Policy Applies to:

- All Mercy Hospital staff who are in contact with patients.
- Compliance by Credentialed Specialists, contractors, visitors, and patients will be supported by Mercy Hospital staff.

Related Standard:

- New Zealand Standard 8006:2006 Screening, Risk assessment and Intervention for Family Violence including Child Abuse and Neglect.
- Ngā paerewa health and disability services standard 8134:2021 (specifically section 1 patients' rights).

Rationale:

Mercy Hospital is committed to ensuring that patients who suffer from any form of family violence are identified through routine inquiry and are offered referral to relevant agencies, where appropriate.

Mercy Hospital follows the Ministry of Health NZ recommendation that hospital settings adapt the 'Family Violence Assessment and Intervention Guideline – Child abuse and intimate partner violence (2016)' for the identification, assessment and referral of persons experiencing family violence of any kind. This includes intimate partner, child abuse and elder abuse.
Legislation mandates health practitioner escalation and sharing of information where there is suspicion of / identification of intimate partner violence, elder abuse or child abuse / neglect.

Cultural considerations:

Services are provided in a way that upholds patients' rights. Service provision is underpinned by Pacific, Māori and other people's world views. Care is provided in a manner that empowers and enables patients, and that the patient deems as being culturally safe.

Definitions:

Whānau / Family violence is violence inflicted against a person by any other person with whom that person is, or has been, in a family relationship. It includes physical, sexual, and psychological abuse. Psychological abuse may include threats, intimidation, and emotional deprivation.
Violence includes spouse/partner violence, dating violence, child abuse and neglect, abuse of teenagers by parents, elder abuse and neglect, sibling abuse, and abuse committed by another family member or person with whom there is a close personal or domestic relationship.

Routine Screening is a verbal enquiry, by healthcare providers of patients about their personal history of partner abuse, child abuse or neglect.
At Mercy Hospital routine screening occurs for -

- all females over the age of 16 (questioning is face-to-face, without another person present). This can be asked in the presence of a child if the child is less than two years old
- All gender diverse people
- 12–15-year-olds on suspicion of abuse ONLY.
- Men on suspicion of abuse ONLY Note – Safety trumps everything. If it is not safe to do so, then do not offer routine screening. (for inpatients who you cannot safely ask, please select the 'not yet asked' box on Trak, so that staff can ask at the next available opportunity).

Risk assessment is a process allowing for a full examination of circumstances and interactions to assess a person's risk of harm either to themselves or from others.

Safety planning and intervention is a process for identifying and planning to minimise harm and maximise safety.

Child refers to Tamariki / children aged 0-14 years inclusive

Child Abuse refers to the harming (physical, emotional, sexual), ill treatment, abuse, neglect or serious deprivation of any Tamariki / children or young person. This includes actual, potential, and/or suspected abuse.

Young person refers to 'any person of or over 14 years but under the age of 18 years' The term 'young person' can also be extended to include some young adults for certain purposes and as specified in the Oranga Tamariki Act 1989"

Section 195A
Section 195A - 'Failure to protect child or vulnerable adult'. This section renders it an offence to fail to protect a child or vulnerable adult from risk of death, grievous bodily harm, or sexual assault. A person is liable if that person is a member of the same household or is a staff member of a hospital, institution, or residence where the child / vulnerable adult resides; and fails to take reasonable steps to protect the child or vulnerable adult from the actions / omissions of a third party.

Elder abuse
A single, or repeated act, or lack of appropriate action, occurring within any relationship where there is an expectation of trust which causes harm or distress to an older person

Objectives:

Clinical Staff are aware of

- The extent of family violence in New Zealand
- The process for routine screening and which groups receive this
- Risk assessments required to identify, evaluate, monitor, and document the level of risk
- Resources / referral agencies relating to Family Violence Interventions

Nonclinical staff are aware of

- The extent of family violence in NZ
- Potential signs of child, intimate partner and elder abuse
- Non-clinical employees are NOT required to undertake family violence screening or risk assessment. They should escalate concerns or disclosures to appropriately trained clinical staff (VIP champion or Nurse in charge)

Implementation:

Relevant reading material / signage for patients / visitors is visible in waiting areas and throughout the hospital.
Policy appendices are available through drop down boxes in TRAK to ensure timely access to information.

Police Vetting and onboarding checks

Pre- employment safety checks are completed for all relevant workers in accordance with the Children's Act 2014 and organisational requirements. Police vetting is undertaken as appropriate to the role. Staff providing overnight care for children must hold current Police Vetting clearance. Staff without direct contact with children or vulnerable persons are subject to Ministry of Justice criminal conviction checks.

Declaration

Credentialing Policy includes declaration concerning Vulnerable Children

New worker safety checks

To support the provision of a safe workforce for children and young people, pre-employment screening and worker safety checks are completed in accordance with the Children's Act 2014 and organisational requirements. Safety checking is undertaken for all relevant workers prior to employment and thereafter as required. This includes Police Vetting for core and non-core workers, as appropriate for their role. Staff who provide overnight care for children are required to hold current Police Vetting clearance. Staff who do not have direct interaction with children or vulnerable persons are subject to Ministry of Justice (MOJ) criminal conviction checks.

EDUCATION

Patient Assessment

Face to Face nursing assessment of patients is completed in admission areas and includes screening for family violence as prompted in TRAK.
For inpatients who you cannot safely ask, please select the 'not yet asked' box on Trak, so that staff can ask at the next available opportunity. This will bring up the red hand with stop across it to alert staff in the future.

Staff Training – Clinical

All clinical staff are required to complete the healthLearn module via Tautoko

Clinical Managers work with the Clinical Learning and Development Co-ordinator and the Clinical Risk Mitigation committee to ensure that each clinical area has at least one VIP representative.

Clinical area VIP representatives are released to attend the 8-hour VIP training day in conjunction with Te whatu ora (Southern) and subsequent annual updates (2hours).
VIP reps work with their Clinical Leads and the Clinical risk mitigation Committee to facilitate VIP awareness training sessions, updating area staff on policy and procedures relating to Patient Family Violence. Update occurs at appropriate forums including staff huddle or ward meetings.
Updates will include, but are not limited to, staff awareness of the extent of violence in NZ, how to access policy and relevant appendices, use of shielded websites, Mercy plans for aligning with national campaigns. Area representatives will proactively seek out new members of the team and orientate them to policy, TRAK assessments, and area specific lines of communication relating to Patient Family Violence.

Support staff education programme (provided by the Chair of the Risk Mitigation committee) will include -

- The extent of family violence in NZ
- Potential signs of child, intimate partner and elder abuse
- The procedure to follow when escalating to clinical staff when there are any concerns
- See Appendix 7 – Non-clinical flowchart VIP

GUIDELINE FOR INTIMATE PARTNER AND INTRAFAMILIAL VIOLENCE SCREENING

This 6-step process is summarised in Appendix 2 'Intimate partner violence intervention flowchart'

Step 1 – Enquire and identify

Use simple, direct questions, asked in a non-threatening manner. Abuse is not usually disclosed without a direct question.

Routine Enquiry at Mercy Hospital

At Mercy Hospital routinely ask -

- All females over the age of 16 (questioning is face-to-face, without another person present). This can be asked in the presence of a child if the child is less than two years old
- All gender diverse people
- 12–15-year-olds on suspicion of abuse ONLY
- Men on suspicion of abuse ONLY

Ask at a time when the person is feeling at ease, for example, when taking a routine history. Only ask routine enquiry questions if the person is alone (or with a child under two years of age).

Start with a framing statement:

"In this service we are concerned about family violence and the impact it has on health. We routinely ask all women (people) about violence in their home".

Routine enquiry questions

1. *Within the past year did anyone scare you or threaten you or someone you care about? This might include somebody trying to control you or make you feel bad about yourself?*
2. *Within the past year have you been hit, pushed, shoved, slapped, kicked, choked or forced to do anything sexual in a way that you did not want to?*

For each 'Yes' answer, ask 'Who did this to you?'

Routine enquiry ends with a No. Reassure the person that "*If this changes for you, please know that we are here to help and support you"* or *"That's good to hear. Have you heard about the shielded website? You can use it to find people who can help"*

Disclosed abuse

Ask *"is this something that you want help with now?"*

Do not pressure the person to leave their situation. A person needs to feel well-resourced and supported before they can leave safely.

General advice – offer the approved pamphlet and remind them to use 111 to access immediate help, if required. Always consult with your Line Manager or area VIP champion.

Where abuse is disclosed, a black broken heart icon will appear on Trak. This will be an alert for ward staff, to check the comments box for specific details.

Suspected abuse

If abuse is **suspected,** but the individual does not acknowledge that it is a problem, provide them with a means of contacting appropriate support agencies, e.g. community agency details.

Step 2 – Validate and support

If abuse is **confirmed,** it is important to empower victims:

Listen to the person's story and **validate** – i.e. *"I'm so sorry to hear this has happened to you", "I believe you", "You are not to blame", "There is help for you", "This is not your fault", "You did nothing to deserve this"*

Inform – provide them with a means of contacting appropriate support agencies. If possible, suggest the patient/ client contacts a Specialist Partner Abuse service, such as Women's Refuge. The patient will need to speak to them on the phone directly. Identify an ongoing support system, for example whanau, friend, or community agency. Reinforce that becoming 'safer' is a process, not a single act.

Unless there is an immediate risk to the victim, or a risk to a child then s/he has the right to choose a course of action. The role of the health professional is to support this decision.

Step 3 – Health and risk assessment (including risk to children)

Aims to assess current risk and safety concerns and better connect the victim to support. We know that non-fatal strangulation and suffocation increase the risk of homicide by 750%.
Any sexual assault requires a specialist pathway and referral to sexual assault services.
Alcohol and drug use may also be involved.

Mental health considerations – family violence has a high correlation with self-harm and suicidality. Immediate danger must be assessed -

- Is the abuser here now?
- Is emergency assistance required? (e.g. Police, Women's Refuge)
- If safety is a concern, access an onsite security presence through 'First Security.'
- Does the abused person have a safe place to go to when leaving the consultation? We can facilitate Women's Refuge and support an early discharge if required in conjunction with the patient's Surgeon.

Any decision regarding contacting the Police or Women's refuge should be made in consultation with the patient, ideally. This is to ensure their safety, as reporting the incident may enrage the perpetrator and increase the risk to the women.
(Refer to Appendix 6 – Family violence intervention services)
On the rare occasion that the healthcare provider believes a person's life is in immediate danger or has good reason to believe that the person is unable to extricate themselves from life-threatening danger, the Police may be notified without patient permission.
The Privacy Act 2020 is not breached if the health care provider has acted in good faith to protect the patient from serious harm.
For any serious events involving staff or patients/clients, including any events where the police are required to be notified, the Executive On-Call should be notified immediately if after hours.

Co-victims - Assess Children's safety.

Child abuse and neglect may be entangled with family violence. Where intimate partner abuse is identified or suspected, it is essential that an assessment of risk to children is conducted. For example, you could ask, *"Are you ever worried about your children's safety? Are they ever hurt?"*

Explain that you are seeking advice or escalating -
"I'm worried about you and need to go and speak with the Nurse in Charge. I will be back and tell you how that went.

Step 4 – Safety planning

If there is an imminent threat or 'high danger risk' of abuse then action is required by health professionals, with or without the victim's consent.

'High Danger Risk' includes

- Life threatening injuries, or assaults, e.g. choking, strangling, beatings
- A threat to kill or a threat with a weapon has been made
- The person has recently separated from the abusive partner, or is considering separation
- Physical violence has increased in severity (upward trend) or the perpetrators has access to weapons

"What you are telling me sounds serious and dangerous. I need to involve more specialist support for everyone's safety"

Consult with Senior colleagues (Nurse in charge or Specialist) and express your concerns to the patient. Joint safety planning and referral processes need to be implemented when both partner abuse and child abuse are identified. The emphasis should be on keeping the child(ren) safe and enabling the abused partner to get real and appropriate help.
For immediate concerns about safety - Call police 111 and contact a specialist abuse partner such as Oranga Tamariki
Actively encourage the person to accept a referral to specialist services – contact the service so that they can explain the help that they can offer. Ask what safety plans they have in place / have tried.

Step 5 – Referral and follow-up
This stage includes consideration of the patient's priorities, making their own decisions, establishing how they are already keeping themselves safe and who they have previously contacted.
Our role is to assist their connection to support, if possible. This might include making a phone call together or offering a joint consult visit. The child's GP MUST be informed where a referral has been made to Oranga Tamariki. The responsibility for this lies with the referrer.

Step 6 – Documentation
Complete an incident form.
Documentation in the clinical record or incident form must be accurate, include direct quotes (verbatim) and employ non-judgemental language. Outline any risk assessed, any consultation with Specialist services (who you spoke to and the outcome) and any safety planning made. Include any referral details.

GUIDELINE FOR CHILD ABUSE AND NEGLECT SCREENING
This process provides a framework for staff to identify and manage actual or suspected child abuse and neglect. It recognises the important role and responsibility that staff have in the accurate detection of suspected child abuse and/or neglect, and the early recognition of children at risk of abuse. Mercy hospital aims to comply with current legislation and requirements regarding Tamariki / children accessing services at Mercy Hospital (or children indirectly involved with a patient e.g. siblings / young visitors). This includes staff education on their responsibilities / expected response following disclosure by a child or following recognition and observation of warning signs / symptoms.

6 step process - summarised in Appendix 5 'Child abuse and neglect intervention flowchart'
Step 1 – Identification
Clinical staff must be alert to the 'Signs and symptoms of Child Neglect or Child Abuse' and take appropriate action to protect the wellbeing and safety of children and young people, whether the child/young person is directly or indirectly a client/patient of the service.
Refer to Appendix 4 – Signs and symptoms of child abuse or neglect. You may observe signs of physical, sexual, psychological / emotional abuse, or neglect.
There are no injuries specific to child abuse and signs of neglect might include unmet basic needs.
Multiple forms of abuse and neglect may co-exist, and all will cause emotional harm.
Child abuse and neglect is a specialist area and consultation MUST occur with specialist partners (such as the on-call Paediatrician at Dunedin Hospital, VIP coordinators and the district police).
Where sexual abuse is suspected or disclosed, this must ALWAYS be escalated to a doctor trained specifically in this field e.g. Paediatrician or local sexual assault specialist services. Forensic examinations may be necessary in some circumstances.

A health professional or Oranga Tamariki staff member may make a 'Report of concern' for a youth under 18. This alert sits nationally to ensure that healthcare providers have relevant information if the child presents to health again. This is referred to as the 'NCPHISS' (national child protection health information sharing system).

Step 2 – Validate and support

Let the child know that you believe them, are pleased that they told you and are sorry that this happened to them.
Remind them that this is not their fault, and that you WILL help them.
Tell them what will happen next and do not promise that Mum or Dad will not get into trouble.

Where a specialist partner is making a 'Report of concern', the communication principles include being nonjudgemental, paying attention to language, communication, cultural safety, honesty and transparency. For instance, a specialist partner may tell whānau *"I am worried about your child. I need to do a 'Report of concern' to ensure that we keep your child safe".*

Step 3 – Health and risk assessment

Health and risk assessment requires a careful, multidisciplinary approach. Decisions are never made in isolation.
Staff who identify child abuse or neglect concerns should immediately contact a senior member of staff (Senior Nurse or member of Executive). The senior member of staff will consult with a specialist partner, e.g. VIP team, Oranga Tamariki, or the police. This contact may be advice seeking or reporting abuse.
Oranga Tamariki (OT) Phone: 0508 FAMILY (0508 326 459) or website www.mcot.govt.nz
Refer to Appendix 6 – Family violence intervention services
If there is an immediate safety issue, the staff member should phone the Police on 111
You may need to be creative to keep children on the ward to allow safety planning to occur.

Step 4 – Intervention and safety planning

Contact the police (111) if there are concerns about immediate safety for the child or young person, or your own safety.
Immediate safety concerns may include abuse or neglect, immediate danger of harm, the child or young person returning to an unsafe environment.

Informing Parents / Caregivers of a referral to the police or OT should be managed with consideration to the safety of the child, staff and other family members. Do NOT inform the caregivers unless it is safe to do so.

Step 5 – Referral and follow-up

Where a 'report of concern' is made to OT, this will be in writing, including the health impacts, with consideration of medical jargon. OT will assess the risk and determine action to be taken which may include a child protection investigation, collaboration with the police, and other agencies.

If a 'Report of concern' is not being made, is there a relevant specialist service that the whānau can link with?

Consider sharing your concerns with others who may be able to support the family, e.g. The child's GP MUST be informed where a referral has been made to OT. The responsibility for this lies with the referrer.

Step 6 - Documentation

Good documentation is a gift for the future of the child, the whānau and the police.
Clinical staff are required to document the following in the clinical record:

- their observations / assessments
- any discussion with Senior staff, Team Leader or others
- documentation of what was reported to OT, police or other agencies

Attention to detail is required. The clinical record includes the notation of 'Child Protection Alert' where this has been made.
Staff involved in cases of suspected or actual child abuse or neglect can access support through a guided debrief with Senior Staff, and/or the Staff Support Programme.

GUIDELINE FOR ELDER ABUSE AND NEGLECT SCREENING

This process includes a 6-step process that clinical staff follow when identifying and responding to elder abuse and neglect (overarching guideline provided in Appendix 3 'Elder abuse or neglect, assessment and response – summary flowchart').
Mercy Hospital clinical staff follow the 6-step process outlined below. The safety of the older person and those working with them is paramount. The autonomy of the older person should be front of mind as well as cultural competency and considerations such as consent and whether an Enduring Power of Attorney (EPOA) for personal care and welfare has been activated.
Five commonly identified categories of elder abuse are physical, sexual, psychological / emotional, financial abuse or neglect (see Appendix 1 – Signs and symptoms of elder abuse and neglect).

Step 1 – Identify

Clinical staff should always remain vigilant and be aware of risk factors and alert features.
Routine screening of all older people is NOT recommended for elder abuse.
Assessment and intervention should be included in a face-to-face health encounter (not by telephone)
When signs and symptoms or alert features are present, then clinical staff are required to ask older people direct elder abuse questions. Alert features include incongruity between clinical observations and information provided to you by the older person, unexplained injuries, conflicting stories, vague explanations or delays in seeking medical help.
Specific abuse questions should be asked in private, away from relatives or caregivers. Face the person squarely and ensure aids for hearing / vision are used, without background noise. Consider pace and allow time for processing and responding to questions asked.
General questions might include - *"How are things going at home"*, *"How are you feeling about the amount of help that you are getting"* or *"How do you feel your caregivers are managing"?*
Direct questioning might include - "*Has anyone at home ever hurt you", "Has anyone ever touched you without your consent", "Has anyone ever threatened you", "Are you afraid of anyone" or "Are you alone a lot".*
Where cognitive impairment is suspected, a comprehensive assessment of the patient's mental and physical state must be undertaken by an experienced health professional, with referral for assessment of mental capacity if needed.
Questions for the caregiver may include *"How has life changed for you since becoming a caregiver".*
When abuse is suspected, collaboration with specialists in elder abuse is essential.

Step 2 – Support / empower

Listen to the person's story and acknowledge what they tell you, with empathy and without blame.
Validate their experience, for instance - *"That must have been terrifying - This is not OK, not your fault", "You are not to blame, you did not deserve this"*
Inform them - "*I can seek help for you", "You have the right to live free of fear"* or *"What they are doing is a crime and not just a family or private matter".*
If abuse is not disclosed or consent for referral is refused, then leave the door open for future contact.
Provide information on support agencies and contact details of services

Step 3 – Assess risk

Determine the level and urgency of safety concerns – Has the person been threatened? Are they afraid to go home? Is there any immediate risk of harm from another person, or self-harm?

Any person expressing suicidal ideation should be assessed by a mental health clinician before being discharged home (contact Emergency Psych services through Dunedin Hospital).
If the older person is at risk of serious harm, then contact the police on 111. Where a health professional contacts the police without the older person's consent (believing that the person's life is in immediate danger), this does NOT constitute a privacy breach.
Telephone advice from specialist elder abuse services may also be useful during preliminary risk assessment and can assist with referral decision-making e.g. Age concern Otago

Step 4 – Plan safety

Most cases of elder abuse are NOT crisis situations but may be longstanding and complex and will take time to work through.
You may need to contact an elder abuse and neglect specialty service (EAN), such as Age Concern Otago. You may need to refer to older person's mental health services.
You may need to plan alternative accommodation such as Whanau refuge (0800REFUGE) or an appropriate mental health agency (Older Person's Mental Health Southern).
Educate and support the person and provide contact information for specialist services.

Step 5 – Document

In situations of identified or suspected physical or sexual abuse, a thorough physical examination is required, to identify past and current injuries.
Record any patient disclosure and phone consultations made. Document any observations, clinical assessments and discussions with Senior staff or other agencies.
Care must be taken to ensure the privacy and confidentiality of any written information and avoid the possibility that the abuser finds out that abuse has been disclosed.
Document any advice or agency resources that you have provided and any follow-up care that you have arranged.

Step 6 – Referral

The point at which referral is made will be influenced by the urgency of safety concerns, the readiness of the older person to disclose information and the complexity of the older person's physical, social, mental health needs.
Referral may be required to a range of agencies including comprehensive mental health assessment (where cognitive impairment is involved), respite care, counselling, alcohol and drug services. This work is specialised and requires case management by an external agency, to ensure coordinated and ongoing support to be provided.
Elder abuse is a crime under the Domestic violence act (1995) and assault charges may be laid. Police family violence coordinators will be consulted by elder abuse services as needed.
Any person who has been threatened or injured can obtain a protection order through the Family Court, with the aid of their lawyer.
Advice may be sought from elder abuse services (e.g. Age Concern Otago), even if referral is not made.

EVALUATION

- Incident reports completed with appropriate identification, assessment and management evident in the patient clinical record
- Staff training records, reflecting staff education appropriate to their role in the identification, assessment and management of family violence including partner, child and elder abuse
- Clinical records containing the identification, assessment, and management of abuse, where this is disclosed
- Ongoing working relationship developed and maintained between the Mercy Hospital VIP Champions and the Te Whatu Ora Family VIP Coordination team
- Staff access (where requested) to the Staff Support Programme.
- Planned updates of clinical staff, coordinated by the Clinical Learning & Development

Coordinator (CLD)
- Planned update of non-clinical staff by the Chair of the Clinical Risk Mitigation cttee
- Area VIP representatives' attendance at the 8-hour workshop in Health NZ I Te Whatu Ora Southern
- Clinical staff including Senior Nurses on Call have completed the relevant HealthLearn (Tautoko) course
- Access to relevant reading material/signage for patients/visitors in waiting areas and throughout the hospital
- Pre- employment screening of all new staff includes police vetting for core and non-core workers, as appropriate for their role.
- Existing staff who care for children overnight have been police vetted
- Credentialing Policy includes declaration concerning Vulnerable Children

External Resources:
- MOH Family Violence Assessment and Intervention Guidelines: Child abuse and intimate partner violence (2016)
- MOH Family Violence Intervention Guidelines: Elder Abuse and Neglect (2007)
- MOH 'Child Abuse Assessment and Response' Flow chart
- MOH 'Partner Abuse Assessment and Response Flowchart'
- Public Health Family violence intervention agency register
- National Child Protection Alert System Memorandum of Agreement with the Ministry of Health and New Zealand Pediatric Society, 2012.

Associated Legislation:
- Vulnerable Children Amendment Act 2017
- Care of Children Act 2004
- Oranga Tamariki Act 1989
- Privacy Act (2020)
- The Children's Act 2014
- Children, Young Persons, and Their Families (Oranga Tamariki) Legislation Act 2017
- Family Violence Act 2018
- Family Violence Regulations 2019
- Health Information Privacy Code (2020)
- Crimes Act (1961)
- Crimes Amendment Act 2005
- Crimes Amendment Act (No. 3) 2011
- Summary of associated legislation found in Family Violence Assessment and Intervention Guideline Child Abuse and Intimate Partner Violence 2016
- Children's (Requirements for Safety Checks of Children's Workers) Regulations 2015

Internal
- Appendix 1 – Signs and symptoms of elder abuse and neglect
- Appendix 2 - Intimate partner violence intervention flowchart
- Appendix 3 - Elder Abuse or Neglect; assessment and response - summary flowchart
- Appendix 4 – Signs and symptoms of child abuse or neglect
- Appendix 5 – Child abuse and neglect intervention flowchart
- Appendix 6 – Family violence intervention services
- Appendix 7 – Family violence response for non-clinical employees
- Patient assessment policy
- HR Guidelines, Section 3 Recruitment, Selection & Appointment