Module 4 Health Care: Improving Quality and Good Practice

Timeframe: Module 4 will take 45 minutes

Content:

Topic 1: How to facilitate institutional accountability and commitment by establishing agreed strategies and policies

Topic 2: Good practices of the ambulance service (first aid, emergency centres etc)

Topic 3: Good clinical practice examples (intervention programme in hospitals)

Topic 4: Evaluation of Domestic Violence Programs

Objectives of Module 4:
The objectives of this module are:
- To formulate steps that health care managers and providers can take to improve the health care response to Intimate Partner Violence (IPV)
- To present good practice examples (emergency centres and hospitals)
- To inform about Tools for Quality improvement
Background information

“Initiatives and projects aimed at changes in practice in health institutions need the support and acceptance of senior managers, such as boards of directors and professional staff such as medical consultants. A clear commitment of responsible leading agents – hospital boards and professional associations – gives essential credibility to the changes that are needed. Projects without such support tend to reply mainly on the commitment of individual professionals and lack sustained implementation (Regan 2004:20ff; Hellbernd et al. 2003:59ff).

Setting up an interdisciplinary, interdepartmental taskforce within a hospital or institution to develop an organisation policy regarding new practice interventions in cases of violence has proved to be a very reliable and efficient approach (Hellbernd et al. 2003:59ff). Including experts on violence from outside the hospital into such taskforces is strongly recommended.

Evaluation results on facilitating institutional responses and taking measures for early identification, intervention, support and referral draw attention to specific quality standards that must be met to provide good and continuous practice. (Westmarland et al. 2004; Regan 2004; Romito et al 2004; Hellbernd et al. 2003; Perttu et al. 2003). These standards are:

- Provide explicit training and education for health professionals on background knowledge of gender based violence;
- Develop specific practice knowledge, i.e. instructions and guidance on how to ask, demonstrating an enquiring attitude, how to provide a safe setting and what to do in case of disclosure;
- Establish protocols that prioritise the safety of potential victims and elaborate written guidelines;
- Ask all patients, conduct routine enquiry, rather than make ad hoc enquires that are susceptible to assumptions and stereotypical views about vulnerable victim groups;
- Provide information material to patients and cultivate cooperation with specialised support agencies in order to facilitate referrals as required;
- Establish valid documentation and monitoring systems to record disclosure and clinical responses in order to maintain and learn from the implementation of routine enquiry.”

(Source: Hanmer/Gloor/Meier et al. 2006)

Further information about domestic abuse policy and the role of policy-makers or managers are published by the British Department of Health (2005):

“A policy-maker or manager in health care service plays an important role in making sure services respond to domestic abuse effectively. This role should be to:

- “create strategies and policies for delivering local service provision which reflect national guidance;
• place at the heart of decision making the safety of women and children who have experienced abuse;
• participate fully in multi-agency initiatives; and
• monitor, evaluate and audit health services’ domestic abuse initiatives and collect appropriate data.”

Source: Department of Health (DH) 2005:83ff: Responding to domestic abuse: a handbook for health professionals

What should be included in domestic abuse policy?
As a bare minimum, policy should include:
• a description of the principles underpinning the policy;
• a definition of domestic abuse;
• information on the national and local context;
• an outline of expectations of policy; and
• the Authority’s or Trust’s approach – to include reference to who has responsibility for asking a woman about domestic abuse.

By saying that everybody needs to take responsibility for asking about domestic abuse, you might risk nobody doing so.

The main responsibility should lie with the person with primary responsibility for a woman’s care.

It is of paramount importance that your policy is underpinned with education and training, supervision and support for staff.

Source: Department of Health (DH) 2005, p. 84

What to include in a Human Resources (HR) policy:
• a statement of commitment to provide support, advice and information;
• an overview of the legal basis for the policy;
• what the organisation will provide for those experiencing domestic abuse;
• how the organisation will respond to perpetrators;
• how policy will be implemented and monitored; and
• what training will be made available to line managers

Source: Department of Health (DH) 2005, p. 92

The WHO (2004) points out how health managers can take important steps to improve the health care response to domestic violence:
• Referral services can include legal and social services, shelters, etc. Referral networks are formal or informal arrangements between health services and other organizations.
• Sensitisation raises awareness and increases knowledge about GBV among staff.
• Privacy and confidentiality may require better infrastructure (e.g. solid doors, walls instead of curtains) and/or policies and training that ensure that staff understand the importance of confidentiality and know procedures to follow.
• In terms of medical records, providers need to know how to document cases of GBV and managers need to establish policies and systems to protect confidentiality of those records.
• Protocols for treating women in crisis need to be adapted to the local context.
- Staff training can address signs of GBV, how to ask about it, document, refer, etc.
- Sexual harassment policies can improve the professional work environment and the extent to which principles of respect for human rights are pervasive throughout the organization.
- Support groups for providers can address their concerns, the emotional toll, and their questions about how to deal with difficult cases.
- Support groups for women may offer a low cost way to help women cope with GBV.

Source: WHO Teach VIP 2004

Material for Health Care Setting
There are valuable tools and information for health care decision-makers and administrators to improve health care and implement domestic violence intervention programs developed by the Family Violence Prevention Fund (www.endabuse.org).

The “Business Case for Domestic Violence Programs” from Family Violence Prevention Fund (FVPF 2007) gives domestic violence identification program supporters the tools to make the case for these programs when meeting with chief executive or financial officers at health care institutions. It includes information on the health impact of domestic violence, the related health care costs of abuse and the ways domestic violence intervention programs can cut these costs.

The Family Violence Prevention Fund and Physicians for A Violence Free Society developed an excel-based program “Return on Investment Tool” that helps analyze the cost and potential benefits of implementing a comprehensive domestic violence response program within health settings. The program promotes quality of care by using evidence to support key changes in infrastructure to care for victims of violence and promotes future outcomes research by offering a model to track and assess clinical improvement goals based on improved patient health and safety.

The presentation provides information about the health impact of abuse, the related health care costs and makes a persuasive argument about the potential to cut these costs with domestic violence intervention programs.
**Topic 2: Good practices of the ambulant service (first aid, emergency centres etc)**

**Indicators of good practice in domestic abuse**
1. Developing a definition of domestic abuse in conjunction with appropriate service provision.
2. Overarching domestic abuse policies and guidelines that include vulnerable adult and child protection issues.
3. Prioritising safety.
4. Awareness raising, education and training.
5. Evaluation, auditing processes and data collection.
6. A multi-agency strategy.

Source: Department of Health (DH) 2005, p. 90

**Part 1: Emergency Medical Services (EMS)**

EMS can be quite often the first service who is called to an incident of domestic violence, especially in cases with severe injury. The first health care professional is the dispatcher and so the education of dispatchers is necessary. There are several important matters to be aware of: the emergency call may have been place for the trauma or other health consequences and not for domestic violence itself, so the professionals must be aware of the whole problem of domestic violence. They must know the “red flags”; knowledge about barriers in seeking help also is essential. Communication training both for dispatchers as well as for field professionals is very useful. The perpetrator is sometimes present at the scene, so the professionals must know the principles of effective communication both with the victim and with the perpetrator and must be able to manage the whole situation. Knowledge about medico-legal issues (informed consent and refusal, patient confidentiality vs. reportable conditions) is necessary.

The phases of emergency response are:
- emergency call – medical dispatch centre
- treatment on scene and transport – physicians / emergency medical nurses / paramedics
- hospital admission or dismissal – physicians and nurses in the hospital (usually emergency department, traumatology, surgery, internal department, otorhinolaryngology and others).

All of these professionals should have the basic theoretical knowledge about the problem, basic skills of effective communication, identification of the victim and legal issues. The dispatchers must be able to identify domestic violence based on the emergency call alone and they must manage the situation including choosing the appropriate response (priority, the response level – physician / non-physician team, sending the police to the scene). The medical dispatchers also should have a database of all support services in the region (social, psychosocial, help lines, women’s shelters, intervention centres etc). The field professionals should be able to identify domestic violence when they are called to address any of the health consequences of it and they should be able to offer appropriate care and support, with the help of dispatch (database of supporting services –

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see above). The treatment must be provided according to urgency with vital functions and major trauma the highest priority. A further responsibility of the hospital is the precise documentation of injuries including body maps or photographs (with consent of the victim) and reporting according to national laws. There should be time for a short crisis intervention.

To ensure these supports are offered several institutional practices need to be in place:
- education of the personnel, which should be obligatory
- support from management
- written protocols
- ideally, a specially trained team (on call in the case of domestic violence)
- funding for these additional activities.

**Topic 3: Good clinical practice examples (intervention programme in hospitals)**

"In order for clinicians to develop and sustain an appropriate response to domestic violence, they must have the support of the institutions in which they practice. As health care professionals attempt to incorporate routine inquiry about abuse into the standard of care for all women patients, the need for a coordinated institutional response to domestic violence becomes increasingly evident."


There is quite a lot of research about intervention programs in clinics, studies about the program implementation and about improvement of health care for patients who are affected by violence (Rodriguez et al. 1999, Coben 2002, Rhodes et al. 2003, McFarlane et al. 2004, Hellbernd et al. 2004, Bacchus et al. 2007).
S.I.G.N.A.L. – A Pilot Project for Intervention to Combat Violence against Women

An example of an intervention program in a hospital is the **S.I.G.N.A.L. intervention program** in Germany. The project was implemented 1999 at the Benjamin Franklin University Clinic of the Free University Berlin, Germany, and devoted to intervention in cases of violence against women. The project goes under the name S.I.G.N.A.L. The name points to the importance of recognising the signals and warning signs of violence against women. At the same time it is an acronym, the individual letters S-I-G-N-A-L (in German) denoting practical steps to be taken when an abused woman turns to the Clinic for help.

The **S.I.G.N.A.L. guidelines** for the hospital staff are as follows:

| S | Speak to the patient and signalise your readiness to help. Women are able to talk about what they have gone through only if they feel that someone is really listening to them and is willing to take their problems seriously. |
| I | Interview the patient, using simple, practical questions. Listen without being judgemental. Women are often afraid of not being taken seriously, and they tend to feel ashamed. They may have difficulty speaking to someone else about the violence they have suffered. |
| G | Make a careful examination of fresh and old injuries. Injuries at different stages of healing may be an indication of domestic violence. |
| N | Note and document all medical findings and information in such a way that they could be used as evidence in court. |
| A | Establish the patient's safety requirements. Every intervention must aim at providing the victim with protection and ending violence. |
| L | Offer the patient guidelines for personal behaviour together with emergency phone numbers and details of available support facilities. Patients will make use of this when they feel that the time is right. |

Besides clinical guidelines the SIGNAL programme includes the following elements to implement a protocol in the hospital:

- Intervention procedures and medical documentation
- Referrals to in-house staff and to community agencies: domestic violence programs, legal advocacy, children’s services, rape crisis services
- Plan for staff education

The **S.I.G.N.A.L. guidelines** form the basis for training programmes for nursing and medical staff and other vocational groups at the University Clinic. The training course units run for two days. The first courses have been held for the staff of the Admissions / First Aid Department. Further courses are scheduled for the Gynaecology, Surgical, Traumatology, Radiology, Psychosomatic and neurology Departments.

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1 The S.I.G.N.A.L. intervention program is adapted from the RADAR program. The RADAR action steps have been developed by the Massachusetts Medical Society in 1992.

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Evaluation, Quality Control and Scientific Monitoring

Between 2000 and 2003 a process evaluation of the pilot project was funded by the German Federal Ministry for Family Affairs, Senior Citizens, Women and Youth, and carried out by the Institute for Health Sciences of the Technical University, Berlin. This evaluation was notable as the first needs assessment and surveillance study in which data were collected and evaluated regarding the need for health care of victimised women in Germany.

The hospital staff considers S.I.G.N.A.L. as a necessary and important program in order to improve health care for female patients who are victims of violence. A feasible and target-group oriented concept for training was developed in the course of the S.I.G.N.A.L. project, successfully reaching various staff members in the hospital. The evaluation of the training program demonstrated that hospital staff viewed this process positively. The trainings were successful in sensitising hospital staff to the problem of domestic violence. Standards for appropriate health care for abused patients were conveyed to staff members, as were guidelines for acting competently. Participants considered the training and curriculum as essential in providing information about the problem of violence against women, intervention and support strategies for these problems; resources regarding local counselling programs and shelters were found to be particularly helpful for their everyday work.

Networking with Other Projects aimed at Combating Violence

The pilot project, the first of its kind in Germany, has raised lively interest among other hospitals in Germany. Networking with other clinics and prevention projects working in the field of combating violence has been an aspect of this pilot project from the onset. In view of the positive feedback received, plans have been made to set up a network designed to co-ordinate the project’s implementation at other public health facilities where there is an interest in doing so.

Topic 4: Evaluation of Domestic Violence Programs

To improve the health care response to victims of domestic violence, hospitals and health care systems are designing and implementing training, screening, and intervention programs. Formal evaluations of the programs are essential.

A formal evaluation instrument of hospital-based domestic violence programs was developed by the Agency for Healthcare Research and Quality (AHRQ) and Jeff Coben. It is the consensus-driven quality assessment tool called “Delphi Instrument for Hospital-based Domestic Violence Programs”\(^2\). The instrument can help to measure the progress of intervention in a hospital and includes the following categories:

- hospital policies and procedures
- hospital physical environment
- hospital cultural environment
- training of providers
- screening & safety assessment

\(^2\) [http://fvpfstore.stores.yahoo.net/deinforhodov.html](http://fvpfstore.stores.yahoo.net/deinforhodov.html)
• documentation
• intervention services
• evaluation activities
• collaboration

How to use the evaluation tool?
It should “first be completed before a new plan is implemented and then completed every six months, for the duration of 2-5 years.” The instrument “can be self-administered or administered by an independent evaluator in conjunction with a representative from the hospital intimate partner violence (IPV) program. In either situation, the individual who is most familiar with the IPV program should participate in the process. The required information can be best obtained via a “site visit” of the hospital. The hospital should be provided with sufficient time to assemble the materials that need to be reviewed (3 weeks advance notice is suggested). The assessment procedures should include a review of these materials as well as a physical tour of the facility to examine posters, brochures, documentation procedures, equipment (i.e., cameras), and other supplies. Approximately four hours should be allocated for completion of the instrument.”

More background information about the tool, including development and testing can be downloaded from http://www.ahrq.gov/research/domesticviol/dvtool.pdf

The instrument was adapted for hospitals in German speaking countries by Brzank (2005).

_The Family Violence Quality assessment Tool for primary Care Offices_3

The “Delphi Instrument for Hospital Domestic Violence Programs” has been modified for use in primary care offices (paediatric, family medicine, internal medicine and Obstetrics/gynaecology), but the modified instrument has not been evaluated in the same way as the original.

“The tool may be used to assess family violence efforts in primary care at the beginning and intermittently (every 6 months, every year, every few years) when focusing on family violence as a quality improvement goal. It is meant to be a tool for identifying deficiencies and so that they can be remedied and the care to patients living with violence and abuse can be improved.”

References:


Department of Health (DH) (2005): 83ff: Responding to domestic abuse: a handbook for health professionals

3 http://fvpfstore.stores.yahoo.net/faviquastofo.html

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http://www.endabuse.org/section/programs/health_care/_resource_manual

Family Violence Prevention Fund: Health Care Website
http://endabuse.org/section/programs/health_care


