SUSPECTED ADULT DOMESTIC VIOLENCE AND ABUSE

This standard is intended as a guideline only. The care given is not necessarily limited to the following.

A. Goals

1. Identify suspected abuse.
2. Treat injuries as appropriate.
3. Provide patient education and referrals.

B. Assessment

On arrival or as soon as possible after arrival, assess for the following indicators of possible abuse on all female adult patients and male patients who exhibit signs of domestic violence:

1. Only staff who are trained in domestic violence are to screen and follow these steps.
2. Patients are to be screened at time of admission in all areas of the hospital where patients are admitted for services.
3. The screening question is to be asked in total privacy. No patient is to be screened in the presence of their partners or other person, including children who are of verbal age. If you are unable to get patient alone, you may point to the screening question on the assessment form and ask the patient to answer all the questions.

   If you are unable to get the patient alone after several attempts, document this.

   > "Since abuse is so common, we are now asking all of our patients; Are you in a relationship in which you are being hurt or threatened?"

4. Explain confidentiality issues relating to disclosure of information. Accept and document that patient may then refuse to disclose information and your observations.

5 If patient responds "yes" to question under #3 or if the patient is exhibiting any of these signs of abuse, then go to step C.

- ✓ Patient describes history of abuse.
- ✓ Patient presents with unexplained bruises, lacerations, burns, fractures, or multiple injuries, old or new, in various stages of healing, particularly in areas that would be covered by clothing.
- ✓ Patient appears embarrassed, evasive, anxious or depressed.
- ✓ Patient's partner reluctant to leave, domineering & answers most of the questions directed to patient.
- ✓ Patient has history of: headaches, depression, STD's, UTI's, chronic pain,
- ✓ Patient states partner has psychiatric, alcohol, or drug abuse history.
- ✓ Patient has psychosomatic complaints with no substantiating physical evidence.
- ✓ Patient expresses a fear of returning home & safety of self and of any children.
- ✓ Patient talks of harming self.

C. Intervention

1. If there is suspicion of abuse based on assessment and/or if patient denies abuse despite presence of indicators, conduct interview utilizing Interview Questions & Body Map in the 'Domestic Violence Packet' (located in ER or L&D)

    a. Provide for privacy
    b. Assure confidentiality and safety, conduct interviews without partner present.
    c. Ask direct, non-threatening questions in an empathetic and non-judgmental manner.
    b. Validate the patient by saying to her; you are concerned about her safety, she is not alone, no one deserves to be physically hurt or abused, and abuse is a crime and there is help.

2. Notify physician if domestic violence is suspected.
3. Contact Social Services if patient is admitted.
4. Contact Florida Abuse Hotline at 1-800-962-2873, if abuse is suspected to a child, elderly or disabled.
5. Preserve evidence, if appropriate, and notify law enforcement to pick up evidence. (Refer to **Procedure for Handling Victims and Evidence of Suspected Criminal Assault.** Located in ER)
6. Extreme caution should be used regarding disclosing or giving out information to non-professional persons not involved.

D. Teaching

Review with patient the "Survival Handbook for Victims of Domestic Violence" (located in Domestic Violence Packet). Allow patient time to read literature. Patient may not take information if she doesn't have a safe place to hide or keep booklet.

a. The dynamics of domestic violence, page 8
b. The cycle of violence, page 10
c. Safety plan, pages 13-16 - Assess patient's safety and provide safety options if indicated.
d. Resources including Refuge House, page 26-33. Refuge House has a 24-hour hotline, shelter, and referrals to other resources, i.e. getting an injunction, prosecuting, etc.

E. Desired Outcome

1. Patient acknowledges abuse.
2. Patient accepts assistance from resources.
3. Patient finds safe place to stay.

F. Documentation

Document findings and intervention using the Nursing Service Policy, "Documentation" and incorporate the completed Interview Questions and Body Map, these forms when indicated. Describe in detail what patient tells you, type of injuries, who inflicted the injury and how it was done (e.g. closed fist, knees, vase, gun, etc.).