This is an example of a Domestic Violence and Strangulation Policy – Brigham and Women's Hospital. 01/2013

Policy Name:	**Domestic Abuse Protocol**
Policy Number:	5.1.4 (formerly V-7)
Approved By	Medical Staff Executive Committee, **11/11** Senior Management Group,

Keywords: Domestic abuse, domestic violence, social work

I. Background

Domestic abuse (also known as domestic violence and intimate partner abuse) is a public health problem of epidemic proportions with devastating effects on the health and well-being of many patients and employees at Brigham and Women's Hospital. Domestic abuse is defined as a systematic and coercive pattern of behaviors that is harmful physically and emotionally and intended to gain power and control over one's partner in an intimate relationship. Acts or threats of physical or sexual violence as well as intimidation, humiliation, isolation, verbal abuse and economic control are typically present in abusive relationships. While some people who are experiencing domestic violence may present with symptoms related to abuse, such as traumatic injury, others may show no obvious signs of victimization and yet may still be at great risk

Domestic abuse affects people from all racial/ethnic, socio-economic, age, and religious groups and occurs in same sex and heterosexual relationships. Adolescents in dating relationships and elders are also at risk. Women are victims in 85% of reported cases of domestic abuse (U.S. Department of Justice). It is critical that health care providers screen for abuse with all patients, be able to recognize indicators of abuse among all of their patients, address the health consequences of abuse and offer support and appropriate interventions as outlined in this policy.

The health care setting offers a critical point of access to support for abuse victims. The sensitive and compassionate manner in which providers approach this issue counters the isolation, shame and fear that victim's experience. Through the health care encounter, many victims are linked to safety options that they would not otherwise be able to find. Addressing domestic abuse and its associated safety threats often leads to improved physical and emotional health for patients and/or increased compliance with treatment and care plans.

Hospital resources are available to assist the health care provider in responding to domestic abuse, including 24-hour social work availability (617-732-6469 or page operator, 617-732-6660) and the ***Passageway*** domestic violence program (617-732-875 or 617-732-6660, pager 31808) described below (See Section 5).

Although this policy outlines the responses to patients at BWH, it is important to recognize that employees are also affected and can receive assistance at ***Passageway*** or through the resources listed in this document.

II. Policy

All health care providers at Brigham and Women's Hospital will routinely screen patients for domestic abuse, be able to recognize indicators of abuse in all patients, and offer support, assessment and appropriate interventions to those affected by abuse in accordance with individual patient's needs and choices. Providers should follow department-specific protocols for screening and intervening in domestic violence in those departments where protocols have been implemented.

II. Procedure

DOMESTIC ABUSE SCREENING

Routine Screening

Routine screening is a key component to identifying abuse. All providers should know the signs of abuse; however, should not restrict their screening when potential indicators are present. The majority of abused patients do not present with obvious signs and will not disclose abuse unless they are asked directly. Abused patients are more likely to disclose abuse and seek assistance if they perceive that it is safe to do so and are asked by a concerned health care provider. Best practice models recommend that a health care provider with primary responsibility for the patient's care is the best person to assume responsibility for screening. It is not appropriate to delegate screening to ancillary service providers.

Universal screening is both an important tool and an intervention because it gives providers knowledge about factors influencing patient's health and informs patients that their providers can offer support and resources if domestic abuse is an issue. If there is a negative screen for abuse, it does not mean that abuse is not an issue. In addition to screening, providers must assess for indicators of abuse (See Section 3).

Screening Frequency

Practice standards recommend domestic violence screening occur at admission to the hospital, in all Emergency Department visits, at pre-determined intervals in ambulatory and specialty services and whenever a patient presents with indicators or injuries. In primary care practices, screening is recommended for all new patients, at annual visits and whenever indicators, injuries or relationship issues are disclosed. In OB/GYN practices, screening is recommended at annual visits, during prenatal visits, at antepartum admissions, and whenever high-risk situations or indicators are present. All health care providers with a primary role in caring for the patient are responsible for ensuring that screening for domestic violence has occurred.

Screening Procedures

1. Always interview the patient alone. Use interpreters as needed. Never use a friend or family member as an interpreter in domestic violence screening.

2. Use gender-neutral language when screening. Use the term "partner" rather than husband/boyfriend/girlfriend in initial questions.

3. Use an introductory statement before screening. It is useful to introduce screening as universal practice. For example, state: "Because abuse is a common problem and affects health and well-being, I ask all patients if anyone is frightening, threatening or hurting them in any way."

4. Inpatient Screening Procedure:

   At admission, the nurse is responsible for screening per the questions included on the Patient Assessment Form.

5. Ambulatory Services Screening Procedures:

   Each ambulatory service practice is responsible for defining its screening procedures in accordance with the protocols outlined in this document.

6. Emergency Department Screening Procedures – Per department-specific protocol:

   Primary Nurse is responsible for screening.

   The three designated Emergency Department screening questions are:
   - *Have you ever felt unsafe or been afraid of anyone (e.g. your partner, a relative, or anyone else?)*
   - *Is anyone trying to control you (e.g. who you see and talk to, where you go, what you wear, how you spend money)?*
   - *Has anyone ever hurt (e.g. hit, kicked, slapped, choked or punched you or forced you to perform sexual acts against your will) or threatened to hurt you or someone else that you care about?*

7. In addition to the abuse screening questions used in the Emergency Department, the following are effective:

   - Have you ever been emotionally or physically abused by your partner or someone important to you?
   - Within the last year, have you been hit, slapped, kicked, choked or otherwise physically hurt by someone?
   - Within the last year, has anyone forced you to have sexual activities?
   - Are you afraid of your partner or anyone?
   - Since you've been pregnant, have you been hit, slapped, kicked, choked or otherwise physically hurt by someone?
   - Do you ever feel unsafe at home?
   - Have you ever felt afraid of your partner?

8. Patient self-assessment questionnaires:
   Clinical services areas may chose to include domestic violence screening questions in written patient self-assessment questionnaires. This method does not replace the mandate for direct provider screening of patients. Providers should both review the written patient self-assessment with patients and verbally screen patients for domestic abuse.

9. Screening when a patient presents with injuries:

   Ask directly whether the injuries or complaints are a result of an assault or abusive situation with a partner or someone that the patient knows.

Provider Responses to Screening

1. Negative screen and no indicators of abuse

   Acknowledge that you (the provider) and Brigham and Women's Hospital are invested in supporting the safety and well-being of all patients. Should abuse issues arise in the future, reinforce that you would like to know about it and can offer assistance and linkages to abuse programs.

2. Negative screen and indicators of abuse

   Acknowledge that you respect that the patient is giving a negative response to the screen. Maintain a non-judgmental approach. The patient may be fearful or mistrustful. State your concerns directly to the patient. Note the pattern of injuries or indicators that could signal abuse.

Emphasize your desire to help the patient and address symptoms or medical conditions. Follow the intervention in this protocol (section 5).

3. Positive screen: Respond to the disclosure

   Offer a compassionate, supportive response. Recognize that an abused person is often at greater risk in disclosing abuse because abusive partners often retaliate and threaten to harm a victim if they tell anyone. Do not judge the person for the situation. Direct statements reassure and offer support and validation. For example, state: "*Thank you for telling me. I'm concerned for you. There are so many people in similar situations - it's not your fault. You deserve to be safe. I can connect you with specialists here at the hospital that can help."* Follow this protocol and refer to social work.

Screening Documentation

1. Use checkbox/screening result section on designated assessment form.

2. If negative screen and form is not available, write: "Patient negative (-) response to abuse screen" or "No patient disclosure of abuse." Include the date and your signature. Avoid subjective description. For example, do NOT write: "patient denies abuse." Abuse may be an issue, but patient is fearful or choosing not to disclose at this time.

3. If positive screen and form is not available, write: "Positive screen for abuse." Where relevant to the current care of the patient, describe abuse and health effects or injuries per clinical documentation standards. Note the assessment and intervention (e.g., referral to social work, immediate safety threat identified and plan of action).

4. If patient presents with indicators of abuse but does not disclose (negative response to screening questions), note the question of abuse, assessment of health effects of abuse or injuries and follow-up plan in clinical note.

III. Indicators of Domestic Abuse

The following table outlines indicators that signal the possibility of abuse. If any indicators are present, further assessment is warranted to determine if abuse is a current or underlying issue impacting the patient's health or well-being.

Indicators of Domestic Violence/Intimate Partner Abuse[1]

History	• Chronic abdominal, pelvic or chest pain • Chronic, unexplained pain • Irritable bowel syndrome • Chronic gynecologic conditions • Sexually transmitted diseases and exposure to HIV through sexual coercion • Exacerbation of systems of a chronic disease such as diabetes or asthma • Headaches, migraines • Chest pain/palpitations • Chronic joint or back pain, headaches, numbness and tingling from injuries • Somatic disorders • Chronic fatigue • Non compliance with medical treatment
Psychological symptoms	• Insomnia, sleep disturbances • Depression and suicidal ideation • Anxiety symptoms and panic disorder • Eating disorders • Substance abuse • Post-traumatic stress disorder • Use of psychiatric services by victim or partner
Physical findings	• Any injury, especially to face, head, neck, throat, chest, abdomen and genital areas • Dental trauma • Burns • Sexual assault
Common characteristics of injuries caused by domestic violence	• Central distribution of injuries • Injuries of the head, neck, mouth • Defensive injuries of the forearms • Injuries that are not explained adequately or consistently • Injuries to multiple areas • Bruises in various stages of healing • Unexplained stroke in a young woman • Any type of injury caused by sexual assault • Unexplained injuries • Internal injuries due to strangulation – MAY NOT BE VISIBLE- if strangulation reported, full exam should be conducted
Behavioral Indicators	• Delay in seeking treatment • Injury inconsistent with explanation given • Repeated use of Emergency Services for trauma or primary care needs • Evasiveness of patient • Isolation • Refers to partner's temper/anger • Silent or reluctant to speak in partner's presence • Partner answers all questions for patient or insists on being present when asked to leave exam room • Overly attentive or verbally abusive partner

[1] Adapted from Eisenstat, S & Bancroft, L, Primary care: Domestic Violence, New England Journal of Medicine, 1999; 341: 886-92
and Lewis-O'Connor, A., Neighborhood Health Plan, 1997 and Passageway at Brigham and Women's Hospital – Training Materials.

	• Any suspected or documented concern of abuse or neglect of children or elderly adult in the home • Abuse of pets
Findings during pregnancy and childbirth	• Any injury • Unwanted pregnancy • Complications such as miscarriage, low birth weight or infant, premature labor, and antepartum hemorrhage • Late or no prenatal care

IV. Intervention

1. Referral to Social Work and Passageway

a. Ambulatory Services

The primary health care provider will make a referral to the social worker assigned to cover a specific ambulatory area. If there is not a dedicated social worker for your service, you may contact Care Coordination main office at 617-732-6469 (page the on-call social worker after business hours) or Passageway 617-732-8753 for assistance in identifying an alternate responder.

In collaboration with the health care provider(s), **social workers** will complete a comprehensive assessment, develop a safety plan, and refer the patient to Passageway or other appropriate services (based on what is most appropriate for the patient).

b. Inpatient Units

The primary nurse or designated health care provider will make a referral to the social worker assigned to cover the unit. The social worker will automatically involve Passageway for case review and internal management of any safety issues.

In collaboration with the health care team, social workers will complete a comprehensive assessment, develop a safety plan, and facilitate a direct referral to Passageway (based on what is most appropriate for the patient.)

c. Emergency Department

The primary nurse or designated health care provider will make a referral to the social worker in the Emergency Department. There is on-site dedicated coverage 7 days/week from 8:30 a.m. to 12:30 a.m. From 12:30 a.m. to 8:30 a.m., there is an on-call social worker who will come on-site for any domestic violence, sexual assault or trauma situation.

In collaboration with the health care team, social workers will complete a comprehensive assessment, develop a safety plan and facilitate a direct referral to Passageway (based on what is most appropriate for the patient). Evening and weekend social workers have access to book follow-up appointments for patients at Passageway the next business day.

2. Address immediate threats to safety

a. Follow hospital safety protocols for any concerns about immediate on-site threats to safety.

b. Call Security at 617-732-6565 (stat line) or call "Code Grey" with immediate concerns.

c. Consult with designated administrators (Nursing, Security, Social Work Administrator, Passageway) as needed to proactively manage any potential safety threats.

d. Director of Social Work and Director of Passageway should be alerted to any high-risk case or media-related case involving domestic abuse for consultation and coordination of services.

3. Address the health consequences of abuse

a. Adhere to standards of practice.

b. Assess how the abuse has impacted the patient's health and well-being and develop appropriate treatment plans.

c. Recognize that a history of abuse or safety threat may affect a patient's health and impair his/her ability to cope with an illness. Incorporate safety planning and sensitivity to victims' trauma in routine care. Make sure a patient is well-connected to social work support and Passageway (as appropriate).

d. Well-coordinated care is essential in addressing complex domestic abuse issues.

4. Documentation

a. Complete documentation of domestic abuse in an accurate and timely manner. Documentation provides a record of the pattern of abuse over time, facilitates coordinated care, and may serve as evidence in court proceedings.

b. Be clear, concise and objective. Providers who document detailed, objective, and legible accounts of patient encounters are less likely to be subpoenaed to appear in court than those who write vague notes.

c. Include what is said by the patient and observed, including:
   - Date and time of incident or abusive situation.
   - Patient's account of what happened, including the name of the person who hurt or threatened them.
   - Specific details about the abuse (e.g., "Pt. reported being punched in the face 4 times by John Smith when she tried to leave the house.")
   - Note any observable physical injuries or bruises.
   - Note patient's coping and responses to the abuse.
   - Relevant history reported.
   - Type of injuries sustained, if relevant and any weapons used.
   - Location of injuries.
   - Type and nature of threat to patient's safety.
   - The provider's intervention – physical findings, assessment, information provided, safety planning, referrals provided. Do not list the names of specific services or agencies if it could jeopardize the person's safety.
   - Mandatory reporting and corresponding safety planning.

d. Avoid using judgmental or legalistic language. For example, do not write "patient alleges", "patient denies", or "patient claims." These phrases may be misinterpreted as disbelief by the provider and used to discredit a victim of abuse in court.

e. Report what you saw and heard and avoid phrases that leave room for misinterpretation. For instance, instead of "Patient was hysterical" write "Patient was shaking and crying while describing abuse history."
f. Referral for Domestic Abuse Services:
   - Document in the record "Referral to Social Work for further domestic abuse assessment" and "Referral to Passageway." Do not write a particular name of an advocate in the record.

PHOTOGRAPHING INJURIES (FORENSIC EVIDENCE COLLECTION)

1. Photographic documentation is intended to complement written documentation and provides additional evidence of abuse that can be used in court proceedings. A camera is available in the Brigham and Women's Hospital Emergency Department and may be borrowed for use in on-site clinical areas. Photographs should be taken by nursing staff for all domestic abuse cases.

2. Take photographs only if a patient consents verbally and signs a written consent form specifically authorizing photography. Place photographs in a sealed envelope within a medical record and label as "Confidential – to be used only for litigation purposes."

3. All patients should be offered the opportunity to have photographs taken. If a patient agrees, complete the written consent form. The photographer must follow the following guidelines for photographs to be useful:

   - Take an initial photo of the person, including the person's face and any visible injuries. It is helpful to include an identifying document (e.g., person's license or ID) in the set of photos.
   - Take a medium range photo showing the location of the injury on the person's body.
   - Take close-up photos of the injury or injuries. Be sure to include a photo that enables the viewer to identify the body part where the injury was sustained.
   - Label each photo with the date (including year) and time the photo is taken, the name of the hospital, the name of the patient, the signature of the patient if able, the photographer and a witness.
   - Indicate in the record that photographs were taken with the photographer's name, date and time.
   - Offer patient visit for follow-up photos (2-4 days) to document the duration and progress of injuries

MANDATORY REPORTING FOR HEALTH CARE PERSONNEL

1. There is no law requiring hospital employees to report domestic violence unless it overlaps with other reportable conditions.

2. If children (under 18 years of age) are at risk or injured in the context of domestic abuse, refer to Administrative Policy V-13.

3. If elders (60 or over) are at risk or injured in the context of domestic abuse, refer to Administrative Policy V-14.

4. If disabled persons are at risk or injured in the context of domestic abuse, refer to Administrative Policy V-15.

5. If sexual assault/rape is part of the domestic abuse, a report to local police -- without identifying the victim—is mandated along with a provider Sexual Crime Report to the Massachusetts

Executive Office of Public Safety. Refer to Emergency Department where staff will offer a sexual assault victim a forensic evaluation through the statewide Sexual Assault Nurse Examiner (SANE program.

6. If domestic abuse involves gunshot wounds, stab wounds, or burns affecting 5% or more of surface area of the body; refer to Administrative Policy V-1, Conditions Reportable by Law.

7. Safety planning directly with the victim of domestic abuse and a collaborative response are critical in all mandatory reporting. Filing a report to a state agency or the police has the unintended effect of escalating risks to the victim of domestic abuse. Consult Social Work and Passageway for assistance in all cases where external reporting is required or a potential.

8. It is essential to notify the victim of domestic abuse of mandatory reports.

V. BWH and Community Resources

1. ***Passageway*** at Brigham and Women's Hospital is a domestic violence program that provides specialized advocacy services and support to patients and employees. The program offers crisis intervention, safety planning, individual counseling, support groups, outreach, medical advocacy, criminal justice advocacy, information and referrals. Services are free, confidential and voluntary. A person does not need to leave an abusive partner nor end a relationship to use the services. The goals are to increase a person's safety, break the isolation/stigma of domestic violence and support a person's choices and rights.

   Passageway hours of operation: Monday - Friday, 8:30 a.m. – 5:00 p.m., 617-732-6660, pager **38108** or confidential voicemail, 617-732-8753. After hours, social workers in the Emergency Department and on-call provide backup assistance.

2. SafeLink, Massachusetts 24-hour domestic violence hotline 1-877-785-2020
3. National 24-hour Domestic Violence Hotline 1-800-799-SAFE (7233)
4. Partners Employee Assistance Program 617-732-6017
5. BWH Security 617-732-6565

VI. Strangulation Protocol for Domestic Abuse Cases

Strangulation is a very serious event. The patient may not recognize injuries from the strangulation for days, weeks, or even years after the event. In fact, most cases **DO NOT** have any visible injuries. Strangulation is a sign of increased violence in a relationship and the patient's safety is threatened. Non-fatal strangulation in an IPV case puts someone at higher risk for being killed or severely injured by their abuser. [2] It only takes 8 pounds of pressure for 30 seconds to render someone unconscious and 4-5 minutes for brain death to occur.

[2] Glass, Laughon, Campbell, Block, Hanson, Sharps & Taliaferro, Strangulation is an Important Risk Factor for Homicide of Women, *J Emerg Med.* 2008; 35(3): 329-335.

Protocol for Strangulation Cases:

1) Conduct a Physical Exam as usual:

    a) If you suspect **ANY** potential recent strangulation or if strangulation is **disclosed,** conduct a **Strangulation Assessment using the Assessment and Documentation sheet.**

    b) If there is **no** concern about strangulation, but there **is** a concern about domestic violence, contact **Social Work** for a full assessment and referral to the **Passageway Program.**[3]

2) Strangulation Assessment**:** ***Follow the instructions on the Assessment and Documentation form (pg 13-14 of this protocol).***

    a) **Assessment & Documentation**
    - Complete a physical exam checking for all possible signs of strangulation. Use the **Strangulation Documentation Form** as a guide.
    - Fill out the **Strangulation Documentation Form** completely and file it in the medical record.
    - Make sure to note not only physical symptoms and injuries, but also the details of the incident as reported by patient.
    - Take photographs of any visible injuries following the protocol for photographic evidence collection.

    b) ***In all cases, it is MANDATORY to notify Social Work for full assessment, including risk assessment and safety planning.***

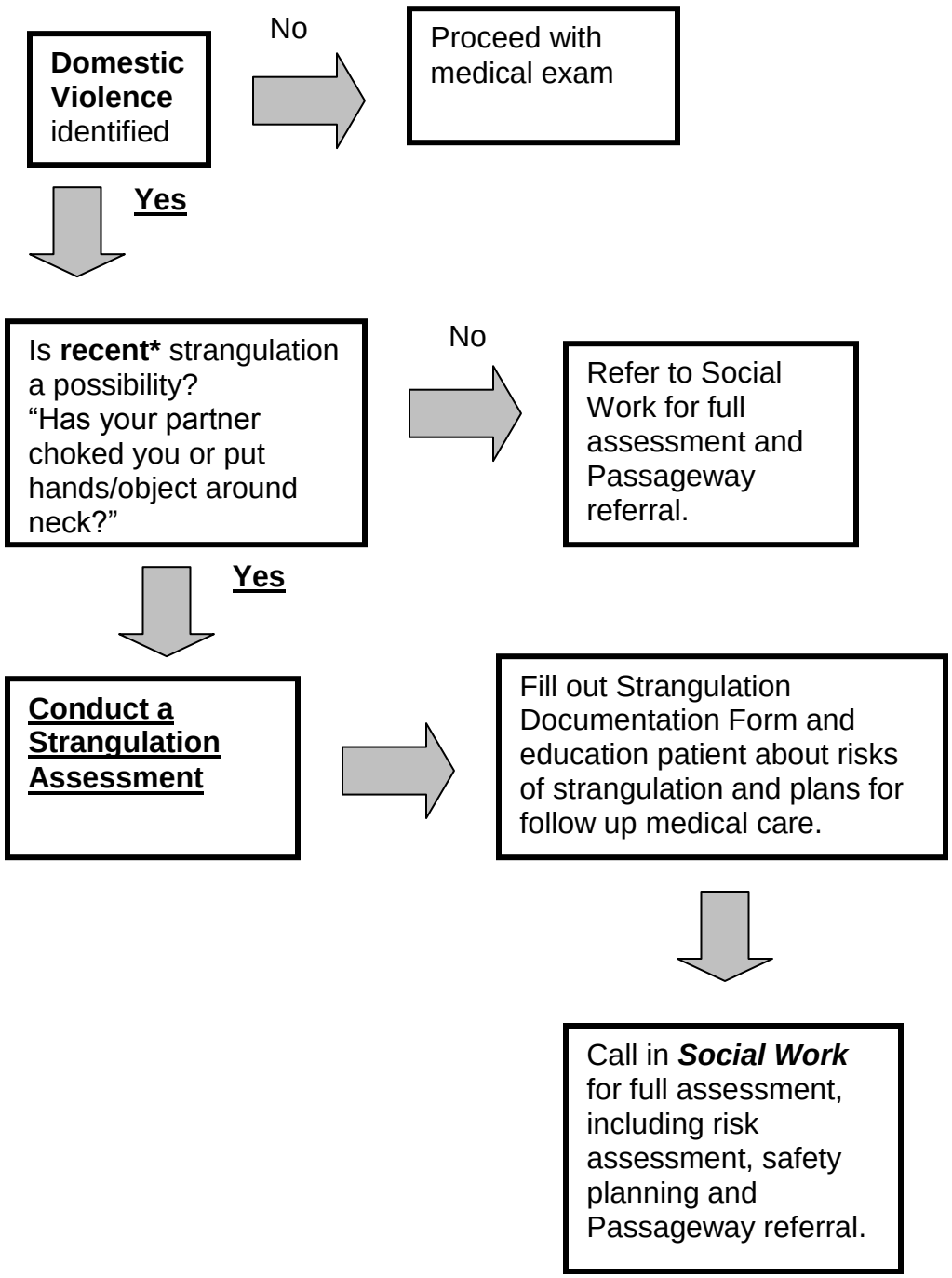
    c) Educate the patient on the risks and life threatening consequences that are associated with strangulation. Review Discharge instructions with them. Give them a copy to take with them if safe to do so.

3) Follow up
    - Make plans for follow up with the patient.
    - Let patient know that they will receive a call from the **Women's GYN Clinic** to schedule a follow up medical appointment.

4) Social Work Intervention
    - Conduct full psychosocial and domestic violence risk assessment. Provide safety planning, including discussing the safety of outreach from the 2 referral sources below, as well as taking a copy of the discharge instructions with them.
    - Make referral to **Women's GYN Clinic** (Annie Lewis O'Connor) for outreach to schedule follow up medical care at 617-732-4806, or pager #18559.
    - Make referral to **Passageway** for follow up advocacy services at 617-732-8753 or pager #31808.

[3] Passageway provides on-site services to any patient who is a victim of IPV. Advocates are available via page 31808 M-F 8:30 – 5:00 for an in-person response to all IPV cases.

Medical Response



**Recent = any incident of strangulation within the last month.*

STRANGULATION DOCUMENTATION FORM

Patient Name: _____ Date: _____
MRN: _____ Time: _____

Strangulation is a serious event that often occurs in the context of intimate partner violence. Many times there are **NO VISIBLE INJURIES** of the strangulation. It is important to ask about strangulation in all IPV cases, and document as indicated if positive disclosure, or if signs and symptoms are present. "Has your partner choked* you or put hands/objects against your neck?"

Symptoms of Strangulation

The following symptoms should be documented, both in writing and photographed (if visible) for evidence collection.

Look for and ask about the following SYMPTOMS of injury, and check ALL that apply:

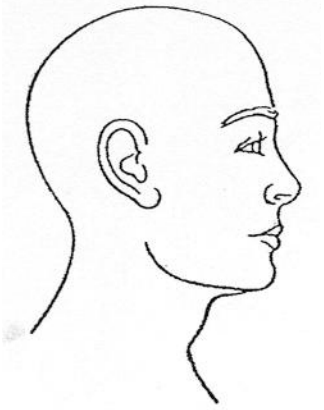
RESPIRATORY	VOICE	THROAT/NECK	BEHAVIOR	OTHER
☐ Stridor	☐ Raspy	☐ Trouble swallowing	☐ Mental status change	☐ Dizzy
☐ Hoarseness	☐ Hoarse	☐ Painful swallowing	☐ Anxiety	☐ Headaches
☐ Subcutaneous emphysema	☐ Coughing	☐ Neck pain	☐ Memory problems	☐ Fainting
☐ Respiratory distress	☐ Aphasia	☐ Nauseous		☐ Urination
☐ HemoptysIs	☐ Unable to speak	☐ Vomiting		☐ Defecation
☐ Inability to tolerate the supine position				☐ Tinnitus
☐ Dysphonia or aphonia				☐ Vaginal bleeding

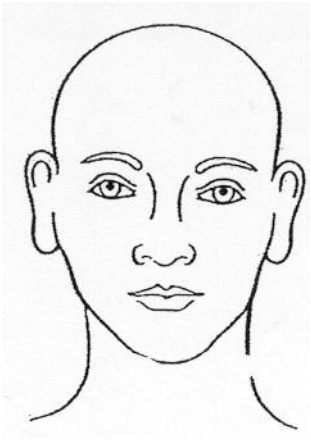
Look for VISIBLE SIGNS of injury and check ALL that apply:

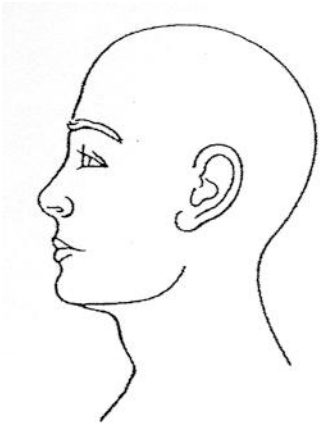
FACE	EYES/EYELIDS	NOSE	EARS	MOUTH
☐ Red, flushed	☐ Petechiae (eyeball) *R or L or Both*	☐ Bloody	☐ Petechiae *R or L or Both*	☐ Bruises
☐ Petechiae	☐ Petechiae (eyelids) *R or L or Both*	☐ Broken	☐ Bleeding from the ear canal *R or L or Both*	☐ Swollen tongue
☐ Scratch marks	☐ Subconjunctival hemorrhage *R or L or Both*	☐ Petechiae		☐ Swollen lips
	☐ Ptosis *R or L or Both*			☐ Cut/abrasion
UNDER CHIN	**CHEST**	**SHOULDERS**	**NECK**	**HEAD**
☐ Redness	☐ Redness	☐ Redness	☐ Redness	☐ Petechiae on scalp
☐ Scratch marks	☐ Scratch marks	☐ Scratch marks	☐ Scratch marks	☐ Pulled hair
☐ Bruises	☐ Bruises	☐ Bruises	☐ Bruises	☐ Bump
☐ Abrasions	☐ Abrasions	☐ Abrasions	☐ Abrasions	☐ Skull fracture
			☐ Swelling	
			☐ Ligature marks	

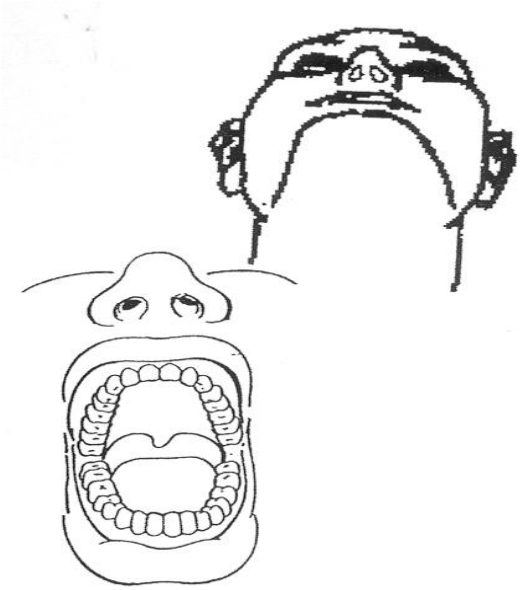
*** use choked when asking patient, strangulation in professional context/documentation.**

Please indicate injuries checked off above on the body maps below:









Notes:_____

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_____

Additional Information:

How long did the strangulation occur? ____seconds _____ minutes

☐ Victim unable to estimate/remember length of time

Was the patient also smothered? ☐YES ☐NO

Was the patient shaken during the incident? ☐ YES ☐NO

Was the patient's head pounded against any object during the incident? ☐YES ☐NO

*Provider Signature:*_____

Date:_____

Provider Name (Printed): _____

Adapted from Taliaferro, Hawley, McClane and Strack, *Strangulation in IPV, Intimate Partner Violence, a Health-Based Perspective (*eds Mitchell,et al) 224 (2009). Adapted from SA-116 Strangulation Documentation Form, SA-110 Strangulation Assessment, Strangulation Form