Primary Health Care Family Violence Responsiveness Evaluation Tool

Family Violence is a significant health issue within Aotearoa New Zealand. This tool aims to support New Zealand Primary Health Organisations (PHOs) and practices in developing a systems approach to family violence assessment and intervention, providing a blueprint for programme development and quality improvement.

Scope of the Evaluation Tool

- Family violence, for the purpose of this tool, includes partner abuse, child abuse and neglect, elder abuse and neglect and sexual assault. It is inclusive of physical, sexual, psychological, emotional, social and economic abuses.
- Primary health care provides a first level of contact with the individual, family and community. The tool focuses on PHO and general practice family violence response, yet recognises the importance of linking with the wider primary health care structure.
- We recognise that PHOs and practices are not equal in size, resource, and independence. Although smaller PHOs and practices may find some items unfeasible, the tool represents a best practice standard to work towards. In some cases the primary responsibility for items is named – ranging from the DHB to individual practitioners.

Cultural Responsiveness

Health services should benefit all peoples. Recognising that cultural value systems inform and shape a person's reality, cultural responsiveness is fundamental to reducing health inequalities and intervention barriers for all victims of family violence. In accordance with the Treaty of Waitangi, health providers are expected to take into account Māori health needs and perspectives, develop culturally appropriate practices and procedures, develop partnerships with whānau, hāpu, iwi, Maori communities and providers as well as recruit and support Māori personnel/health workers. The tool aims to set a standard of cultural responsiveness reflective of all cultures across a PHO region.

Tool Development

The tool is informed by Family Violence Intervention Guidelines[1,2] the General Practice Resources[3,4] and the current Hospital Responsiveness to Family Violence Evaluation Tools (accessible at www.trauma-research.info). Items were identified by expert panellists as indicators of an ideal primary health care family violence response programme. Tool categories are purposefully ordered (from 1 to 10) to guide programme implementation. Each category is standardised resulting in a possible score from 0 to 100 with higher scores indicating greater programme development. An overall score is generated using category weightings.

TOOL CATEGORIES	Weighting
1. Governance and Leadership	10.7%
2. Collaboration	10.4%
3. Policies & Procedures:	10.6%
4. Resourcing:	9.5%
5. Documentation:	9.9%
6. Physical Environment:	9.3%
7. Workplace Culture:	9.5%
8. Education	11.1%
9. Routine Inquiry/Assessment:	10.1%
10. Quality Improvement:	8.9%

[1] Fanslow, J. (2002). *Family violence intervention guidelines: Child and partner abuse*. Wellington, New Zealand: Ministry of Health.
[2] Glasgow, K., & Fanslow, J. (2006). *Family violence intervention guidelines: Elder abuse and neglect.* Wellington, New Zealand: Ministry of Health.
[3] Ministry of Health. (2003). *Recognising and responding to partner abuse: A resource for general practice*. Wellington, New Zealand.
[4] Ministry of Health. (2000). *Suspected child abuse and neglect: Recommended referral process for general practitioners*. Wellington, New Zealand.

CATEGORY 1: GOVERNANCE AND LEADERSHIP		
Senior management/leadership level support for the programme to encourage organisational commitment, buy-in and achievement of outcomes underpinned by the Treaty of Waitangi		**WEIGHTING:** 10.7%
Indicators	**Scoring**	**Measurement Notes**
1.1 Is family violence included in the PHO strategic plan?	15	Sight strategic plan.
1.2 Does the PHO work with Māori in accordance with the Treaty?	15	Sight evidence of PHO processes which are based on partnership, protection and participation with Māori. Sight evidence that verifies local Māori have established working relationship with the PHO. For example: Māori governance included in the organisational plan, or within a PHO structure synopsis within the PHO Annual Report.
1.3 Is family violence included in the PHO Māori Health Action Plan?	15	View Māori Health Action Plan at the PHO level.
1.4 Is there a PHO identifiable coordinator for violence/abuse prevention and intervention?	25	Responsibilities include programme development and working with practices. Must be included with job description. Ideally in association with a clinical champion.
Subtotal:	(70)	
1.5 Is there a PHO based family violence steering group that includes:		Steering group has responsibility for programme implementation and strategic direction. Terms of Reference to indicate responsibility and authority for programme decision making. May have a combined DHB &PHO steering group if the Terms of Reference are inclusive of PHO programme.
i) PHO & DHB Family Violence Intervention Coordinators?	5	Both DHB & PHO Coordinators must attend meetings.
ii) PHO & Practice management representatives?	5	Designated management representatives from both PHO and practices to attend working group meetings.
iii) Clinicians?	5	Must include both doctors **and** practice nurses who are on, or have relationship to, clinical advisory board or group
iv) Māori and other relevant non-Māori, non-Pakeha group representatives, including immigrant and refugee groups?	5	Based on PHO population demographics.
v) Community service representative(s)?	5	Must include both Government and NGO representatives such as Police, MSD, CYF, refuge, Rape Crisis, iwi organisations, Plunket, Age Concern and the disability sector.
a) Does the steering group meet at least quarterly?	5	Sight agenda and minutes.
Subtotal:	(30)	
	SUM ALL POINTS SCORED TOTAL =	

CATEGORY 2: COLLABORATION		
Collaboration with others, such as government agencies, community organisations, PHOs and other health services		**WEIGHTING:** 10.4%
Indicators	**Scoring**	**Measurement Notes**
2.1 Does the PHO collaborate with:		Collaboration is PHO responsibility to be formalised through MOUs or similar. Collaboration must support PHO or practice programme development (not DHB programme development for example). Programme coordinator(s) and other relevant staff from PHO or practice should maintain working relationships with agencies.
i) DHB Violence Intervention Programme (VIP) and other secondary health care services?	10	
ii) Local Māori?	10	
iii) Community service providers? [e.g. Women's Refuge, Age Concern, Rape Crisis]	10	
iv) Statutory agencies? [e.g. CYF, Police]	10	
v) Community family violence interagency group?	10	
a) Does the PHO collaborate with these groups on policy and procedure development and review?	10	Sight evidence of collaboration with DHB VIP programme, iwi and at least one other group specifically on FV policy & procedure development and review.
Subtotal:	(60)	
2.2 Does a relevant staff member collaborate with community child protection, adult and elder protection agencies?	5	Must collaborate with all agency types to be achieved. Sight evidence of programme collaboration (not case by case) from either the PHO or practice level.
2.3 Does a relevant staff member collaborate with local Sexual Abuse Assessment Treatment Service (SAATS)?	5	Sight evidence of list of contact phone numbers. Must be programme collaboration (not case by case) from either the PHO or practice level. Collaboration must be on sexual assault. Not general family violence training.
2.4 Is training conducted in collaboration with other agencies? [e.g. Women's Refuge, Age Concern, CYF, Police]	15	Sight evidence of programme collaboration on FV training from the PHO or practice level. Sight training plan.
2.5 Does the PHO collaborate with the community in promoting family violence awareness, prevention and intervention as a health issue?	15	Evidence community collaboration (e.g. public education activities, community forums, white ribbon day).
Subtotal:	(40)	
	SUM ALL POINTS SCORED TOTAL =	

CATEGORY 3: POLICIES AND PROCEDURES		
Existence of written policies and procedures to support family violence (FV) identification and intervention.		**WEIGHTING:** 10.6%
Indicators	**Scoring**	**Measurement Notes**
3.1 Do written policies addressing the assessment and treatment of victims of family violence: *Tick which apply:* Practice Policies ❑ PHO Policies ❑		Family Violence policies and procedures must be endorsed and current (not acceptable if more than 6 months past review date). In each case, definitions must include sexual abuse.
a) Define family violence?		
i) Child abuse and neglect	5	
ii) Partner abuse	5	
iii) Elder abuse and neglect	5	
Subtotal:	(15)	
b) Mandate family violence education for staff? *Select i, ii **OR** iii*		
i)Mandatory for all staff *[clinicians and non-clinicians]*	15	
ii) Mandatory for clinicians only	7	
iii) 'Recommended' for any staff *[rather than mandated]*	4	
Subtotal:	(15)	
c) Require family violence assessment for all women, men and children as per current guidelines?[5]		In each case, must include sexual abuse assessment. *[Cited Ministry of Health guidelines are in process for review]*
i) Children assessed for child abuse and neglect	5	Suspected Child Abuse and Neglect - Recommended Referral Process for General Practitioners (2001), Pg 1 of laminated insert.
ii) Young persons and adults assessed for partner abuse	5	Recognising and Responding to Partner Abuse (Jun 2003), Pg 1 of laminated insert.
iii) Older adults assessed for elder abuse and neglect	5	Policy may also indicate routine inquiry in the presence of high risk factors but in the absence of signs and symptoms.
iv) Policy requires co-assessment of partner abuse & child abuse & neglect	5	
Subtotal:	(20)	
d) Indicate that all staff share responsibility for appropriately addressing family violence?	5	

[5] See: Family Violence Intervention Guidelines: Child and Partner Abuse (2002) & Elder Abuse and Neglect (2006), Recognising and Responding to Partner Abuse: A Resource for General Practice (2003), Suspected Child Abuse and Neglect: Recommended Referral Process for General Practitioners (2000).

e) Address appropriate confidential documentation to a standard of professional excellence, within legal limitations?	10	
f) Outline best practice reporting requirements of:		
i) Reporting suspected or disclosed child abuse & neglect to specialist paediatrician and CYF or Police	5	Requires verbal and written referral for suspected abuse and neglect with clear reporting lines.
ii) Appropriate referral of vulnerable elders with suspected or disclosed abuse and neglect	5	Policy must require elder abuse & neglect victim referral to appropriate elder abuse & neglect support services; may include specialised geriatrician services.
g) Address private space and time for confidential interviewing?	10	Policy must outline (a) FV interviewing to take place in a private space (no children of verbal age present) (b) no family members or children to translate. In the absence of a sign language interpreter, written communication is to be undertaken. Expectation of PHOs to develop relationships with sign language interpreter services.
Subtotal:	(35)	
h) Address safety and security?		
i) Is practice safety with regard to family violence intervention risks addressed?	5	Can be addressed in either family violence or safety and security policies (if clearly linked to family violence) Must state management of verbal and physical abuse in the health setting.
ii) Is a response for employees experiencing or perpetrating Family Violence addressed?	5	Referral pathway must be identified within policy.
i) Supported by translation materials?	5	Policy should include flow-charts, cue cards, hyperlinks etc.
Subtotal:	(15)	
	SUM ALL POINTS SCORED TOTAL =	

CATEGORY 4: RESOURCING		
Provision of sufficient resources and support structures for the programme		**WEIGHTING:** 9.5%
Items/Sub Items	**Scoring**	**Measurement Notes**
4.1 Does the PHO allocate adequate staff time for the programme? [e.g., release time for collaboration with community and training]	10	Resources must include allowing relevant staff 8 hours minimum to attend initial training & 2 hours a year for refresher training & community collaboration meetings/events. Attendance at DSAC training would also qualify.
4.2 Does the PHO allocate adequate financial resources for programme?		Financial resources for example: funding training, community activities, resources including Coordinator FTE. Includes adequate budget allocation (regardless of source). Minimum annual contribution ≥ $10,000.
a) No funding	0	
b) $10,000 – $20,000	5	
c) ≥ $20,000	10	
Subtotal:	(20)	
4.3 Does an available resource list of local family violence service agencies		Must be a hardcopy list with local and national contact details. Consider achieved if resource is

include:		available on-site.
i) Child Abuse and Neglect agencies	1	
ii) Partner Abuse agencies	1	
iii) Stopping Violence/Violence Prevention Programmes	1	
iv) Elder Abuse and Neglect agencies	1	
v) Sexual Abuse agencies	1	
vi) A list of counsellors knowledgeable in family and sexual violence	1	
vii) Local advocacy services (e.g. victim support)	1	
viii) Social work services	1	
ix) National services	1	
x) Culturally relevant services	1	Including Maori, refugee, non-Maori non-Pakeha groups. Should reflect community profile.
xi) LGBT services	1	
xii) Deaf and Disability services	1	
Subtotal:	(12)	
4.4 Are victim advocacy services accessible on-site? [This does not include a social worker, see 4.5]	12	To qualify for a 'yes' must have access to specialised trained services (e.g. rape crisis, refuge) onsite during clinic hours. May be through a LLA (Local Level Agreement).
4.5 Is a social worker accessible on-site, including the use of an available room?	12	To qualify for a 'yes' must have access to services onsite during clinic hours. May be through a LLA.
Subtotal:	(24)	
4.6 Is there a designated family violence leader in the practice?	20	Sight evidence of leader position. May work across practices. Must be included in job description. Responsibilities may include; liaising with clinicians, programme monitoring, resource management, peer supervision, case review, family violence agenda item at staff meetings, undertaking additional training.
4.7 Are procedures in place to ensure patient safety when leaving the practice? [e.g. taxi chits, contacting women's refuge]	7	Sight evidence of formal processes. Must be in place minimally for those assessed as being in immediate danger.
4.8 Are the resources for Primary Healthcare 'Recognising & Responding to Partner Abuse' and 'Suspected Child Abuse and Neglect' available for reference by GPs, RNs, and Community Health Workers?	7	Ascertain availability of the resource ('blue books') by talking with GPs, RNs and community Health Workers.
4.9 Are trained interpreters available (including access to telephone interpreter service) for working with victims if English is not the first language?	10	Practice must have access to certified health interpreter services (e.g. language line). To qualify for a 'yes' this must include evidence of access to sign language interpreters for appropriate translation for victims who require this service.
Subtotal:	(44)	

	SUM ALL POINTS SCORED TOTAL =

CATEGORY 5: DOCUMENTATION		
Forms for accurate documentation of family violence		**WEIGHTING:** 9.9%
Items/Sub Items	**Scoring**	**Measurement Notes**
IDENTIFICATION: **5.1** Are standardised intervention checklists, electronic resources or card prompts available for staff to use/refer to when victims are identified?		View resources. Best practice would include assessment for life time and current abuse.
i) Child Abuse and Neglect	6	
ii) Partner Abuse	6	
iii) Elder Abuse and Neglect	6	
iv) Sexual Abuse	6	
Subtotal:	(24)	
5.2 Is an alert system used within the practice?	6	Procedures should outline: use of PHO alert system when signs/symptoms are present and a coding system for confidentiality. Primarily alert system should be for use within the PHO, and local community agencies and where possible for interaction with DHBs.
Subtotal:	(6)	
ASSESSMENT: **5.3** Which standardised forms are used following identification?		Review documentation forms/instruments. Open ended narrative sections to record information which are not standardised are not sufficient to obtain a 'yes' response. Record results of one instrument only.
a) Body map to document injuries	5	The body map may be in different formats e.g. paper, electronic. A similar tool which collects the same information may be employed.
b) Safety assessment	15	Must consist of a series of prompts that the practitioner uses to assess risk and what immediate action needs to be taken (e.g. call Police, refer to CYF). Assessing risk includes determining potential or immediate possibility of harm. Including self-harm and harm to others, such as children in the home. These are NOT questions that the practitioner asks a child. Must include assessment of partner abuse and child abuse and neglect co-occurrence. Refer to: General Practice Resource Appendix 1 p.g3 & Appendix 2 p.6. Ministry of Health Elder Abuse & Neglect Guidelines p.39 & 40. Ministry of Health Child & Partner Abuse Guidelines p.45 & Appendix 1 p.67.
c) Safety plan	15	Safety planning may be done by expert agency on the phone, and not necessarily by the practice. It must be indicated on form if an agency has been contacted. Child issues should be separately documented including the referral, date and time. Refer to: Ministry of Health Guidelines; Elder Abuse & Neglect p.41 – 43, Child Abuse p.33, Partner Abuse p.48, General Practice Partner Abuse Resource Appendix 2 & 7.
d) Medical photography is offered to persons with family violence	5	Must have access to a trained person available to photograph injuries following patient consent.

injuries.		This may be provided by Police, although photographs must be kept with FV medical record and not be reliant on filing a police report. Sexual Assault photographs are only to be taken by a Doctor for Sexual Abuse Care trained or accredited doctor.
e) In the case of Māori, is it documented whether the individual was offered access to appropriate Māori services?	5	Sight form.
f) Is it documented that culturally appropriate services were offered to non-Maori?	5	Sight form.
Subtotal:	(50)	
REFERRAL **5.4** Does standardised referral documentation form record:		Review referral form. Open ended narrative sections to record information which are not standardised are not sufficient to obtain a 'yes' response. Record results of one instrument only.
i) The service the patient was referred to?	5	
ii) Person referral was sent to?	5	
iii) Any follow up actions?	5	
Subtotal:	(15)	
5.5 The outcome of referral or follow-up?	5	This can be evidenced by a space indicated on the form to encourage recording of outcome if known, or in file notes.
Subtotal:	(5)	
	SUM ALL POINTS SCORED TOTAL =	

CATEGORY 6: PHYSICAL ENVIRONMENT		
Presence of family violence information and resources, and provision of private space for confidential inquiry and assessment.		**WEIGHTING:** 9.3%
Items/Sub Items	**Scoring**	**Measurement Notes**
6.1 Are there posters related to violence/abuse on public display:		Obtain information from direct observation. Posters should be easily viewed in public locations (such as waiting room, hallway, exam rooms, toilets). Posters may focus on awareness raising, violence as a human rights issue, prevention (health relationships, whanau ora) or intervention (No hitting place). One or more posters must be viewable.
i) In the waiting room **with** referral number	10	
OR In the waiting room **without** referral number	5	
ii) In other areas **with** referral number	10	
OR In other areas **without** referral number	5	
Subtotal:	(20)	
6.2 Are brochures publicly available that include family violence referral information for local and/or national services on:		
i) Child abuse and neglect	5	

ii) Partner abuse	5	
iii)Elder abuse and neglect	5	
iv) Sexual assault/abuse	5	
a) Do brochures include referral information for Māori and other relevant culturally-specific services?	10	Referral information must be relevant to PHO population demographics.
b) Are brochures with referral information available in languages other than English?	10	Languages must be relevant to PHO population demographics. Brochures may be printed as required.
Subtotal:	(40)	
6.3 How does the practice provide a safe and private environment for inquiry? *Select i OR ii*		
i) All clinical assessment areas are private for family violence intervention?	25	All consultation spaces must be orally, aurally and visually safe and self contained to achieve maximum points.
ii) Measures are in place to maximize safety of patient? [If all clinical areas are not single rooms]	15	Additional safety measurements must be in place if no private area for interviewing.
Subtotal:	(25)	
6.4 Is a message of zero tolerance for violence displayed for safety of staff and patients?	15	
Subtotal:	(15)	
	SUM ALL POINTS SCORED TOTAL =	

CATEGORY 7: WORKPLACE CULTURE		
The culture that exists within the workplace relating to issues of family violence.		**WEIGHTING:** 9.5%
Items/Sub Items	**Scoring**	**Measurement Notes**
7.1 In the last 2 years, has there been a formal (written) assessment of practice staff's knowledge and attitude about family violence and their competence and comfort in assessing?	15	Requires sighting of written assessment of knowledge and attitude (e.g. survey). Must include a summary report with recommendations. Must address attitudes, knowledge competence and comfort about family violence context and assessment for Māori. May use VIP tool: http://www.moh.govt.nz/familyviolence
Subtotal:	(15)	
7.2 What formal procedures are in place to support PHO and practice employees who are experiencing family violence (victims or perpetrators):		Only qualifies if addressed in both PHO and practice.
a) Is the topic of family violence in the workplace (experienced or perpetrated by employees) included in:		Sight training & orientation documents
i) Training sessions?	5	

ii) Orientation for new employees?	5	
b) Are supervisors/managers trained on family violence in the workplace?	10	Sight management training package documents. Management training must address: policies & procedures, employee workplace indicators, risk assessment, workplace safety and referral plans.
c) Do employees have access to an Employee Assistance Programme (or similar)?	5	Policies and procedures must outline an appropriate referral pathway to Employee Assistance Programme (or similar) services for employees.
d) Does the PHO and practice ensure that Employee Assistance Programme providers (or similar) are skilled in addressing family violence?	5	Employee Assistance Programme or other service provider reports to PHO on availability of counsellors trained in family violence, family violence assessment and intervention policies (including communication of workplace safety planning) and summary of family violence services provided (aggregated).
e) Is there a requirement for a pre-employment staff check by the Police?	10	Family violence & Human Resources policies must outline a pre-employment check for all employees.
Subtotal:	(40)	
7.3 Do policies or procedures recommend & provide access to trained peer support following an abuse disclosure (or suspicion, in the case of child and elder abuse or neglect)?	5	Policy must identify trained appropriate peer support and outline access.
7.4 If there is a periodic newsletter, does it include updates on violence prevention/intervention issues?	5	Sight newsletter with family violence feature, at least six monthly.
7.5 Is family violence on the agenda at regular staff meetings?	5	Sight minutes, agenda and actions taken.
Subtotal:	(15)	
7.6 Do policies and procedures support cultural safety:		Family violence policy and procedures must indicate culture groups within PHO population.
a) Is assessment and inquiry specifically recommended in family violence policy regardless of the patient's cultural background?	10	Policy must state routine inquiry for '**all**' patients regardless within policy in accordance with MOH Guidelines.
b) Do staff participate in cultural safety training including refresher?	10	Evidence of staff participation in cultural safety training in past two years. View attendance list and identify proportion of staff which attended.
c) Does the family violence policy address not using family members (including children) to translate for family violence discussion and other sensitive issues?	10	Use of appropriate (e.g. certified or other same language professional staff member) translators must be outlined within policy.
Subtotal:	(30)	
	SUM ALL POINTS SCORED TOTAL =	

CATEGORY 8: EDUCATION		
Provision of education about family violence must include child abuse & neglect, partner abuse, elder abuse & neglect & sexual assault for Primary Health Care providers		**WEIGHTING:** 11.1%
Items/Sub Items	**Scoring**	**Measurement Notes**

8.1 Formal PHO Family Violence Training Plan: Training Funder:_____		Formal training plan indicates that training is systematic and ongoing, rather than irregular and episodic. Evidence of strategic planning for systematic training should be provided and MUST include a schedule of dates for training, the programme of training, and the schedule of presenters. Training must be mandated, funded, and align with the MOH & GP guidelines. Items below should only be scored if included within the training plan.
a) Are there provisions outlined for initial training to be delivered within the first 12 months of employment for clinical **AND** non-clinical staff?	5	Sight training schedule and attendance register. The Ministry of Health has funded Doctors for Sexual Abuse Care to provide family violence training in Primary Health Care. Shine provides VIP training within DHBs. Clinical: e.g. GPs, NPs, RNs, Midwives, Community Health Workers, Physiotherapists, Pharmacists. Non-Clinical: Managers, Reception and health promoters.
b) Are there provisions outlined for ongoing training for clinical **AND** non-clinical staff?	5	At a minimum ongoing updates every two years. The Ministry of Health has funded Doctors for Sexual Abuse Care to provide family violence training in Primary Health Care. Shine provides VIP training within DHBs.
c) Is family violence training part of orientation for new staff?	5	Sight current orientation package.
d) Have employed clinical and non-clinical staff attended family violence training within the last two years? Percent: _____%	5	Sight training register, workforce development plan and feedback from external trainer. Recorded percentage attending must be more than 80% across the PHO and practice. If unknown, no points.
e) Is training developed and delivered in consultation with relevant community stakeholders?	5	Includes consultation with relevant cultural groups.
f) Does the PHO/practice support medical and nursing staff to receive specialised sexual assault/abuse training (i.e. DSAC facilitated training)?	5	Contact made with DSAC to arrange PHO tailored training in the medical response to sexual assault/abuse.
g) Are staff enabled to attend training?	5	Requires more than an invitation to attend. Training is funded, or staff reimbursed. Attendance may be enabled by staff rotations or temporary clinic closure.
h) Is an evaluation of staff knowledge, confidence and attitude of family violence conducted pre and post training?	5	Staff evaluations must (a) include FV in the workplace and (b) a process for reviewing evaluations including approval and accountability.
8.2 In the **last 12 months** have professionals or community experts with family violence expertise in violence/abuse provided training at the practice?	5	Sight list of recognized or approved training providers and the dates on which training occurred. Training examples: referral and management of offenders, child exposure to IPV, elder abuse/neglect, child abuse/neglect, sexual assault, and same sex partner violence.
Subtotal:	(45)	
8.3 Does training information include:		
a) Definition, contexts and patterns of family violence?	5	Family violence must be defined as including all types of abuse (Partner Abuse, Child Abuse & Neglect, Elder Abuse & Neglect & Sexual Assault).
b) Sexual assault as a part of family violence?	5	
c) Cultural issues?	5	Including: general cultural issues, Treaty of Waitangi, Māori models of health, context in which Māori FV occurs (e.g. colonisation, urbanisation) and service providers and community resources for Māori and non-Māori non-Pakeha groups.

d) Disability and family violence	5	
e) Recognition and assessment as per MOH Guidelines and General Practice resources?	5	
f) Intervention as per MOH Guidelines and General Practice resources?	5	
g) Patient safety	5	Outline security and safety planning procedures.
h) On-going support for victims and perpetrators	5	Provide information on support services.
i) Appropriate referral pathways?	5	Including local referral pathways for victims and victim's family, and local sexual abuse referral pathways. Also include referrals for alcohol and substance abuse, mental health and sexual and reproductive health services as indicated.
8.4 Training includes skill development (e.g. case scenarios)	10	
Subtotal:	(55)	
	SUM ALL POINTS SCORED TOTAL =	

CATEGORY 9: ROUTINE INQUIRY/ASSESSMENT		
Recognise, Respond, Refer.		**WEIGHTING:** 10.1%
Items/Sub Items	**Scoring**	**Measurement Notes**
9.1 Which standardised family violence assessments (e.g. written, computer prompts, and/or verbal) are included on health/clinical record forms?		Sight all assessment instruments. Best practice would include assessment of life time and current abuse.
i) Child Abuse and Neglect	10	Must assess for partner abuse
ii) Partner Abuse	10	Assessment must include safety of children, young people.
iii) Elder Abuse and Neglect	10	
iv) Sexual Abuse/Assault	10	
a) Is the recording of family violence safety status coded yet unidentifiable?	10	Sight documentation that outlines coding system e.g. RQ (Routine Questioning) Yes No / + - Must not use words such as 'child protection'.
Subtotal:	(50)	
9.2 Is the percentage of eligible patients assessed for partner abuse in the past 12 months recorded?	5	View audit sample which includes a breakdown of each of the sub-item data. This would be facilitated by electronic advanced forms.
a) Is the percentage of patients referred to an appropriate agency following a routine inquiry recorded?	5	
b) Is the percentage of patients followed up by practice staff after routine inquiry recorded?	5	

c) Is the reason for not assessing recorded?	5	d) Reason for not assessing must be recorded in relation to all forms of violence.
d) Are child abuse & neglect referral rates to CYF, Police & specialist paediatrician monitored?	5	
e) Are elder abuse & neglect referral rates to specialist support services monitored?	5	
Subtotal:	(30)	
9.3 Is there a follow up process to improve assessment rates?	10	View strategy implemented to improve routine inquiry rates.
9.4 Are there referral pathways for persons who self disclose abusive behaviours?	10	Sight referral pathway.
Subtotal:	(20)	
	SUM ALL POINTS SCORED TOTAL =	

CATEGORY 10: QUALITY IMPROVEMENT		
Evaluation and measurement of the quality of primary health care family violence programme		**WEIGHTING:** 8.9%
Items/Sub Items	**Scoring**	**Measurement Notes**
10.1 Is there a formal quality improvement plan in place to monitor the family violence programme?	10	Sight evidence of a written, strategic evaluation plan. May be at PHO or practice level. Plan must outline standards, measurements, outcomes and regular review periods.
a) Does quality improvement planning and review include an interdisciplinary team?	5	Evaluation planning/review must be interdisciplinary and include relevant cultural groups & Māori. May be included in the FV steering group Terms of Reference.
b) Is the responsibility for acting on evaluation recommendations specified in policies and procedures?	5	May be listed in Terms of Reference.
c) Do evaluation activity reports follow a plan-do-study-act process?	10	Refer to: Toward Clinical Excellence: An Introduction to Clinical Audit, Peer Review and Other Clinical Practice Improvement Activities, Ministry of Health, 2002.
Subtotal:	(30)	
10.2 Do quality improvement activities include relevant audit and review of policy implementation for:		Sight evidence of a review to assess compliance with FV policy.
a) Safety Planning	4	
b) Documentation	4	
c) Data relating to identification, assessment, and referral	4	Record percentage of eligible patients who are assessed (routine inquiry for adults), disclosed and referred (life time and current abuse)
10.3 Are standardised case reviews conducted?	4	Review should be standardised against Guideline processes. Review quarterly at least four cases a year and in response to sentinel events.
10.4 Are demographics, risk assessment & types of abuse trends	4	

reviewed?		
10.5 Is programme effectiveness and outcome measures collected from relevant stakeholders?		Must be evidence of: a) Sharing audit findings with stakeholder groups b) External feedback documentation A Māori approach must be used when asking for feedback from Māori community stakeholder groups. Similarly, a culturally-specific approach should be used for other groups. View the mechanism for eliciting client satisfaction (e.g. general practice survey). Health care provider collaboration should include DHB VIP Coordinator & PHO or Practice Manager. Such as He Taura Tieke. Refer to: Family Violence Intervention Guidelines: Child and Partner Abuse Appendix N.
i) Government & NGO service providers? [e.g. Women's Refuge, CYF]	5	
ii) Client & community stakeholders? [Māori, individual end-users]	5	
iii) Relevant health care providers?	5	
a) Is a quality framework used to evaluate programme cultural safety?	5	
b) Do outcomes focus on whānau rather than individuals?	5	Outcomes should include whānau options. E.g. Parental or sibling referral/assessments.
c) Are positive outcomes being achieved for whānau?	5	Evidence use of Whānau Ora. Measurement of referral to parenting support services, housing referrals, skills for adolescent referrals etc.
Subtotal:	(50)	
10.6 Are evaluation recommendations reported to stakeholder groups?	10	Including government & NGO service providers, health care providers and client and community stakeholders.
10.7 Are staff routine inquiry and prevention efforts recognised and reinforced?	10	Evidence method – citations, awards/certificates for CNE/CME.
Subtotal:	(20)	
	SUM ALL POINTS SCORED TOTAL =	