COHESIVE HEALTHCARE MANAGEMENT & CONSULTING

Mangum Regional Medical Center

TITLE		POLICY
Intimate Partner Violence Screening		
MANUAL	EFFECTIVE DATE	REVIEW DATE
Emergency Department		
DEPARTMENT	REFERENCE	
Emergency Department		

I. SCOPE

This policy applies to Mangum Regional Medical Center for the identification, screening, and response of patients who present to the Emergency Department (ED) with signs and/or symptoms of intimate partner violence or abuse.

II. PURPOSE

Intimate partner violence (IPV), also known as domestic violence, is a serious public health problem that is found across all cultural, ethnic, religious, educational, socioeconomical backgrounds, ages, races or sexual orientation. IPV is also associated with increased gynecologic, gastrointestinal, central nervous system, musculoskeletal and cardiac complaints, as well as an increased risk of depression, anxiety, post-traumatic stress disorder, suicidal ideation and/or attempts, and substance abuse.

According to data from the Center for Disease Control and Prevention's Intimate Partner and Sexual Violence Survey (NISVS) during their lifetime approximately 1 in 4 women and 1 in 10 men have experienced some form of sexual or physical violence, and/or stalking by an intimate partner, and over 43 million women and 38 million men have reported experiencing some form of physical aggression in their lifetime. Approximately 11 million women and 5 million men have reported experiencing teen dating violence which is some form of sexual/physical violence, stalking of psychological aggression by an intimate partner before the age of 18. Of those who experience intimate partner violence research has found that 44% of women who have been murdered by their partner had visited an ED within two years of their death. And of these, 93% had at least one visit to the ED related to an injury.

Information developed by the Family Violence Prevention Fund represents findings that may suggest intimate partner violence or abuse. The list includes but is not limited to the following indicators of abuse:

Common Complaints:

- Indication of having been hurt physically, sexually, and/or emotionally
- Unexplained injuries or injuries inconsistent with the history provided by the patient
- Allegedly assaulted by a stranger
- Chronic pain syndromes, headaches
- Overdose/suicide attempts
- Anxiety, depression, insomnia, multiple somatic complaints
- Miscarriage, sexually transmitted disease, and non-specific gynecologic complaints (i.e. pelvic pain, painful intercourse), as well as rapid repeated pregnancies and (unwanted) abortions
- Multiple motor vehicle and single vehicle accidents

Red Flags in Medical History:

- Any old unexplained injuries
- Delay in seeking care
- "Accident prone" patient
- Documented history of family violence
- Frequent Emergency Department, urgent care, or office visits
- Drug/alcohol addiction (patient and/or partner)
- Request for medication for anxiety, sleep or "nerves"

Red Flags for Patient Presentation:

- Evasive/guarded
- Appears embarrassed and/or exhibits poor eye contact
- Presents with injuries and depressed
- Financial concerns
- Denies abuse too strongly
- Minimizes injury or demonstrates unexpected responses (i.e. cries, laughs)
- Intense and/or fearful behavior with partner
- Appears angry and defensive "Last straw phenomena"
- Defers to partner
- Partner answers questions and/or refuses to leave patient alone

Physical Findings:

- Injuries to areas not prone to injuries by falls
- Injuries to multiple sites
- Symmetrical injuries
- Wounds in varying stages of healing
- Mid arm injuries (defensive)
- Strangulation marks: petechiae, ligature marks and subconjunctival hemorrhage
- Weapon injuries or marks
- Bites/burns (scald and cigarette)

- Black eyes
- Dental injuries
- Mid-face injuries
- Breast/abdomen (particularly during pregnancy)
- Neck injury
- Injuries to hidden sites (covered by clothes)
- Internal injuries

The purpose of this policy is to minimize the morbidity and mortality of intimate partner violence through:

- Universal screening for all adolescent and adult patients in a private and safe setting without the patient's partner, friends, family, caregiver or children over the age of two.
- Use of a framing statement to show the patient the screening assessment is done universally and not because IPV is suspected, and to inform patients of the confidentiality of the discussion.
- Provision of interdisciplinary approaches for interventions and safety planning for victims of intimate partner violence.
- Provision of community resources and appropriate referrals for victims of intimate partner violence.

III. DEFINITIONS

Specific definitions used in this policy reflect guidelines provided by the Centers for Disease Control and Injury Prevention sponsored panel of experts from the government, private sector, and education/research areas and published in the *Intimate Partner Violence Surveillance Uniform Definitions and Recommended Data Elements*. These include:

A. **Intimate Partner Violence:** refers to "physical and/or sexual violence, stalking, psychological aggression including coercive tactics by a current or former intimate partner."

B. **Intimate Partner:** refers to "anyone with whom a person has a close personal relationship with and that may be characterized by the partners' emotional connectedness, regular contact, ongoing physical contact and sexual behavior, identity as a couple, and familiarity and knowledge about each other's lives. The relationship does not need to involve all these dimensions. Intimate partner relationships include current and former: spouses (married, common-law, civil union, domestic), boyfriend/girlfriend, dating partners, and ongoing sexual partners. Intimate partners may or may not be living together…and may be of the same sex."

C. **Physical Violence/Abuse:** refers to "the intentional use of physical force or coercion with the possibility of causing harm, injury, death or disability. Physical violence includes but is not limited to: hitting, kicking, scratching, shoving,

throwing, grabbing, choking, shaking, slapping, punching, pushing, hair-pulling, burning, use of a restraint and/or use of a weapon."

D. **Sexual Violence/Abuse:** refers to "forcing or attempting to force a partner to take part in a sex act, sexual touching, or a non-physical sexual event such as sexting when the partner does not or cannot consent."

E. **Stalking:** refers to "a pattern of repeated, unwanted attention and contact that causes fear or concern for one's own safety or the safety of someone else (i.e. family member or close friend)."

F, **Psychological Aggression:** also known as "emotional abuse" refers to the "use of verbal and non-verbal communication with the intent to harm another person mentally or emotionally and/or to exert control over another person." Areas of emotional abuse include humiliation, deprivation, and coercion. Other examples of emotional or psychological abuse are rooted in financial and social areas and include controlling money, use of the car, monitoring whereabouts and electronic communications, contact with friends and family and other extracurricular activities.

IV. POLICY

Often the victims of intimate partner violence have utilized the ED many times without being identified as victims, even when an injury was the presenting complaint. Multiple organizations including the American College of Emergency Physicians (ACEP), Emergency Nurses Association (ENA) and the Joint Commission recommend universal screening of all patients due to higher rates of identification of intimate partner violence.

The Abuse Assessment Screen (See Attachment A) will be utilized by hospital staff to assess for physical, sexual and/or emotional abuse. The screening will take place in a private place and no friends, relatives, caregivers or children over the age of two will be allowed during the screening. The patient will be notified of the confidentiality of the screening, including the limits of that confidentiality mandated by state law.

If the patient discloses any form of violence or abuse hospital staff will encourage and support intervention and safety strategies. Hospital staff will encourage and assist the patient to create a safety plan that will include domestic violence resources.

The hospital staff will document all clinical interactions in the patient's medical record to provide an accurate account of the patient's medical condition, including any pertinent photographs or body maps. There should be as many patient quotes as possible. If abuse is denied, but the hospital staff suspects abuse, the hospital staff should document their suspicions and validate with objective observations that the injuries are inconsistent with patient explanations.

V. PROCEDURE

A. Upon presentation to the hospital all patients will be triaged using the ESI Triage Algorithm in order to identify a life-threatening or high-risk situation condition and prioritize patients according to acuity.

B. During triage all adolescent (10-19) and adult (20 and older) patients will be screened for intimate partner violence using the Abuse Assessment Screen.
   1. Screening will be done in private with no friends, relatives, caregivers, or children present over the age of two.
   2. Screening questions should be performed using a respectful and non-judgmental tone of voice and body language.
   3. Limits of confidentiality will be discussed PRIOR to doing the screening, and report as necessary.

C. If the Abuse Assessment Screen is positive for intimate partner violence:
   1. Hospital staff will validate the patient's feelings. Reassure them that they are not responsible, and that abuse occurs in many relationships. Tell the patient that they are not alone, and help is available. If the Abuse Assessment Screen is positive an expanded assessment using the Intimate Partner Violence Screening Form will be performed by the provider.
   2. Provider will complete the Intimate Partner Violence Screening Form (Attachment B) as part of the patient assessment.
      a. Review the Intimate Partner Violence Screening with the patient, explaining that the screen assists victims in identifying the danger present in their life so that they can make informed decisions about their safety.
      b. Upon completion of the Intimate Partner Violence Screen, hospital staff will ask the patient if it is safe to go home.
         i. If the patient indicates it is not safe to return home, hospital staff will offer to make a referral to a battered woman's shelter or other community resource upon completing the patient's exam.
         ii. If the patient indicates they wish to return home, hospital staff will emphasize ways to increase their safety in all situations using the Domestic Violence Personalized Safety Plan (Attachment C).
   3. The provider will perform an expanded assessment that will include assessment of:
      a. Immediate safety needs
      b. Patient's state of mind
      c. Chief complaint and present illness
      d. Patient's past safety strategies
      e. Current access to advocacy and support resources
      f. Pattern and history of abuse
      g. Present intact coping skills
      h. Present intact resources
      i. Effects of abuse on patient's health

j. Effects on children in the family
k. Patient's mental health issues (depression, suicide, homicide, substance abuse, etc.)
l. Ability to manage other illnesses
m. Risk of suicide/homicidal thoughts
n. Questions about the batterer

D. If the Abuse Assessment Screen is negative, patient denies abuse and no indicators of abuse are present, hospital staff will document the findings in the patient's medical record and offer referral information for future reference.

E. If the Abuse Assessment Screen is negative and patient denies abuse, but hospital staff still suspects abuse, hospital staff may advise the patient:

1. "Even though you have said that you have not experienced any type of violence, you seem (describe patient's affect that increases the index of suspicion). Is there anything else that you can tell me that might explain your being uncomfortable with these questions? OR
2. "If you are ever experience abuse, please come back to the hospital or contact the local domestic violence program:"

Oklahoma Hotline 1-800-522-SAFE (7233)

3. There are experts and help available provide contacts to local and national hotlines (See Attachment D Domestic Violence Resource Brochure).
5. Do not write any domestic violence referral on discharge papers that will be taken home with the patient.

VI. INTERVENTIONS

Hospital staff will encourage or provide interventions for suspected or known victims of intimate partner violence. Appropriate interventions may include:

A. Assess the immediate safety of the patient and the children (if any).
B, Verbal reassurance that they are not alone.
C. Verbal reassurance that no one deserves to be abused.
D. Verbal reassurance that the violence is not their fault.
E. Affirm that it is hard to talk about abuse.
F. Verbal reassurance that they can talk to someone privately for information and support.
G. Offer information about intimate partner violence, community resources (i.e. mental health services, crisis hotlines, shelters, and police contact information) and appropriate referrals.
H. Offer a private phone to use to call a domestic violence agency.
I. If the patient requests, hospital staff will assist in making a safety plan which respects the integrity and authority of the victim in making his/her own choices about the abusive relationship.
J. Advocacy and assistance in accessing the services of other community agencies.
K. Information will be provided to the patient regarding confidentiality. Hospital staff will inform patient that staff will not reveal information about their violence experiences with their families or perpetrators.

1. Keep the chart and abuse documentation in a secure area isolated from visitors.

L. Information will be provided regarding mandatory reporting of child abuse if indicated.

M. Information will be provided regarding mandatory reporting of vulnerable adult abuse if indicated.

N. Reassurance that they will continue to be offered assistance whenever they seek help.

O. Assist the patient to identify trusted individuals that they can approach for assistance.

VII. DOCUMENTATION

Findings of intimate partner violence or suspected abuse should be clearly documented so that future providers know to follow up on the issue. Medical records can provide crucial evidence in support of the victim in court. Documentation should include:

A. Document findings objectively.

B. Use as many patient quotes as possible. Use terms such as "stated" and "said".

C. Date and time of arrival.

D. Attempt to record name, address, and phone number of anyone accompanying the patient.

E. Primary complaint

F. Detailed description of injuries, including type, number, size, location, resolution, possible causes, and explanation from patient on how injury occurred.

G. Patient's statements of past battering incidents (direct quotes).

H. Complete medical history and relevant social history.

I. Laboratory and diagnostic results.

J. Describe detailed positive and negative findings from the physical assessment and interview.

K. Note the patient's general demeanor.

L. Completed Abuse Assessment Screen, with the body map indicating designated areas of injury.

M. Completed Intimate Partner Violence Screening Form.

N. Documentation of non-bodily evidence of abuse, such as torn clothing or damaged jewelry.

O. Attempt to record any identifying information of the alleged abuser.

P. Photographs, when permitted by patient prior to treatment, from different angles, at least two photographs of every major injury. Obtain patient consent for any photographs taken. Photographs should be taken on facility-owned equipment. All photographs must be appropriately identified with the patient name, medical record number, and date taken and retained in the patient's medical record. External disclosures that require patient authorization include, but are not limited to:

i. Requests by law enforcement;

ii. Requests by Social Services

Q. Document the completion of a safety plan if the patient requests to complete one, specific referrals and plans made.
R. Document contacts with police and other community resources if requested that were initiated prior to patient discharge.
S. Describe discharge plans (i.e. patient's plans for safety after leaving the ED).
T. If abuse is denied, but abuse is suspected the provider should document the suspicions and validate with objective observations that the injuries are inconsistent with the patient's explanation.

VIII. DISCHARGE SAFETY PLAN

A safety plan is intended to be a personalized, practical plan that describes a plan of actions that can help keep the victim remain safe in a relationship, planning to leave or after they leave the abusive relationship.

The hospital staff should start from the assumption that an abuser is dangerous and try to assist the victim/survivor identify the circumstances under which the abuser typically becomes violent and how the abuser may react to help seeking strategies.

If requested by the patient Hospital staff will assist the patient with completing the Domestic Violence Safety Plan prior to discharge. Hospital staff will ensure the patient has all the appropriate contact numbers for law enforcement and community resources on the safety plan prior to discharge.

If the patient does not wish to complete a safety plan prior to discharge the patient will be offered harm reduction strategies, referral to an advocate when appropriate to promote safety, and resources including local and national domestic violence hotlines.

IX. QUALITY MONITORING

Hospital leadership including but not limited to, the Chief Clinical Officer (CCO) are responsible for ensuring that all individuals adhere to the requirements of this policy, procedures are implemented and followed at the Hospital and instances of non-compliance with the policy are reported to the Chief Clinical Officer and an incident report are completed.

All patient and visitor reports of law enforcement involvement or security risk events will require the completion of an incident report.

All incident reports will be forward to the Quality Risk Manager and reported to Safety/EOC, QAPI, MEC, and Governing Board.

X. EDUCATION AND TRAINING

All hospital staff will be required to have orientation and on-going education and competency for initiate partner violence that includes the following standards:

- Statistics for Intimate Partner Violence as a Public Health Problem
- Definition of Intimate Partner Violence/Domestic Violence
- The etiology of Intimate Partner Violence/Domestic Violence
- Barriers to identify victims
- The importance of universal screening
- Diagnosis and clinical indicators
- Documentation
- Appropriate interventions
- Understanding and Compliance with Hospital Policy

XI. ATTACHMENTS

Attachment A: Abuse Assessment Screen
Attachment B: Intimate Partner Violence Screening Tool
Attachment C: Domestic Violence Personalized Safety Plan
Attachment D: Domestic Violence Resource Brochure
Attachment E: Consent for Photograph and Multimedia

XII. REFERENCES

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REVISIONS/UPDATES

Date	Brief Description of Revision/Change