

Division of Injury and Violence Prevention  
Office of Family Health Services  
Virginia Department of Health

# The 2008 Virginia Intimate Partner Violence Hospital Policy Analysis Project

PROJECT

**RADAR**

Violence Prevention Steps for Health Care Professionals

A VDH Initiative to Promote Intimate  
Partner Violence Assessment,  
Intervention, and Prevention for Health  
Care Providers



**VDH** VIRGINIA  
DEPARTMENT  
OF HEALTH  
*Protecting You and Your Environment*



# The 2008 Virginia Intimate Partner Violence Hospital Policy Analysis Project

This study was conducted through a collaborative effort between the Virginia Department of Health and Old Dominion University. The Model Virginia Hospital Policy on Intimate Partner Violence was developed by a group of community partners committed to ending intimate partner/domestic violence (IPV/DV) and improving the lives of victims. The Division of Injury and Violence Prevention (DIVP) would like to thank the members of the Model Hospital Policy Advisory Group for their input as well as their feedback and support throughout the course of the policy project.

The concept of the policy analysis project was largely based upon the work of the Connecticut Health Initiative for Identification and Prevention (CHIP) Program which, in 2005, shared their work on establishing and analyzing IPV/DV policy in a health care setting. DIVP extends appreciation to those that staffed the CHIP project and shared their invaluable expertise and experience.

DIVP would especially like to thank those hospital administrators and staff who were willing to share their policies with the Virginia Department of Health and Old Dominion University.

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# Executive Summary

## The Problem

- Intimate partner violence/domestic violence (IPV/DV) is a public health problem. 25-30% of women report experiencing IPV/DV at some point in their lives; and it has significant negative effects on the physical and mental health of its victims.
- Research strongly suggests that health care providers can play a critical role in mitigating and/or reducing the negative consequences of IPV/DV through the use of appropriate identification, assessment, management, and referral procedures.

## The Study

- The IPV/DV hospital policy analysis project provided each participating hospital with review of its existing policy on IPV/DV, based on Joint Commission on Accreditation of Health Care Organizations (JCAHO) and best practice standards, as well as a suggested revised policy that incorporated recommendations.
- All hospitals with a 24-hour publicly available emergency room (N=82) were invited to submit their policies for review. Of the 82 hospitals invited, 61 participated. The overall response rate was 74%.

## The Results

- 75% of hospitals did not have a 'stand-alone' policy for IPV/DV. IPV/DV policies were included in policies on other forms of abuse (child, elder, etc.) with very different reporting mandates and referral options.
- Although 58 of the 61 study hospitals are JCAHO accredited, only two of the policies made reference to JCAHO standards on abuse in their policies.
- Over 1/3 (36%) of the policies did not provide any definition of IPV/DV, and only 5% used a comprehensive definition, such as that utilized by the Centers for Disease Control (CDC) or VDH.
- Only 8% of hospital policies dictated routine screening/assessment for IPV/DV.
- Over 70% of the hospital policies mentioned documentation, but less than half (42%) specified the procedures for doing so.
- Even though 2 out of every 3 hospital policies contained information about reviewing options and making referrals, most did not discuss safety planning.
- Legal reporting requirements for IPV/DV were incorrectly or unclearly stated in over half of the policies.
- Just over 1/3 (38%) of hospital policies state a requirement for staff education on IPV/DV.
- Security risks related to IPV/DV were mentioned in just 7% of the policies reviewed.



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## Introduction/Background

Intimate partner violence/domestic violence (IPV/DV) is a pattern of assaultive and coercive behaviors that may include inflicted physical injury, psychological abuse, sexual assault, progressive social isolation, stalking, deprivation, intimidation and threats. These behaviors are perpetrated by someone who is, was, or wishes to be involved in an intimate or dating relationship with an adult or adolescent, and are aimed at establishing control by one partner over another. IPV crosses all racial, cultural, and socioeconomic backgrounds and has significant and long-term health consequences for victims.

IPV is more prevalent among women than breast cancer, cervical cancer, or diabetes, with 25-30% of women reporting abuse at some point in their lifetimes.<sup>1,2</sup> In addition to injuries sustained through traumatic events, abuse is linked to chronic neck, back, and pelvic pain, sexually transmitted infections, arthritis, migraines, gastrointestinal problems, and pregnancy complications. Psychologically, victims of IPV suffer from increased risk for post-traumatic stress disorder, anxiety, depression, panic and sleep disorders, substance abuse, and suicide. In Virginia, the most severe consequence of IPV is evident, as the Office of the Chief Medical Examiner reports that half of all homicides are family or intimate partner related and that over half of all female homicide victims die at the hands of current or former intimate partners.<sup>3</sup>

Research strongly suggests that health care providers can play a critical role in mitigating and/or reducing these negative health consequences by using appropriate procedures for identifying, assessing, managing, and referring victims of IPV. Isolating victims from friends, family, and others is a common control tactic used by abusers. However, retrospective studies indicate that almost half of women killed by their intimate partners have been seen by a health care provider for some reason in the year prior to their deaths.<sup>4,5</sup> Although we cannot say with certainty the degree to which intervention on the part of medical professionals might make a difference in all of these cases, it is plausible to infer that effective screening, assessment, and referral procedures could prevent more serious injury or death in some. Additionally, victims report that they feel that being asked about IPV would strengthen their relationship with their health care providers and that they feel providers can provide help and assistance.<sup>6</sup>

In an effort to educate medical providers on the health impact of IPV and to better enable them to respond effectively to patients experiencing abuse, in 2005, the Virginia Department of Health implemented Project RADAR, a health care provider-focused initiative on policy and education around the issue of IPV. Although the Project RADAR initiative provides education and consultation to all health care providers in all health care settings (clinics, individual physicians and physician groups, health departments, etc.), hospitals were chosen as the focus of this project because of the large number of patients seen.

In early 2006, the Division of Injury & Violence Prevention at the Virginia Department of Health convened a diverse group of healthcare providers, educators, advocates, and academics from throughout the state to sit as members of an advisory committee to develop a model hospital policy on IPV with the goal of providing guidance to Virginia's hospitals in establishing procedures for the effective

identification, management and treatment of patients experiencing abuse. The group met a number of times over the course of six months and developed the policy (Appendix A). Reflective of both best-practice standards and those set forth by JCAHO, the model policy is intended to be used as a template by hospitals and related healthcare institutions in developing/revising their own policies on IPV.

In an effort to make an assessment as to how effectively Virginia’s hospitals are addressing and responding to the health and service needs of patients experiencing IPV/DV and to provide hospitals and other health care institutions with the tools needed to most seamlessly incorporate and/or adopt the core elements of the Virginia Model Hospital Policy on Intimate Partner Violence, VDH entered into a joint project with Old Dominion University (ODU). Each participating hospital was provided with an objective analysis/review of its current IPV/DV policy, based on standardized critiquing guidelines (Appendix B), as well as a revised policy, which incorporated the recommendations.

## Methods

All hospitals in Virginia with a 24-hour publicly available emergency department (N=82) were invited to participate in the project. Of these hospitals, 61 (RR=74%) provided their policies on/related to IPV/DV for review. Participating hospitals were evenly distributed across the five health planning districts in Virginia and were representative in terms of bed size, system membership, hospital type, and mean annual number of emergency department visits (Table 1).

**Table 1. Characteristics of Hospitals Participating in Review**

	Hospitals in Review (n=61)	All Virginia Hospitals with 24 hr. ED (n=82)
<b>Bed Size</b>		
25-99	36.2%	34.5%
100-199	29.3%	29.8%
200-500+	34.5%	35.7%
<b>System Membership</b>		
In a system	67.2%	60.7%
<b>Hospital Type</b>		
Not-for-profit	72.6%	75.0%
Investor-Owned	19.4%	20.2%
Government	8.1%	4.8%
<b>Mean Annual # ED Visits</b>	35,500	32,855

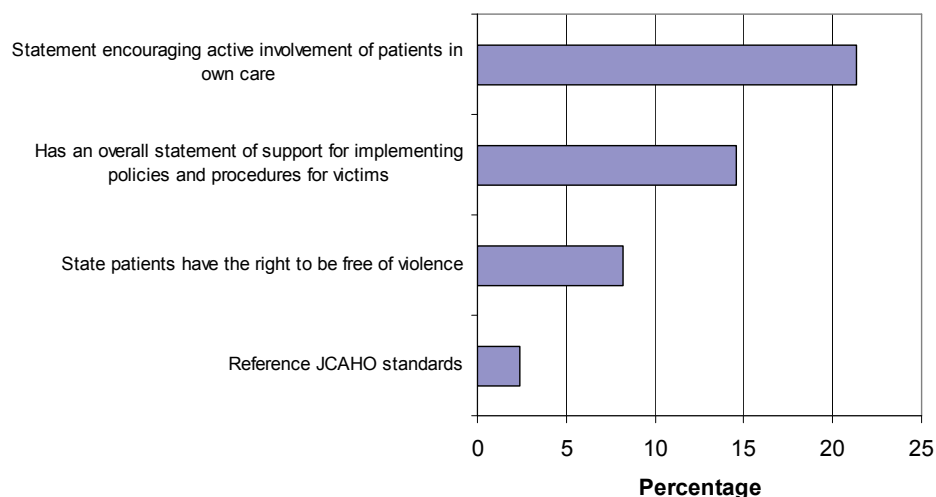
Each policy was reviewed, using the critiquing guidelines, by two ODU researchers and the VDH Project RADAR program manager. Policy reviews included an executive summary of the evaluation, followed by specific assessments in eight areas: overall statement of support for implementing policies and procedures for victims; definitions of IPV/DV; patient screening and assessment protocols; specification of documentation protocols; preparedness to develop plans and refer; legal reporting requirements; staff education and training; and security and employee safety.

## Results

### Statement of Support for Implementing Policies and Procedures for Victims

One of the first things assessed in the analysis was whether each hospital explicitly expressed a recognition of IPV/DV as a health care issue and a commitment to identifying and effectively managing victims and whether it included any reference to professional standards clarifying the hospital's role and responsibilities on the issue. Although JCAHO provides oversight to the vast majority of hospitals, only 2.4% of the policies reviewed included any reference to JCAHO's standards on abuse.

**Figure 1. Percentage of hospitals with some form of written statement of support in their hospital policy**

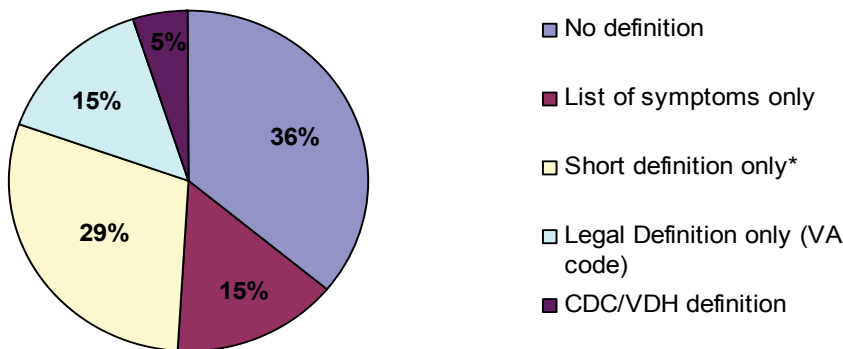


## Definitions

In this section, policies were examined in terms of whether they included a definition of intimate partner/domestic violence (IPV/DV) and, if so, the nature and extent of the definition. Over one-third of the hospital policies did not include any definition of IPV/DV, and, of the remaining 64%, only 15% used a comprehensive definition such as that employed by the Centers for Disease Control & Prevention (CDC) and VDH.

**From the Virginia Department of Health:**  
*Intimate partner violence (IPV) is a pattern of assaultive and coercive behaviors that may include inflicted physical injury, psychological abuse, sexual assault, progressive social isolation, stalking, deprivation, intimidation, and threats. These behaviors are perpetrated by someone who is, was, or wishes to be involved in an intimate or dating relationship with an adult or adolescent, and are aimed at establishing control by one partner over another.*

Figure 2. How Hospitals defined IPV/DV in hospital policies



**From the Centers for Disease Control & Prevention:**  
*Intimate partner violence (IPV) is abuse that occurs between two people in a close relationship. The term "intimate partner" includes current and former spouses and dating partners. IPV exists along a continuum from a single episode of violence to ongoing battering. IPV includes four types of behavior: physical abuse; sexual abuse; threats; and emotional abuse. Often, IPV starts with emotional abuse. This behavior can progress to physical or sexual assault. Several types of IPV may occur together.*

**From the Virginia Department of Criminal Justice Services:**  
*Family abuse is any act involving violence, force or threat, including forceful detention, which results in physical injury or places one in reasonable fear of serious bodily injury which is committed by a person against a family or household member.*

\* Short definition was defined as any partial CDC, VDH, or short legal definition that went beyond a list of signs and symptoms.

## Patient Screening and Assessment Protocols

When analyzing for screening and assessment protocols, policies were reviewed as to whether they specified methods or procedures for screening and managing victims of IPV/DV and the extent to which they contained information and/or tools to assist providers in assessing for lethality and in safety planning with victims. A little over one-fourth (26.2%) of the policies contained explicit assessment procedures, only 18% mentioning safety planning and even fewer (4.9%) containing information about and/or forms for lethality assessment.

**Table 2. Percentage of hospitals with some form of written procedures regarding routine assessment/screening for IPV/DV<sup>1</sup>**

	% of Hospitals n=61
<b>Routinely assess all patients</b>	
Not ever mentioned	83.6%
Assess only when suspected	8.2%
Assess all patients at intake	8.2%
<b>Explicit assessment procedures<sup>2</sup></b>	26.2%
<b>Employ direct questions about IPV/DV</b>	24.6%
<b>Mention safety planning</b>	18.0%
<b>Lethality assessment</b>	4.9%

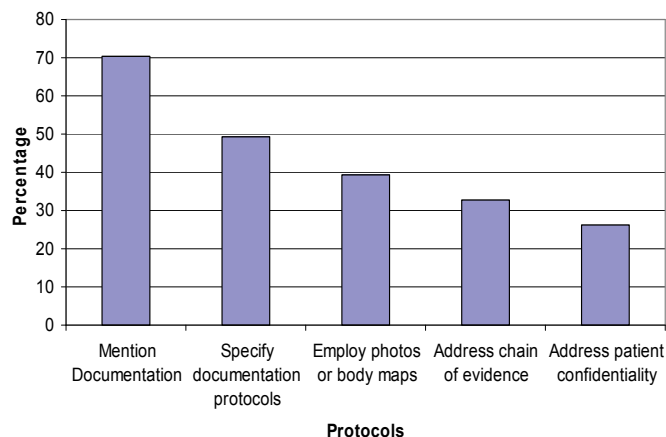
<sup>1</sup> More than one procedure may be noted in each hospital policy. Procedures will not sum to 100%.

<sup>2</sup> Policies with 'explicit assessment procedures' were those that included a set of steps (procedures, screening questions, etc.)

## Documentation Protocols

In order to record diagnoses and health history as well as a patient's treatment history, detailed documentation protocols help to ensure a high standard of care. In the case of IPV/DV, victims often present to the emergency department to be treated for injuries sustained during an assault. The criminal nature of these cases increases the need to have specified protocols in place so that injuries and patient statements about the incident are recorded and evidence is properly collected and preserved. Although over 70% of hospitals in the study did mention the need for documentation in cases of IPV/DV, less than half (49.2%) dictated specific procedures and less than one-third (32.8%) addressed the issue of chain of custody for evidence collected.

**Figure 3. Percentage of hospitals with some form of written procedures regarding documentation protocols<sup>1,2</sup>**



<sup>1</sup> More than one procedure may be noted in each hospital policy. Procedures will not sum to 100%.

<sup>2</sup> Those policies that 'mention documentation' included a direction to document with no guidance as to how to do so. Those that 'specified' protocols were those that gave a list of things to be recorded in the medical record.

## Preparedness to Develop Treatment Plans and Make Referrals

This section of the review focused on how well the policy provided guidance to hospital staff for enhancing safety and making referrals for IPV/DV victims post-treatment. The majority (88.5%) contained information about internal and/or external resources, and 63.9% included procedures for reviewing options with and making referrals for patients experiencing IPV/DV. However, the majority of hospitals did not address planning for a victim's safety, with only 13% directing that safety planning be done, and even less (6.6%) including a safety planning form in the body or appendix of the policy.

**Table 3. Percentage of hospitals with written treatment plans and referral procedures<sup>1,2</sup>**

	% of Hospitals n=61
<b>Access to a advocacy/protective services</b>	
Have none stated	11.5%
Referrals to outside help only	50.8%
Referrals to internal resources (hospital staff such as a social worker) and, in most cases, outside resources	37.7%
<b>Specify safety planning</b>	13.1%
<b>Written safety plan</b>	6.6%
<b>Review options and refer IPV patients</b>	63.9%

<sup>1</sup> More than one procedure may be noted in each hospital policy. Procedures will not sum to 100%.

<sup>2</sup> See Appendix for detailed definition of procedures.

## Legal Reporting Requirements

Legal reporting requirements on IPV/DV were unclearly or incorrectly stated in 41% of the policies reviewed, and just over one-fourth (26.2%) made specific reference to the mandate and/or code section regarding reporting of IPV/DV.

Unless the victim is a child, elder, or person with a disability, health care providers are only mandated reporters of IPV/DV when injuries have been caused by certain weapons. Otherwise, to report without a victim's consent violates patient confidentiality.

Most of the study hospitals (over 75%) combined IPV/DV policies in with policies for other forms of abuse (child, elder abuse, sexual assault) rather than making it a 'stand-alone' policy. Reporting mandates are very different for IPV/DV than for these other forms of abuse; and, therefore, grouping them together may have contributed to the lack of clarity on reporting requirements for health care providers.

*There is no federal or state statute that requires health care providers or institutions to report all cases of intimate partner violence. Hospital personnel are, however, required to make a report to law enforcement when they believe that specific weapons such as firearms or knives have inflicted a wound. (Code of Virginia § 54.1-2967 & § 18.2-308).*

## Staff Education and Training

The provision of staff training and education about IPV/DV is integral to a hospital's effectiveness at identifying, managing, and referring victims. In addition to achieving a high standard of care for these patients, training is also key to providing services to employees experiencing IPV/DV, maintaining hospital security and ensuring employee, patient, and visitor safety. A review of the policies' statements regarding education indicated that only 37.7% made mention of ANY requirements for initial or continuing education for hospital staff on the issue of IPV/DV.

## Security and Employee Safety

IPV/DV can pose a threat to anyone in the vicinity of a victim, thereby making procedures for handling these cases an issue of workplace safety. In a hospital setting, health care providers, other staff members, other patients, and visitors may be at risk for violence by an abuser. Although hospitals often have separate policies on security and workplace safety, given the volatile and violent nature of IPV/DV, it is important to specify those procedures again or at least reference them in any policy on abuse. Of the study hospitals, however, only 6.6% addressed the risk to staff treating victims and under one-fifth (18%) made a recommendation to separate the victim and abuser.

**Table 4. Percentage of hospitals with some form of written procedures pertaining to security and employee safety<sup>1</sup>**

	<b>% of Hospitals</b>
Security risk to staff of treating IPV/DV victims is addressed (e.g. notifying hospital security that a potential abuser is on-site)	6.6%
Discuss how to talk to alleged abusers	11.5%
Recommend separating alleged abusers from IPV patient	18.0%

<sup>1</sup> More than one procedure may be noted in each hospital policy. Procedures will not sum to 100%.

## Conclusions & Recommendations

The hospital policy review project was designed and carried out with two goals in mind. The first was to make an assessment on how effectively Virginia's hospitals are addressing and responding to the health and service needs of patients experiencing IPV/DV, and the second was to provide hospitals with the tools needed to most seamlessly incorporate and/or adopt the core elements of the Virginia Model Hospital Policy on Intimate Partner Violence. Although follow up with the hospitals is needed to determine the long-term impact of the project, the findings of the analyses indicate the following conclusions and recommendations:

- Statewide, Virginia's hospital policies do not provide adequate direction for identifying, assessing, treating, and referring victims of IPV.
- Policies vary widely, even within health systems. More consistency in procedures and methodology (i.e. adopting key components of the model policy) is needed.
- Although JCAHO has a number of relevant standards on abuse to which accredited hospitals must adhere, the overwhelming majority of study hospitals, though JCAHO accredited, did not mention, reference, or appear to meet these standards in their IPV policies. It is recommended that JCAHO view IPV as a priority issue and work with accredited hospitals in Virginia to more adequately meet their standards on abuse.
- Most hospitals in combine their policies on IPV/DV with those on other types of abuse, which appears to lead to a lack of clarity or misinformation in terms of reporting mandates, protocols, and referrals. Hospitals should create 'stand-alone' policies on IPV/DV.
- A majority of policies on IPV/DV were lacking specificity in terms of assessment/screening and documentation for IPV/DV. Policies should employ a specific method, such as RADAR, that describes more explicitly how to perform these procedures.
- Most hospital policies do not address the issue of employees affected by IPV/DV. Including information such as resources available to assist employee victims and relevant human resources policies would improve employee relations and enhance workplace safety.
- Several of the policies included important direction on safety and security (e.g. how to interact with alleged perpetrators) that had not been included in the model policy prior to the project. The 2008 Virginia Model Hospital Policy on IPV (Appendix A) was modified to include protocols in these areas.

How to measure whether or to what extent the study hospitals make recommended changes to their policies is an area for future research. Further, and more challenging, is the task of determining to what extent policy change impacts practice. Because there is currently no state-specific data on outcomes (e.g. the number of victims seen/identified in hospitals and provider screening, assessment, and referral procedures) it is difficult to determine how effective changes to policy, as well as training and education, does or would impact providers' ability to identify IPV, their practices in managing, treating, and referring victims, and patient outcomes. In order to determine the best strategies for improving the health care response to IPV, future research projects to collect such outcomes data must be conducted.

## References

<sup>1</sup>The Centers for Disease Control and Prevention and The National Institute of Justice, *Extent, Nature, and Consequences of Intimate Partner Violence*, July 2000.

<sup>2</sup>The Commonwealth Fund, *Health Concerns Across a Woman's Lifespan: 1998 Survey of Women's Health*, May 1999.

<sup>3</sup>Family and Intimate Partner Homicide Virginia 2005. Virginia Department of Health Office of the Chief Medical Examiner. July 2007.

<sup>4</sup>Shadigan, E.M., and Bauer, S.T. (2005). Pregnancy-associated death: a qualitative systematic review of homicide and suicide. *Obstetrical and Gynecological Survey*, 60(3), 183-190.

<sup>5</sup>Sharps, P.W., Koziol-McLain, J., Campbell, J.C., McFarlane, J., Sachs, C., & Xu, X. (2001). Missed opportunities for the prevention of femicide by health care providers. *Preventive Medicine*, 33, 373-380.

<sup>6</sup>McNutt, A., van Ryn, M., Clark, C., and Fraiser, I. (2000). Partner Violence and medical encounters: African-American women's perspectives. *American Journal of Preventive Medicine*, 19(4), 264-269.

## Resources

Centers for Disease Control and Prevention—Intimate Partner Violence Prevention  
[www.cdc.gov/ncipc/dvp/IPV](http://www.cdc.gov/ncipc/dvp/IPV)

Family Violence Prevention Fund—National Health Resource Center on Domestic Violence  
[www.endabuse.org/section/programs/health\\_care/\\_national\\_health\\_center](http://www.endabuse.org/section/programs/health_care/_national_health_center)  
888-Rx-ABUSE TTY: 800-595-4889

Virginia Department of Health—Project RADAR  
[www.projectradarva.com](http://www.projectradarva.com)  
804-864-7705

Virginia Sexual and Domestic Violence Action Alliance  
[www.vsdvalliance.org](http://www.vsdvalliance.org)  
Virginia Family Violence & Sexual Assault Hotline: 800-838-8238 (v/tty)

# Appendix A: Background and Model Policy

*In early 2006, the Division of Injury & Violence Prevention at the Virginia Department of Health convened a diverse group of healthcare providers, educators, advocates, and academics from throughout the state to sit as members of an advisory committee to develop a model hospital policy on intimate partner violence. With the goal of providing guidance to Virginia's hospitals in establishing procedures for the effective identification, management, and treatment of patients experiencing abuse, the group met a number of times over the course of six months and developed the policy which follows. The policy, reflective of both best-practice standards and those set forth by the Joint Commission on the Accreditation of Healthcare Organizations, is intended to be used as a template by hospitals and related healthcare institutions in developing their own policies on intimate partner violence.*

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**XX Hospital  
Department of XX**

**Policy and Procedure Manual**

<b>SUBJECT:</b>	<b>File Section:</b>	
<b>INTIMATE PARTNER VIOLENCE</b>	<b>Original Date:</b>	
	<b>Review Date:</b>	
	<b>Effective Date:</b>	

**POLICY:**

At *(the name of your hospital)* we believe every patient should feel safe and free of harm. Because intimate partner violence (IPV) impacts the health and well being of our patients, health care providers must actively participate in the process of identifying, treating, and referring victims. Our facility actively supports standards set forth by the Joint Commission on the Accreditation of Healthcare Organizations (JCAHO) requiring accredited hospitals to implement policies and procedures to respond to victims of abuse.

**II. DEFINITIONS:**

Intimate partner violence (IPV) is defined as a pattern of assaultive and coercive behaviors that may include inflicted physical injury, psychological abuse, sexual assault, progressive social isolation, stalking, deprivation, intimidation, and threats. These behaviors are perpetrated by someone who is, was, or wishes to be involved in an intimate or dating relationship with an adult or adolescent, and are aimed at establishing control by one partner over another.

**III. PROCEDURE:**

A. Clinical providers will utilize the RADAR methodology, detailed below, as the principle strategy for identifying and responding to IPV victims in healthcare settings.

1. **Routinely Assess for Violence**

Assessment for IPV in a clinical database/medical record will be integrated into routine health screens and/or anticipatory guidance practice utilizing standardized forms. Examples of forms may be found at [www.projectradarva.com](http://www.projectradarva.com).

2. **Ask Direct Questions**

Evidence-based questions will be used for integrating IPV assessment into regular health screens. These include:

- Have you ever been emotionally or physically abused by your partner or someone important to you?
- Within the past year, have you been hit, slapped, kicked or otherwise physically hurt by someone?
- Within the last year, has anyone forced you to have sexual activities?

JCAHO Standard RI.2.10 – The hospital respects the rights of patients.

JCAHO Standard RI.2.140 – The hospital creates a supportive environment for all patients.

JCAHO Standard RI.2.150 – Patients have the right to be free from mental, physical, sexual, and verbal abuse, neglect, and exploitation.

JCAHO Standard RI.2.170 – Patients have the right to access protective and advocacy services.

**Revised October 2008**

## Document Findings

In addition to established documentation procedures, when documenting IPV, providers will include patient's statements regarding the relationship, injuries, and violent events) as well as the results of any health and safety assessments, interventions, and referrals.

**Safety Note:** IPV should not be documented on any discharge forms or billing statements due to the increased risk of violence to the victim should the perpetrator acquire the information. Child and adolescent health providers should be mindful that any information included in a child's medical records is accessible by both parents and, therefore, any information pertaining to a parent's victimization should be documented in a separate record.

### Assess Safety

Providers will assess whether the victim has any immediate safety concerns. Assessments will be based on the victim's perception of safety and should consider:

- a. Increasing frequency and/or severity of violent incidents
- b. Access to and prior use of weapons
- c. Threats of homicide or suicide
- d. Risk of violence to children in the home

As indicated, more comprehensive danger/lethality assessments may be completed. Standardized forms for completing these assessments may be found at [www.projectradarva.com](http://www.projectradarva.com).

### Review options and referrals

Where available, providers will contact hospital social workers to provide immediate assistance to victims of IPV. Providers should make referrals to local domestic violence and/or sexual assault advocacy programs. (*Information about facility or locality-specific resources should be inserted here.*)

In Virginia, the Virginia Sexual & Domestic Violence Action Alliance provides confidential, 24-hour support, advocacy, and resource information to victims of sexual and domestic violence and providers via their hotline, 1-800-838-8238.

- B.** When providers/staff members suspect that they are interacting with perpetrators of IPV/DV, they will:
1. Alert hospital security that a suspected perpetrator of IPV/DV is in the facility.
  2. Attempt to talk with the patient without the presence of the suspected perpetrator
  3. Not accuse, threaten or antagonize the suspected perpetrator.
  4. Be a good listener. There can be much guilt, which may appear as confusion or antagonism. Offering support and a willingness to listen will often put the person at ease. You are their contact with what may be seem to be a threatening situation.
  5. Be clear, if the patient, family or suspected perpetrator is aware that a report is being made to the authorities, that state law requires reporting.

Note: When a patient identifies himself or herself as a perpetrator of IPV/DV, a healthcare provider has an ethical responsibility to determine if there is any risk of imminent harm to the patient or anyone else and report as mandated by law.

## IV. LEGAL REPORTING REQUIREMENTS

There is no federal or state statute that requires health care providers or institutions to report all incidents of intimate partner violence. Hospital personnel, however, are required to make a report to law enforcement when

they believe that specific weapons such as firearms or knives have inflicted a wound. (Code of Virginia § 54.1-2967 & § 18.2-308)

If providers suspect that a child under the age of 18 has been abused or neglected, they must make an immediate report to Child Protective Services. (Code of Virginia § 63.2-1509)

When providers suspect abuse, neglect, or exploitation of an adult with a disability or who is over the age of 60, they are required to make a report to Adult Protective Services. (Code of Virginia § 63.2-1606)

If any sexual assault, including those perpetrated by a spouse or intimate partner, is suspected, refer to the Sexual Assault Protocol. When evidence is collected per the Sexual Assault Protocol, victims should be offered both domestic and sexual violence resource information.

## TRAINING & EDUCATION

Providers must remain current in IPV knowledge by incorporating IPV training as part of their continuing education activities. *(Any training requirements specific to the facility should be detailed here.)*

## SUPPORT FOR EMPLOYEE VICTIMS

The Employee Assistance Program (EAP) in the Human Resources Department will develop policies and procedures that ensure that employees (and their families) affected by IPV are provided with necessary support. Policies will ensure that victims are: provided with resource information; assisted in safety planning; and that neither their ability to work or to maintain their professional position is negatively impacted by their victimization. *(Any relevant portions/content of the Human Resource Department's policy on IPV, violence, abuse, and the Employee Assistance Program should be inserted here.)*

## VII. RELEASE OF INFORMATION

In all cases of suspected intimate partner violence/domestic violence (IPV/DV), all personnel are to maintain patient confidentiality. Contents of the medical record are confidential and protected by the legal rights of the patient. The medical record is the property of the hospital and is maintained for the benefit of the patient, the medical staff and the hospital. It is the hospital's responsibility to safeguard both the record and its contents against loss, defacement and tampering, and from use by unauthorized individuals in accordance with the hospital policy relating to current HIPPA regulations.

APPROVED BY:

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# Appendix B: Critiquing Guidelines

## Detailed Policy Analysis

*A few sentences here about the overall strengths and weaknesses of the policy  
First, does the hospital have an IPV protocol in place?*

### **I. Overall statement of support for implementing policies & procedures for victims**

*Does the statement explicitly state that health care providers should address IPV?*

*Does the statement refer to the prevalence, effect on health and public health impact of IPV?*

*Does the statement refer to the relevant JCAHO standards?*

*Are other related forms of abuse (neglect, rape, child physical and sexual abuse) mentioned and either: addressed in this protocol or referred to in another protocol?*

### **II. Definition of intimate partner violence.**

*Does the policy have a clear and specific definition of intimate partner violence/ domestic violence? It should be similar to one of these:*

From VDH: Intimate partner violence (IPV) is defined as a pattern of assaultive and coercive behaviors that may include inflicted physical injury, psychological abuse, sexual assault, progressive social isolation, stalking, deprivation, intimidation, and threats. These behaviors are perpetrated by someone who is, was, or wishes to be involved in an intimate or dating relationship with an adult or adolescent, and are aimed at establishing control by one partner over another.

From the CDC: The term “intimate partner violence” describes physical, sexual, or psychological harm by a current or former partner or spouse. This type of violence can occur among heterosexual or same-sex couples and does not require sexual intimacy. There are four main types: Physical, psychological/emotional, sexual and stalking. IPV can vary in frequency and severity. It occurs on a continuum, ranging from one hit that may or may not impact the victim to chronic, severe battering. Repeated abuse is also known as battering.

### **III. Patient screening and assessment protocols**

*Does the policy state that assessment for IPV will be integrated into routine health screens using a standardized method? Does the policy state WHEN the screening will be done or how often?*

*Does the policy clearly state the criteria for identifying victims of IPV/DV? Is a specific approach (such as RADAR) referred to? Are specific questions defined in the protocol? If not in the protocol, is the location of the questions clearly stated?*

*Does the protocol address assessing for immediate safety concerns, including suicide, homicide and injury?*

*Is a lethality assessment (where indicated) part of the protocol?*

*Is safety planning with the patient part of the protocol?*

*Are specific tools for danger and/or lethality assessment provided? If not in the protocol, is the location of the tools clearly stated?*

*Does the protocol discuss how to handle patients that disclose they are abusers or at risk of abusing an intimate partner?*

### **IV. Specification of documentation protocols**

*Does the protocol clearly state that IPV is to be documented in the medical record?*

*Is a specific form for documentation provided or referred to? (e.g. a body map)?*

*Does the protocol specify that the patient’s statements regarding the relationship, injuries and violent events are to be documented as well?*

*Does the protocol specify that all interventions and referrals are to be specified in the medical record?*

*Does the protocol specify that consent will be obtained for the recording or filming of any injuries made for purposes other than the identification, diagnosis or treatment of the patient (e.g. such as evidentiary)?*

*Does the protocol state that all cases of possible IPV are immediately reported to the group in the hospital that keeps hospital statistics?*

#### **V. Hospital's preparedness to develop treatment plans and refer where appropriate**

*Is a specific staff person (e.g. social worker or forensic nurse) named as the resource to be contacted to provide assistance to victims of IPV?*

*Does the protocol contain specific and up-to-date information regarding pertinent private and public community agencies that provide or arrange for the assessment and care of abuse victims (such as local and state advocacy groups, shelters, hotlines, crisis centers)?*

*Does the protocol specify that referrals are to be given patients where indicated?*

*Is safety planning with the IPV victim directly addressed?*

*Does the hospital have a standard safety planning form to be used with victims?*

#### **VI. Legal reporting requirements**

*Does the protocol contain the following information?*

*Is the contact information for each agency in the protocol?*

There is no federal or state statute that requires health care providers or institutions to report all incidents of intimate partner violence. Hospital personnel, however, are required to make a report to law enforcement when they believe that specific weapons such as firearms or knives have inflicted a wound. (Code of Virginia § 54.1-2967 & § 18.2-308)

If providers suspect that a child under the age of 18 has been abused or neglected, they must make an immediate report to Child Protective Services. (Code of Virginia § 63.2-1509)

When providers suspect abuse, neglect, or exploitation of an adult with a disability or who is over the age of 60, they are required to make a report to Adult Protective Services. (Code of Virginia § 63.2-1606)

#### **VII. Staff education and training**

*Is an expectation that staff will be competent to assist IPV victims specified in the protocol?*

*Are IPV training requirements specified for staff?*

#### **VIII. Security and employee safety**

*Are the security measures to be taken when victims and/or perpetrators of IPV are identified clearly stated?*

*Are provisions for safe discharge of IPV victims discussed?*

*Are the security measures to be taken in the event of a security incident such as an abduction, assault, rape or homicide in the hospital setting specified here or in another protocol (the IPV protocol should specifically refer to the other protocol - EC.2.10, #7)?*

*Is there a specific plan to assist employees who are affected by IPV? The specific agency in the hospital that the employee will work with should be named.*

## Appendix C: JCAHO Standards

<b>2007 JCAHO Standards Related to Intimate Partner Violence &amp; Domestic Violence</b>	
<b><i>Standards specific to IPV/DV</i></b>	
Standard #	Standard Text
RI.2.150	Patients have the right to be free from mental, physical, sexual and verbal abuse
R1.2.170	Patients have a right to access protective and advocacy services
PC.3.10	Patients who may be victims of abuse or neglect are assessed.
EC.2.10	The hospital identifies and manages its security risks.
<b><i>General standards applicable to IPV/DV</i></b>	
Standard #	Standard Text
R1.2.10	The hospital respects the rights of patients.
R1.2.130	The hospital respects the needs of patients for confidentiality, privacy and security.
R1.2.140	Patients have a right to an environment that preserves dignity and contributes to a positive self-image
PC.2.20	The hospital defines in writing the data and information gathered during the assessment and re-assessment.
PC.4.10	Development of a plan for care treatment and services is individualized and appropriate to the patient's needs, strengths, limitations and goals.
PC.5.50	Care, treatment and services are provided in an interdisciplinary, collaborative manner
PC.6.10 PC.6.30	The patient received education and training specific to the patients needs and abilities and as appropriate to the care, treatment and services provided
PC.15.10	A process addresses the needs for continuing care, treatment and services after discharge or transfer
HR.2.10	The hospital provides initial orientation
HR.2.30	Ongoing education, including in-services, training and other activities maintains and improves staff competence.
IM.1.10	Information privacy and confidentiality are maintained
IM.6.10	The hospital has a complete and accurate medical record for patients assessed, cared for, treated or served
<b><i>Patient Safety Goals Related to IPV/DV</i></b>	
Goal 13	Encourage patients' active involvement in their own care as a patient safety strategy
Goal 15	The organization identifies safety risks inherent in its patient population
<b><i>Reviewable Sentinel Events Related to IPV/DV</i></b>	
	Suicide of any patient receiving care within 72 hours of discharge
	Assault, homicide or other crime resulting in death or major permanent loss of function.
	Abduction of any patient receiving care, treatment or services
	Rape (while being treated in the hospital)
	An elopement (unauthorized departure) of a patient resulting in a temporally related death (suicide, homicide, accident) or major permanent loss of function.



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