Sex Resource's "Window Period" page.

Additional Education [9-10, 24]

Counsel individuals:

- abstain from sexual activity during the 7-day course of treatment or for 7 days post-single-dose therapy for those who test positive and their contacts.
- regarding the appropriate use of medications (dosage, side effects, and need for the re-treatment if dosage not completed).
- regarding follow-up care, community supports and referral services available for individuals who have been sexually assaulted; support and arrange for referrals as needed.
- Per Sexually Transmitted and Blood-Borne Infections Standard Education

This DST is endorsed by the B.C. Centre for Disease Control (BCCDC) & the B.C. Women's Sexual Assault Service (BCW SAS).

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Appendix A: Core Nursing Competencies for Dispensing Prophylactic Medications for Post Sexual Assault

This appendix outlines the competencies that RN(C)s, SANEs, RNs and RPNs (in collaboration with another health professional*), must meet to dispense prophylactic medications post sexual assault as outlined in the BCCDC Non-certified Decision Support Tool: Dispensing Prophylactic Medications Post-Sexual Assault.

*As per BCCNM and in the context of this DST, listed health professionals are physicians, nurse practitioners and RN(C)s

Requirements

Follow and reference:

1. BCCNM Professional Standards, Practice Standards, RN Scope of Practice and Entry-level Competencies.
2. BCCNM's Indigenous Cultural Safety, Cultural Humility and Anti-Racism practice standard, taking a distinctions-based approach and recognizing the distinct cultures, self-determination, and the individual and collective rights of First Nations, Inuit and Métis.
3. Your employer's most current policies and guidance related to post-sexual assault care, including gender- affirming care (e.g., Trans Care BC) and trauma- and violence-informed practice.
4. Nurses and Nurse Practitioners of British Columbia (NNPBC) Certified Practice Registered Nurse and Registered Psychiatric Nurse Competencies (inclusive of Part 2: Sexually Transmitted Infections).
5. Competencies outlined below.

Competencies

Using a person-centred approach while providing care from a trauma and violence informed, anti-racist framework the RN(C), SANE, RN and RPN:

1. Identifies scope of practice according to nursing role, individual competence and organizational policies.
2. Demonstrates empathy and sensitivity regarding:
    - the impact of sexual assault

- obtaining history of a client who has experienced a sexual assault
- Recognizing and responding to intersecting social identities (e.g. gender, race, disability)

3. Demonstrates the knowledge, skills and judgement to:
    - Determine appropriate interventions for STI and HIV prophylaxis and/or emergency contraception post-sexual assault
    - Provide guidance for baseline and follow up testing recommendations for STI, HIV and pregnancy as applicable
    - Consult or refer with the appropriate team member when care is out of scope
4. Demonstrates respect for client autonomy regarding values and beliefs regarding assessment, taking medications, and/or accessing follow-up care.
5. Knowledge of sexual assault health care services and available local community resources to assist in client care, follow-up, and referral.