HOSPITAL RESPONSIVENESS TO FAMILY VIOLENCE:

96 MONTH FOLLOW-UP EVALUATION









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Acknowledgements

Text from ITRC Report No 10 is included with permission.

The evaluation team would like to thank the DHB Family Violence Intervention Coordinators, VIP portfolio managers and other steering group members that took part in site visits. We also give our appreciation to the Ministry of Health Portfolio Manager - Violence Prevention Issues Lead, Sue Zimmerman and to the National VIP Manager for DHBs, Miranda Ritchie.

This evaluation project was approved by the Multi-region Ethics Committee (AKY/03/09/218, including annual renewal August 2011).

For more information visit www.aut.ac.nz/vipevaluation

Disclaimer

This report was commissioned by the Ministry of Health. The views expressed in this report are those of the authors and do not necessarily represent the views of the Ministry of Health.

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ITRC Report No 11 ISSN 2230-6366 (Print) ISSN 2230-6374 (Online)

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EXECUTIVE SUMMARY

The Ministry of Health (MOH) Violence Intervention Programme (VIP) seeks to reduce and prevent the health impacts of violence and abuse through early identification, assessment and referral of victims presenting to designated District Health Board (DHB) services. The Ministry of Health-funded national resources support a comprehensive, systems approach to addressing family violence.

This evaluation summary documents the result of measuring system indicators at 27 hospitals (20 DHBs), providing Government, MOH and DHBs with information on family violence intervention programme implementation. Based on previous audit scores and programme maturity, 10 DHBs transitioned to self audit only for the 96 month follow-up audit, all other data is based on external audit scores for 2011/2012.

• 100% of DHBs achieved the target score (≥ 70) for both partner abuse and child abuse and neglect intervention programmes at 30 June 2012, exceeding the 2012 MOH goal of 90%.



- All DHBs have VIP systems in place to support an efficient, safe response to those experiencing partner abuse and child abuse and neglect.
- Roll out of staff training and delivery of VIP services is occurring across designated services (emergency, maternity, child health, sexual health, mental health and alcohol and drug).
- At the time of the audit 100% (n=20) of DHBs had a dedicated VIP coordinator position.
- 75% (n=15) of DHBs had been approved to deliver the Ministry-approved standardised national VIP training package.
- 60% of DHBs (n=12) had a VIP Quality Improvement (QI) Plan at the time of the audit.
- Internal audit processes monitoring policy implementation remain variable across DHBs, despite the VIP QI Toolkit resource.
- Internal chart reviews suggest that 30% of DHBS (n=6) are screening at least half of all eligible women.

VIP recognises culturally responsive health systems contribute to reducing health inequalities. Cultural responsiveness scores continue to increase over time. Overall DHB VIP cultural responsiveness scores increased 6% and 3% since the previous audit for partner abuse and child abuse and neglect programmes respectively. VIP Whānau Ora advisors continue to support programmes in applying the principles of Whānau Ora and to achieve cultural indicators that performed poorly in past audit periods (see page 20).

New Zealand District Health Boards (DHBs) continue to make significant progress in developing systems for responding to women and children at risk for ongoing exposure to family violence. All DHBs achieved the benchmark target score in both their partner abuse and child abuse and neglect programmes. While programmes are doing well overall, there are still significant gaps. Implementation of the Ministry's Family Violence Intervention Guidelines: Child and Partner Abuse ³ (*The Guidelines*) is still in progress. DHBs are continuing to roll out VIP in designated services and increasing service delivery by trained staff. Quality monitoring and improvement activities continue to present challenges to programme development. Improved leadership, coordination, quality monitoring and evaluation activities are required to enhance programme integration and inter-sectoral collaboration.

BACKGROUND

Family violence (FV) is recognised to have significant social, economic, and health tolls internationally and in Aotearoa New Zealand.³⁻¹¹ With the identification of family violence as a preventable public health problem,¹² the Ministry of Health ('the Ministry') began a Family Violence Health Intervention Project in 2001 (see Appendix A). In 2007, the Ministry launched the renamed Violence Intervention Programme (VIP) in District Health Boards (DHBs). VIP seeks to reduce and prevent the health impacts of violence and abuse through early identification, assessment and referral of victims presenting to health services. This programme is part of the health sector response which is one component of the multi-agency approach to reduce family violence in New Zealand led by Government's Taskforce for Action on Violence within Families.¹³

VIP is premised on a standardised, comprehensive systems approach supported by six programme components funded by the Ministry (Figure 2). These components include:

- District Health Board Family Violence Intervention Coordinators (FVIC).
- Ministry of Health Family Violence Intervention Guidelines: Child and Partner Abuse.
- Resources that include а Ministry Family Violence website, a VIP section on the Health Improvement and Innovation Resource Centre (HIIRC) website, posters, cue cards, pamphlets and VIP Quality Improvement Toolkit.
- Technical Advice and support provided by a National VIP Manager for DHBs, Whānau Ora Advisor, and biannual national and regional FVIC networking meetings.
- **District Health Board Family Violence** Monitoring and Intervention Evaluation Coordinators Audits, QIA Resource Kit **Family Violence** Standardised Intervention National Guidelines Training Resources Technical Website, posters, cure Advice/support cards, pamphlets Whanau ora Development National VIP Manager Network meetings

Figure 2. Ministry of Health VIP Systems Support Model (Secondary Care)

- National training contracts (GPs, midwives, primary care providers and DHB staff).
- External evaluation of DHB family violence responsiveness.

The VIP external evaluation project, operating since 2003, provides information to DHBs and the Ministry about the implementation of family violence programmes.^a This 96 month followup report documents the development of DHB family violence systems across seven rounds of hospital audits. This longitudinal data contribute to the nationwide picture of family violence healthcare initiatives across Aotearoa New Zealand acute care services. The quantitative data are the result of applying standardised audit tools to measure system indicators at 27 hospitals across 20 District Health Boards.

The 96 month follow-up evaluation mirrored the 84 month follow-up¹⁴ evaluation processes with the following change:

^a For the full series of evaluation reports go to: www.aut.ac.nz/vipevaulation

• DHBs that had achieved the Ministry VIP target score (>70) for both partner abuse and child abuse and neglect programmes in the 84 month follow-up audit and had established programme implementation across several services over time, transitioned to self audit only.

The transition to self audit processes recognises increasing programme maturity across DHBs and supports identification of strengths, weaknesses, opportunities for improvement and prevention of problems.^{15,16}

This evaluation sought to answer the following questions:

- 1. How are New Zealand District Health Boards performing in terms of institutional support for family violence prevention?
- 2. Is institutional change sustained over time?
- 3. Do self audit scores accurately represent programme system development?

The evaluation is an important component of the Ministry's efforts to reduce and prevent the health impacts of family violence. Evaluation data supports an evidence-based programme, providing information to guide DHB and Ministry decisions and resource investment (Letter to DHBs, Ministry of Health, August 2010).

METHODS

Participation in the audit process was specified in Ministry VIP contracts with DHBs. Ninety-six month follow up audits were conducted in the 20 DHBs covering 27 acute secondary and tertiary public hospitals across New Zealand (see Appendix B).

All DHBs were invited to submit self audit data 12 months following their previous audit. A session explaining self audit purpose, procedures and best practice processes (such as 'plan ahead') was presented at national FVIC network meetings in 2010 and 2011.

FVIC were requested to complete and forward self audit documentation including:

- 1. Partner Abuse Audit Tool
- 2. Child Abuse and Neglect Audit Tool
- 3. Programme Information Form (Appendix C)
- 4. Self Audit Report (for self audit only DHBs).

In addition to self-audit, external audit site visits were conducted at 10 DHBs (Table 1). These included 3 DHBs which did not achieve the MOH target score (70 in both PA and CAN programmes) at the last audit and 7 DHBs (out of 9) that had been invited to participate in an external audit due to identified programme vulnerabilities.

96 month follow-up self and external audit data were collected between October 2011 and May 2012. The seven audit round periods are shown in Figure 3. The evaluation project was approved by the Multi-region Ethics Committee (AKY/03/09/218 with annual renewal including 10/08/2011). Table 1. Self and External Audit Assignments for96 month follow up

| Self Audit Only (14 hospitals; 10 DHBs) | External & Self audit (13 hospitals; 10 DHBs) | |
|---|---|--|
| Auguland | Contorbury | |
| Auckland | Canterbury | |
| Bay of Plenty | Capital & Coast | |
| Hawke's Bay | Counties Manukau | |
| MidCentral | Hutt Valley | |
| Nelson Marlborough | Lakes | |
| South Canterbury | Northland | |
| Southern | Tairawhiti | |
| Wairarapa | Taranaki | |
| Waitemata | Waikato | |
| West Coast | Whanganui | |



Note: M=months from baseline.

Figure 3. Audit Round Time Periods

Audit Tool

Quantitative external and self audit data were collected applying the *Partner Abuse (PA) Programme Evaluation Tool* and *Child Abuse and Neglect (CAN) Programme Evaluation Tool*. These tools reflect modifications of the *Delphi Instrument for Hospital-Based Domestic Violence Programmes*^{17,18} for the bicultural Aotearoa New Zealand context. The audit tools assess programmes against criteria for an ideal programme given current knowledge and expertise.

The Partner Abuse (*PA*) *Tool* has been used without change across all audit periods. In 2007, a Delphi process with a New Zealand expert panel was conducted to revise the Child Abuse and Neglect (*CAN*) *Tool* to improve its content validity.² This *Revised CAN Tool* was subsequently used for the 48, 60, 84 and 96 month follow-up audits.

The audit tools have been available (open access at www.aut.ac.nz/vipevaluation) as interactive Excel files since 2008. This format allows users to see measurement notes, enter their indicator data and be provided score results.

The 64 performance measures in the *Revised CAN Tool* and 127 performance measures in the *PA Tool* are categorised into nine domains (see Table 2). The *Screening and Safety Assessment* domain is unique to the PA tool; the *Safety and Security* domain is unique to the CAN tool. The domains reflect components consistent with a systems model approach.¹⁹⁻²¹ Each domain score is standardised resulting in a possible score from 0 to 100, with higher scores indicating greater levels of programme development. An overall score is generated using a scheme where some domains are weighted higher than others (see Appendix D for domain weights).

| Policies and Procedures | policies and procedures outline assessment and treatment of victims; mandate identification and training; and direct sustainability |
|------------------------------------|---|
| Safety and Security | children and young people are assessed for safety, safety risks are identified and security plans implemented [CAN tool only] |
| Physical Environment | posters and brochures let patients and vistors know it is OK to talk about and seek help for family violence |
| Institutional Culture | •family violence is recognised as an important issue for the health organisation |
| Training of Providers | •staff receive core and refresher training to identify and respond to family violence based on a training plan |
| Screening and Safety Assessment | standardised screening and safety assessments are performed [PA tool only] |
| Documentation | •standardised family violence documentation forms are available |
| Intervention Services | •checklists guide intervention and access to advocacy services |
| Evaluation Activities | activities monitor programme efficiency and whether goals are achieved |
| Collaboration | •internal and external collaborators are involved across programme processes |

Table 2. Audit Tool Domains

Recognising that culturally responsive health systems contribute to reducing health inequalities, indicators addressing Māori, Non-Māori non-Pakeha (e.g. Pacific Island, Asian, migrant and refugee) and general cultural issues for planning and implementing a family

violence response in the health sector have been integrated within the Partner Abuse (n=30) and Child Abuse and Neglect (n=28) audit tools. These items contribute to a cultural responsiveness score, standardised to range from 0 to 100.

Procedure

Evaluation procedures were conducted based on a philosophy of supporting programme leaders in building a culture of improvement. Integrating the evaluation into the VIP systems approach allowed for clear and consistent communication and resources to support audit activities. Details of evaluation processes are outlined in Figure 4 and Appendix E. The 96 month follow up process (Round Two in Figure 4) began with a letter from the Ministry advising DHB Chief Executives of the upcoming 2011-2012 audit rounds.

Shortly after DHB notification by the Ministry, external audit staff contacted VIP managers and FVIC by e-mail to outline whether they were scheduled for self audit only (n=8), self and external audit (n=3), or whether they could elect self audit only or combined self and external audit (n=9). A confirmatory e-mail identified site visit dates for DHBs scheduled or requesting an external audit.

Where an external audit was conducted, FVIC were requested to submit an audit day itinerary outlining audit participants, venue and an agenda to include a debriefing meeting at the end of the site visit day. Debriefing meetings were to be attended by DHB VIP leaders such as senior management, FVIC, audit participants, and steering group members. Debriefing meetings provided the opportunity to discuss programme highlights and challenges alongside preliminary audit results.

Reporting

Where external audits were conducted, a draft report was provided to the DHB FVIC or designee by the evaluation team. The report included a summary outlining DHB programme progress, strengths and recommendations for improvement, external audit scores and an indicator table of achievements and suggested improvements. Self audit scores were also noted within the report. FVIC were asked to involve relevant others (e.g., DHB VIP portfolio managers, steering group members) in the review process and confirm the accuracy of the draft audit report and provide feedback. Once confirmed, the finalised report was sent to the DHB Chief Executive, copied to the DHB VIP portfolio manager, FVIC and the Ministry.



Figure 4. 2010 – 2012 Audit Plan

Documentation received from self audit only DHBs (n=10) were reviewed by the external evaluation team. Modifications to the submitted self audit report were made to correct errors and enhance readability. Brief external auditor comments were added; comments typically addressed programme scores, service delivery status, and the self audit report. The modified self audit report was then sent to the DHB CEO copied to the DHB VIP portfolio manager, FVIC and the Ministry.

Analysis Plan

Self and external audit data were exported from Excel audit tools into an SPSS Statistics (Version 17) file. Score calculations were confirmed between Excel and SPSS files. Programme information (Appendix C) data were also entered into an SPSS file. All analyses were conducted in SPSS.

Analysis began with assessment of agreement between self audit and external audit values for all indicators, domain and overall scores among the 10 DHBs that had both self and external audit data. The decision was then made to amalgamate the external and self audit scores. This means that 96 month follow up scores represent external audit scores for the 13 hospitals (10 DHBs) that had an external evaluation and self audit scores for the remaining 14 hospitals (10 DHBs). By 2014, it is expected that only self audit scores will be reported.

 96 month follow up results combine external audit scores for 13 hospitals (10 DHBs) and self audit scores for the remaining 14 hospitals (10 DHBs).

In this report we present baseline, 12, 30, 48, 60, 84 and 96 month follow-up domain and overall Delphi scores for comparison. Box plots and league tables are used to examine the distribution of scores over time (see Appendix F: *How to Interpret Box Plots*). The unit of analysis of hospitals has been maintained across evaluation reports with the exception of league tables and some indicator reporting, which are reported by DHB. Recognising the potential of individual extreme scores to influence mean scores, we favour reporting medians (and box plots).

FINDINGS

Partner Abuse Programmes

- At the 96 month follow-up, the partner abuse intervention programme score ranged from 74 to 98, with 91 as the typical (median) score.
- 100% of DHBs achieved an overall partner abuse programme score ≥ 70, exceeding the 2012 MOH goal of 90%.

As demonstrated in Figure 5, partner abuse programme scores have increased substantially over time. Most recently, the median score increased from 84 at the 84 month follow up audit to 91 at the 96 month follow up. The proportion of hospitals achieving the minimal achievement target score of 70 increased from 93% to 100% between the 84 and 96 month follow up audits (see also the section on League tables, page 13). Appendix G provides the data supporting the Figures and Tables in this section.



Figure 5. Partner Abuse Programme Scores 2004-2012

Variability in scores over time is shown in Figure 6. At baseline, scores were consistently (SD=18.1) at the lower range of the scale, with a single high scoring outlier. This was followed by a period of wide score variation peaking at the 30 month follow up audit (SD at 12, 30, 48 and 60 month audits = 21.9, 26.2, 21.6 and 20.1 respectively), indicating a period of change. At the 84 and 96 month follow up, audit scores were again consistent (SD=11.5, 6.3), but now at the higher range of the scale.



Figure 6. Overall Partner Abuse Score Distributions over Time

Partner Abuse Programme Indicators

Many indicators of a systems approach for responding to partner abuse are now in place across all 27 hospitals in all DHBs. Selected high achieving partner abuse programme indicators are highlighted below. Frequencies for individual partner abuse programme tool indicators are provided in Appendix H.

All 27 (100%) hospitals employ an identifiable partner abuse intervention programme coordinator.

All 27 (100%) hospitals have endorsed policies regarding the assessment and treatment of victims of partner abuse.

All 27 (100%) hospitals have instituted partner abuse screening in one or more services.

All 27 (100%) hospitals have a formal partner abuse response training plan; 26 (96%) hospitals (19 DHBs) have agreements with regional refuge services or similar to support health professional training.

All 27 (100%) hospitals have conducted quality improvement activities since the last audit.

Some indicators, though improving over time, are not yet present across all hospitals (see below).

18 (67%) hospitals have written procedures outlining security's role in working with partner abuse victims and perpetrators. 12 (44%) hospitals have an Employee Assistance Programme (or similar) that maintains specific policies and procedures for responding to employees experiencing partner abuse.

As the majority of programmes have the infrastructure in place to support a systems approach for responding to partner abuse, there is increasing attention on evaluating service delivery. The diffusion of partner abuse screening across services and rate of screening of eligible women within those services are useful measures of programme implementation.

The Ministry funds DHBs to implement VIP in the following six targeted services:

- Child Health
 - \circ acute care
 - o community
- Maternity

- Sexual Health
- Mental Health
- Alcohol and Drug
- Emergency Department

While all DHBs had implemented routine screening in at least one service at the time of the 96 month follow up audit, many were still in the process of programme diffusion across targeted services. A few DHBs were in the process of providing support for screening beyond the identified Ministry targeted services (such as in medical wards and primary care services).

To assist standardisation of data collection, the *Quality Improvement Toolkit* included an Excel file for partner violence screening data entry and analysis. VIP staff were beginning to gain experience in standardising routine data collection (such as frequency of auditing and number of random charts selected), though for the most part, collection remained variable. The reader is cautioned that the summary data are likely to include significant error and future reporting

is recommended with more attention to data collection rigour, with differentiation of screening rates by targeted service.

All DHBs now monitor their intimate partner violence screening rate across one or more services. The proportion of eligible women screened is improving over time (Figure 7). It is encouraging that almost one in three DHBs report screening at least half of eligible women in selected services. Equally, however, it demonstrates that increased attention is needed to promote the diffusion of partner abuse screening in practice. The goal would be for all DHBs to screen near 100% of eligible women.



Figure 7. Summary Screening Rate of Eligible Women (n=DHBs)

One measure of screening quality is the rate of partner abuse identified as a result of screening, the 'disclosure rate'. Research and practice identify that the quality of screening (including the environment, and screener knowledge and attitude) will influence whether or not a woman will choose to disclose abuse.²³⁻²⁵ With New Zealand population past year partner abuse rates among women estimated at 5%,^{8,26} we would expect disclosure rates among women seeking health care to be at least that, and most likely higher given a higher use of health services among women who experience abuse.^{8,27,28} Disclosure rates (and past year incidence) would be expected to vary across services, with higher rates for example in mental health, alcohol and drug and sexual health services. To date, disclosure rates have not been routinely measured and analysed. Anecdotally, reported disclosure rates are often less than 1%, indicating the need to consider strategies to improve performance.

Other potential measures of service delivery are the rates of completed risk assessment and provision of specialised family violence services (at the time or through referral) to women who disclose abuse. This data is not currently available. Most DHBs (15, 75%) measure community satisfaction with the partner abuse programme, such as from Refuge services and Police. Few, however, include gathering client satisfaction data.

Partner Abuse Programme Domains^a

All nine partner abuse programme domain scores increased or remained the same between the 84 and 96 month follow up audits (Figure 8). The most important median score increase was in the *Evaluation Activities* domain, increasing from 66 to 80. All median domain scores now exceed 70. Four hospitals have yet to achieve a score of 70 for *Evaluation Activities* and five have yet to achieve a score of 70 for *Screening and Safety Assessment* (see Appendix G).

^a Tool domains are described in Table 2 (page 6).





Partner Abuse Programme League Tables

Hospital league tables provide a pictorial representation of development across the seven audit rounds from 2004 to 2012 (Figure 9, next page). The horizontal line indicates the target minimum achievement score of 70. The development of programmes over time apparent in Figure 8 is impressive.

A **DHB** league table for the 96 month follow up audit is presented in Table 3. The amount of change since the last audit (absolute score difference) ranged from a decrease of 2 to an increase of 33 (achieved by Hutt Valley DHB). Note the DHB median score (89) varies slightly from the hospital median score (91).

| | | | Target | Change |
|-----|-------------------------------|--------------|-----------------|--------------|
| Ran | k | Score | (70) | from 84M |
| 1 | Hawke's Bay (S) | 98 | | 4 |
| 2 | Bay of Plenty (S) | 97 | | 6 |
| 3 | Waitemata (S) | 96 | | 1 |
| 4 | MidCentral (S) | 95 | | 3 |
| 5 | Northland | 93 | | 11 |
| 6 | Counties Manukau | 92 | | 2 |
| 7 | Canterbury | 92 | | 12 |
| 8 | South Canterbury (S) | 92 | | 6 |
| 9 | Southern* (S) | 91 | | 4 |
| 10 | Wairarapa (S) | 90 | | 1 |
| 11 | Auckland (S) | 89 | | -2 |
| 12 | Whanganui | 89 | | 5 |
| 13 | Lakes | 86 | | 16 |
| 14 | Waikato | 85 | | 14 |
| 15 | West Coast (S) | 84 | | -2 |
| 16 | Taranaki | 83 | | 1 |
| 17 | Tairawhiti | 82 | | 3 |
| 18 | Nelson Marlborough (S | 5) 81 | | -1 |
| 19 | Capital & Coast | 79 | | 11 |
| 20 | Hutt Valley | 74 | | 33 |
| | DHB Median | 89 | | 4 |
| Not | oc: (S) Salf Audit: * Southor | n scoro chan | ngo bacod on lo | wort 94 Mont |

Table 3. 96 Month Follow-Up Partner Abuse DHB League Table

Notes: (S) Self Audit; * Southern score change based on lowest 84 Month FU DHB score

96 Month Follow-up Audit Report



Figure 9. Partner Abuse Intervention Hospital League Tables Note: Similarly ranked bars do not represent the same hospital across the six graphs.

Child Abuse and Neglect Programmes

- At the 96 month follow-up, the child abuse and neglect intervention programme score ranged from 79 to 100, with 91 as the typical (median) score.
- 100% of DHBs achieved an overall child abuse and neglect programme score ≥ 70, exceeding the 2012 MOH goal of 90%.

As demonstrated in Figure 10, child abuse and neglect programme scores have increased substantially over time. Most recently, the median score increased from 87 at the 84 month follow up audit to 91 at the 96 month follow up. Appendix I provides the data supporting the Figures and Tables in this section.



Figure 10: Child Abuse and Neglect Programme Scores (2004-2012)

At baseline, child abuse and neglect programme scores were higher compared to partner abuse programme scores (median =37 vs 20 respectively). There has also been less variability in scores over time (See Figure 11). The maximum score variation for child abuse and neglect programmes (SD=19.4) was at baseline, compared to at the 30 month follow-up audit for partner abuse programmes. Scores at the 84 and 96 month follow-up audits were consistently high (SD=8.6 and 5.0 respectively), with a few lower scoring outliers.

Note: To increase content validity, the *Revised CAN Audit Tool* was developed in 2007 and implemented at the 48 month follow up audit^{1,2}. The revised tool included an additional 28 indicators and a new *Safety and Security* domain. The 48 month follow up report¹ includes a comparison of the original and revised tool.





CHILD ABUSE AND NEGLECT PROGRAMME INDICATORS

Most indicators of a systems approach for responding to child abuse and neglect are in place across all 27 hospitals in all DHBs. Selected child abuse and neglect programme indicators are highlighted below. Frequencies for individual child abuse and neglect programme tool indicators are provided in Appendix J.

All 27 (100%) hospitals have a clinical assessment policy for identifying signs and symptoms of child abuse and neglect and for identifying children at risk.

21 (78%) hospitals have protocols for collaborative safety planning that explicitly involve primary health providers; 19 (70%) involve primary health care services in discharge planning.

All 27 (100%) hospitals include their child abuse and neglect programme in their DHB Quality and Risk programme. All 27 (100%) hospitals' child abuse and neglect programmes collaborate with Child, Youth and Family and the Police in programme planning and safety planning for children at risk.

24 (89%) hospitals have a local alert system in the acute care setting recording any concerns about children at risk of abuse and neglect; 2 DHBs had implemented the National Child Protection Alert System.

19 (70%) hospitals record, collate and report to the DHB data related to child abuse and neglect assessment referrals and alert placements; 16 (59%) hospitals monitor demographics, risk factors and types of abuse trends.

DHBs have achieved significant infrastructure to support a systems approach for responding to child abuse and neglect that includes collaboration with Child, Youth and Family and the Police. Multi-Disciplinary Team (MDT) processes are improving over time as working relationships within and external to DHBs are developed. It is anticipated that working relationships promoting health and safety for children will further improve as regions adopt the revised national Memorandum of Understanding between DHBs, CYF and Police, and work with CYF-appointed DHB liaison social worker leaders.

Internal systems for recording abuse and neglect concerns are common among hospitals (89%). At the time of the 96 month follow-up audit, two DHBs had implemented the National Child Protection Alert System (NCPAS), a component of the VIP programmes developed between the Ministry, the NZ Paediatric Society of New Zealand Child Protection Special Interest Group and DHBs. An additional five DHBs were working to join NCPAS.

All DHBs have protocols for safety planning for children identified at risk. Collaborating with primary health care providers occurs in three quarters of hospitals (21; 78%), this is an increase from 11 hospitals at the 84 month follow-up. Nineteen (70%) hospitals coordinate referral processes for care transitions of children at risk between secondary and primary care.

Child injury flow charts raise awareness of child abuse and neglect and increase the number of cases identified as requiring consultation for suspected abuse. ^{29,30} Twenty-six hospitals (96%)

had a standardised child injury assessment documentation form. The age group to which the child injury flow chart was applied, however, ranged across hospitals from children under 2 years of age to under 18 years of age. Ten hospitals reported reviewing emergency department child records for completed injury flow charts. Sixteen hospitals (59%) reported reviewing Reports of Concern submitted to Child, Youth and Family from the DHB; between 6 and 531 reports were reviewed during a single audit period.

Child Abuse & Neglect Programme Domains^a

All nine child abuse and neglect programme median domain scores exceeded 70 (Figure 12). Similar to partner abuse programmes, *Evaluation Activities* was the least developed, 9 hospitals had yet to achieve a score of 70 for *Evaluation Activities*. Three hospitals had yet to achieve a score of 70 for *Documentation*. All hospitals achieved the target score for the remaining seven domains (see Appendix G).

^a Tool domains are described in Table 1 (page 5).





Child Abuse and Neglect Programme League Tables

Hospital league tables provide a pictorial representation of development across the seven audit rounds from 2004 to 2012 (Figure 13). The horizontal line indicates the target minimum achievement score of 70. The development of programmes over time is impressive.

A **DHB** league table for the 96 month follow up audit is presented in Table 4. The amount of change since the last audit (absolute score difference) ranged from no change to an increase of 20. Note the DHB median score (90) varies slightly from the hospital median score (91).

| | | _ | Tar | - | Change |
|------|------------------------|-------|-----|----|----------|
| Ranl | - | Score | (70 |)) | from 84M |
| 1 | Auckland (S) | 100 | | | 4 |
| 2 | Waitemata (S) | 100 | | | 1 |
| 3 | Hawke's Bay (S) | 96 | | | 6 |
| 4 | Canterbury | 94 | | | 3 |
| 5 | Bay of Plenty (S) | 94 | | | 9 |
| 6 | Wairarapa (S) | 94 | | | 4 |
| 7 | MidCentral (S) | 92 | | | 5 |
| 8 | Southern* (S) | 92 | | | 1 |
| 9 | Counties Manukau | 91 | | | 7 |
| 10 | South Canterbury (S) | 91 | | | 11 |
| 11 | Nelson Marlborough (S) | 90 | | | 4 |
| 12 | Capital & Coast | 89 | | | 2 |
| 13 | Northland | 89 | | | 3 |
| 14 | Waikato | 89 | | | 7 |
| 15 | West Coast (S) | 88 | | | 2 |
| 16 | Whanganui | 87 | | | 0 |
| 17 | Taranaki | 86 | | | 3 |
| 18 | Lakes | 85 | | | 20 |
| 19 | Tairawhiti | 81 | | | 10 |
| 20 | Hutt Valley | 79 | | | 18 |
| | DHB Median | 90 | | | 4 |

Table 4. 96 Month Follow-Up Child Abuse and Neglect DHB League Table

Notes: (S) Self Audit; * Southern score change based on lowest 84 Month FU DHB score

96 Month Follow-up Audit Report





Notes: Similarly ranked bars do not represent the same hospital across the six graphs. The Revised CAN audit tool was implemented beginning with the 48 month follow up audit.

Cultural Responsiveness and Whānau Ora

- Hospital 96 Month follow-up Partner Abuse programme cultural responsiveness scores ranged from 77 to 100, with a median score of 90.
- Hospital 96 Month follow-up Child Abuse and Neglect programme cultural responsiveness ranged from 68 to 100, with a median score of 89.

VIP recognises culturally responsive health systems contribute to reducing health inequalities. The following Figure (Figure 14) summarises the sub-set of audit tool indicators evaluating cultural responsiveness within VIP programmes across the seven evaluation periods. Cultural responsiveness scores continue to increase over time.



Figure 14. Median Hospital VIP Cultural Responsiveness Scores 2004-2012 (N=27 hospitals).

In addition to overall cultural responsiveness scores, VIP has focussed on addressing four selected indicators (Figure 15). The selected indicators are increasingly evident in VIP, though further development is needed. For example, six and nine DHBs report evaluating whether partner abuse and child abuse and neglect VIP services, respectively, are effective for Māori.



TRANSITION TO SELF AUDIT

In this section we address the transition to self audit. We provide data comparing self audit scores to external audit scores. This was the second audit round in which DHB VIPs submitted self audit data.

All DHBs submitted self audit scores for partner abuse and child abuse and neglect audit tools. In importing and checking calculations in SPSS some errors in submitted self audit Excel files were noted and subsequently corrected. A full quality check of submitted self audits, however, was not conducted. Errors and explanations for identified errors are listed below:

- Incorrect score entered in the proper cell user would have manually entered the incorrect score, either over-riding or not using the macro.
- Score entered in the wrong cell user would have manually entered a score in the wrong cell, over-riding or not using the macro.
- Category score incorrect (a) user would have manually entered an incorrect category score, or (b) the macro calculation was incorrect due to source cell errors (see previous 2 bullets).
- Presence of poster/brochures not entered or not in agreement with the count field (PA tool only) missing value, or incorrect data entry. For non-Pakeha posters and brochures this error may result in an incorrect cultural responsiveness score.
- Several cultural indicators in the CAN tool, if user selects YES (1) and then NO (0), the score does not return to zero this is a file versus user error.

Additional training for FVIC would serve to improve self audit reliability, particularly in managing Excel file macros and cell entry, and logic checks between domain items and domain scores.

In 10 DHBS, external audits were conducted in addition to the self audit. The external auditor reviewed the partner abuse programme at all 10 DHBs. The child abuse and neglect programme was reviewed at only 8 DHBs, as the other 2 DHBs evidenced established, mature child abuse and neglect programmes over time.

The overall partner abuse self and external audit score difference (self audit minus external audit score) was less than 1 (0-.55; 85.9 vs 86.4). The overall child abuse and neglect mean score difference was also less than 1 (0.79; 87.3 vs. 86.7). There were, however important domain differences (see Table 5 and Figures 16 and 17). Evaluation activities were often overstated and physical environment understated.

| Programme | Domain Mean Difference 95% Confidence of the Difference | | | |
|-----------|---|------------|--------|--------|
| | | Difference | Lower | Upper |
| CAN | Safety & Security | 11.7 | 4.42 | 18.98 |
| | Documentation | 11.1 | 1.99 | 20.20 |
| | Evaluation Activities | 16.9 | 7.658 | 26.042 |
| | Physical Environment | -14.4 | -26.74 | -2.059 |
| PA | Policies & Procedures | 9.00 | 2.1 | 15.9 |
| | Collaboration | -5.4 | -10.8 | -0.10 |

Table 5. Significant differences between domain self and external audit scores (n=10).

Note: Difference= self audit minus external audit score; CAN=child abuse and neglect programme; PA=partner abuse programme



Figure 16. Partner abuse external and self audit domain differences.



Figure 17. Child abuse and neglect external and self audit domain score differences.

Along with submitting Delphi audit tools, DHBs submitted a completed Programme Information Form (Appendix C). In the Programme Information Form, internal audit data were requested. Review of internal audit data indicated that there is significant variation from the VIP QI Toolkit guidelines for internal audit. Several issues are noted below:

- The time period for selecting records to review was variable from 2 days to 12 months.
- The number of eligible records reviewed was often less than the number recommended in the Toolkit.
- Data provided was typically the most recent audit, while in other instances data had been merged across two or more audits.
- There is no allowance for reporting variation in screening rates across hospitals within a DHB.
- The patient population (census) of various services is unknown.
- The proportion of personnel in a service who have completed VIP training is unknown.
- The definition of 'eligible' and 'screened' is variable. For example, in some locations screening documentation achievement includes when 'not screened' is documented.
- Disclosure data were rarely provided.
- The applicable age for completion of child injury flow charts ranges from under 2 to under 18 years of age.

These issues highlight the need for supporting more rigorous and consistent internal audit processes to inform improving service delivery quality.

PROGRAMME IMPLICATIONS

VIP programme funding is continuing and will support DHBs in transitioning to self audit of programme system indicators by July 2014. In addition to submitting audit tools, DHBs will analyse audit results to inform local quality improvement action plans.

There is a need to increase implementation and value of quality improvement activities.

Variation in internal quality monitoring was noted across DHBs. A need for clearer standards, resources and quality monitoring skills and knowledge was identified. Future monitoring will focus on activities such as monitoring partner abuse screening, assessment and disclosure rates, with national 'snapshot' evaluations planned for 2013/14 and 2014/2015.

Infrastructure Monitoring 2012-2014:

- All DHBs will submit a self audit in 2013 and 2014. External evaluators will provide comment on self audit documents.
- External audits will be conducted at four DHBs identified with development and sustainability risks in 2013.
- External audits will be conducted in two randomly selected DHBs in 2014. This spotcheck will assess quality of self auditing.

Internal Quality Monitoring of Programme Delivery:

- Standards and resources for VIP will be reviewed and refined in 2012.
- Workforce training in quality improvement will be provided to VIP staff focusing on standardised methods, data reliability and the Model of Improvement.³¹
- Standardised 'snapshot' data will be collated nationally in 2013 and 2014.

VIP PRIORITIES FOR 2012-2015

Evaluation activities will support VIP priorities for 2012 to 2015. These priorities include the following:

- Improving identification, assessment and responses to vulnerable children and their families/whānau
- Improving service delivery for women, children and whānau experiencing family violence evidenced by quality improvement data
- Supporting integration of safety planning for vulnerable families across primary, community and acute health services
- Contributing to better integration across health and social services for vulnerable families
- Supporting government priorities to reduce assaults on children by 2017
- Increasing the number of DHBs that have implemented National Child Protection Alert Systems
- Supporting DHB implementation of Shaken Baby Prevention Programmes
- Further development of DHB Whānau Ora Workforce Development activities that improve VIP responsiveness to Māori
- Supporting DHB implementation of elder abuse and neglect programmes

Strengths and Limitations

Strengths of this evaluation project include using established family violence programme evaluation instruments^{2,18,32} and following standard quality improvement processes in auditing.^{31,33} The project promotes a comprehensive systems approach to addressing family violence, a key characteristic for delivering effective services.^{19,21,32}

Our processes of audit planning, site visits and reporting facilitate DHB VIP programme development over time. The evaluation project is also integrated in the VIP management programme, providing the Ministry the ability to target remedial actions in the context of limited resources. Development and implementation of the *VIP Quality Improvement Toolkit* and financial and technical support for DHB Whānau Ora initiatives are two such examples. The repeated audit rounds also foster a sense of urgency,³⁴ supporting timely policy revisions, procedure endorsements and filling of FVIC positions. Finally, and perhaps most importantly, the longitudinal nature of the evaluation has allowed monitoring of change over time (2004 to 2012).

Limitations are important to consider in interpreting the findings and making recommendations based on this evaluation work. These include:

 By design, this study is limited to acute hospital and community services of secondary and tertiary public hospitals provided by DHBs. The VIP does not include services provided by private hospitals which may also provide publicly funded services, or primary care where family violence prevention programmes are being introduced opportunistically in DHB regions.

- Audit tool scores range from 0 to 100. This means that as programmes mature they approach the top end of the scale and have little room for score improvement, creating a 'ceiling effect'.
- As the VIP programme has evolved, some indicators become 'out of date', such as the partner abuse programme tool requiring monthly (rather than quarterly) governance (steering group) meetings. While we might have altered the tool over time, we chose to hold the tool constant for the sake of comparisons over time.
- Finally, the VIP audit does not include indicators related to the *Family Violence Intervention Guidelines: Elder Abuse and Neglect*,³⁵ although an increasing number of DHBs have endorsed policies addressing elder abuse and neglect assessment and intervention (n=12 DHBs, 60%).

Conclusions

New Zealand DHBs have continued to make significant progress in developing systems for responding to women and children at risk for ongoing exposure to family violence. All DHBs have achieved the benchmark target score in both their partner abuse and child abuse and neglect programmes at 30 June 2012, exceeding the 2012 MOH goal of 90%.

The majority of DHB Violence Intervention Programmes have policies and procedures in place, good leadership and governance and established collaboration with local government and non-government specialist family violence services. Standardised one day training programmes for clinical staff are supported by service level clinical champions and Family Violence Intervention Coordinators. While programmes are doing well overall, there are still significant gaps.

The most important programme development need continues to be internal quality improvement activities. Evaluation activities have increased over time, supported by the *VIP Quality Improvement Toolkit*. Yet, furthering the scope of activities, improving measurement rigour and translating internal audit information into VIP quality improvements are areas for further attention. And while VIP Cultural Responsiveness scores continue to increase over time, Whānau Ora training activities to improve VIP responsiveness to Māori are still needed.

Aside from programme system developments, implementation of the Ministry's Family Violence Intervention Guidelines: Child and Partner Abuse³ (*The Guidelines*) across target services is still in progress. Many DHBs have yet to roll out their VIP to all targeted services. For those implementing *The Guidelines*, increasing service delivery and quality continues to present challenges. Leadership, coordination, quality monitoring and evaluation activities are all elements required to enhance programme integration and inter-sectoral collaboration.

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APPENDIX A: Family Violence Project Programme Logic⁴



⁴ MOH Advisory Committee; modified from Duignan, Version 4, 16-10-02

APPENDIX B: District Health Board Hospitals

| District Health Board | Hospital | Level of care |
|------------------------------|------------------|---------------|
| Northland | Kaitaia | S |
| | Whangarei | S |
| Waitemata | North Shore | S |
| | Waitakere | S |
| Auckland | Auckland City | Т |
| Counties Manukau | Middlemore | Т |
| Waikato | Waikato | Т |
| | Thames | S |
| Bay of Plenty | Tauranga | S |
| | Whakatane | S |
| Lakes | Rotorua | S |
| Tairawhiti | Gisborne | S |
| Taranaki | New Plymouth | S |
| Hawkes Bay | Hawkes Bay | S |
| Whanganui | Whanganui | S |
| MidCentral | Palmerston North | S |
| Capital and Coast | Wellington | Т |
| Wairarapa | Wairarapa | S |
| Hutt Valley | Hutt | S |
| Nelson-Marlborough | Nelson | S |
| | Wairau | S |
| Canterbury | Christchurch | Т |
| | Ashburton | S |
| West Coast | Grey Base | S |
| South Canterbury | Timaru | S |
| Southern | Otago | Т |
| | Southland | S |

S = secondary service, T = tertiary

Links to DHB Maps: http://www.moh.govt.nz/dhbmaps

APPENDIX C: DHB Programme Information Form

Violence Intervention Programme Evaluation 96 Month Follow-up Audit

Programme Information Form

DHB Information:

Please complete:

DHB:

Hospital(s):

Self Audit Due Date:

External Audit Site Visit Date (*if applicable*):

Please enter relevant name, position, and department:

DHB CEO:

DHB Funding & Planning Manager:

DHB VIP Sponsor (person with VIP signing authority):

DHB Audit contact details:

Name:

Title:

Phone/Mobile:

E-Mail:
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Please include others who have been in the role since the last audit, but not currently. Coordinators may have primary responsibility for child abuse and Please complete the following for all persons in your DHB who have a dedicated Family Violence Intervention Coordination role at the date of this audit. neglect (CAN), partner abuse (PA), or both ('dual')

| | ר | 2 | 3 | 4 | 2 |
|----------------------------|--------------|---|---|---|---|
| Name | | | | | |
| FTE | | | | | |
| PA/CAN/DUAL | | | | | |
| Permanent/Fixed Start Date | | | | | |
| Start Date | | | | | |
| End Date | | | | | |
| Reports to | | | | | |

2. Additional VIP Support Positions

Please list any additional dedicated VIP programme support positions and FTE funded by the DHB or other agencies (e.g. EAN, Primary Care, CYF Social

| | d Reports to | | | | | |
|---------|--------------------------------|---|---|---|---|---|
| | Responsibility Permanent/Fixed | | | | | |
| | Responsibility | | | | | |
| | Position Title | | | | | |
| | VIP FTE | | | | | |
| Worker) | Name | | | | | |
| MC | | 1 | 2 | ŝ | 4 | S |

| Wānau Ora Woi Please complete th | Wānau Ora Workforce Development Please complete the following regarding VIP Whanau Ora initiatives undertaken. | u Ora initiatives undertaken. | | | | |
|---|--|--|-----------------------------------|----------------------------|------------------------------|---------|
| Funding Amount | Funding Source (VIP or other) | Initiative | Date | Partnerships | | Outcome |
| | | | | | | |
| 4. National Training Package | ıg Package | | | | | |
| Sign Off Date | Number of DHB employees trained in past 12 months | ined in past 12 months | Training Provider | wider | Comments | |
| | Non-Clinical: Clinical: | | | | | |
| 5. Elder Abuse | | | | | | |
| Does the DHB have | Does the DHB have policies on Older Adult/Elder Abuse? | use? | | | YES/NO (Delete one) | e one) |
| Title: Date of Endorsement: | ent: | | | | | |
| 6. Disability | | | | | | |
| Has your programn Please elaborate: | Has your programme addressed issues for persons with disa Please elaborate: | vith disabilities? | | | YES/NO (Delete one) | e one) |
| 7. Status Change | | | | | | |
| Has there been an Please elaborate (f | Has there been any significant DHB status change since the last audit that have affected VIP at this DHB? Please elaborate (for example: changes in FVIC, programme sponsor, CEO, merger, restructuring): | nce the last audit that have affected VIP at thi gramme sponsor, CEO, merger, restructuring): | ffected VIP at r, restructurii | t this DHB? <i>ng):</i> | YES/NO (<i>Delete one</i>) | e one) |
| | | | | | | |

96 Month Follow-up Audit Report

| | | | Partner Abuse Refer to QIA T | e Screening Au oolkit: VIP Pari | Partner Abuse Screening Audit (enter data for most recent audit) Refer to QIA Toolkit: VIP Partner Abuse Screening and Documentat | or most rece ning and Doc | <mark>nt audit)</mark> umentation | Partner Abuse Screening Audit (enter data for most recent audit) Refer to QIA Toolkit: VIP Partner Abuse Screening and Documentation Clinical Audit Tool |
|--|--------------------------------------|--|---------------------------------|------------------------------------|--|------------------------------|--------------------------------------|---|
| service (note whether hospital in patient or community out patient service) | ل السوافس (tick YE for each | VIP Implementation ⁵ (tick YES or NO for each service) | Review Period Start | Review Period End | No. Eligible Records Reviewed | No. Screened | No. Disclosed | Comments |
| | YES | ON | dd/mm/yy | dd/mm/yy | | | | |
| Emergency Department | | | | | | | | |
| Child Health – In Patient | | | | | | | | |
| Child Health – Community | | | | | | | | |
| Child Health – Other: | | | | | | | | |
| Maternity - In Patient | | | | | | | | |
| Maternity – Community | | | | | | | | |
| Sexual Health – Community | | | | | | | | |
| Mental Health – In Patient | | | | | | | | |
| Mental Health – Community | | | | | | | | |
| Alcohol & Drug – Community | | | | | | | | |
| Other (e.g., EAN, Primary Care, other Family/Whanau health services): | | | | | | | | |
| Other: | | | | | | | | |

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8. VIP Roll Out and Clinical Audit: Partner Abuse Screening

| 9. Clinical Aud (refer to QIA To | 9. Clinical Audit: Injury Assessment of Children Presenti (refer to QIA Toolkit: <i>Clinical audit of Violence Intervention Pro</i> g | sment of Childre t of Violence Interv | <mark>en Presenting t</mark> c rention Programn | o the Emerg ne; Injury ass | ing to the Emergency Department gramme; Injury assessment of children | 9. Clinical Audit: Injury Assessment of Children Presenting to the Emergency Department (refer to QIA Toolkit: <i>Clinical audit of Violence Intervention Programme; Injury assessment of children presenting to the Emergency Department</i>) | gency Department) | |
|---|--|--|--|--------------------------------------|---|--|------------------------------------|----------------------|
| Does the DHB one) | have a standardi | ised child injury | assessment doc | cumentatior | Does the DHB have a standardised child injury assessment documentation form (injury flow chart)? one) | chart)? | | YES/NO (Delete |
| What is the ag | What is the age of children included? | luded? | | | | | | Years of age or less |
| | | | | | - | | | |
| | | Review Period Start (dd/mm/yy) | Review Period End (dd/mm/yy) | No. Eligible Records Reviewed | le No. Injury flow chart in notes | w No. with appropriate s referral (both discussion and plan documented) | oropriate Comments ר nd plan | nents |
| Emergency Department | epartment | | | | | | | |
| 10. Clinical A u (refer to QIA To | idit: Documentat olkit: <i>Clinical audit</i> | t ion audit of ref u tof Violence Interv | errals made by ention Programn | DHB to Chil. n; CYF Refer | 10. Clinical Audit: Documentation audit of referrals made by DHB to Child Youth and Family (CYF) (refer to QIA Toolkit: <i>Clinical audit of Violence Intervention Programm; CYF Referral Documentation Audit</i>) | <mark>y (CYF)</mark> Audit) | | |
| Review | Review | No. Report of | | | No. include | No. child | No. child | Comments |
| (dd/mm/yy) | (dd/mm/yy) | by DHB to CYF | | 80 | co-occurrence of | confirmed or | protection concerns included | |
| | | during period | health records Reviewed | | partner abuse | suspected included in health diagnosis | in discharge summary | |
| | | | | | | | | |

96 Month Follow-up Audit Report

11. Child Protection Interagency MOU between Child Youth and Family, New Zealand Police and DHB

| Sign Off Date | Comments (please note local schedules to the MOU) |
|---------------|---|
| | |
| | |

12. National Child Protection Alert participation status

| Sign Off Date | Comments |
|---------------|----------|
| | |
| | |

13. VIP strategic planning documents

| | Title (time period) | Sign Off Date | Comments |
|--------------------------------|---------------------|---------------|----------|
| Programme Strategic Plan | | | |
| Training Plan | | | |
| Quality Improvement Plan | | | |
| Other | | | |

14. Most significant VIP achievements since the last audit:

15. Programme Strengths:

16. Recommendations for programme improvement:

17. Any other comments?

APPENDIX D: Delphi Scoring Weights

The reader is referred to the original Delphi scoring guidelines available at: http://www.ahcpr.gov/research/domesticviol/.

The weightings used for this study are provided below.

| Domain | Partner Abuse | Child Abuse & Neglect | Revised Child Abuse & Neglect |
|------------------------------------|------------------|-----------------------------|--|
| 1. Policies and Procedures | 1.16 | 1.16 | 1.21 |
| 2. Physical Environment | 0.86 | 0.86 | .95 |
| 3. Institutional Culture | 1.19 | 1.19 | 1.16 |
| 4. Training of staff | 1.15 | 1.15 | 1.16 |
| 5. Screening and Safety Assessment | 1.22 | N/A | N/A |
| 6. Documentation | 0.95 | 0.95 | 1.05 |
| 7. Intervention Services | 1.29 | 1.29 | 1.09 |
| 8. Evaluation Activities | 1.14 | 1.14 | 1.01 |
| 9. Collaboration | 1.04 | 1.04 | 1.17 |
| 10. Safety and Security | N/A | N/A | 1.20 |

Total score for Partner Abuse= sum across domains (domain raw score * weight)/10

Total score for Child Abuse & Neglect = sum across domains (domain raw score*weight)/8.78

APPENDIX E: 2011-2012 Audit Round Process

[Letterhead removed]

VIP AUDIT PREPARATION INFORMATION Self and External Audits

96 Month Follow-Up Evaluation, 2011-2012

The VIP evaluation provides the opportunity for DHBs to build competence in family violence service delivery as well as measure progress over time. Processes are guided by a philosophy of supporting programme leaders in building a culture of improvement. External auditor participation requires access only to DHB and hospital system-level information and materials. No patient data is required. The evaluation project is approved by the Multi-region Ethics Committee (AKY/03/09/218 with current approval to 8 December 2012).

Audit Preparation

In recognition of increasing programme maturity nationally, DHBs are being supported in transitioning to VIP self audit. This transition aims to increase evaluation transparency and build VIP leader quality improvement expertise.

We encourage specification of a Self Audit Plan to guide evaluation processes. The plan is ideally developed in collaboration with the DHB VIP manager, steering group and Family Violence Intervention Coordinator(s). Additional self audit resources are available to assist you in effective self auditing. These include:

- Self Audit Preparation notes
- Self Audit Plan Example
- Physical Environment Walk Through Form

Preparation should build on previous audit documentation, updating and improving evidence collation. If required, blank partner abuse and child abuse and neglect audit files are available to download at www.aut.ac.nz/vipevaluation.

Submitting Your Self Audit

Complete the following items:

- □ Programme Information Form (attached)
- Partner Abuse excel audit tool
- □ Child Abuse and Neglect excel audit tool

Please double-check all items have been answered and submit the above items to Claire Gear by your due date. You will not be notified of any missing items.

Self audit indicator evidence:

- Collate and have available (Ministry may choose to spot check evidence).
- Reference in the respective 'evidence' columns of the excel audit tools
- **Do not** submit evidence (such as policies and procedures) with the self-audit

External Audit Preparation (one day on-site visit)

- □ Have indicator evidence (as prepared for the self audit) available for viewing by the external evaluator
- **D** Submit audit day itinerary (see below) and finalise with Claire Gear

Reporting

Self Audit Report. We encourage all DHBs to develop site-specific VIP audit reports, based on self audit results. A report template is available on HIRRC to assist this process. You are not required to submit this report to AUT if you are also having an external audit.

External Audit Report.

- FVICs will receive a draft audit report approximately two weeks following the external audit including child abuse and neglect, partner abuse and cultural responsiveness programme scores, self audit scores, summary, recommendations.
- FVICs are asked to provide feedback on draft report in two weeks. NOTE: Feedback should be limited to correcting errors in scoring or interpretation. DHB plans to act on audit recommendations should be included in VIP reporting to the Ministry of Health.
- 3. A final report encompassing feedback will be sent to DHB CEO, copied to portfolio managers, FVICs and MOH.

National Report. A national report and summary documenting VIP programme development across the audit periods will be made available in July 2012. Confidentiality: Audit discussions and individual DHB reports provided by auditors will be kept confidential between the DHB and MOH VIP team. National reports of overall programme and cultural responsiveness scores, however, will identify DHBs (e.g., in league tables).

Audit Support

Audit support is available through various means. Regional FVICs may be the first point of contact. FVIC, particularly those new to the role, are encouraged to discuss audit preparation with the VIP National Manager. Please contact Claire Gear with queries about the audit tool or process. The Ministry of Health contact person is Sue Zimmerman. Please feel free to contact her in regards to the study on (09) 580 9145 or <u>Sue Zimmerman@moh.govt.nz</u>.

Concerns: For concerns regarding the process or conduct of the audit please contact Jane Koziol-McLain or Sue Zimmerman.

Research Team:

External audits will be conducted by Professor Jane Koziol-McLain, supported by Claire Gear.

| Claire Gear, BSocSci (Hons) | Professor Jane Koziol-McLain, PhD, RN |
|---|--|
| Research Officer | Principal Investigator |
| Interdisciplinary Trauma Research Centre | Interdisciplinary Trauma Research Centre |
| | |
| School of Health Care Practice | School of Health Care Practice |
| Auckland University of Technology | Auckland University of Technology |
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| | |



APPENDIX F: How to Interpret Box Plots



- The length of the box is \geq important. The lower boundary of the box represents the 25th percentile and the upper boundary of the box the 75th percentile. This means that the box includes the middle half of all scores. So, 25% of scores will fall below the box and 25% above the box.
- The thick black line indicates the middle score (median or 50th percentile). This sometimes differs from the mean, which is the arithmetic average score.
- A circle indicates an 'outlier', a value that is outside the general range of scores (1.5 box-lengths from the edge of a box).
- A star indicates an 'extreme' score (3 box-lengths from the edge of a box).
- The whiskers or needles extending from the box indicate the score range, the highest and lowest scores that are not outliers (or extreme values).

(SPSS)

| Scores | |
|--------------------|--|
| Follow-Up | |
| seline and | |
| r Abuse Ba | |
| G. Partne | |
| APPENDIX G. | |

| | | | Hospital | | Median Scores | | | | Hospit | als Achievi | ing Target | Hospitals Achieving Target Score (≥70) n (%) | (%) u (| |
|---------------------------------|------|----------|-----------------|-----------------|-----------------|----------|----------------|------------|-------------|--------------|--------------------------|--|--------------|--------------|
| | B | F_{12} | F ₃₀ | F ₄₈ | F ₆₀ | F_{84} | $F_{96}{}^{c}$ | B | F_{12} | F_{30}^{b} | F_{48} | F_{60} | F_{84} | F_{96}^{c} |
| Overall Score | 19.6 | 27.6 | 49.2 | 6.99 | 74.4 | 84.4 | 91.3 | 1 (4%) | 2 (8%) | 5 (19%) | 13 ^ª (48%) | 15 (56%) | 25 (93%) | 27 (100%) |
| Domain Scores | | | | | | | | | | | | | | |
| Policies and Procedures | 19.4 | 29.5 | 48.8 | 62.0 | 75.1 | 82.1 | 86.8 | 1 (4%) | 2 (8%) | 7 (26%) | 11 (41%) | 16 (59%) | 20 (74%) | 24 (89%) |
| Physical Environment | 7.1 | 14.7 | 23.1 | 75.0 | 78.8 | 91.3 | 100 | (%0) 0 | 1 (4%) | 4 (15%) | 16 (59%) | 16 (59%) | 23 (85%) | 25 (93%) |
| Institutional Culture | 22.1 | 30.7 | 59.0 | 72.4 | 83.4 | 88.9 | 93.7 | 2 (8%) | 5 (20%) | 8 (30%) | 15 (56%) | 16 (59%) | 23 (85%) | 25 (93%) |
| Training of Providers | 10.9 | 31.9 | 58.7 | 78.2 | 88.4 | 89.1 | 100 | 1 (4%) | 5 (20%) | 8 (30%) | 15 (56%) | 18 (67%) | 26 (96%) | 26 (96%) |
| Screening and Safety Assessment | 0.0 | 0.0 | 42.5 | 65.3 | 73.2 | 80.3 | 80.3 | 1 (4%) | 2 (8%) | 5 (19%) | 13 (48%) | 15 (56%) | 18 (67%) | 22 (82%) |
| Documentation | 0.0 | 19.1 | 28.6 | 66.6 | 76.1 | 90.4 | 90.5 | (%0) 0 | 0%) 0 | 2 (7%) | 12 (44%) | 14 (52%) | 22 (82%) | 24 (89%) |
| Intervention Services | 26.4 | 45.7 | 62.1 | 65.0 | 79.2 | 92.8 | 100 | 4 (16%) | 6 (24%) | 9 (33%) | 11 (41%) | 17 (63%) | 24 (89%) | 27 (100%) |
| Evaluation Activities | 0.0 | 0.0 | 20.0 | 34.4 | 63.2 | 66.4 | 80.0 | 1 (4%) | 1 (4%) | 4 (15%) | 6 (22%) | 11(41%) | 13 (48%) | 23 (85%) |
| Collaboration | 37.5 | 77.1 | 78.5 | 93.0 | 91.6 | 100.0 | 100 | 1 (4%) | 15 (60%) | 19 (70%) | 23 (85%) | 25 (93%) | 27 (100%) | 27 (100%) |

Notes: **B** = Baseline; F_{12} = 12 month follow-up; F_{30} = 30 month follow-up; F_{48} = 48 month follow-up; F_{60} = 60 month follow-up; F_{24} = 84 month follow-up; F_{34} = 84 month follow-up; F_{94} = 96 month follow-up; 70 is selected benchmark score.³ Includes one hospital score which was rounded up during analysis; ^b 30 month follow-up percentages corrected.⁵ 96 month follow-up scores include external scores (n=13 hospitals) and self audit scores (n=14 hospitals).

APPENDIX H: Partner Abuse Delphi Item Analysis

Note: 96 month follow-up scores include external scores (n=13 hospitals) and self audit scores (n=14 hospitals).

| TCS' responses 84 mo EU Arrent Propriets 94 mo EU Arrent Pre official, written hospital policies regarding the assessment and treatment of victims of partner abuse? If yes, policies. 26 (96%) 1 Are there official, written hospital policies regarding the assessment and treatment of victims of partner abuse? If yes, policies. 26 (96%) 1 Are there official, written hospital policies regarding the assessment and treatment of victims of partner abuse? 26 (96%) 1 Ordentess relater of victims? 26 (96%) 26 (96%) 1 Ordentess relater of victims? 26 (96%) 26 (96%) 1 Ordentess relater of victims? 26 (96%) 26 (96%) 1 Ordentess the reads of victimes? 26 (96%) 26 (96%) 1 Ordentess the reads of victime? 26 (96%) 26 (96%) 1 Ordentess the reads of victime? 26 (96%) 26 (96%) 1 Ordentess the reads of victime? 26 (96%) 26 (96%) 1 Ordentes the needs of victime? 26 (96%) 26 (96%) 1 Ordentes the needs of victime? 26 (96%) 26 (96%) 2 Ordentes the needs of victime? 26 (96%) 26 (96%) <th></th> <th></th> <th></th> <th></th> | | | | |
|---|-----------|--|-------------------|-------------------|
| GORY 1. POLICIES AND PROCEDURES Are there official, written hospital policies regarding the assessment and treatment of victims of partner abuse? If yes, do policies: Are there official, written hospital policies regarding the assessment and treatment of victims of partner abuse? b) mandate training on partner abuse for any staff? c) advocate universal screening for women anywhere in the hospital? c) advocate universal screening? c) address the needs of victims? c) address the needs of other (non-Masch/non-Pakeha) cultural | | "YES" responses | 84 mo FU n (%) | 96 mo FU n (%) |
| Are there official, written hospital policies regarding the assessment and treatment of victims of partner abuse? If yes, do policies: do policies: b) mandate training on partner abuse for any staff? c) advocate universal screening for women anywhere in the hospital? c) advocate universal screening? l) address the needs of | CATE | EGORY 1. POLICIES AND PROCEDURES | <i>for V</i> | (o/) |
| a) definetes? a) definetes? a) define partner abuse? b) mandate training on partner abuse for any staff? b) mandate training on partner abuse for any staff? c) advocate universal screening? c) address documentation? c) address ident on by define whol is responsible for screening? f) address isgal reporting requirements? f) address isgal reporting requirements? f) address isgal reporting requirements? f) address isgal reporting requirements? h) address isgal reporting requirements? f) address isgal reporting requirements? i) address isgal reporting requirements? f) address the needs of other (non-Mäori/non-Pakeha) cultural and/or ethnic groups? k) address the needs of other (non-Mäori/non-Pakeha) cultural and/or ethnic groups? f) address the needs of other (non-Mäori/non-Pakeha) cultural and/or ethnic groups? k) address the needs of other (non-Mäori/non-Pakeha) cultural and/or ethnic groups? f) address the needs of inclust. i) address the needs of inclust. i) address the needs of inclust. i) address the needs of inclust. i) include representative(s) from more than two department?? i) include representative(s) from more than two department?? i) include representative(s) from more than two department?? d) include representative(s) from more than two department?? i) include representative(s) from more than two department?? <tr< td=""><th>1.1</th><td></td><td>26 (96%)</td><td>27 (100%)</td></tr<> | 1.1 | | 26 (96%) | 27 (100%) |
| b) mandate training on partner abuse for any staff? c) advocate universal screening? c) address last exponsible for screening? d) define who is responsible for screening? d) define who is responsible for screening? d) address referral of victims? e) address tage reporting requirements? f) address the needs of other (non-Mäori/non-Pakeha) cultural and/or ethnic groups? h) address the needs of tother (non-Mäori/non-Pakeha) cultural and/or ethnic groups? k) address the needs of tother (non-Mäori/non-Pakeha) cultural and/or ethnic groups? k) address the needs of tother (non-Mäori/non-Pakeha) cultural and/or ethnic groups? k) address the needs of tother (non-Mäori/non-Pakeha) cultural and/or ethnic groups? k) address the needs of tother (non-Mäori/non-Pakeha) cultural and/or ethnic groups? k) address the needs of tother (non-Mäori/non-Pakeha) cultural and/or ethnic groups? k) address the needs of tother (non-Mäori/non-Pakeha) cultural and/or ethnic group? k) address the needs of tother (s) from more than two departments? c) include representative(s) from the security department? d) include presentative(s) from the medical staff? e) include representative(s) from the medical staff? f) include frepresentative(s) from hospital administration? g) include staside specifically for Mäori programme starter abuse programme (bey | | at poincies. a) define partner ablise? | 26 (96%) | 27 (100%) |
| c) advocate universal screening for women anywhere in the hospital? d) define who is responsible for screening? d) define who is responsible for screening? e) address decumentation? e) address referral of victims? e) address the responsibilities to, and needs of, Maori? f) address the responsibilities to, and needs of, Maori? e) address the responsibilities to, and needs of, Maori? h) address the needs of GBR clients? e) address the needs of GBR clients? i) address the needs of GBR clients? e) address the needs of GBR clients? i) address the needs of GBR clients? i) address the needs of GBR clients? i) address the needs of GBR clients? i) meet at least every month? i) include representative(s) from more than two departments? include representative(s) from the security department? i) include representative(s) from the security department? i) include representative(s) from the security department? i) include representative(s) from the medical staff? e) include representative(s) from the security department? i) include representative(s) from the medical staff? e) include representative(s) from the security department? i) include representative(s) from the medical staff? e) include representative(s)? i) include representative(s) from the medical staff? e) include representative(s)? i) include representative(s) f | | b) mandate training on partner abuse for any staff? | 26 (96%) | 27 (100%) |
| d) define who is responsible for screening? d) define who is responsible for screening? e) address referral of victims? f) address referral of victims? f) address referral of victims? f) address the responsibilities to, and needs of, Mäori? g) address the responsibilities to, and needs of, Mäori? i) address the responsibilities to, and needs of, Mäori? h) address the needs of tother (non-Maori/non-Pakeha) cultural and/or ethnic groups? ii address the needs of LGBT clients? is there evidence of a hospital-based partner abuse working group? If yes, does the group: ii address the needs of LGBT clients? is there evidence of a hospital-based partner abuse working group? If yes, does the group: ii address the needs of LGBT clients? is there evidence of a hospital-based partner abuse working group? If yes, does the group: ii address the needs of LGBT clients? is there evidence of a hospital-based partner abuse working group? ii yes, does the group: include representative(s) from more than two department? ii niclude representative(s)? i) niclude representative(s) from the medical staff? ii niclude representative(s)? ii niclude representative(s)? ii niclude representative(s)? ji niclude representative(s)? ii niclude representative(s)? ji niclude representative(s)? ii niclude representative(s)? ji niclude representati | | c) advocate universal screening for women anywhere in the hospital? | 26 (96%) | 27 (100%) |
| e) address focumentation? e) address focumentation? f) address referral of victims? f) address referral of victims? g) address the responsibilities to, and needs of, Mãori? h) address the responsibilities to, and needs of, Mãori? h) address the needs of tuber (non-Mãori/non-Pakeha) cultural and/or ethnic groups? h i) address the needs of LGBT clients? i) address the needs of LGBT clients? l) address the needs of LGBT clients? ii there evidence of a hospital-based partner abuse working group? If yes, does the group: a) meet at least every month? i) include representative(s) from more than two departments? i) include representative(s) from the security department? ii niclude representative(s) from the security department? i) include representative(s) from the security department? ii niclude representative(s) from the security department? ii niclude representative(s) from the security department? ii niclude representative(s)? ii niclude representative(s) from hospital administration? ii niclude second second or station? ii niclude representative(s) from hospital administration? ii niclude second second or stative(s)? ii niclude representative(s) from hospital administration? ii niclude second vice for the partner abuse programme (beyond VIP funding)? ii niclude representative(s) from hospital administration? ii stunding set aside specifically f | | d) define who is responsible for screening? | 26 (96%) | 27 (100%) |
| 1 address referral of victims? 1 9 address legal reporting requirements? 1 1 address the responsibilities to, and needs of, Māori? 1 1 address the responsibilities to, and needs of, Māori? 1 1 address the needs of other (non-Māori/non-Pakeha) cultural and/or ethnic groups? 1 1 address the needs of tuber (non-Māori/non-Pakeha) cultural and/or ethnic groups? 1 1 address the needs of LGBT clients? 1 1 address the needs of LGBT clients? 1 2 bi niclude representative(s) from more than two departments? 1 3 meet at least every month? 1 9 include representative(s) from the security department? 1 1 include representative(s) from the security department? 1 1 include representative(s) from the medical staff? 1 9 include representative(s) from hospital administration? 1 9 include representative(s) from hospital administration? 1 9 include representative(s)? 1 10 include representative(s)? 1 10 include representative(s)? 1 10 include representative(s)? 1 11 include representative(s)? 1 11 include representative(s)? 1< | | e) address documentation? | 76 (%96) (%96) | 27 (100%) |
| g) address legal reporting requirements? b) address the responsibilities to, and needs of, Mãori? b) address the responsibilities to, and needs of, Mãori? h) address the needs of other (non-Mãori/non-Pakeha) cultural and/or ethnic groups? b) address the needs of tother (non-Mãori/non-Pakeha) cultural and/or ethnic groups? k) address the needs of tother (non-Mãori/non-Pakeha) cultural and/or ethnic groups? b) address the needs of tother (non-Mãori/non-Pakeha) cultural and/or ethnic groups? k) address the needs of LGBT clients? b) include representative(s) from more than two departments? b) include representative(s) from the security department? a) meet at least every month? b) include representative(s) from the security department? b) include representative(s) from the security department? d) include representative(s) from the medical staft? c) include representative(s) from the medical staft? c) include representative(s) from the medical staft? f) include representative(s) from the medical staft? c) include representative(s) from hospital administration? c) f) include representative(s) from the medical staft? c) include representative(s)? c) f) include representative(s) from hospital administration? c) c) f) include representative(s) from hospital administration? c) c) f) include representative(s) from hospital administration? c) c) < | | f) address referral of victims? | 26 (96%) | 27 (100%) |
| h) address the responsibilities to, and needs of, Mãori? i) address the responsibilities to, and needs of, Mãori? i) address the needs of other (non-Mãori/non-Pakeha) cultural and/or ethnic groups? k) address the needs of LGBT clients? k) address the needs of LGBT clients? is there evidence of a hospital-based partner abuse working group? If yes, does the group: a) meet at least every month? i) include representative(s) from more than two departments? b) include representative(s) from the security department? include physician(s) from the medical staff? c) include representative(s) from the medical staff? include representative(s) from a partner abuse advocacy organization (eg., Women's Refuge)? f) include representative(s) from a partner abuse advocacy organization (eg., Women's Refuge)? include main staff? b) include representative(s) from a partner abuse advocacy organization (eg., Women's Refuge)? include main staff? f) include representative(s) from a partner abuse programme (beyond VIP funding)? include main staff? f) include representative(s) from a partner abuse programme (beyond VIP funding)? is funding set aside specifically for Mãori programmes and initiatives? l) finclude main staff? is funding set aside specifically for Mãori programmes and initiatives? is there a mandatory universal screening policy in place? lost the readility assurance procedures in place to ensure partner abuse screening? is regular chart | | | 26 (96%) | 26 (96%) |
| i) address the needs of other (non-Mãori/non-Pakeha) cultural and/or ethnic groups? i) address the needs of LGBT clients? k) address the needs of LGBT clients? is there evidence of a hospital-based partner abuse working group? If yes, does the group: a) meet at least every month? i) include representative(s) from more than two department? b) include representative(s) from the security department? ii) include representative(s) from the security department? c) include representative(s) from the medical staff? iii) include representative(s) from hospital administration? i) include representative(s) from hospital administration? iii) include representative(s) from hospital administration? i) include representative(s) from hospital administration? iii) include representative(s) from hospital administration? iii) include representative(s) from hospital administration? iiii) include representative(s) from hospital administration? iiii include representative(s) from hospital administration? iiiii include representative(s)? iii include representative(s) from hospital administration? iiii include representative(s)? iii include representative(s) from hospital administration? iiii include representative(s)? iii include representative(s) from hospital administration? iiii iiiiiiiiiiiiiiiiiiiiiiiiiiiiiiii | | | (%96) 97 | 27 (100%) |
| k) address the needs of LGBT clients? k) address the needs of LGBT clients? Is there evidence of a hospital-based partner abuse working group? If yes, does the group: a) meet at least every month? a) meet at least every month? b) include representative(s) from more than two departments? b) b) include representative(s) from the security department? c) include representative(s) from the medical staff? c) d) include representative(s) from the medical staff? c) include representative(s) from hospital administration? c) f) include representative(s) from hospital administration? f) include representative(s)? c) f) include representative(s)? for the partner abuse programme (beyond VIP funding)? c) f) include fract financial support for the partner abuse programme (beyond VIP funding)? c) c) f) include set aside specifically for Mãori programmes and initiatives? fs there a mandatory universal screening policy in place? c) for there quality assurance procedures in place to ensure partner abuse screening? a) regular chart audits to assess screening? c) | | i) address the needs of other (non-Māori/non-Pakeha) cultural and/or ethnic groups? | 26 (96%) | 25 (93%) |
| Is there evidence of a hospital-based partner abuse working group? If yes, does the group: is there evidence of a hospital-based partner abuse working group? If yes, does the group: a) meet at least every month? include representative(s) from more than two department?? b) include representative(s) from the security department? include physician(s) from the medical staff? c) include physician(s) from the medical staff? include physician(s) from the medical staff? d) include representative(s) from the medical staff? include representative(s) from hospital administration? f) include representative(s) from hospital administration? include maior's Refuge)? f) include representative(s) from hospital administration? include from the medical support for the partner abuse programme (beyond VIP funding)? f) include from set aside specifically for Mãori programmes and initiatives? is funding set aside specifically for Mãori programmes and initiatives? Is there a mandatory universal screening policy in place? Are there quality assurance procedures in place to ensure partner abuse screening? Are there quality assurance procedures in place to ensure partner abuse screening? is gualar chart audits to assess screening? | | k) address the needs of LGBT clients? | (%02) 61 | 24 (89%) |
| a) meet at least every month? a) meet at least every month? b) include representative(s) from more than two departments? b) c) include representative(s) from the security department? c) include physician(s) from the medical staff? c) d) include physician(s) from the medical staff? c) include physician(s) from the medical staff? c) include representative(s) from a partner abuse advocacy organization (eg., Women's Refuge)? c) f) include representative(s) from hospital administration? c) g) include representative(s)? c) Does the hospital provide direct financial support for the partner abuse programme (beyond VIP funding)? c) Is funding set aside specifically for Mãori programmes and initiatives? c) Is there a mandatory universal screening policy in place? c) Are there quality assurance procedures in place to ensure partner abuse screening? c) a) regular chart audits to assess screening? c) | 1.2 | Is there evidence of a hospital-based partner abuse working group? If yes, does the group: | 27 (100%) | 27 (100%) |
| b) include representative(s) from more than two department?c) include representative(s) from the security department?d) include physician(s) from the medical staff?d) include physician(s) from the medical staff?e) include representative(s) from a partner abuse advocacy organization (eg., Women's Refuge)?f) include representative(s) from hospital administration?g) include Rãori representative(s) from hospital administration?g) include Rãori representative(s)?Does the hospital provide direct financial support for the partner abuse programme (beyond VIP funding)?Is funding set aside specifically for Mãori programmes and initiatives?Is there a mandatory universal screening policy in place?Are there quality assurance procedures in place to ensure partner abuse screening?a) regular chart audits to assess screening? | | a) meet at least every month? | 8 (%08) | 11 (41%) |
| c) include representative(s) from the security department?d) include physician(s) from the medical staff?d) include physician(s) from the medical staff?e) include representative(s) from a partner abuse advocacy organization (eg., Women's Refuge)?f) include representative(s) from hospital administration?g) include Māori representative(s)?Does the hospital provide direct financial support for the partner abuse programme (beyond VIP funding)?Is funding set aside specifically for Mãori programmes and initiatives?Is there a mandatory universal screening policy in place?Are there quality assurance procedures in place to ensure partner abuse screening?a) regular chart audits to assess screening? | | b) include representative(s) from more than two departments? | 27 (100%) | 27 (100%) |
| d) include physician(s) from the medical staff?e) include representative(s) from a partner abuse advocacy organization (eg., Women's Refuge)?f) include representative(s) from hospital administration?g) include mãori representative(s)?Does the hospital provide direct financial support for the partner abuse programme (beyond VIP funding)?Is funding set aside specifically for Mãori programmes and initiatives?Is there a mandatory universal screening policy in place?Are there quality assurance procedures in place to ensure partner abuse screening?a) regular chart audits to asses screening? | | c) include representative(s) from the security department? | 18 (67%) | 21 (78%) |
| e) include representative(s) from a partner abuse advocacy organization (eg., Women's Refuge)? Poinclude representative(s) from hospital administration? Poinclude representative(s) from hospital administration? Poinclude Mãori representative(s)? Poinclude Mãori provide direct financial support for the partner abuse programme (beyond VIP funding)? Poinclude Representative(s)? Poinclude Repre | | d) include physician(s) from the medical staff? | 24 (89%) | 26 (96%) |
| f) include representative(s) from hospital administration? g) include Māori representative(s)? Does the hospital provide direct financial support for the partner abuse programme (beyond VIP funding)? Is funding set aside specifically for Māori programmes and initiatives? Is there a mandatory universal screening policy in place? Are there quality assurance procedures in place to ensure partner abuse screening? a) regular chart audits to assess screening? | | e) include representative(s) from a partner abuse advocacy organization (eg., Women's Refuge)? | 25 (93%) | 25 (93%) |
| g) include Māori representative(s)? Does the hospital provide direct financial support for the partner abuse programme (beyond VIP funding)? Is funding set aside specifically for Māori programmes and initiatives? Is there a mandatory universal screening policy in place? Are there quality assurance procedures in place to ensure partner abuse screening? a) regular chart audits to assess screening? | | f) include representative(s) from hospital administration? | 27 (100%) | 27 (100%) |
| Does the hospital provide direct financial support for the partner abuse programme (beyond VIP funding)?Is funding set aside specifically for Mãori programmes and initiatives?Is there a mandatory universal screening policy in place?Are there quality assurance procedures in place to ensure partner abuse screening?a) regular chart audits to assess screening? | | g) include Māori representative(s)? | 27 (100%) | 27 (100%) |
| Is funding set aside specifically for Māori programmes and initiatives? Is there a mandatory universal screening policy in place? Are there quality assurance procedures in place to ensure partner abuse screening? a) regular chart audits to assess screening? | 1.3 | Does the hospital provide direct financial support for the partner abuse programme (beyond VIP funding)? | 22 (81%) | 21 (78%) |
| Is there a mandatory universal screening policy in place? Are there quality assurance procedures in place to ensure partner abuse screening? a) regular chart audits to assess screening? | 1.3_{a} | Is funding set aside specifically for Māori programmes and initiatives? | 13 (48%) | 15 (56%) |
| Are there quality assurance procedures in place to ensure partner abuse screening? a) regular chart audits to assess screening? | 1.4 | | 26 (96%) | 27 (100%) |
| | 1.5 | Are there quality assurance procedures in place to ensure partner abuse screening? | 23 (85%) | 27 (100%) |
| | | a) regular chart audits to assess screening? | 23 (85%) | 26 (96%) |

| | "VEC" reconness | 01 mo El I | 06 mo El I |
|------|--|------------|------------|
| | | n (%) | n (%) |
| | b) positive reinforcers to promote screening? | 22 (82%) | 25 (93%) |
| | c) is there regular supervision? | 12 (44%) | 24 (89%) |
| 1.6 | Are there procedures for security measures to be taken when victims of partner abuse are identified? If yes, | | |
| | a) written procedures that outline the security department's role in working with victims and perpetrators? | 12 (44%) | 18 (67%) |
| | b) procedures that include name/phone block for victims admitted to hospital? | 20 (74%) | 21 (78%) |
| | c) procedures that include provisions for safe transport from the hospital to shelter? | 17 (63%) | 23 (85%) |
| | d) do these procedures take into account the needs of Māori? | 13 (48%) | 14 (52%) |
| 1.7 | Is there an identifiable partner abuse coordinator at the hospital? If yes is it a: (choose one) | 27 (100%) | 27 (100%) |
| | a) part time position or included with other responsibilities? | 13 (48%) | 8 (%08) |
| | b) full-time position with no other responsibilities? | 14 (52%) | (%02) 61 |
| CATE | CATEGORY 2. PHYSICAL ENVIRONMENT | | |
| 2.1 | In how many locations are posters/brochures related to partner abuse on display in the hospital? (up to 35): | | |
| | 11-20 | 1 (4%) | 3 (11%) |
| | 21-35 | 26 (96%) | 24 (89%) |
| | In how many locations are there Māori images related to partner abuse on display? (up to 17): | | |
| | 1-10 | 1 (4%) | 0 (0%) |
| | 11-17 | 26 (96%) | 27 (100%) |
| 2.2 | In how many locations is there referral information related to partner abuse services on display in the hospital? (Can be included on the posters/brochure noted above)(up to 35): | | |
| | 11-20 | 3 (11%) | 3 (11%) |
| | 21-35 | 23 (85%) | 24 (89%) |
| | In how many locations is there referral information related to Māori providers of partner abuse services on public | | |
| | display in the hospital? (up to 17): | | |
| | 0-10 | 4 (15%) | 1 (4%) |
| | 11-17 | 23 (85%) | 26 (96%) |
| | In how many locations is there referral information re non- Māori non-Pakeha on public display? (up to 17) | | |
| | 0-9 | 6 (22%) | 4 (16%) |
| | 7-17 | 21 (78%) | 23 (84%) |
| 2.3 | Does the hospital provide temporary (<24 hours) safe shelter for victims of partner abuse who cannot go home or | 20 (74%) | 24 (89%) |
| | cannot be placed in a community-based shelter? If yes: | | |

| | | n (%) | n (%) |
|-------|--|-----------|-----------|
| | d) Does the design and use of the safe shelter support Māori cultural beliefs and practices? | 18 (67%) | 22 (82%) |
| CATEC | CATEGORY 3. INSTITUTIONAL CULTURE | | |
| 3.1 | In the last 3 years, has there been a formal (written) assessment of the hospital staff's knowledge and attitude about | | |
| | partner abuse? If yes, which groups have been assessed? | | |
| | a) nursing staff | 26 (96%) | 27 (100%) |
| | b) medical staff | 19 (70%) | 24 (89%) |
| | c) administration | 19 (70%) | 20 (74%) |
| | d) other staff/employees | 25 (93%) | 27 (100%) |
| | If yes, did the assessment address staff knowledge and attitude about Māori and partner abuse? | 17 (63%) | 25 (93%) |
| 3.2 | How long has the hospital's partner abuse programme been in existence? | | |
| | 1-24 months | 3 (11%) | 0 (0%) |
| | 24-48 months | 5 (19%) | 5 (19%) |
| | >48 months | 19 (70%) | 22 (81 %) |
| 3.3 | Does the hospital address the following in responding to employees experiencing partner abuse? | | |
| | a) Is there a hospital policy covering the topic of partner abuse in the workplace? | 25 (93%) | 24 (89%) |
| | b) Does the Employee Assistance programme (or equivalent) maintain specific policies and procedures for dealing with | 12 (44%) | 12 (44%) |
| | employees experiencing partner abuse? | 10/11/27 | 10/221 37 |
| | c) Is the topic of partner abuse among employees covered in the hospital training sessions and/or orientation? | 25 (93%) | 27 (100%) |
| 3.4 | Does the hospital's partner abuse programme address cultural competency issues? If yes: | | |
| | a) Does the hospital's policy specifically recommend universal screening regardless of the patient's cultural | 26 (96%) | 27 (100%) |
| | | | |
| | b) Are cultural issues discussed in the hospital's partner abuse training programme? | 25 (93%) | 27 (100%) |
| | c) Are translators/interpreters available for working with victims if English is not the victim's first language? | 27 (100%) | 27 (100%) |
| | d) Are referral information and brochures related to partner abuse available in languages other than English? | 27 (100%) | 27 (100%) |
| 3.5 | Does the hospital participate in preventive outreach and public education activities on the topic of partner abuse? If | 27 (100%) | 25 (93%) |
| | a) 1 nrogramme in the last 12 months? | 0 (0%) | 1 (4%) |
| | b) >1 programme in the last 12 months? | 27 (100%) | 24 (89%) |
| | c) Does the hospital collaborate with Māori community organizations and providers to deliver preventive outreach and | (1000) 10 | ()0001 50 |
| | public education activities? | 24 (83%) | (%68) 47 |
| CATE(| CATEGORY 4. TRAINING OF PROVIDERS | | |
| 4.1 | Has a formal training plan been developed for the institution? If yes: | 25 (93%) | 27 (100%) |
| 1 | a) Does the plan include the provision of regular, ongoing education for clinical staff? | 26 (96%) | 27 (100%) |

| | "YES" responses | 84 mo FU | 96 mo FU |
|-----|--|-----------|-----------|
| | - | u (%) | n (%) |
| | b) Does the plan include the provision of regular, ongoing education for non-clinical staff? | 21 (78%) | 25 (93%) |
| 4.2 | During the past 12 months, has the hospital provided training on partner abuse: | | |
| | a) as part of the mandatory orientation for new staff? | 26 (96%) | 27 (100%) |
| | b) to members of the clinical staff via colloquia or other sessions? | 27 (100%) | 27 (100%) |
| 4.3 | Does the hospital's training/education on partner abuse include information about: | | |
| | a) definitions of partner abuse? | 25 (93%) | 27 (100%) |
| | b) dynamics of partner abuse? | 27 (100%) | 27 (100%) |
| | c) epidemiology? | 27 (100%) | 27 (100%) |
| | d) health consequences? | 27 (100%) | 27 (100%) |
| | e) strategies for screening? | 24 (89%) | 27 (100%) |
| | f) risk assessment? | 27 (100%) | 27 (100%) |
| | g) documentation? | 23 (85%) | 27 (100%) |
| | h) intervention? | 25 (93%) | 27 (100%) |
| | i) safety planning? | 24 (89%) | 27 (100%) |
| | j) community resources? | 25 (93%) | 27 (100%) |
| | k) reporting requirements? | 27 (100%) | 27 (100%) |
| | l) legal issues? | 27 (100%) | 27 (100%) |
| | m) confidentiality? | 27 (100%) | 27 (100%) |
| | n) cultural competency? | 26 (96%) | 27 (100%) |
| | o) clinical signs/symptoms? | 24 (89%) | 27 (100%) |
| | p) Māori models of health? | 23 (85%) | 27 (100%) |
| | q) risk assessment for children of victims? | 27 (100%) | 27 (100%) |
| | r) social, cultural, historic, and economic context in which Māori family violence occurs? | 22 (82%) | 27 (100%) |
| | s) te Tiriti o Waitangi? | 23 (85%) | 27 (100%) |
| | t) Māori service providers and community resources? | 24 (89%) | 27 (100%) |
| | u) service providers and community resources for ethnic and cultural groups other than Pakeha and Māori? | 23 (85%) | 27 (100%) |
| | v) partner abuse in same-sex relationships? | 25 (93%) | 27 (100%) |
| | w) service providers and community resources for victims of partner abuse who are in same-sex relationships? | 19 (70%) | 26 (96%) |
| 4.4 | Is the partner abuse training provided by: (choose one a-d and answer e-f) | | |
| | b) a single individual? | 0 (0%) | 1 (4%) |
| | | 1 (4%) | 0(0%) |
| | d) a team, including community expert(s)? | 26 (96%) | 26 (96%) |
| | It provided by a team, does it include: | | |

| e) a Māori representative? f) a representative(s) of other ethnic/cultural groups? CATEGORY S. SCREENING AND SAFTY ASSESSIMENT 5.1 Does the hospital uses a standardized instrument, with at least 3 questions, to screent of all charts in two or more out-out-out-out-out-out-out-out-out-out- | | 84 mo FU | 96 mo FU |
|--|--|-----------|-----------|
| | | n (%) | n (%) |
| | | 25 (93%) | 26 (96%) |
| | cultural groups? | 13 (48%) | 23 (85%) |
| Does the hospital use a standardized instrumen a) included, as a separate form, in the clinical reco b) incorporated as questions in the clinical record for what percentage of eligible patients have docu choice porated as questions in the clinical record for what percentage of eligible patients have docu choice porated as questions in clinical record for what percentage of eligible patients have docu choice porated as questions in clinical record for what percentage of eligible patients have docu choice porated as questions in clinical record for what percentage of eligible patients have docu choice porated as questions in clinical record for what percentage of eligible patients have docu choice state any clinical area)? a) also assess the safety of any children in the v yes, does this: a) also assess the safety of any children in the v foos the hospital use a standardized document foos the form include: a) also assess the safety of any children in the v foos the form include: a) also assess the safety of any children in the v foos the form include: a) information on the results of partner abuse s b) the victim's description of current and/or pasic) the set of map to document injurises? e) in | | | |
| a) included, as a separate form, in the clinical reco b) incorporated as questions in the clinical record fo d) incorporated as questions in clinical record fo What percentage of eligible patients have docu charts in any clinical area)? what percentage of eligible patients have docu charts in any clinical area)? standardized safety assessment performed yes, does this: a) also assess the safety of any children in the v is a standardized safety of any children in the v is a standardized safety of any children in the v is a standardized safety of any children in the v is a standardized safety of any children in the v is a standardized safety of any children in the v is a standardized safety of any children in the v is a standardized safety of any children in the v is a standardized bocument if yes, does the form include: a) information on the results of partner abuse s b) the victim's description of current and/or pasid information documenting the referrals providing in the case of Mãori, information documenting the referrals providing is a fully operational camera with adequate fi b) to hospital staff rocive on-going training on c) to hospital staff rocive on-going training on | Does the hospital use a standardized instrument, with at least 3 questions, to screen patients for partner abuse? If yes, | 27 (100%) | 27 (100%) |
| b) incorporated as questions in the clinical record for a concorporated as questions in clinical record for what percentage of eligible patients have docu charts in any clinical area)? what percentage of eligible patients have docu charts in any clinical area)? what percentage of eligible patients have docu charts in any clinical area)? what percentage of eligible patients have docu charts in any clinical area)? what percentage of eligible patients have docu charts in any clinical area)? what percentage of eligible patients have docu charts in any clinical area)? what percentage of eligible patients have docu charts in any clinical area)? what percentage of area)? si also assess the safety assessment performed yes, does this: a) also assess the safety of any children in the volutions: a) also assess the safety of any children in the volution of a any children in the volution of a bod volute are a standardized document if yes, does the form include: Does the hospital use a standardized document if yes, does the form include: a) information on the results of partner abuse s b) the victim's description of current and/or past c) the name of the alleged perpetrator and related and in the doce a) information document injuries? e) information document injuries? e) information document injuries? a) is a fully operational camera with adequate for and in the doce | clinical record? | 0 (0%) | 1 (4%) |
| c) incorporated as questions in the clinical record for What percentage of eligible patients have docu charts in any clinical area)? What percentage of eligible patients have docu charts in any clinical area)? Vector vector Is a standardized safety assessment performed yes, does this: a) also assess the safety of any children in the v If yes, does this: a) also assess the safety of any children in the v If yes, does this: a) also assess the safety of any children in the v If yes, does the form include: Does the hospital use a standardized document If yes, does the alleged perpetrator and relat of a body map to document injuries? a) information on the results of partner abuse s b) the victim's description of current and/or pas (c) the name of the alleged perpetrator and relat d) a body map to document injuries? e) information document injuries? a) is a fully operational camera with adequate for a boroging training on c) Do hospital staff receive on-going training on c) Do hospital staff routinely offer to photography | b) incorporated as questions in the clinical record for all charts in ED or other out-patient area? | 4 (15%) | 0 (0%) |
| d) incorporated as questions in clinical record for What percentage of eligible patients have docu charts in any clinical area)? What percentage of eligible patients have docu charts in any clinical area)? Vesting of the second for the second for the second second second second the second second second the second the second second second the second | c) incorporated as questions in the clinical record for all charts in two or more out-patient areas? | 16 (59%) | 17 (63%) |
| What percentage of eligible patients have docu charts in any clinical area)? charts in any clinical area)? Is a standardized safety assessment performed yes, does this: a) also assess the safety of any children in the v a) also assess the safety of any children in the v If yes, does this: a) also assess the safety of any children in the v b) the vocumental use a standardized document If yes, does the form include: a) information on the results of partner abuse s b) the victim's description of current and/or past c) the name of the alleged perpetrator and related d) a body map to document injuries? e) information documenting the referrals provited f) in the case of Māori, information documentin ls forensic photography incorporated in the doc a) is a fully operational camera with adequate fi b) Do hospital staff routinely offer to photograp c) Do hospital staff routinely offer to photograp | d) incorporated as questions in clinical record for all charts in out-patient and in-patient areas? | 7 (26%) | 9 (33%) |
| Is a standardized safety assessment performed yes, does this: a) also assess the safety of any children in the v a) also assess the safety of any children in the v EGORY 6. DOCUMENTATION Does the hospital use a standardized document If yes, does the form include: a) information on the results of partner abuse s b) the victim's description of current and/or pas c) the name of the alleged perpetrator and relai d) a body map to document injuries? b) the case of Māori, information documentin Is forensic photography incorporated in the doc a) is a fully operational camera with adequate fi b) Do hospital staff receive on-going training on c) Do hospital staff receive on-going training on | What percentage of eligible patients have documentation of partner abuse screening (based upon random sample of charts in any clinical area?? | | |
| Is a standardized safety assessment performed yes, does this: a) also assess the safety of any children in the v a) also assess the safety of any children in the v a) also assess the safety of any children in the v EGORY 6. DOCUMENTATION Does the hospital use a standardized document If yes, does the form include: a) information on the results of partner abuse s b) the victim's description of current and/or pas c) the name of the alleged perpetrator and relai d) a body map to document injuries? b) the victim's description of current and/or pas c) the name of the alleged perpetrator and relai d) a body map to document injuries? e) information documenting the referrals provit f) in the case of Mãori, information documentin Is forensic photography incorporated in the doc a) is a fully operational camera with adequate fi b) Do hospital staff receive on-going training on c) Do hospital staff routinely offer to photograp | Not done or not applicable | 5 (19%) | 0 (0%) |
| Is a standardized safety assessment performed yes, does this: a) also assess the safety of any children in the v a) also assess the safety of any children in the v a) also assess the safety of any children in the v EGORY 6. DOCUMENTATION Does the hospital use a standardized document If yes, does the form include: a) information on the results of partner abuse s b) the victim's description of current and/or pas c) the name of the alleged perpetrator and relai d) a body map to document injuries? b) the case of Māori, information documentin f) in the case of Māori, information documentin ls forensic photography incorporated in the doc a) Is a fully operational camera with adequate fi b) Do hospital staff receive on-going training on c) Do hospital staff routinely offer to photograp | 0% - 10% | 2 (8%) | 5 (18%) |
| Is a standardized safety assessment performed yes, does this: a) also assess the safety of any children in the v EGORY 6. DOCUMENTATION Does the hospital use a standardized document If yes, does the form include: a) information on the results of partner abuse s b) the victim's description of current and/or pas (c) the name of the alleged perpetrator and relation) a) body map to document injuries? (d) a body map to document injuries? (e) information documenting the referrals provic (f) in the case of Māori, information documentin Is forensic photography incorporated in the doc (a) Is a fully operational camera with adequate fi (b) Do hospital staff receive on-going training on (c) Do hospital staff routinely offer to photograp | 11% - 25% | 5 (19%) | 2 (8%) |
| Is a standardized safety assessment performed yes, does this: a) also assess the safety of any children in the v <u>reGORY 6. DOCUMENTATION</u> Does the hospital use a standardized document If yes, does the form include: a) information on the results of partner abuse s b) the victim's description of current and/or pas (c) the name of the alleged perpetrator and relai d) a body map to document injuries? (d) a body map to documenting the referrals provic f) in the case of Mãori, information documentin Is forensic photography incorporated in the doc a) Is a fully operational camera with adequate fi b) Do hospital staff receive on-going training on (c) Do hospital staff routinely offer to photograp | 26% - 50% | 9 (33%) | 11 (41%) |
| Is a standardized safety assessment performed yes, does this: a) also assess the safety of any children in the v EGORY 6. DOCUMENTATION Does the hospital use a standardized document If yes, does the form include: a) information on the results of partner abuse s b) the victim's description of current and/or pas c) the name of the alleged perpetrator and relai d) a body map to document injuries? d) a body map to document injuries? e) information documenting the referrals provic f) in the case of Mãori, information documentin Is forensic photography incorporated in the doc a) Is a fully operational camera with adequate fi b) Do hospital staff receive on-going training on c) Do hospital staff routinely offer to photograp | 51% - 75% | 6 (22%) | 6 (22%) |
| Is a standardized safety assessment performed yes, does this: a) also assess the safety of any children in the v IEGORY 6. DOCUMENTATION Does the hospital use a standardized document If yes, does the form include: a) information on the results of partner abuse s b) the victim's description of current and/or pas c) the name of the alleged perpetrator and relai d) a body map to document injuries? d) a body map to documenting the referrals provic f) in the case of Māori, information documentin Is forensic photography incorporated in the doc a) Is a fully operational camera with adequate fi b) Do hospital staff receive on-going training on c) Do hospital staff routinely offer to photograp | 76% - 100% | 0 (%) | 3 (11%) |
| a) also assess the safety of any children in the v IEGORY 6. DOCUMENTATION Does the hospital use a standardized document If yes, does the form include: a) information on the results of partner abuse s b) the victim's description of current and/or pas c) the name of the alleged perpetrator and relation d) a body map to document injuries? d) a body map to document injuries? e) information documenting the referrals proviting in the case of Māori, information documentin Is forensic photography incorporated in the docanal is a fully operational camera with adequate field to hospital staff receive on-going training on c) Do hospital staff routinely offer to photograp | erformed and discussed with victims who screen positive for partner abuse? If | 26 (96%) | 27 (100%) |
| EGORY 6. DOCUMENTATION Does the hospital use a standardized document If yes, does the form include: a) information on the results of partner abuse s b) the victim's description of current and/or pas c) the name of the alleged perpetrator and related) a body map to document injuries? d) a body map to document injuries? e) information documenting the referrals provicing in the case of Māori, information documenting the referrals provicing is forensic photography incorporated in the docted and is a fully operational camera with adequate for b) Do hospital staff receive on-going training on c) Do hospital staff routinely offer to photograph | n in the victim's care? | 26 (96%) | 27 (100%) |
| Does the hospital use a standardized document If yes, does the form include: a) information on the results of partner abuse s b) the victim's description of current and/or pas c) the name of the alleged perpetrator and relai d) a body map to document injuries? e) information documenting the referrals provic f) in the case of Māori, information documentin Is forensic photography incorporated in the doc a) Is a fully operational camera with adequate fi b) Do hospital staff receive on-going training on c) Do hospital staff routinely offer to photograp | | | |
| a) information on the results of partner abuse s b) the victim's description of current and/or paid) c) the name of the alleged perpetrator and relad) d) a body map to document injuries? e) information documenting the referrals provision the case of Mãori, information documentir f) in the case of Mãori, information documentir f) in the case of Mãori, information documentir a) is a fully operational camera with adequate f b) Do hospital staff receive on-going training or c) Do hospital staff routinely offer to photograph | documentation instrument to record known or suspected cases of partner abuse? | 27 (100%) | 26 (96%) |
| b) the victim's description of current and/or participation of the name of the alleged perpetrator and relain a body map to document injuries? d) a body map to document injuries? e) information documenting the referrals provision of the case of Māori, information documentin f) in the case of Māori, information documentin is forensic photography incorporated in the docimal is a fully operational camera with adequate f b) Do hospital staff receive on-going training or c) Do hospital staff routinely offer to photograph | er abuse screening? | 27 (100%) | 26 (96%) |
| c) the name of the alleged perpetrator and rela d) a body map to document injuries? e) information documenting the referrals provii f) in the case of Māori, information documentir f) in the case of Māori, information documentir a) is a fully operational camera with adequate f b) Do hospital staff receive on-going training or c) Do hospital staff routinely offer to photograph | nd/or past abuse? | 19 (70%) | 24 (89%) |
| d) a body map to document injuries? e) information documenting the referrals provi f) in the case of Māori, information documentir ls forensic photography incorporated in the doc a) Is a fully operational camera with adequate f b) Do hospital staff receive on-going training or c) Do hospital staff routinely offer to photograp | r and relationship to the victim? | 18 (67%) | 24 (89%) |
| e) information documenting the referrals provii f) in the case of Māori, information documentir ls forensic photography incorporated in the doc a) Is a fully operational camera with adequate f b) Do hospital staff receive on-going training or c) Do hospital staff routinely offer to photograp | | 21 (78%) | 23 (85%) |
| f) in the case of Māori, information documentir Is forensic photography incorporated in the doc a) Is a fully operational camera with adequate f b) Do hospital staff receive on-going training or c) Do hospital staff routinely offer to photograp | als provided to the victim? | 26 (96%) | 26 (96%) |
| | cumenting whether the individual was offered a Māori advocate? | 19 (70%) | 25 (93%) |
| a) Is a fully operational camera with adequate film averation b) Do hospital staff receive on-going training on the uclimation c) Do hospital staff routinely offer to photograph all is | in the documentation procedure? If yes: | | |
| b) Do hospital staff receive on-going training on the u c) Do hospital staff routinely offer to photograph all | dequate film available in the treatment area? | 25 (93%) | 25 (93%) |
| c) Do hospital staff routinely offer to photograph all | aining on the use of the camera? | 21 (78%) | 18 (67%) |
| | hotograph all abused patients with injuries? | 11 (41%) | 16 (59%) |
| d) Is a specific, unique consent-to-photograph form o | d) Is a specific, unique consent-to-photograph form obtained prior to photographing any injuries? | 22 (82%) | 21 (78%) |

| e) Do medical or nursing staff (not social work or a partner abuse advocate) photograph all injuries for medical documentation purposes, even if police obtain their own photographs for evidence purposes? CATEGORY 7. INTERVENTION SERVICES Catter a standard intervention checklist for staff to use/refer to when victims are identified? 7.1 Is three a standard intervention checklist for staff to use/refer to when victims are identified? 7.2 A trained victim advocate provides services growinde? If (ys. choose one a-b ond onswer c-d): 9.1 A trained victim advocate provides services all times. 1.2 A trained victim advocate is available on site to mabe growing and induction advocate is available on site of the programme? If yes, are there: 1.3 A trained victim advocate is available on site to mabe growing more than "a state for Mabor available onsite"? 1.3 Are mental health/psychological assessments performed within the context of the programme? If yes, are there: 1.4 Distribution provided Distribution advocate is available on site edd? 1.4 Distribution provided Distribution advocate is available on site edd? 1.3 Are mental health/psychological assessments performed within the context of the programme? If yes, are there: 1.3 Distribution provided Distribution advocate programme of for and provide patruer abuse programme? If yes, are there: | | "YES" responses | 84 mo FU | 96 mo FU |
|--|------|--|-----------|-----------|
| | | | n (%) | u (%) |
| | | e) Do medical or nursing staff (not social work or a partner abuse advocate) photograph all injuries for medical documentation purposes? | 22 (82%) | 17 (63%) |
| | CATE | GORY 7. INTERVENTION SERVICES | | |
| | 7.1 | Is there a standard intervention checklist for staff to use/refer to when victims are identified? | 26 (96%) | 27 (100%) |
| | 7.2 | Are on-site victim advocacy services provided? If yes, choose one a-b and answer c-d): | 26 (96%) | 27 (100%) |
| | | a) A trained victim advocate provides services during certain hours. | 7 (26%) | 4 (15%) |
| | | b) A trained victim advocate provides service at all times. | 19 (70%) | 23 (85%) |
| | | c) is a Māori advocate is available on-site for Māori victims? | 27 (100%) | 27 (100%) |
| | | d) is an advocate(s) of ethnic and cultural background other than Pakeha and Māori available onsite? | 24 (89%) | 26 (96%) |
| | 7.3 | Are mental health/psychological assessments performed within the context of the programme? If yes, are they: | 26 (96%) | 27 (100%) |
| | | a) available, when indicated? | 0 (0%) | 4 (15%) |
| | | b) performed routinely? | 26 (96%) | 23 (85%) |
| | 7.4 | ls transportation provided for victims, if needed? | 18 (67%) | 24 (89%) |
| | 7.5 | Does the hospital partner abuse programme include follow-up contact and counselling with victims after the initial | 19 (70%) | 26 (96%) |
| | | assessment? | | |
| | 7.6 | Does the hospital partner abuse programme offer and provide on-site legal options counselling for victims? | 23 (85%) | 27 (100%) |
| | 7.7 | Does the hospital partner abuse programme offer and provide partner abuse services for the children of victims? | 26 (96%) | 27 (100%) |
| and substance abuse screening and treatment: FEGORY 8. EVALUATION ACTIVITIES Are any formal evaluation procedures in place 1 a) Do evaluation activities include periodic mor b) Do evaluation activities include peer-to-peer Do health care providers receive standardized 1 Is there any measurement of client satisfaction Is a quality framework (such as Whanau Ora) uils a quality framework (such as Whanau Ora) uils collaboration with training? a i) collaboration with training? a i) collaboration on policy and procedure devisition iii) collaboration on policy and procedure devisition iii) collaboration on site service provision? | 7.8 | Is there evidence of coordination between the hospital partner abuse programme and sexual assault, mental health | 26 (96%) | 27 (100%) |
| ACOLATOR ACLIVILES Are any formal evaluation activities include periodic mor a) Do evaluation activities include peer-to-peer b) Do evaluation activities include peer-to-peer b) Do evaluation activities include peer-to-peer b) Do evaluation activities include peer-to-peer ls there any measurement of client satisfaction ls there any measurement of client satisfaction ls a quality framework (such as Whanau Ora) u Is a quality framework clue active standardized is a quality framework (such as Whanau Ora) u u Is a quality framework (such as Whanau Ora) u u Is a quality framework (such as Whanau Ora) u u Is a quality framework (such as Whanau Ora) u u Is a quality framework (such as Whanau Ora) u u Is a quality framework (such as Whanau Ora) u u Is a quality framework (such as Whanau Ora) u u Is a quality framework (such as Whanau Ora) u u Is a quality framework (such as Whanau Ora) u u Is a quality framework (such as Whanau Ora) u u Is a quality framework (such as Whanau Ora) u u Is a quality framework (such as Whanau Ora) u u Is a guality framework (such as Whanau Ora) u u Is a jo collaboration on policy and procedure | | and substance abuse screening and treatment? | | |
| Are any formal evaluation procedures in place 1 a) Do evaluation activities include periodic mor b) Do evaluation activities include peer-to-peer b) Do evaluation activities include peer-to-peer b) Do evaluation activities include peer-to-peer ls there any measurement of client satisfaction ls there any measurement of client satisfaction ls a quality framework (such as Whanau Ora) u IEGORY 9. COLLABORATION Does the hospital collaborate with local partnel a i) collaboration with training? ii) collaboration on policy and procedure devisit iii) collaboration on partner abuse working g iv) collaboration on site service provision? | CATE | | | |
| a) Do evaluation activities include periodic mor b) Do evaluation activities include peer-to-peer b) Do health care providers receive standardized 1 Is there any measurement of client satisfaction Is a quality framework (such as Whanau Ora) u Is a quality framework (such as Whanau Ora) u Is a quality framework (such as Whanau Ora) u Is a quality framework (such as Whanau Ora) u Is a quality framework (such as Whanau Ora) u Is a quality framework (such as Whanau Ora) u Is a quality framework (such as Whanau Ora) u Is a quality framework (such as Whanau Ora) u Is a quality framework (such as Whanau Ora) u Is a quality framework (such as Whanau Ora) u Is a quality framework (such as Whanau Ora) u Is a quality framework (such as Whanau Ora) u Is a quality framework (such as Whanau Ora) u Is a quality framework (such as Whanau Ora) u Is a quality framework (such as Whanau Ora) u | 8.1 | | 27 (100%) | 26 (96%) |
| b) Do evaluation activities include peer-to-peer Do health care providers receive standardized 1 Do health care providers receive standardized 1 Is there any measurement of client satisfaction Is a quality framework (such as Whanau Ora) u Is a quality framework (such as Whanau Ora) u Is a quality framework (such as Whanau Ora) u Is a quality framework (such as Whanau Ora) u Is a quality framework (such as Whanau Ora) u Is a quality framework (such as Whanau Ora) u Is a quality framework (such as Whanau Ora) u Is a quality framework (such as Whanau Ora) u Is a quality framework (such as Whanau Ora) u Is a quality framework (such as Whanau Ora) u Is a quality framework (such as Whanau Ora) u Is a quality framework (such as Whanau Ora) u Is a quality framework (such as Whanau Ora) u Is a quality framework (such as Whanau Ora) u | | a) Do evaluation activities include periodic monitoring of charts to audit for partner abuse screening? | 22 (82%) | 27 (100%) |
| Do health care providers receive standardized 1 Is there any measurement of client satisfaction Is a quality framework (such as Whanau Ora) u: Is a quality framework client satisfaction Is a quality framework (such as Whanau Ora) u: Is a quality framework (such as Whanau Ora) u: Is a quality framework (such as Whanau Ora) u: Is a guality framework (such as Whanau Ora) u: Is a guality framework (such as Whanau Ora) u: Is a guality framework (such as Whanau Ora) u: Is a guality framework (such as Whanau Ora) u: Is a guality framework (such as Whanau Ora) u: Is a guality framework (such as Whanau Ora) u: Is a guality framework (such as Whanau Ora) u: Is a journal on such a training? ii) collaboration on policy and procedure devisition giv) collaboration on site service provision? | | b) Do evaluation activities include peer-to-peer case reviews around partner abuse? | 23 (85%) | 26 (96%) |
| Is there any measurement of client satisfaction Is a quality framework (such as Whanau Ora) u: IEGORY 9. COLLABORATION Does the hospital collaborate with local partne a i) collaboration with training? ii) collaboration on policy and procedure dev iii) collaboration on partner abuse working g iv) collaboration on site service provision? | 8.2 | | 15 (56%) | 22 (82%) |
| 8.4 Is a quality framework (such as Whanau Ora) used to evaluate whether services are effective for Māori? CATEGORY 9. COLLABORATION Does the hospital collaborate with local partner abuse programmes? If yes, 1 Does the hospital collaboration with training? i) collaboration on policy and procedure development? ii) collaboration on partner abuse working group? iv) collaboration on site service provision? | 8.3 | | 17 (63%) | 21 (78%) |
| CATEGORY 9. COLLABORATION 9.1 Does the hospital collaborate with local partner abuse programmes? If yes, a i) collaboration with training? ii) collaboration on policy and procedure development? iii) collaboration on partner abuse working group? iii) collaboration on site service provision? iv) collaboration on site service provision? | 8.4 | Is a quality framework (such as Whanau Ora) used to evaluate whether services are effective for Māori? | 10 (37%) | 10 (37%) |
| | CATE | GORY 9. COLLABORATION | | |
| | 9.1 | Does the hospital collaborate with local partner abuse programmes? If yes, | 27 (100%) | 27 (100%) |
| ii) collaboration on policy and procedure development? iii) collaboration on partner abuse working group? iv) collaboration on site service provision? | | | 26 (96%) | 26 (96%) |
| iii) collaboration on partner abuse working group? iv) collaboration on site service provision? | | ii) collaboration on policy and procedure development? | 27 (100%) | 27 (100%) |
| iv) collaboration on site service provision? | | iii) collaboration on partner abuse working group? | 25 (93%) | 25 (93%) |
| | | iv) collaboration on site service provision? | 26 (96%) | 27 (100%) |

| | TES' responses | n (%) | n (%) |
|-----|---|-----------|-----------|
| | b) is collaboration with | | |
| I | i) Māori provider(s) or representative(s)? | 27 (100%) | 27 (100%) |
| | iii) Provider(s) or representative(s) for ethnic or cultural groups other than Pakeha or Māori? | 24 (89%) | 25 (93%) |
| 9.2 | Does the hospital collaborate with local police and courts in conjunction with their partner abuse programme? If yes: | 27 (100%) | 27 (100%) |
| | a) collaboration with training? | 25 (93%) | 26 (96%) |
| | b) collaboration on policy and procedure development? | 27 (100%) | 27 (100%) |
| | c) collaboration on partner abuse working group? | 24 (89%) | 25 (93%) |
| 9.3 | ls there collaboration with the partner abuse programme of other health care facilities? If yes, which types of collaboration apply: | 27 (100%) | 27 (100%) |
| 1 | a) within the same health care system? | 27 (100%) | 27 (100%) |
| | lf yes, with a Māori health unit? | 27 (100%) | 26 (96%) |
| | b) with other systems in the region? | 27 (100%) | 27 (100%) |
| | lf yes, with a Māori health provider? | 26 (96%) | 26 (96%) |

| | | | | Median | | | | | | Hospitals , | Hospitals Achieving Target Score ≥70 | rget Score ≥ | 70 | |
|-------------------------|------|------------------------|-----------------|----------------|------------------------|-----------------|--------------|---------|-----------------|--------------|--------------------------------------|-----------------|-----------|----------------|
| | B | F ₁₂ | F ₃₀ | $F_{48}^{\ a}$ | F ₆₀ | F ₈₄ | F_{96}^{c} | B | F ₁₂ | F_{30}^{b} | $F_{48}^{\ a}$ | F ₆₀ | F_{84} | ا ر الم |
| Overall Score | 36.7 | 50.8 | 59.3 | 74.5 | 80.9 | 86.5 | 90.8 | 2 (8%) | 3 (12%) | 4 (15%) | 17 (65%) | 21 (78%) | 25 (93%) | 27 (100%) |
| Domain Scores | | | | | | | | | | | | | | |
| Policies and Procedures | 42.5 | 50.0 | 59.7 | 81.0 | 84.0 | 92.0 | 95.0 | 3 (12%) | 5 (20%) | 8 (29%) | 23 (89%) | 19 (70%) | 26 (96%) | 27 (100%) |
| Safety & Security | I. | 1 | 1 | 77.0 | 72.0 | 82.0 | 90.0 | i. | 1 | 1 | 17 (65%) | 17 (63%) | 23 (85%) | 27 (100%) |
| Collaboration | 46.5 | 70.8 | 85.4 | 82.5 | 91.0 | 94.0 | 97.0 | 5 (20%) | 15 (60%) | 20 (74%) | 21 (81%) | 25 (93%) | 26 (96%) | 27 (100%) |
| Institutional Culture | 41.5 | 43.4 | 56.6 | 80.0 | 82.0 | 86.0 | 90.0 | 3 (12%) | 5 (20%) | 6 (22%) | 18 (69%) | 20 (74%) | 25 (93%) | 27 (100%) |
| Training of Providers | 39.7 | 49.4 | 66.7 | 92.5 | 96.0 | 98.0 | 100.0 | 2 (8%) | 9 (36%) | 14 (52%) | 19 (73%) | 22 (82%) | 26 (96%) | 27 (100%) |
| Intervention Services | 65.4 | 70.4 | 72.8 | 82.0 | 84.0 | 89.0 | 92.0 | 12(48%) | 13 (52%) | 15 (56%) | 21 (81%) | 22 (82%) | 27 (100%) | 27 (100%) |
| Documentation | 19.0 | 28.6 | 58.4 | 83.5 | 83.0 | 87.0 | 93.0 | 5 (20%) | 5 (20%) | 8 (29%) | 22 (85%) | 19 (70%) | 22 (82%) | 24 (89%) |
| Evaluation Activities | 35.1 | 36.6 | 36.6 | 29.8 | 58.5 | 72.0 | 75.5 | 1 (4%) | 1 (4%) | 5 (19%) | 3 (12%) | 7 (26%) | 14 (52%) | 18 (67%) |
| Physical Environment | 23.0 | 28.0 | 35.6 | 68.0 | 91.0 | 100.0 | 100.0 | 1 (4%) | 2 (5%) | 2 (7%) | 12 (46%) | 26 (96%) | 27 (100%) | 27 (100%) |
| | | | | | | | | | | | | | | |

follow-up; 70 is selected benchmark score;^a Change to Revised Delphi tool;^b 30 month follow-up percentages corrected;^c change to imputing self audit scores -96 month follow-up scores include external scores (n=13 hospitals) and self audit scores (n=14 hospitals). Notes: **B** = Baseline; F_{12} = 12 month follow-up; F_{30} = 30 month follow-up; F_{48} = 48 month follow-up; F_{60} = 60 month follow-up; F_{24} = 84 month follow-up; F_{36} = 96 month

96 Month Follow-up Audit Report

APPENDIX J: Revised Child Abuse and Neglect Delphi Tool Item Analysis

Note: 96 month follow-up scores include external scores (n=13 hospitals) and self audit scores (n=14 hospitals).

| | וערבי הת וותוונו ותוות אים בתרבי וורומתב בערבונום פרתו בא נוו-דה וותפארים פאות פרתו בה וותפארים איום אים שנות פר | | |
|-----|--|-------------------|-------------------|
| | "YES" responses | 84 mo FU n (%) | 96 mo FU n (%) |
| CA | CATEGORY 1. POLICIES AND PROCEDURES | for 1 m | fort :: |
| 1.1 | Are there official, written DHB policies regarding the clinical assessment, appropriate questioning, and treatment of suspected abused and neglected children? If so, do the policies: | 26 (96%) | 27 (100%) |
| | a) Define child abuse and neglect? | 27 (100%) | 27 (100%) |
| | b) Mandate training on child abuse and neglect for staff? | 26 (96%) | 25 (93%) |
| | c) Outline age-appropriate protocols for risk assessment? | 20 (74%) | 23 (85%) |
| | d) Define who is responsible for risk assessment? | 27 (100%) | 27 (100%) |
| | e) Address the issue of contamination during interviewing? | 24 (89%) | 24 (89%) |
| | f) Address documentation? | 27 (100%) | 27 (100%) |
| | g) Address referrals for children and their families? | 27 (100%) | 27 (100%) |
| | h) Address child protection reporting requirements? | 27 (100%) | 27 (100%) |
| | i) Address the responsibilities to, and needs of, Māori? | 27 (100%) | 27 (100%) |
| | j) Address other cultural and/or ethnic groups? | 27 (100%) | 26 (96%) |
| 1.2 | Who is consulted regarding child protection policies and procedures? | | |
| | Maori and Pacific? | 26 (96%) | 27 (100%) |
| | CYF? | 27 (100%) | 27 (100%) |
| | Police? | 24 (89%) | 27 (100%) |
| | Child abuse and neglect programme and Violence Intervention Programme staff? | 27 (100%) | 27 (100%) |
| | Plus Other Agencies: such as Refuge; National Network of Stopping Violence Services (NNSVS); Office of the Children's Commissioner (OCC); Community Alcohol & Drug Service (CADS) | 25 (93%) | 27 (100%) |
| 1.3 | Is there evidence of a DHB-based child abuse and neglect steering group? If yes, does the: | | |
| | a) Steering group meet at least every three (3) months? | 25 (93%) | 26 (97%) |
| | b) Include representatives from more than two departments? | 26 (96%) | 27 (100%) |
| 1.4 | Does the DHB provide direct financial support for the child abuse and neglect programme (beyond VIP funding)? | 25 (93%) | 24 (89%) |
| | e) Is funding set aside specifically for Māori programmes and initiatives? | 13 (48%) | 19 (70%) |
| 1.5 | Is there a policy for identifying signs and symptoms of child abuse and neglect and for identifying children at high risk? d) in both inpatient and outpatient areas? | 27 (100%) | 27 (100%) |
|] | | | |

| | "YES" responses | 84 mo FU | 96 mo FU |
|--------|--|-----------|-----------|
| | | n (%) | n (%) |
| 1.6 | Are there procedures for security measures to be taken when suspected cases of child abuse and neglect are identified and the child is perceived to be at immediate risk? If yes, are the procedures: | | |
| | a) written? | 27 (100%) | 27 (100%) |
| | b) include name/phone block? | 17 (63%) | 21 (78%) |
| | c) provide for safe transportation? | 19 (70%) | 20 (74%) |
| | d) account for the needs of Māori? | 16 (59%) | 23 (85%) |
| 1.7 | Is there an identifiable child protection coordinator at the DHB? If yes, is the coordinator position (choose one): | 26 (96%) | 27 (100%) |
| | a) part-time <0.5 FTE | 1 (%4) | 1 (%4) |
| | a) part-time >0.5 FTE? | 13 (48%) | 8 (%67) |
| | b) full-time? | 12 (44%) | 18 (67%) |
| 1.8 | Are there policies that outline the minimum expectation for all staff: | | |
| | a) to attend mandatory training? | (%96) 97 | 52 (93%) |
| | b) to identification and referral children at risk? | 27 (100%) | 27 (100%) |
| | c) to reporting child protection concerns? | 52 (93%) | 27 (100%) |
| 1.9 | Do the child abuse and neglect policies and procedures indicate collaboration with government agencies and other | | |
| | relevant groups, such as the Police, CYF, refuge, and NNSVS ('men's programme provider')? | | |
| | a) government agencies? | 27 (100%) | 27 (100%) |
| | b) community groups? | 26 (96%) | 27 (100%) |
| 1.10 | Are the DHB policies and procedures easily accessible and user-friendly? If yes, are | 27 (100%) | 27 (100%) |
| | a) they available on the DHB intranet? | 27 (100%) | 27 (100%) |
| | b) there supporting and reference documents appended to the appropriate policies and procedures? | 27 (100%) | 27 (100%) |
| | c) there translation materials to facilitate the application of policy and procedures, such as flowcharts and algorithms? | 27 (100%) | 27 (100%) |
| 1.11 | Are the DHB policies and procedures cross-referenced to other forms of family violence, such as partner abuse and | 26 (96%) | 26 (96%) |
| CAT | CATEGORY 2. SAFETY & SECURITY | | |
| 2.1 | Does the DHB have a policy in place that all children are assessed when signs and symptoms are suggestive of abuse | 25 (93%) | 27 (100%) |
| r r | diu/Of inegred.r Door the DUD have a arctional for collaborative cafative alonging for childron at high vick2 | | |
| 7.7 | | | |
| | a) are safety plans available of used for children identified at risk? Which types of collaboration apply: | 26 (96%) | 27 (100%) |
| | b) within the DHB? | 27 (100%) | 27 (100%) |
| | c) with other groups and agencies in the region? | (%96) 97 | 27 (100%) |
| | | | |

| d Pacific hackth providers? 1 (14) d Pacific hackth providers? 24 (189%) evant ettic/cultural groups? 24 (189%) ry healt steror? 24 (189%) we a protocol to promote the safety of children identified at risk of abuse or neglect? 21 (14.%) B? 21 (14.%) primary health care providers as part of discharge planning? 27 (100%) primary health care providers as part of discharge planning? 22 (10.%) primary health care providers as part of discharge planning? 22 (10.%) ecessary support services for the child and family to promote ongoing safety of the child? 22 (10.%) itiles have a a curtry plan where people at risk of perpetrating abuse, or who have a protection order 25 (10.%) itiles have a setting 23 (10.%) 23 (10.%) itiles have an alert system or a central database recording any concerns about children at risk of abuse 23 (10.%) itiles have a setting 25 (10.%) 23 (10.%) itile art system or a central database recording any concerns about children at risk of abuse 23 (10.%) itile art system or a central database recording any concerns about children at risk of abuse 23 (10.%) itile art system 23 (10.%) 23 (10.%) itile art system | | "YES" responses | 84 mo FU | 96 mo FU |
|---|-----|--|-----------|------------|
| 0 with Máori and Pacific health providers? 24 (89%) 11 (41%) 0 with Máori and Pacific health providers? 22 (82%) 11 (41%) 0 with the primary health sectors 27 (100%) 27 (100%) 27 (100%) 0 with the DHave a protocol to promote the safety of children identified at risk of abuse or neglect? 27 (100%) 27 (100%) 1 with the DHB 27 (100%) 12 (44%) 27 (100%) 21 (44%) 1 built relevant primary health care providers as part of discharge planing? 27 (100%) 21 (44%) 22 (82%) 1 built relevant primary health care providers as part of discharge planing? 22 (93%) 22 (93%) 23 (93%) 1 built relifies have a security plan where people at risk of prove more about children at risk of abuse 23 (93%) 23 (93%) 1 bi olocal alert system in acute care setting 23 (93%) 24 (93%) 25 (93%) 1 al neglect in place? 1 24 (94%) 23 (93%) 26 (93%) 1 al neglect in place? 1 21 (93%) 21 (93%) 21 (93%) 21 (93%) 1 al neglect in place? 1 1 21 (93%) | | - | u (%) | u (%) |
| b with other relevant ethnic/cultural groups? 22 (82%) 1 with the primary health sector? 21 (10%) 0 bott the primary health sector? 27 (100%) 1 with the primary health sector? 27 (100%) 1 with the primary health sector? 27 (100%) 2 with the DHS 22 (82%) 1 with the DHS 22 (82%) 2 10 with relevant primary health care providers as part of discharge planning? 22 (82%) 2 10 with relevant primary health care providers as part of discharge planning? 22 (82%) 2 10 with relevant primary health care providers as part of discharge planning? 23 (82%) 2 10 with relevant primary health care providers as part of discharge planning? 23 (82%) 2 10 with relevant primary health care providers as part of discharge planning? 23 (83%) 2 10 othe DHB services flave an alert system or a central database recording any concerns about children at risk of abuse 26 (93%) 2 10 process for notification of alert placements to relevant providers 26 (93%) 26 (93%) 10 al process for notification of alert system 28 (30%) 18 (57%) 26 (93%) 10 al p | | d) with Māori and Pacific health providers? | 24 (89%) | 27 (100%) |
| (huth the primary health sector) 11(41%) Does the DHB have a protocol to promote the safety of children identified at risk of abuse or neglect? 21(10%) Does the DHB have a protocol to promote the safety of children identified at risk of abuse or neglect? 21(10%) Dub the leveant primary health care providers as part of discharge planning? 12(43%) 21(43%) Dub the leveant primary reating care providers as part of discharge planning? 21(43%) 25(33%) Dup the DHB services for the child and family to promote ongoing safety of the child? 25(33%) 25(33%) Dup the DHB services for an alter system or a central database recording any concerns about children at risk of abuse 25(33%) 26(33%) Database the DHB services for the child of PHO 13 alter system in cancer care setting 26(33%) 26(33%) Database for alter system in acture care setting 13 altors 26(33%) 26(33%) 26(33%) Database for alter system in acture care setting 13 and robuses for notification of alter placements to relevant providers 26(33%) 26(33%) 26(33%) Database for alter system in acture care setting 13 and robuses for notification of alter placements to relevant providers 26(33%) 26(33%) Database for alter system 13 and robuses for notiling inplace 27(100%) | | e) with other relevant ethnic/cultural groups? | 22 (82%) | 24 (89%) |
| Does the DHB have a protocol to promote the safety of children identified at risk of abuse or neglect? 27 (300%) 1 within the DHB? 27 (300%) 27 (300%) 1 within the DHB? 12 (44%) 12 (44%) 2 (1) with relevant primary rearrises for the child and family to promote ongoing safety of the child? 23 (33%) 2 (1) with relevant primary repricts a providers as part of discipates planning? 23 (33%) 23 (33%) 2 (1) with relevant primary repricts for the child and family to promote ongoing safety of the child? 25 (33%) 25 (33%) 2 (1) with relevant providers as part of discipates recording any concerns about children at risk of abuse 23 (30%) 23 (30%) 2 (1) a local alert system in acute care setting 1 alot system in acute care setting 25 (33%) 26 (30%) 2 (1) a local alert system in acute care setting 1 alot system 25 (33%) 26 (30%) 2 (1) a local alert system in community setting, including PHO 26 (30%) 26 (30%) 26 (30%) 2 (1) a local alert system in contribution a left system 26 (30%) 26 (30%) 27 (30%) 2 (1) a local alert system in contribution a left system 26 (30%) 27 (30%) 27 (30%) 2 (1) a local alert system 26 | | f) with the primary health sector? | 11 (41%) | 21 (78%) |
| a) within the DHB?27 (100%)1b) with relevant primary health care providers as part of discharge planning?27 (100%)12 (43%)b) with relevant primary health care providers as part of discharge planning?12 (43%)12 (43%)b) with relevant primary health care providers as part of discharge planning?23 (93%)23 (93%)b) nipatient facilities have an alert system or a central database recording any concerns about children at risk of abuse25 (93%)25 (93%)gainst them. can be denied entry?25 (93%)26 (93%)28 (93%)28 (93%)b) a local alert system in acute care setting13 nocess for notification of alert platements to relevant providers28 (93%)28 (93%)b) a local alert system in acute care setting13 nocess for notification of alert platements to relevant providers28 (93%)28 (93%)c) a local alert system in acute care setting10 a process for notification of alert platements to relevant providers28 (93%)28 (93%)c) a local alert system10 a process for notification of alert platements to relevant providers28 (93%)28 (93%)f) a process for notification of alert platements to relevant providers28 (93%)28 (93%)28 (93%)f) a process for notification of alert platements to relevant providers28 (93%)28 (93%)28 (93%)f) a process for notification of alert system18 (67%)28 (93%)28 (93%)28 (93%)f) a process for notification of alert system28 (93%)28 (93%)28 (93%)28 (93%)f) a process for notification of alert system28 (93%) </td <td>2.3</td> <td></td> <td></td> <td></td> | 2.3 | | | |
| b) with relevant primary health care providers as part of discharge planning?12 (44%)1210 by accessing necessary support services for the child and family to promote orgoing safety of the child?22 (82%)22 (82%)10 by accessing necessary support services for the child and family to promote orgoing safety of the child?25 (93%)25 (93%)11 by additing the an a be denied entry?26 (93%)26 (93%)26 (93%)26 (93%)12 by all costal elert system or a central database recording any concerns about children at risk of abuse25 (93%)26 (93%)26 (93%)12 by a local alert system in community setting, including PHO10 a local alert system28 (93%)26 (93%)26 (93%)26 (93%)13 a local alert system in community setting, including PHO10 a local alert system28 (93%)26 (9 | | a) within the DHB? | 27 (100%) | 27 (100%) |
| () by accessing necessary support services for the child and family to promote ongoing safety of the child? 22 (82%) Do inpatient facilities have a security plan where people at risk of perpetrating abuse, or who have a protection order 25 (93%) Do inpatient facilities have a security plan where people at risk of perpetrating abuse, or who have a protection order 25 (93%) Do inpatient facilities have a security plan where people at risk of perpetrating any concerns about children at risk of abuse 25 (93%) Do integlect in place? 13 alocal alert system in acute care setting 25 (93%) D a colal alert system in community setting, including PHO 8 (30%) 18 (67%) D a local alert system in community setting, including PHO 18 (67%) 26 (96%) D a process for notification of alert placements to relevant providers 8 (30%) 18 (67%) D a process for notification of alert placements to relevant providers 8 (30%) 18 (67%) D a process for notification of alert placements to relevant providers 18 (67%) 26 (96%) 26 (96%) D a process for notification of the risk assessed for these children? 13 (48%) 27 (100%) 26 (96%) D process that notloder stask force? D which types of collaborate with training? 27 (100%) 27 (100%) D socess that notloder stask force? < | | b) with relevant primary health care providers as part of discharge planning? | 12 (44%) | 19 (70%) |
| Do inpatient facilities have a security plan where people at risk of perpertating abuse, or who have a protection order aginost them, can be denied entry? 25 (93%) Do inpetent facilities have a security plan where people at risk of perpertating any concerns about children at risk of abuse and negled services have an alert system or a central database recording any concerns about children at risk of abuse and negled services have an alert system or a central database recording any concerns about children at risk of abuse and negled services have an alert system or a central database recording any concerns about children at risk of abuse and negled services have an alert system in community setting, including PHO 25 (93%) 25 (93%) 25 (93%) 26 (95%) 27 (100%) 28 (30%)< | | | 22 (82%) | 27 (100%) |
| Do the DHB services have an alert system or a central database recording any concerns about children at risk of abuse and neglect in place? 25 (93%) and neglect in place? 25 (93%) b) a local alert system in acute care setting 25 (93%) c) a local alert system in acute care setting 25 (93%) c) a local alert system in acute care setting 8 (30%) c) a brocess for notification of alert placements to relevant providers 8 (30%) d) a process for notification of alert system 8 (30%) f) clear criteria for identifying levels of risk, and process that guides the use of the alert system 8 (30%) f) clear criteria for identifying levels of risk, and process that guides the use of the alert system 8 (30%) f) clear criteria for identifying levels of risk, and process that guides the use of the alert system 27 (100%) a) process that includes the safety of other children in the home are considered? 27 (100%) b) process for notifying CYF and/or other agencies? 27 (100%) c) referral form that requires the documentation of the risk assessed for these children? 27 (100%) d) a which types of collaborate with CYF and NGC child advocacy and protection? 27 (100%) o) a which types of collaborate with CYF and NGC child advocacy and protection? 27 (100%) i) collaboration on policy and proce | 2.4 | Do inpatient facilities have a security plan where people at risk of perpetrating abuse, or who have a protection order against them, can be denied entry? | 25 (93%) | 27 (100%) |
| and neglect in place?25 (93%)b) a local alert system in acute care setting25 (93%)b) a local alert system in acute care setting25 (93%)c) a local alert system in community setting, including PHO8 (30%)d) a process for notification of alert placements to relevant providers8 (30%)d) a process for notification of alert system18 (67%)d) a process for notification in a national alert system8 (30%)f) clear criteria for identifying levels of risk, and process that guides the use of the alert system18 (67%)f) clear criteria for identifying levels of risk, and process to assess or refer to CYF and/or other appropriate agencies all children27 (100%)a) process that includes the safety of other children in the home are considered?21 (100%)b) process for notifying CYF and/or other agencies?26 (96%)27 (100%)c) cleferral form that requires the documentation of the risk assessed for these children?27 (100%)27 (100%)f) clognoration apply:10 caleborate with CYF and NGO child advocacy and protection?27 (100%)27 (100%)i) collaboration with training?10 collaboration apply:27 (100%)27 (100%)ii) collaboration on policy and procedure development?27 (100%)27 (100%)27 (100%)ii) collaboration on policy and procedure development?27 (100%)27 (100%)27 (100%)ii) collaboration on policy and procedure development?27 (100%)27 (100%)27 (100%)ii) collaboration on site service provision?27 (100%)27 (100%)27 (100%)ii) collaboration | 2.5 | | | |
| b) a local alert system in acute care setting25 (33%)c) a local alert system in community setting, including PHO8 (30%)c) a local alert system in community setting, including PHO8 (30%)d) a process for notification of alert placements to relevant providers18 (67%)e) participation in a national alert system18 (57%)f) clear criteria for identifying levels of risk, and process that guides the use of the alert system18 (57%)f) clear criteria for identifying levels of risk, and process that guides the use of the alert system27 (100%)f) clear criteria for interval of other children in the home are considered?27 (100%)a) process that includes the safety of other children in the home are considered?26 (96%)b) process for notifying CYF and/or other agencies?26 (96%)c) referral form that requires the documentation of the risk assessed for these children?13 (48%)f) referral form that requires the documentation of the risk assessed for these children?27 (100%)f) referral form that requires the documentation of the risk assessed for these children?27 (100%)f) referral form that requires the documentation of the risk assessed for these children?27 (100%)f) referral form that requires the documentation of the risk assessed for these children?27 (100%)f) referral form that requires the documentation of the risk assessed for these children?27 (100%)i) rollaboration on thild abuse and neglect task force?27 (100%)ii) collaboration on thild abuse and neglect task force?27 (100%)iii) collaboration on thild abuse and neglect task force? <td></td> <td>and neglect in place?</td> <td></td> <td></td> | | and neglect in place? | | |
| c) a local alert system in community setting, including PHO8 (30%)8 (30%)18 (67%)< | | b) a local alert system in acute care setting | 25 (93%) | 24 (89%) |
| d) a process for notification of alert placements to relevant providers18 (67%)18 (67%)e) participation in a national alert system8 (30%)18 (67%)f) clear criteria for identifying levels of risk, and process that guides the use of the alert system18 (67%)18 (67%)f) clear criteria for identifying levels of risk, and process that guides the use of the alert system18 (67%)18 (67%)f) clear criteria for identifying levels of risk, and process to assess or refer to CYF and/or other appropriate agencies all children27 (100%)a) process that includes the safety of other children in the home are considered?27 (100%)26 (96%)b) process for notifying CYF and/or other agencies?23 (100%)27 (100%)c) referral form that requires the documentation of the risk assessed for these children?21 (100%)27 (100%)Does the DHB collaborate with CYF and NGO child advocacy and protection?27 (100%)27 (100%)27 (100%)i) collaboration apply:i) collaboration apply:27 (100%)27 (100%)27 (100%)ii) collaboration on policy and procedure development?ii) collaboration on site service provision?27 (100%)iii) collaboration on site service provision?27 (100%)27 (100%)27 (100%)v) collaboration is two-way?27 (100%)27 (100%)27 (100%) | | c) a local alert system in community setting, including PHO | 8 (30%) | 9 (%72) |
| e) participation in a national alert system8 (30%)f) clear criteria for identifying levels of risk, and process that guides the use of the alert system8 (30%)f) clear criteria for identifying levels of risk, and process to assess or refer to CYF and/or other appropriate agencies all children18 (67%)ls there evidence in protocols of processes to assess or refer to CYF and/or other appropriate agencies all children28 (67%)a) process that includes the safety of other children in the home are considered?27 (100%)b) process that includes the safety of other children in the home are considered?26 (96%)c) referral form that requires the documentation of the risk assessed for these children?13 (48%)D) process for notifying CYF and/Or other agencies?27 (100%)mathematical form that requires the documentation of the risk assessed for these children?27 (100%)mathematical form apply:10 collaborate with CYF and NGO child advocacy and protection?27 (100%)mathematical form with training?27 (100%)27 (100%)i) collaboration on policy and procedure development?27 (100%)27 (100%)ii) collaboration on policy and procedure development?27 (100%)27 (100%)iii) collaboration on site service provision?27 (100%)27 (100%)iv) collaboration on site service provision?27 (100%)27 (100%)v) collaboration is two-way?27 (100%)27 (100%) | | d) a process for notification of alert placements to relevant providers | 18 (67%) | 15 (56%) |
| f) clear criteria for identifying levels of risk, and process that guides the use of the alert system18 (67%) <th< td=""><td></td><td>e) participation in a national alert system</td><td>8 (30%)</td><td>13 (48%)</td></th<> | | e) participation in a national alert system | 8 (30%) | 13 (48%) |
| Is there evidence in protocols of processes to assess or refer to CYF and/or other appropriate agencies all children1a) process that includes the safety of other children in the home are considered?27 (100%)27 (100%)b) process for notifying CYF and/or other agencies?26 (96%)26 (96%)26 (96%)b) process for notifying CYF and/or other agencies?13 (48%)13 (48%)26 (96%)26 (96%)c) referral form that requires the documentation of the risk assessed for these children?13 (48%)26 (96%)27 (100%)Does the DHB collaborate with CYF and NGO child advocacy and protection?20 (100%)27 (100%)27 (100%)a) which types of collaboration apply:i) collaboration with training?27 (100%)27 (100%)27 (100%)ii) collaboration on policy and procedure development?ii) collaboration on policy and neglect task force?27 (100%)27 (100%)27 (100%)iii) collaboration on site service provision?27 (100%)27 (100%)27 (100%)27 (100%)v) collaboration on site service provision?27 (100%)27 (100%)27 (100%) | | | 18 (67%) | 18 (67%) |
| a) process that includes the safety of other children in the home are considered?27 (100%)27 (100%)b) process for notifying CYF and/or other agencies?26 (96%)26 (96%)26 (96%)c) referral form that requires the documentation of the risk assessed for these children?13 (48%)26 (96%)27 (100%)c) referral form that requires the documentation of the risk assessed for these children?27 (100%)27 (100%)27 (100%)modes the DHB collaborate with CYF and NGO child advocacy and protection?20 (100%)27 (100%)27 (100%)27 (100%)n) which types of collaboration apply:i) collaboration with training?27 (100%)27 (100%)27 (100%)27 (100%)ii) collaboration on policy and procedure development?ii) collaboration on child abuse and neglect task force?27 (100%)27 (100%)27 (100%)iii) collaboration on site service provision?iv) collaboration on site service provision?27 (100%)27 (100%)27 (100%)v) collaboration is two-way?iv) collaboration is two-way?27 (100%)27 (100%)27 (100%) | 2.6 | Is there evidence in protocols of processes to assess or refer to CYF and/or other appropriate agencies all children | | |
| b) process for notifying CYF and/or other agencies?26 (96%)27 (100%) <td></td> <td>a) process that includes the safety of other children in the home are considered?</td> <td>27 (100%)</td> <td>(%96) 92</td> | | a) process that includes the safety of other children in the home are considered? | 27 (100%) | (%96) 92 |
| c) referral form that requires the documentation of the risk assessed for these children?13 (48%) CATEGORY 3. COLLABORATION 13 (48%) CATEGORY 3. COLLABORATION 27 (100%)Does the DHB collaborate with CYF and NGO child advocacy and protection?27 (100%)a) which types of collaboration apply:27 (100%)i) collaboration with training?27 (100%)ii) collaboration on policy and procedure development?27 (100%)iii) collaboration on child abuse and neglect task force?27 (100%)iv) collaboration on site service provision?27 (100%)v) collaboration is two-way?27 (100%) | | b) process for notifying CYF and/or other agencies? | 26 (96%) | 26 (96%) |
| CATEGORY 3. COLLABORATION27 (100%)Does the DHB collaborate with CYF and NGO child advocacy and protection?27 (100%)a) which types of collaboration apply:27 (100%)i) collaboration with training?27 (100%)ii) collaboration on policy and procedure development?27 (100%)iii) collaboration on child abuse and neglect task force?27 (100%)iv) collaboration on site service provision?27 (100%)v) collaboration is two-way?27 (100%) | | c) referral form that requires the documentation of the risk assessed for these children? | 13 (48%) | 19 (70.4%) |
| Does the DHB collaborate with CYF and NGO child advocacy and protection? $27 (100\%)$ $27 (100\%)$ a) which types of collaboration apply: $27 (100\%)$ $27 (100\%)$ i) collaboration with training? $27 (100\%)$ $27 (100\%)$ ii) collaboration on policy and procedure development? $27 (100\%)$ $27 (100\%)$ iii) collaboration on child abuse and neglect task force? $27 (100\%)$ $27 (100\%)$ iv) collaboration on site service provision? $27 (100\%)$ $27 (100\%)$ v) collaboration is two-way? $27 (100\%)$ $27 (100\%)$ | | CATEGORY 3. COLLABORATION | | |
| edure development? 27 (100%) edure development? 27 (100%) d neglect task force? 27 (100%) wision? 27 (100%) | 3.1 | Does the DHB collaborate with CYF and NGO child advocacy and protection? | 27 (100%) | 27 (100%) |
| procedure development? 27 (100%) procedure development? 27 (100%) ie and neglect task force? 27 (100%) e provision? 27 (100%) | | a) which types of collaboration apply: | | |
| d procedure development? 27 (100%) Lse and neglect task force? 27 (100%) ice provision? 27 (100%) | | i) collaboration with training? | 27 (100%) | 27 (100%) |
| Lse and neglect task force? 27 (100%) ice provision? 27 (100%) | | ii) collaboration on policy and procedure development? | 27 (100%) | 27 (100%) |
| ice provision? 27 (100%) 27 (100%) 27 (100%) | | | 27 (100%) | 27 (100%) |
| 27 (100%) | | iv) collaboration on site service provision? | 27 (100%) | 27 (100%) |
| | | v) collaboration is two-way? | 27 (100%) | 27 (100%) |

| b) is collaboration with: i) CYF7 ii) NGOs and other agencies such as Women's Refuge? iii) MGOs and other agencies such as Women's Refuge? iii) MGOs and other agencies such as Women's Refuge? iii) MGOs and other agencies such as Women's Refuge? iii) MGOs and other agencies such as Women's Refuge? iii) MGOs and other agencies such as Women's Refuge? iii) MGOs and other agencies in conjunction programme? If yes, which types of collaboration apply: a) collaboration on policy and procedure development? b) collaboration on policy and procedure development? c) collaboration on policy and procedure development? b) collaboration on policy and procedure development? c) collaboration on child abuse and neglect task force? 3.3 Is there collaboration of the child abuse and neglect programme with other he lf yes, which types of collaboration apply: b) with a Mãori unit? c) collaboration in the DHB? b) with a Mãori unit? c) with the DHB? b) with a Mãori unit? c) with the DHB? b) with a Mãori unit? c) with the DHB? b) with a Mãori unit? c) with a Mãori unit? c) with the DHB? b) with a Mãori unit? <t< th=""><th></th><th>84 mo FU n (%)</th><th>96 mo FU n (%)</th></t<> | | 84 mo FU n (%) | 96 mo FU n (%) |
|---|---|-------------------|-------------------|
| | | | |
| | | 27 (100%) | 27 (100%) |
| | ich as Women's Refuge? | 27 (100%) | 27 (100%) |
| | entative(s)? | 27 (100%) | 27 (100%) |
| | /e(s) for ethnic or cultural groups other than Pakeha or Māori? | 25 (93%) | 27 (100%) |
| | ween relevant staff within the DHB evident? | 27 (100%) | 27 (100%) |
| | Does the DHB collaborate with police and prosecution agencies in conjunction with their child abuse and neglect programme? If yes, which types of collaboration apply: | 27 (100%) | 27 (100%) |
| | | 27 (100%) | 27 (100%) |
| | ocedure development? | 26 (96%) | 27 (100%) |
| | nd neglect task force? | 26 (96%) | 27 (100%) |
| | ls there collaboration of the child abuse and neglect programme with other health care facilities? | 27 (100%) | (%001) 20 |
| | on apply: | (~~~~~ / · ~ | 10/00T) 17 |
| | | 27 (100%) | 27 (100%) |
| | | 27 (100%) | 27 (100%) |
| | s in the region? | 27 (100%) | 27 (100%) |
| | | 24 (89%) | 25 (93%) |
| | .ector? | 25 (93%) | 27 (100%) |
| | l protection and family violence coordinators? | 27 (100%) | 27 (100%) |
| | hip on, or attend: | | |
| | :ection team? | 27 (100%) | 27 (100%) |
| | | 27 (100%) | 27 (100%) |
| | | 25 (93%) | 26 (96%) |
| | urce Panel? | 24 (89%) | 25 (93%) |
| | olence Intervention Coordinators? | 27 (100%) | 27 (100%) |
| a) CYF? | Does the DHB have a Memorandum of Understanding that enables the sharing of details of children at risk for entry on their database with the Police and/or CYF? | | |
| | | 22 (82%) | 25 (93%) |
| b) the Police? | | 20 (74%) | 25 (93%) |

| n (%) n (%) ave a Memorandum of Understanding or service agreement that enables timely medical examinations 15 (56%) 15 (56%) 16 (59%) 14 (52%) 14 (52%) 14 (52%) 14 (52%) 14 (52%) 14 (52%) 14 (52%) 14 (52%) 15 (56%) 15 (56%) 16 (59%) 16 (59%) 16 (59%) 16 (59%) 16 (59%) 16 (50%) 16 (50%) 16 (50%) 16 (50%) 16 (50%) 16 (50%) 16 (50%) 16 (50%) 16 (50%) 17 (10%) 12 (43%) 10 (51%) 13 (48%) 10 (51%) 13 (48%) 11 (40%) <td< th=""><th></th><th>"YES" responses</th><th>84 mo FU</th><th>96 mo FU</th></td<> | | "YES" responses | 84 mo FU | 96 mo FU |
|---|-----|--|-----------|-----------|
| Does the DHB have a Memorandum of Understanding or service agreement that enables timely medical examinations 15 (55%) 0. Orbitation 15 (55%) 15 (55%) 10. Defice? 14 (52%) 15 (55%) 10. Defice? 14 (55%) 15 (55%) 10. Defice? 14 (55%) 15 (55%) 10. Defice? 14 (55%) 16 (55%) 10. Defice? 13 (55%) 16 (55%) 10. Defice? 20 (74%) 20 (74%) 10. FOBACT 10 (55%) 20 (74%) 23 (55%) 10. child protection programme is adequety resourced, including dedicated programme staff? 21 (43%) 23 (35%) 10. the child protection programme is adequety resourced, including dedicated programme staff? 21 (34%) 25 (35%) 10. a working group of skilled and trained people who operationalises policies and procedures, in addition to the child 27 (100%) 26 (95%) 10. a working group of skilled and trained people who operationalises policies and procedures, in addition to the child 27 (30%) 26 (95%) 10. a working group of skilled and trained people who operationalises policies and procedures, in addition to the child 27 (30%) 26 (95%) 11. othes of those in the child abuse | | | n (%) | n (%) |
| a) Criti b) Policie? 15 (56%) b) Policie? 14 (52%) c) DAGE 14 (52%) a) Child protection is in the DHB Strategic Plan? 20 (74%) a) Child protection is in the DHB Strategic Plan? 21 (43%) a) Child protection is in the DHB Strategic Plan? 21 (43%) a) Child protection is in the DHB Strategic Plan? 23 (45%) c) Child protection is in the CHE and trained people who operationalises policies and procedures, in addition to the child 27 (100%) p at working group of skilled and trained people who operationalises policies and procedures, in addition to the child 27 (100%) p attendance at raining as a key performance included in position descriptions? 25 (33%) p other staff 10 (5%) 13 (45%) p other staff 10 (5%) 27 (100%) p other staff 26 (96%) 27 (100%) p other staff 26 (96%) 26 (96%) p other staff 26 (96%) 27 (100%) <td>3.6</td> <td>Does the DHB have a Memorandum of Understanding or service agreement that enables timely medical examinations to support:</td> <td></td> <td></td> | 3.6 | Does the DHB have a Memorandum of Understanding or service agreement that enables timely medical examinations to support: | | |
| b) Police? 16 (59%) 16 (59%) CODSACT 14 (57%) 14 (57%) TEGORY 4. INSTITUTIONAL CULTURE 14 (57%) 14 (57%) TEGORY 4. INSTITUTIONAL CULTURE 20 (74%) 14 (57%) TEGORY 4. INSTITUTIONAL CULTURE 20 (74%) 14 (57%) Description is in the DHB Strategic Plan? 20 (74%) 20 (74%) a) child protection is in the DHB Arnual Plan? 20 (74%) 21 (40%) b) child protection is in the DHB Arnual Plan? 20 (74%) 23 (100%) c) child protection is in the DHB Arnual Plan? 21 (40%) 23 (40%) c) child protection is in the DHB Arnual Plan? 23 (100%) 23 (100%) p) a working group of skilled and trained people who operationalises policies and procedures, in addition to the child abuse and neglect working team are included in position descriptions? 23 (100%) 23 (100%) protection coordinator? 20 (74%) 23 (100%) 23 (100%) 23 (100%) p) the child abuse and neglect working team are included in position descriptions? 23 (100%) 23 (100%) 23 (100%) 23 (100%) 23 (100%) 23 (100%) 24 (45%) 23 (100%) 24 (45%) 24 (45%) 24 (45%) 24 (45%) 24 (45%) | | a) CYF? | 15 (56%) | 23 (85%) |
| c) DSAC? 14 (52%) TEGEORY 4. INSTITUTIONAL CULTURE 14 (52%) TEGEORY 4. INSTITUTIONAL CULTURE 20 (14%) Dest the DHB searing emenet support and promote the child abuse and neglect programme? 20 (14%) Dest the DHB searing emenet support and promote the child abuse and neglect programme? 20 (14%) D child protection is in the DHB Amual Plan? 20 (14%) D child protection is in the DHB Amual Plan? 23 (85%) D owning group of skilled and trained people who operationalises policies and procedures, in addition to the child 2 (44%) 21 (100%) D owning group of skilled and trained people who operationalises policies and procedures, in addition to the child 2 (100%) 21 (100%) D a working group of skilled and trained people who operationalises policies and procedures, in addition to the child 2 (44%) 13 (43%) D a working group of skilled and trained people who operationalises policies and procedures, in addition to the child 2 (100%) 21 (100%) D a working group of skilled and trained people who operational set of the OHB staff's knowledge and attitude about child 26 (95%) D D medicate T D B B the presentation on the CYF Care and Protection Resource Plane)? 26 (95%) D D B the transformation of the DHB staff's knowledge and attitude about child 26 (95%) D D medicate Staff know | | b) Police? | 16 (59%) | 23 (85%) |
| TEGORY 4. INSTITUTIONAL CULTURE Does the DHB senior management support and promote the child abuse and neglect programme? 20 (74%) Does the DHB senior management support and promote the child abuse and neglect programme? 20 (74%) Does the DHB senior management support and promote the child abuse and neglect programme staff? 21 (44%) D) child protection programme is adequately resourced, including dedicated programme staff? 12 (44%) D) a working group of skilled and trained people who operationalises policies and procedures, in addition to the child abuse and neglect working team are included in position descriptions? 23 (100%) D) a working group of skilled and trained people who operation field in position descriptions? 13 (48%) 13 (48%) D) a working group of skilled and trained people who operation field in position descriptions? 13 (48%) 13 (48%) D) a vorking group of skilled and trained people who operation field in position descriptions? 13 (48%) 13 (48%) D) PlB representation on the CYF Care and Protection Resource Panel? 23 (33%) 26 (96%) 26 (96%) D) Difficing staff D) rote staff 26 (96%) 21 (100%) 26 (96%) 21 (30%) D) necircal staff D) medical staff D) medical staff 21 (30%) 26 (96%) 21 (30%) D) neticing staff D) medical sta | | c) DSAC? | 14 (52%) | 18 (67%) |
| Does the DHB senior management support and promote the child abuse and neglect programme?20 (74%)a) child protection is in the DHB strategic Plan?20 (74%)b) child protection programme is adequately resourced, including dedicated programme staff?23 (85%)c) the child protection programme is adequately resourced, including dedicated programme staff?23 (48%)c) the child protection programme is adequately resourced, including dedicated programme staff?23 (40%)c) the child protection programme is adequately resourced, including dedicated programme staff?27 (100%)c) the child protection for the child abuse and Protection Bost the child abuse included in position descriptions?23 (48%)f) elastendance at training as a key performance indicator (KP) for staff?13 (48%)19 (70%)f) the child buse and Protection Bost the DHB staff's knowledge and attitude about child26 (96%)26 (96%)h) the child buse and Protection Bost the DHB staff's knowledge and attitude about child26 (96%)21 (66%)h) the child buse and neglect?3 nursing staff20 (74%)21 (65%)h) medical staff3 nursing staff20 (74%)21 (65%)h) medical staff3 nursing staff20 (74%)21 (65%)h) medical staff3 nursing staff21 (65%)21 (65%)h) medical staff3 nursing staff21 (65%)21 (65%)h) medical staff3 nursing staff21 (30%)21 (65%)h) medical staff3 nursing staff21 (30%)21 (65%)h) medical staff3 nursing staff21 (65%)21 (65%) | CA | FEGORY 4. INSTITUTIONAL CULTURE | | |
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| Does the DHB support and promote child protection and intervention within the primary sector.Image: Total and the primary health care providers in the planning and development of child abuse and neglect and child a) involvement of primary health care providers in the planning?Image: Total abuse and neglect training?Image: Total abuse and activities that focus on prevention and promoting child protection?Image: Total abuse and activities that focus on prevention and promoting child protection?Image: Total abuse and activities that focus on prevention and promoting child protection?Image: Total abuse and activities that focus on prevention and promoting child protection?Image: Total abuse and activities that focus on prevention and promoting child protection?Image: Total abuse and activities that focus on prevention and promoting child protection?Image: Total abuse and activities that focus on prevention and promoting child protection?Image: Total abuse and activities that focus on prevention and promoting child protection?Image: Total abuse ab | | c) translators used that are gender and age appropriate? | 16 (59%) | 18 (67%) |
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| b) access to child abuse and neglect training?22 (82%)c) coordination of referral processes between the DHB and primary health care sectors?13 (48%)d) ongoing relationships and activities that focus on prevention and promoting child protection?23 (85%) TEGORY 5. TRAINING OF PROVIDERS 23 (85%)Is there evidence of a formal training plan that is specific to child abuse and neglect for clinical staff and non-clinical staff?25 (93%)a) a strategic plan for training?25 (93%)b) an operational plan that outlines the provision of regular, ongoing education for clinical staff?25 (93%)c) Does the plan include the provision of regular, ongoing education for clinical staff?25 (93%)d) Does the plan include the provision of regular, ongoing education for non-clinical staff?25 (93%) | | a) involvement of primary health care providers in the planning and development of child abuse and neglect and child protection prot | 19 (70%) | 26 (96%) |
| c) coordination of referral processes between the DHB and primary health care sectors?13 (48%)d) ongoing relationships and activities that focus on prevention and promoting child protection?23 (85%) TEGORY 5. TRAINING OF PROVIDERS 23 (85%)Is there evidence of a formal training plan that is specific to child abuse and neglect for clinical staff and non-clinical23 (85%)is there evidence of a formal training plan that is specific to child abuse and neglect for clinical staff and non-clinical25 (93%)a) a strategic plan for training?25 (93%)25 (93%)b) an operational plan that outlines the specifics of the programme of training?25 (93%)25 (93%)c) Does the plan include the provision of regular, ongoing education for clinical staff?25 (93%)25 (93%)d) Does the plan include the provision of regular, ongoing education for non-clinical staff?25 (93%)25 (93%) | | b) access to child abuse and neglect training? | 22 (82%) | 26 (96%) |
| d) ongoing relationships and activities that focus on prevention and promoting child protection? 23 (85%) TEGORY 5. TRAINING OF PROVIDERS 23 (85%) Is there evidence of a formal training plan that is specific to child abuse and neglect for clinical staff and non-clinical staff and non-clinical 25 (93%) Is there evidence of a formal training? 25 (93%) 25 (93%) a) a strategic plan for training? 25 (93%) 25 (93%) b) an operational plan that outlines the specifics of the programme of training? 25 (93%) 25 (93%) c) Does the plan include the provision of regular, ongoing education for clinical staff? 25 (93%) 25 (93%) d) Does the plan include the provision of regular, ongoing education for non-clinical staff? 25 (93%) 25 (93%) | | c) coordination of referral processes between the DHB and primary health care sectors? | 13 (48%) | 20 (74%) |
| TEGORY 5. TRAINING OF PROVIDERS Is there evidence of a formal training plan that is specific to child abuse and neglect for clinical staff and non-clinicalIs there evidence of a formal training plan that is specific to child abuse and neglect for clinical staff and non-clinicalstaff?a) a strategic plan for training?b) an operational plan that outlines the specifics of the programme of training?c) Does the plan include the provision of regular, ongoing education for clinical staff?d) Does the plan include the provision of regular, ongoing education for non-clinical staff?22 (82%) | | d) ongoing relationships and activities that focus on prevention and promoting child protection? | 23 (85%) | 25 (93%) |
| Is there evidence of a formal training plan that is specific to child abuse and neglect for clinical staff and non-clinical25 (93%)staff?a) a strategic plan for training?25 (93%)25 (93%)b) an operational plan that outlines the specifics of the programme of training?25 (93%)25 (93%)c) Does the plan include the provision of regular, ongoing education for clinical staff?25 (93%)25 (93%)d) Does the plan include the provision of regular, ongoing education for non-clinical staff?22 (82%)22 (82%) | CA | EGORY 5. TRAINING OF PROVIDERS | | |
| rategic plan for training? 25 (93%) 25 (93%) 25 (93%) 25 (93%) 25 (93%) 25 (93%) 25 (93%) 25 (93%) 25 (93%) 25 (93%) 25 (93%) 25 (93%) 25 (93%) 25 the plan include the provision of regular, ongoing education for clinical staff? 25 (93%) 22 (82%) 22 (82%) | 5.1 | | | |
| 25 (93%) 25 (93%) 25 (93%) 25 (93%) 22 (82%) | | staff? | | |
| 25 (93%) 25 (93%) taff? 22 (82%) | | a) a strategic plan for training? | 25 (93%) | 26 (96%) |
| 25 (93%) taff? 22 (82%) | | b) an operational plan that outlines the specifics of the programme of training? | 25 (93%) | 27 (100%) |
| 22 (82%) | | c) Does the plan include the provision of regular, ongoing education for clinical staff? | 25 (93%) | 27 (100%) |
| | | d) Does the plan include the provision of regular, ongoing education for non-clinical staff? | 22 (82%) | 25 (93%) |

| | "YES" responses | 84 mo FU | 96 mo FU |
|-----|--|-----------|-----------|
| | | u (%) | u (%) |
| 5.2 | During the past 12 months, has the DHB provided training on child abuse and neglect? | | |
| | a) as part of the mandatory orientation for new staff? | 27 (100%) | 27 (100%) |
| | b) to members of the clinical staff via colloquia or other sessions? | 27 (100%) | 27 (100%) |
| 5.3 | Does the training/education on child abuse and neglect include information about: | | |
| | a) definitions of child abuse and neglect? | 27 (100%) | 27 (100%) |
| | b) dynamics of child abuse and neglect? | 27 (100%) | 27 (100%) |
| | c) child advocacy? | 25 (93%) | 27 (100%) |
| | d) appropriate child-centred interviewing? | 26 (96%) | 26 (96%) |
| | e) issues of contamination? | 27 (100%) | 27 (100%) |
| | f) ethical dilemmas? | 26 (96%) | 27 (100%) |
| | g) conflict of interest? | 25 (93%) | 27 (100%) |
| | h) epidemiology? | 27 (100%) | 27 (100%) |
| | i) health consequences? | 26 (96%) | 25 (93%) |
| | j) identifying high risk indicators? | 27 (100%) | 27 (100%) |
| | k) physical signs and symptoms? | 27 (100%) | 27 (100%) |
| | I) dual assessment with partner violence? | 26 (96%) | 27 (100%) |
| | m) documentation? | 27 (100%) | 27 (100%) |
| | n) intervention? | 27 (100%) | 27 (100%) |
| | o) safety planning? | 26 (96%) | 27 (100%) |
| | p) community resources? | 26 (96%) | 27 (100%) |
| | q) child protection reporting requirements? | 27 (100%) | 27 (100%) |
| | r) linking with the police and child youth and family? | 27 (100%) | 27 (100%) |
| | s) limits of confidentiality? | 27 (100%) | 27 (100%) |
| | t) age appropriate assessment and intervention? | 25 (93%) | 27 (100%) |
| | u) cultural issues? | 26 (96%) | 27 (100%) |
| | v) link between partner violence and child abuse and neglect? | 27 (100%) | 27 (100%) |
| | w) Māori models of health? | 21 (78%) | 24 (89%) |
| | x) the social, cultural, historic, and economic context in which Māori family violence occurs? | 22 (82%) | 23 (85%) |
| | y) Te Tiriti o Waitangi? | 23 (85%) | 26 (96%) |
| | z) Māori service providers and community resources? | 25 (93%) | 27 (100%) |
| | aa) service providers and community resources for ethic and cultural groups other than Pakeha and Māori? | 23 (85%) | 27 (100%) |
| | | | |

| | "YES" responses | 84 mo FU | 96 mo FU |
|-----|---|------------|------------|
| | | n (%) | n (%) |
| 5.4 | Is the child abuse and neglect training provided by: (choose one of a-d and answer e-f) | | |
| | c) a team of DHB employees only? | 1 (4%) | 0 (0%) |
| | d) a team, including community expert(s)? | 26 (96%) | 27 (100%) |
| | e) a Child Youth and Family statutory social worker? | 26 (96%) | 27 (100%) |
| | f) a Māori representative? | 26 (96%) | 26 (96%) |
| | g) a representative(s) of other ethnic/cultural groups? | 16 (59%) | 22 (82%) |
| 5.5 | Is the training delivered in collaboration with various disciplines, and providers of child protection services, such as CYF, | 26 (96%) | 27 (100%) |
| 5.6 | Does the plan include a range of teaching and learning approaches used to deliver training on child abuse and neglect? | 26 (96%) | 27 (100%) |
| CAT | | | |
| 6.1 | Is there a standard intervention checklist for staff to use/refer to when suspected cases of child abuse and neglect are | 27 (100%) | 27 (100%) |
| | identified? | | |
| 6.2 | Are child protection services available "on-site"? If yes, choose one of a-b and answer c-d: | 27 (100%) | 27 (100%) |
| | a) A member of the child protection team or social worker provides services during certain hours. | 5 (19%) | 3 (11%) |
| | b) A member of the child protection team or social worker provides service at all times. | 22 (82%) | 24 (89%) |
| | c) A Māori advocate or social worker is available "on-site" for Māori victims. | 27 (100%) | 26 (96%) |
| | d) An advocate of ethnic and cultural background other Pakeha and Māori is available onsite. | 17 (63%) | 23 (85%) |
| 6.3 | Are mental health/psychological assessments performed within the context of the programme? | (%001) 20 | (%)001/20 |
| | If yes, are they: (choose a or b and answer c) | 10/00T) 17 | 10/00T) 17 |
| | a) available, when indicated? | 18 (67%) | 11 (41%) |
| | b) performed routinely? | 6 (33%) | 16 (59%) |
| | c) age-appropriate? | 26 (96%) | 27 (100%) |
| 6.4 | Do the intervention services include: | | |
| | a) access to physical and sexual examination? | 27 (100%) | 27 (100%) |
| | b) access to specialised sexual abuse services? | 27 (100%) | 27 (100%) |
| | c) family focused interventions? | 24 (89%) | 27 (100%) |
| | d) support services that include relevant NGOs, or acute crisis counsellors/support? | 27 (100%) | 27 (100%) |
| | e) culturally appropriate advocacy and support? | 27 (100%) | 27 (100%) |
| 6.5 | Are Social Workers available? | | |
| | a) Monday to Friday 8 am to 4 pm service, with referrals outside of these hours? | 15 (56%) | 16 (59%) |
| | b) 0n-call after 4 pm and at weekends? | 3 (11%) | 3 (11%) |
| | c) as a 24 hour service? | 6 (33%) | 8 (30%) |
| | | | |

| | "VFS" responses | 84 mo Fl J | 96 mo FU |
|------|---|------------|-----------|
| | | u (%) | u (%) |
| 6.6 | Is there a current list of relevant services available to support child and family safety? | 25 (93%) | 27 (100%) |
| 6.7 | Is provision made for transport for victims and their families, if needed? | 23 (85%) | 24 (89%) |
| 6.8 | Does the DHB child abuse and neglect programme include follow-up contact and counselling with victims after the | 22 (82%) | 27 (100%) |
| | Initial assessment? | | |
| 6.9 | Does the child abuse and neglect programme assess and provide family violence intervention services and appropriate | | |
| | referral for: | | |
| | a) the mother | 26 (96%) | 26 (96%) |
| | b) siblings | 27 (100%) | 26 (96%) |
| 6.10 | Is there evidence of coordination with CYF and the Police for children identified at risk of child abuse and neglect? | 27 (100%) | 27 (100%) |
| CAT | CATEGORY 7. DOCUMENTATION | | |
| 7.1 | Is there evidence of use of a standardised documentation form to record known or suspected cases of child abuse and | (70001) 20 | 1/20/30 |
| | neglect, and safety assessments? If yes, does the form include: | (%/NNT) /7 | 20 (30%) |
| | a) Reason for presentation? | 27 (100%) | 26 (96%) |
| | a) information generated by risk assessment? | 21 (78%) | 25 (93%) |
| | b) the victim or caregiver's description of current and/or past abuse? | 22 (82%) | 26 (96%) |
| | c) the name of the alleged perpetrator and relationship to the victim? | 13 (48%) | 21 (78%) |
| | d) a body map to document injuries? | 19 (70%) | 25 (93%) |
| | f) Past medical history? | 19 (70%) | 22 (82%) |
| | g) A social history, including living circumstances? | 13 (48%) | 24 (89%) |
| | h) An injury assessment, including photographic evidence (if appropriate)? | 19 (70%) | 23 (85%) |
| | i) The interventions undertaken? | 19 (70%) | 23 (85%) |
| | e) information documenting the referrals provided to the victim and their family? | 19 (70%) | 21 (78%) |
| | f) in the case of Māori, information documenting whether the victim and their family were offered a Māori advocate? | 12 (44%) | 19 (70%) |
| 7.2 | Does the DHB have sexual abuse specific forms that include: | | |
| | a) a genital diagram? | 24 (89%) | 24 (89%) |
| | b) a consent form? | 23 (85%) | 23 (85%) |
| 7.3 | Is there evidence of use of a standardised referral form and process for CYF and/or Police notification? If yes, is a | 27 (100%) | 27 (100%) |
| | referral form and process available for: | | |
| | a) CYF notification? | 27 (100%) | 27 (100%) |
| | b) Police notification? | 17 (63%) | 19 (70%) |
| 7.4 | Are staff provided training on documentation for children regarding abuse and neglect? | 27 (100%) | 27 (100%) |
| | | | |

| | "YES" responses | 84 mo FU | 96 mo FU |
|-----|--|----------|-----------|
| CAT | CATEGORY 8. EVALUATION ACTIVITIES | (%) II | (%) II |
| 8.1 | Are any formal evaluation procedures in place to monitor the quality of the child abuse and neglect programme? If yes: | | |
| | a) Do evaluation activities include periodic monitoring of implementation of child abuse and neglect clinical assessment | 26 (96%) | 26 (96%) |
| | b) Is the evaluation process standardised? | 22 (82%) | 25 (93%) |
| | c) Do evaluation activities measure outcomes, either for entire programme or components thereof? | 26 (96%) | 26 (96%) |
| | | | |
| | Identification, risk assessment, admissions and referral activities? | 18 (67%) | 24 (89%) |
| | Monitoring trends re demographics, risk factors, and types of abuse? | 14 (52%) | 16 (59%) |
| | Documentation? | 20 (74%) | 22 (82%) |
| | Referrals to CYF and the Police? | 21 (78%) | 23 (85%) |
| | Case reviews? | 23 (85%) | 24 (89%) |
| | Critical incidents? | 20 (74%) | 21 (78%) |
| | Mortality morbidity review? | 20 (74%) | 24 (89%) |
| | Policy and procedure reviews? | 26 (96%) | 27 (100%) |
| | e) Do the evaluation activities include: | | |
| | Multidisciplinary team members? | 26 (96%) | 27 (100%) |
| | Police? | 22 (82%) | 27 (100%) |
| | CYF? | 26 (96%) | 27 (100%) |
| | Community agencies? | 20 (74%) | 26 (96%) |
| 8.2 | Is there evidence of feedback on the child abuse and neglect programme from community agencies and government services providers, such as CYF, the Police, refuge, and well child providers? | 24 (89%) | (%68) 77 |
| 8.3 | Do health care providers receive standardized feedback on their performance and on patients from CYF? | 18 (67%) | 23 (85%) |
| 8.4 | Is there any measurement of client satisfaction and community satisfaction with the child abuse and neglect programme? | | |
| | a) client satisfaction? | 7 (26%) | 11 (41%) |
| | b) community satisfaction? | 17 (63%) | 23 (85%) |
| 8.5 | Is a quality framework used to evaluate whether services are effective for Māori? | 8 (30%) | 14 (52%) |
| 8.6 | Are data related to child abuse and neglect assessments, identifications, referrals and alert status recorded, collated and reported on to the DHB? | 20 (74%) | 19 (70%) |
| 8.7 | Is the child abuse and neglect programme evident in the DHB quality and risk programme? | 16 (59%) | 27 (100%) |
| 8.8 | Is the responsibility for acting on evaluation recommendations specified in the policies and procedures? | 17 (63%) | 11 (41%) |
| | | | |

| | "YES" responses | 84 mo FU | 96 mo FU |
|-----|---|-----------|-----------|
| | | u (%) | u (%) |
| J | CATEGORY 9. PHYSICAL ENVIRONMENT | | |
| 9.1 | 1 How many locations with posters/images relevant to children and young people which are they child-friendly, contain | in | |
| | messages about child rights and safety, and contain Māori and other relevant cultural or ethnic images? | | |
| | a) <10 posters or images | 0 (0%) | (%0) 0 |
| | b) 10-20 posters or images | 2 (7%) | 1 (4%) |
| | c) >20 posters or images | 25 (93%) | 26 (96%) |
| 9.2 | 2 Is there referral information (local or national phone numbers) related to child advocacy and relevant services on | | |
| | public display in the DHB? (Can be included on the posters/brochure noted above). | | |
| | a) <10 locations | 2 (7%) | (%0) 0 |
| | b) 10-20 locations | 2 (7%) | 1 (4%) |
| | c) >20 locations | 23 (85%) | 26 (96%) |
| 9.3 | 3 Are there designated private spaces available for interviewing? | | |
| | c) > 4 locations? | 27 (100%) | 27 (100%) |
| 9.4 | 4 Does the DHB provide temporary (<24 hours) safe shelter for victims of child abuse and neglect and their families who | | |
| | cannot go home or cannot be placed in a community-based shelter until CYF or a refuge intervene? | | |
| | a) 'Social admissions" mentioned in child abuse and neglect policies? | 23 (85%) | 24 (89%) |
| | b) Temporary safe shelter is available? | 25 (93%) | 27 (100%) |
| | | | |