Intimate Partner Violence-Evidence Collection and Documentation for Home Care Clinicians

Expires Saturday, November 30, 2019 Nursing Colleen Symanski-Sanders , RN

Objectives

1. Describe how evidence should be collected and documented when dealing with intimate partner violence.
2. List the dos and don'ts of asking questions when evaluating a victim of intimate partner violence.
3. Discuss the importance of confidentiality and ensuring privacy.

Article

Intimate Partner Violence

Evidence Collection and Documentation for Home Care Clinicians

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Introduction

Home health services offer clinicians' diversity and independence in clinical practice. Most home health clinicians need competency in both pediatric and adult skills and knowledge in a variety of diseases. Diagnoses requiring home care can include sexually transmitted diseases, depressive disorders, urinary tract infections, lacerations, musculoskeletal injuries (such as fractures), irritable bowel syndrome, prenatal services, antepartum hemorrhage, low birth weight infants, and/or failure to thrive. In addition, clinicians must be prepared for an unexpected environment and be capable of communicating with the patient's significant others, spouses, and children. These diagnoses can lead to unanticipated challenges for home care clinicians, as they can be the result of domestic violence. This article focuses on the evidence collection obtained through Intimate Partner Violence screening and documentation for home care clinicians. Many hospitals today have forensic nurses or nurses specifically trained in sexual assault. Unfortunately, home care is not a viable practice for these clinicians; leaving home care clinicians to fill the void.

Clinical forensic nursing has developed from, and expands as a means of coping with the increased complexity of nursing practice, society, and the law. When we talk of a living forensic population, we are referring to survivors of criminal or liability-related injuries that result or may result in a legal investigation. Such as, but not necessarily limited to, injuries or crimes which involve:

- intimate partner violence,
- police custody deaths,
- abuse and neglect of the child, elderly, or disabled,
- hate crimes,
- sudden and unexpected deaths,
- occupational and environmental hazards,
- sexual assault,
- substance abuse,
- violence against oneself, and
- natural or man-made disasters and/or terrorist attacks

"Domestic violence" is interchangeable with the updated phrase "intimate partner violence" (IPV) and refers to violent behavior between partners regardless of gender. Intimate partners need not be cohabiting nor is sexual activity necessarily involved. IPV generally is a continuing pattern of behavior rather than a single violent act, and for women, is defined as "a pattern of coercive behaviors that may include repeated battering and injury, psychological abuse, sexual assault, progressive social isolation, deprivation, or intimidation. These behaviors are perpetrated by someone who is or was involved in an intimate relationship with the victim".

Once a forensic patient is recognized, four overlapping clinical practice issues are addressed. They are physical evidence collection, non-physical evidence collection, meticulous documentation, and crisis intervention.

Evidence Collection

Evidence collection is the use of an index of suspicion to uncover the how and why of the patient's mechanisms of injury. It involves an assessment of psychosocial history, separating the injuries from the story and asking hard questions. Physical evidence is anything that has been used, left, removed, altered, or contaminated during the committing of a crime by either the suspect or victim. The ability to recognize evidence acknowledges that it has relevance and may come in varying forms and sizes. In many situations, important information that may not be required for patient care is nonetheless vital to later investigation and requires the patient's consent to ensure that collection of the evidence will not amount to an illegal search (or perhaps malpractice). Proper collection of evidence is imperative to avoid the possibility of compromising its integrity. Preservation of evidence in the clinical setting requires planning, attention to detail, and the guidance of agency policies and procedures.

Domestic violence injuries range from minor scratches to death and frequently include lacerations, bruises, contusions, musculoskeletal injuries, and neurological problems. Patients may complain of headaches, depression, nightmares, or hearing difficulty. The face, neck, throat, and genitals are common sites of injury; up to 50% of injuries resulting from abuse are to the head and neck. Facial injuries are reported in 94% of victims of domestic violence. Other common sites of injury are areas usually covered by clothing, such as the chest, breast, and abdomen. Patients may try to hide injuries with makeup, turtleneck collars, or wigs. There may be vaginal and/or anal tears if sexual abuse occurred. Rape injuries are generally very bold and not subtle. Look for inconsistencies in the clinical presentation of a patient. Use the "null theory", which means every injury has a story.

Injuries during pregnancy are most frequently (but not exclusively) to the breast or abdomen. The patient may have unexplained pain, poor nutrition with poor weight gain, vaginal bleeding, or preterm contractions. Violence during pregnancy is associated with an increased risk of spontaneous abortion, antepartum hemorrhage, intrauterine growth restriction, premature delivery, and prenatal death, and may be more prevalent than other common pregnancy disorders, such as preeclampsia or gestational diabetes.

Core Competencies

Routine screening for abuse and IPV is a standard of care for clinicians in all settings, including home care. The CDC and experts in the field of IPV developed the following competency recommendations for health care providers:

1. To acquire a core body of knowledge on intimate partner violence.
2. To master the specific clinical skills needed for identification, intervention, and prevention in cases of domestic abuse.
3. To develop relationships with local community organizations that assist victims of abuse.

The American Association of Colleges of Nursing recently published their position statement on "Competencies Necessary for Nurses to Provide High Quality Care to Victims of Domestic Violence". The complete position statement is available without charge and can be accessed at http://www.aacn.nche.edu/Publications/positions/violence.htm. The position statement addresses the competencies outlined below.

1. Acknowledging the scope of the problem;
2. Identification and documentation of abuse and its health effects;
3. Interventions to reduce vulnerability and increase safety, especially of women, children, and elders;
4. Ethical, legal, and cultural issues of reporting and treatment; and
5. Prevention activities.

Reporting and Confidentiality

Each state has laws regarding whether violence needs to be reported to state/local authorities. It is important to know the law in the state you practice and what your responsibilities are before you screen patients. Most states do not currently mandate clinicians/providers to report domestic violence. The reason is that many victims of violence do not want to contact the police because of fears, such as retaliation by the perpetrator. Apprehension that providers might submit a report on their own (if the injured party discloses present-day violence) can also silence a victim. Confidentiality needs to be assured when screening. If what your patient tells you about violence will not be kept confidential, you must inform the patient before she or he answers your questions about violence.

Confidentiality also means that medical records/files are locked in a cabinet and kept in a place that only staff members, involved in the patient's care, have access to. Do not discuss this information with one another unless it is relevant to the patient's care. Safe guarding the patient's confidentiality is especially important in small communities.

Evidence Collection: Screening Guidelines

A: Ensure Privacy

It is imperative to ask questions regarding potential abuse and personal safety when the patient is alone. A partner or significant-other that is unwilling to leave during your assessment and is obviously domineering should be a red flag that the patient is a potential victim of IPV. A diversion may be necessary in order for the patient to have privacy alone, away from the partner, such as assisting the patient to the bathroom. You may need to phone the patient to set up a time when he/she will be home alone. Do not conduct screening for IPV in the following situations:

1. The partner/significant-other refuses to leave the room;
2. You cannot secure a private space to conduct the screening;
3. You are concerned that screening is unsafe for either the patient or for you; and/or
4. You do not have an appropriate interpreter if a language barrier exists.

If you cannot screen the patient during your visit, document this in the patient's chart and notify the physician.

B: Ask Questions in a Nonjudgmental Mannerism

Begin by addressing IPV in a general manner so that it is clear to the patient that screening is a routine part of your assessment. This gives the questions a more global context and helps reduce defensiveness. Below are some examples that can be used to introduce the topic along with other important issues when asking questions:

1. "I know that we just met, and yet I have to ask you personal questions. Let me explain why I need to conduct a complete assessment of your health and well-being."
2. "As your nurse, we need to have an open partnership. We know that many women, as well as men, have experienced violence in their lives. It would be helpful if you could answer my questions about this topic."
3. "I ask all of my patients these questions because it is important for me to know what has gone on and what is going on in their lives. For instance, someone witnessing or experiencing violence can be traumatized."
4. Make and keep eye contact with the patient when you ask about IPV and when she/he answers you.
5. Stay calm and do not exhibit emotional or body language reactions to what you hear.
6. Do not dismiss what you are told, even if the patient minimizes the information. Many victims minimize what happened to them as a way of surviving the abuse.
7. Do not rush on to the next question; wait to hear the answers.

C: Ask Direct Questions About Past and Present Violence

Being direct and understood in your questioning is important. Avoid words like "domestic violence", "abused", "battered", or anything else that sounds demeaning or judgmental or is a technical term understood best by trained professionals. Avoid medical jargon. Questions can be worded as follows:

1. "Have you ever been touched in a way that made you feel uncomfortable?"
2. "Have you ever been forced or pressured to have sex?"

3. "Do you feel that you have control over your sexual relationships and are listened to if you say "no" to having sex?"
4. "Have you ever been hit, punched, or beaten by a partner?"
5. "Have you ever been scared to go home? Are you scared now?"

D: Validate the Patient

Clinicians must respond to a patient that discloses IPV in a calm and caring manner. Let the patient know that she/he is not to blame for what happened and that help is available. Remember that the victims need to decide what their next steps will be after hearing the possible options. Do not dictate or tell the patient what they should do – rather validate the patient by saying that:

1. You believe her/him;
2. You do not blame her/him for what happened;
3. Telling you is an optimistic sign and a good first step;
4. She/he is not alone – that this has happened to other women/men;
5. Your relationship with her/him will not change based on their disclosure.

E: Responding When a Patient Answers "Yes" to IPV

If the patient answers "yes," there is certain information that the healthcare provider needs to try to obtain. You do not have to listen to the whole story of what happened, but it is important to know the following:

1. What type of violence was it?
2. When did the violence occur and does the patient have a relationship with the alleged perpetrator currently?
3. Is the patient in danger from the alleged perpetrator, such as is the perpetrator stalking the patient and/or does the perpetrator have access to guns or other weapons?
4. How is the IPV experience affecting the patient physically and psychologically?
5. Have children in the home seen or heard any violence between the patient and the alleged perpetrator? Can the patient explain what they thought the child/children saw/heard?
6. Have any of the children been threatened or hurt during IPV?
7. Has the patient and/or the alleged perpetrator had any suicidal ideation or suicide attempts?
8. Are the patient and/or the alleged perpetrator using drugs and/or alcohol?
9. Is there anything else the patient wants to tell or ask you?
10. Does the patient want you to reveal this information to her/his physician or her obstetrician or to your agency's medical social worker for further intervention?
11. Does the patient have a safety plan? (A Safety Plan is a plan for a victim in the event that he or she decided to leave the abuser quickly.)

F: Responding When a Patient Answers "No" to IPV

Many abused persons are afraid to talk about their situation. Accept "no" as an answer and continue to be supportive if you have future appointments. If your screening and assessment findings conflict with the patient's report of the situation, note the difference. For example:

1. Write: "Routine screening questions for abuse asked. Patient stated that abuse is not an issue at the present time." Do not write: "Patient denies abuse." If a provider writes that the patient "denies" abuse and the situation becomes a legal matter, the subjective documentation creates a legal doubt about whether or not the patient is a credible reporter.
2. Write: "The patient is seven months pregnant and reports that she accidentally fell down a flight of stairs. This clinician is concerned that the injury may have been inflicted. The patient reported multiple incidents of physical abuse by the boyfriend. She said that he often hit her and shoved her during her past pregnancy. When speaking today about the fall, the patient did not make eye contact, declined to answer, and began to cry when I asked if her boyfriend pushed her down the steps."
3. Document what you saw and what you heard. Document bruises in various stages of healing and wounds that do not fit with the description of the stated injury.

Note: Consider the welfare of children in the home**.** Children who have witnessed or experienced violence may need an urgent response to address their needs and/or fears.

Documentation of Evidence

Don’t let a lack of documentation leave a patient/victim defenseless in a court of law. The medical record can be pivotal in a criminal matter if it contains information on abuse and/or injuries. Meticulous documentation provides evidence that something was done or not done, exists or doesn’t exist. It provides evidence for the client, protection for the nurse and the agency, and testimony for the court.

Appropriate documentation has several distinct areas that need to be in the record, which are a body map, photographs, and a narrative note of the patient’s statements/history and the physical findings. The screening questionnaire that you use according to your agency’s policy ideally should guide you.

A: Body Map

Home care clinicians are familiar with body maps for documentation of pressure sores or surgical wounds; however, body maps are also used for graphical identification of the location and extent of the wounds and bruises resulting from IPV. Identify or list wounds alphabetically versus numerically. Every wound gets a letter and description. Don’t use words like "multiple". Document the facts: the size and location of the patient’s bruises, wounds, and markings. Be specific and detailed – use fixed anatomical locations (top of head, bottom of feet, midline abdomen, etc.).

B: Photographs

Home care clinicians are familiar with taking photographs of pressure or surgical wounds. Photographs can provide compelling evidence of the impact of the abuse when taken correctly. Photographs provide compelling graphic detail that can exceed the impact of language.

Before taking photographs, know your agency’s policy on taking photographs and obtain appropriate patient consent (prior to taking the photographs). Number all photos and identify them with the patients name, medical record number, and date. Indicate the total number of photos taken and file them in the medical record. In addition, follow the recommendations listed below:

1. Include a ruler or some other common object (such as a quarter) to be able to visually see the scale of the wounds.
2. Use a tape measure or wound measuring device to give exact dimensions.
3. Take serial photographs of injuries over time, which shows the various stages of the injuries.
4. Some states or agency policies may require the signature of the patient and/or the photographer along with a witness.
5. Take a medium range photo showing the location of the injury on the person’s body. Then take close-up photos of the injury or injuries. Include a photo that enables the viewer to identify the body part where the injury was sustained.

C: Narrative Note – Documentation of Patient Statements and History

1. Do not place the term "domestic violence" or abbreviations such as "IPV" in the diagnosis section of the medical record. Such terms do not convey factual information and are not medical terminology. The court determines IPV. Avoid summarizing a patient’s report of abuse in conclusive terms. If language, such as "the patient is a battered woman", "assault and battery", or "rape", lacks sufficient accompanying factual information, it is inadmissible in court.
2. Delineate the patient’s own words in quotation marks or use such phrases as "patient states" or "patient reports" to indicate that the information recorded reflects the patient’s words. To write "patient was kicked in the abdomen" obscures the identity of the speaker.
3. Describe the patient’s demeanor, such as she/he was crying, was shaking, or seemed angry, agitated, upset, calm, or happy. Avoid phrases that leave room for misinterpretation. For instance, avoid writing "The patient was hysterical."
4. Describe the person who allegedly hurt the patient by using quotation marks to set off the statement. E*xample: The patient stated, "My boyfriend kicked and punched me."*
5. Record the time of day the patient is examined and, if possible, indicate how much time has elapsed since the abuse occurred. *Example: The patient states that early this morning her boyfriend hit her.*

D: Narrative Note – Documentation of Physical Findings:

Bruises of identical age and cause on one person may not have the same color and may not change at the same rate in another person. Some basic guidelines as to the appearance of contusions are as follows:

1. Red, blue, purple, or black colors may occur any time from 1 hour after the causal trauma to resolution of the contusion. The presence of red coloration, therefore, has no bearing on the age of the bruise.
2. A bruise with any yellow coloration is older than 18 hours. Yellow, brown, or green bruises indicate an older injury and

further specification of age is difficult.

Conclusion

Imagine getting stopped by a police officer and you receive a speeding ticket. There was no radar and no other evidence that you were speeding. You plead innocent in court because you were not speeding; however, the judge finds you guilty. Or perhaps you have a charge on your credit card statement for a purchase that you did not make. You call the credit card company and ask to see a record of the purchase. They tell you that there are no available details, but you are still responsible for the charge. It is very probable that you might feel angry or victimized by the system. Don't let patients of IPV feel victimized by the healthcare system because of poor documentation or inadequate collection of the necessary information.

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About the Author(s)

Colleen Symanski-Sanders, RN, Forensic Nurse Specialist, has been a Registered Nurse for over 18 years. She has extended her education into forensic nursing, criminal profiling, and psychopathy receiving a Certificate as a Forensic Nurse Specialist. She has over 16 years experience in public health and home care nursing.

Colleen has been an author of educational material for St. Petersburg College, St. Petersburg, Florida. She has also lectured on a variety of topics at numerous nursing symposiums and conferences across the country. She is on the Editorial Board for "Home Health Aide Digest" and "Private Duty Homecare" publications.