

VI. Creating a Protocol

Once screening is implemented and health care providers see the extent of the problem of intimate partner violence in their practice, the next step may be making organizational changes that institutionalize IPV screening and response. Research indicates that the identification of adult patients experiencing abuse increases when there is a protocol in place addressing intimate partner violence in the medical setting.

There are many protocols in existence that can serve as models for your practice. The Family Violence Prevention Fund has a free Protocol Packet available for health care providers containing a number of protocols for both hospital and clinic settings (see resources section for contact information). In this section you will find information regarding protocol development, and a sample protocol as a reference tool.

DEVELOPING AN INTIMATE PARTNER VIOLENCE PROTOCOL

Following are suggested steps in IPV protocol development:

1. Define the departments within your clinic or hospital where the protocol will be used.
2. Review the various existing protocols relevant to your practice.
3. Address issues specific to your state, institution, and clinical setting, such as documentation, confidentiality, liability, and reporting.
4. Determine site-specific interventions and coordination.
5. Define roles and responsibilities regarding screening, identification and assessment, documentation, interventions (including safety planning), referrals and follow-up.
6. Work with local domestic violence experts to develop a community-based referral network.
7. Make the protocol easily accessible by posting it in a central area. Be sure it is produced in a "user friendly" and readable format.

Excerpt from "Establishing An Appropriate Response to Domestic Violence in Your Practice, Institution and Community"; C. Warshaw, MD. Improving the Health Care Response to Domestic Violence: A Resource Manual for Health Care Providers, Family Violence Prevention Fund, Pennsylvania Coalition Against Domestic Violence, 1995. For more information call 415/252-8900.

MINIMAL ELEMENTS OF AN INTIMATE PARTNER VIOLENCE PROTOCOL

1. **DEFINITIONS.** Include the various manifestations and types (physical, sexual, psychological) of abuse and who (adult, adolescent, elderly, lesbian/gay) is covered by the policies.
2. **SCREENING PROCEDURES.** Information should be available to clinicians either within the protocol or as an addendum addressing how to ask about abuse directly, including sample questions. Specify who is to do the screening (i.e., physician, nurse or both). Specify precautions for ensuring safety and confidentiality (i.e., arrange for a private screening area, availability of security if necessary, etc.).
3. **INTERVENTION PROCEDURES.** Include interviewing strategies, safety assessment and planning, and discharge instructions. Information on assessment (sample questions and techniques) and intervention (supportive information to communicate, referrals, patient education materials, etc.) should be available to clinicians either within the protocol or as addendums.
4. **STATE REPORTING REQUIREMENTS.** Clarify the law(s), if any. Include procedures for the release of information to the proper authorities as required by law. Also define who is responsible for making the report.
5. **COLLECTION OF EVIDENCE AND PHOTOGRAPHS.** Include procedures for the collection, retention and release of evidentiary materials. In particular, clarify procedures for taking in-house photographs and securing release forms.
6. **MEDICAL RECORD DOCUMENTATION.** Clearly delineate what information is to be included in the medical record (e.g., a description of the injuries, coloration, size, use of a body map to indicate location of injuries, stated or suspected cause of injury, action taken by clinician, etc.).
7. **REFERRALS.** Include instructions regarding available resources, and how to make referrals to in-house staff, domestic violence programs, legal advocacy, children's services or other appropriate community agencies. Keep phone numbers updated on a regular basis.
8. **PLAN FOR STAFF EDUCATION.** All health care personnel, including security and allied health professionals should receive ongoing training on the dynamics of domestic violence protocol and procedures with an emphasis on staff roles and coordination. The Joint Commission for the Accreditation of Hospitals and Health Care Organizations (JCAHO) requires a staff education plan be developed for every department within hospitals.

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CARONDELET HEALTH NETWORK

Domestic Violence Policy and Procedure

I. PHILOSOPHY

Carondelet Healthcare believes that all people are entitled to the right to live free from violence or threat of violence from current or former partners. 95% of domestic violence involves female victims and male abusers. Sometimes men are abused by women, and domestic violence also occurs in gay and lesbian relationships. Due to the fact that the vast majority of domestic violence occurs toward women by male partners, the convention of using "she" to refer to the victim and "he" to refer to the abuser will be used in this policy and procedure.

Because healthcare providers may be the first non-family member to whom an abused woman turns for help, the provider has an opportunity and responsibility to provide appropriate and sensitive interventions. Carondelet Healthcare is committed to developing and implementing policies and procedures for identifying, treating, and referring victims of domestic abuse.

II. BACKGROUND

- A. **DEFINITIONS:** Domestic Violence is an ongoing, debilitating experience of physical, psychological and/or sexual abuse involving force or threat of force from a current or former partner associated with increased isolation from the outside world and limited personal freedom and accessibility to resources. A victim of domestic violence is anyone who has been injured or has been emotionally or sexually abused by a person with whom she has or has had a primary relationship.
- B. **LEGAL CONSIDERATION:** The AZ codes define domestic violence as a criminal offense and allows a person to seek relief through the legal system.
- C. **REPORTING REQUIREMENTS:** Arizona does not have an explicit law requiring healthcare providers to report instances of domestic violence. For a physician or other healthcare providers, reporting domestic violence to law enforcement should only be done with the abused person's knowledge; consent should also be obtained if possible. Only the abused person can assess the danger and relative risk of reporting vs. non-reporting. All other reporting requirements, such as for current material inflicted injuries, gunshot wounds, stabbings, second-degree burns, child abuse, elder abuse, must be followed in accordance with state laws.

III. PURPOSE

- A. Guide treatment of all injuries and illness.
- B. Provide and communicate a safe environment for the patient.
- C. Identify battered women through screening and through recognition of possible indicators of abuse.
- D. Offer supportive counseling, validation of her concerns, and attention to safety issues after discharge.
- E. Document correctly and offer photos.
- F. Provide referral information during the healthcare contact.

IV. ROLES AND PROCEDURES

A. RN Role

1. Initiate abuse assessment screen.
2. Do initial assessment in private (ask patient's visitor(s) to have seat in the lobby before starting the assessment process and inform this is standard routine).
3. **SCREEN FOR ABUSE** in all patients, using screening question, e.g., "Are you in a relationship in which you have been threatened, controlled, or physically hurt?"

IF ABUSE IS IDENTIFIED:

- a. Let her know that she will have an opportunity to talk about this in private and that conversations will be confidential within the limits of reporting requirements.
- b. Assess immediate safety: e.g. "Are you safe here now?"
- c. Offer to assist patient with safety planning.

IF THE PATIENT VERBALIZES DANGER:

- a. Page or refer to Social Worker and notify doctor.
- b. Notify Security if immediate danger present to patient or staff.
- d. Observe for danger of patient leaving prior to being seen: e.g. emotional lability, ambivalence, stated deadline for leaving.

IF PRESENT:

- a. Page or refer to Social Worker
- b. For all others with abuse identified: i.e. safe in lobby, no risk of leaving.
- c. Notify doctor and initiate Social Work consult.
- d. Document objectively, include specifics of abuse.
- e. If abuse is documented in record, ensure that record is kept in area where abuser does not have access.

IF NO ABUSE IS IDENTIFIED and for NON-INJURED PATIENTS

- a. Review possible indicators of abuse

IF FOUND

- a. Refer to Social work to "screen patient in private".

IF ABUSE IS IDENTIFIED

- a. Validate her feelings. Let her know she is not responsible for the abuse.
- b. Express concern for her SAFETY.
- c. Inform her that a SOCIAL WORK REFERRAL will be made. Page or refer to social worker.
- d. Notify physician
- d. If social worker not available to meet with patient prior to discharge, offer numbers for Brewster, TCWC, or wallet card and document.
- f. Document findings objectively.

If patient DENIES ABUSE OR REFUSES SOCIAL WORK VISIT. but SUSPICION still exists notify physician and social worker who will also address findings.

Advise patient who CONTINUES TO DENY ABUSE but in whom you still suspect abuse:

- a. Confer with social worker.
- b. "If you are abused, please come back to the E.D. or contact Brewster or TCWC".
- c. Offer a wallet card (See Appendix)
- d. Do not write any Domestic Violence referral on discharge instructions.

B. SOCIAL WORKER ROLE:

1. Interview in private room.
2. Social worker will assess patient's situation, evaluate safety risks, provide supportive counseling and make appropriate referrals, according to Social Worker Domestic Violence Procedure.
3. Checks with patient re: which visitors should be screened out, documents and informs staff to follow-up and pass on in report. Is DNP/DNS status requested?
4. Social Worker notifies security and other involved staff if potential problem with visitor exists.
5. If abused patient has children, Social Worker will make needed referrals as appropriate regarding their safety and well being.
6. Document "Screen Completed" or "Unable to Screen". Indicate reasons for inability to screen in nursing record.
7. If after hours of social work coverage, RN and MD will address needs and apply procedure as far as possible.

C. MD ROLE

1. Evaluate and treat injuries. All battered women will receive complete physical exam including, neurological exam; x-rays, if indicated, looking for evidence of old and new fractures.
2. Consider Domestic Violence in all female patients and be aware of high-risk indicators.
3. When advised by RN that abuse exists;
 - a. Validate feelings and that she is not to blame for the violence.
 - b. Emphasize safety and the risk of further violence.
 - c. Let her know that Social Worker will be answering questions and helping with referrals.
4. If patient has not admitted abuse, but MD or RN is suspicious of injuries/complaints, attempt to facilitate disclosure with questions such as: "Your injuries concern me. Injuries such as these are often caused by abuse. Could this be happening to you?"
"We see many women who have been abused and help is available."
5. If abuse is acknowledged to MD, notify RN and initiate social work referral. Document abuse.
6. If injuries noted, encourage photos. A primary purpose of photos is to allow useful evidence to be available to patients if needed in future.
7. If patient has obvious or suspected abuse but cannot communicate or acknowledge abuse (i.e. unconscious or impaired), notify Social Worker for consultation.
8. Document the history and physical exam with attention to objective findings. Document that social work referral was made to evaluate for Domestic Violence. Indicate discharge diagnosis, injury, illness or symptom, etc. Do not use the terms "Domestic Violence" or "Abuse" as discharge diagnosis. These could potentially get to abuser as part of insurance billing notification.)

V. DOCUMENTATION

A. RN NOTE may include:

1. "Screens in private" if suspicious of abuse present/patient does not acknowledge.
2. Document any findings of abuse or probable abuse and warning to patient of risk of further violence.
3. Document social work referral and reason for referral.
4. Discharge instructions should not have domestic violence indicated. (Wallet card will have referral information.)
5. Document "screen completed" or "unable to screen" and explanation.

B. SOCIAL WORK DOCUMENTATION

1. Indicate reason for referral, i.e., "Evaluate for Domestic Violence".
2. Indicate all pertinent psychosocial findings (See Social Work Domestic Violence Procedure).
3. Comments regarding abuse may be indicated.
4. Document referral information given, and patient's plan for use of it.
5. Indicate if photos were taken and disposition of photos.

C. PHYSICIAN DOCUMENTATION

1. Patient's comments regarding abuse may be noted.
2. Document referral to Social Worker for evaluation for domestic violence/abuse.
3. May document "findings suspicious of abuse" or indication of domestic violence" in body of note.
4. Discharge diagnosis describes injury/illness or symptoms. Do not use terms "domestic violence" or "abuse" in discharge diagnosis.
5. Document referrals and warning to patient of risk of further violence.
5. On discharge instruction sheet do not indicate "abuse, domestic violence, or abuse referral".
6. Document photos taken. Include in photograph a size indicator such as a metric ruler.

D. PHOTOS

1. When injury lends itself to photographic documentation, MD, RN or Social Worker may assist with photos. Make sure an identifying characteristic or ID band appears in the photo and a ruler to indicate size of the injury.
2. Instant photos taken, noting the following on the back of photo: date, location e.g. CSMH or CSJH ED, patient name, MR#, photographer's initials, part of body photographed, patient's own initials (indicated approval for photos). Photos will be placed in patient's chart. Patient needs to sign consent for photographs.

CARONDELET HEALTH NETWORK - Domestic Violence Policy and Procedure (cont.)

Directions for using domestic violence screening tool

- A. "In addition to your health problems we are also asking all women about the possibility for abuse, since abuse and violence is so common (in women's lives). We hope that just having this discussion will also make everyone more aware of this problem. Please be assured that whatever you say will be kept confidential, though we are required by law to report incidents involving current material injury or use of a weapon; if you are someone who has been abused, we would like to give you a chance to talk about it. I have a few questions to ask.

"Are you (or have you ever been) in a relationship with someone who has ever hit, slapped, kicked or otherwise physically hurt or threatened you?" If yes, total number of times.

"We all fight or disagree sometimes with the people we live with. When you disagree at home, are you ever afraid of what your partner might do to you or to your children?"

- B. "During pregnancy, have you been hit, slapped, kicked or otherwise hurt by someone?" If yes, by whom and total number of times.
- C. "Does your partner ever try to control what you do, where you go, your money, or your relationships with your family and friends?"
- D. "Does your partner ever force you to engage in sexual activities that make you feel uncomfortable?"

MARK THE AREA OF INJURY ON THE BODY MAP, SCORE EACH INCIDENT ACCORDING TO THE FOLLOWING SCALE

- 1= Threats of abuse including use of a weapon
- 2= Slapping, pushing; no injuries and/or lasting pain
- 3= Punching, kicking, bruises, cuts, and/or continuing pain
- 4= Beating up, severe contusions, burns, broken bones
- 5= Head injury, internal injury, permanent injury
- 6= Use of weapon; wound from weapon

(If any of the descriptions for the higher numbers apply, use the higher number)

I. POSSIBLE INDICATORS OF DOMESTIC VIOLENCE

The following represent findings that may suggest abuse. They are in no way all inclusive. Any woman seen in the healthcare setting may be a victim of abuse.

A. POSSIBLE PRESENTING COMPLAINTS

1. Complains of abuse directly
2. "Falls"
3. "Stranger" assault
4. Chronic pain syndrome, headaches
5. Overdose/suicide attempts
6. Anxiety, depression, multiple somatic complaints
7. Miscarriage/vague gynecological complaints (e.g. pelvic pain)
8. Psychosomatic complaints

B. POSSIBLE INDICATORS OF ABUSE FROM PATIENT'S HISTORY

1. Mechanisms described by patient do not fit injury
2. Delay in seeking care
3. "Accident Prone" patient
4. History of children being abused
5. High stress in family, i.e. financial, pregnancy
6. Frequent Emergency Department visits (review past medical history)
7. Drug/Alcoholism (partner/or patient)
8. Marital problems

C. POSSIBLE BEHAVIORAL INDICATORS OF ABUSE

1. Patient evasive/guarded
2. Patient embarrassment with poor eye contact
3. Patient depressed with injuries
4. Patient denies abuse too strongly
5. Patient has charged/fearful behavior with partner
6. Patient defers to partner
7. Partner hovers
8. Patient minimizes injury or demonstrates inappropriate responses (e.g., cries, laughs)

D. FINDINGS THAT MAY INDICATE ABUSE

1. Mid-arm injuries (defensive)
2. Strangulation marks
3. Injuries to areas not prone to injury by falls
4. Weapon injuries or marks
5. Symmetrical injuries
6. Old, as well as new injuries
7. Bites/burns (scald and cigarette)
8. Injuries to multiple sites
9. Poor nutrition

E. COMMON INJURIES THAT MAY INDICATE ABUSE

1. Black eyes
2. Front tooth injuries
3. Mid-face injury
4. Breast/abdomen (particularly during pregnancy)
5. Neck Injury
6. Injuries to sites hidden by clothing
7. Internal injuries