violence intervention programme

Funded by
Ministry of Health

Quality Improvement Activity Terms of Reference

XXDHB Audit Aims:

- ☑ To identify actual or potential adverse outcomes or processes
- ☑ To identify ways of solving problems and/or preventing adverse outcomes or processes
- ☑ To communicate findings and improvement initiatives with relevant key stakeholders
- ☑ To promote learning and improvement of VIP within XXDHB
- ☑ To enhance interagency collaboration

Activity Title: *Name of Quality Improvement Activity (QIA) /Audit (usually reflects the title of the associated policy/guiding document/standard).*	Clinical Audit of the Violence Intervention Programme: Intimate Partner Violence (IPV) routine enquiry and documentation of risk and health assessment and intervention
Audit Sponsor(s): *Person who resources and/or has accountability for the QIA/audit's outcome.*	Programme Sponsor and VIP Coordinator(s)
Auditor(s): *The person(s) involved in planning and undertaking the audit. Identify the Lead Auditor if more than one auditor.*	VIP Coordinator(s) and or designated staff
Audit Background: *History and rationale of need for audit – i.e. what prompted the audit (e.g. a change in practice/ policy/ standard/ protocol/ guideline, actual or suspected risk/problem/issue or variance in practice/outcome).*	The XDHB Violence Intervention Programme requires health professionals to introduce routine enquiry for IPV into their practice. This is a difficult practice change. Staff need a large amount of support to attain a level of comfort with questioning. The DHB uses a multifaceted approach to achieve this change, including policy, training and, monitoring and evaluation. The system support processes include a commitment to provide effective training that provides staff with the knowledge and skills to be competent to implement family violence intervention into clinical practice.
QIA/Audit Objectives: *Description of the intended outcome of the audit, ideally expressed in terms implying commitment to improvement in quality of care/practice*	The quarterly clinical audit process is a critical aspect of the VIP Quality Improvement Activity (QIA) plan. The QIA objectives are: Objective 1: To identify current rate of routine enquiry for IPV Objective 2: To identify if appropriate health and risk assessment and referrals were made in response to disclosures Objective 3: To identify trends in programme implementation Objective 4: To provide feedback and support for staff in relation to the VIP to achieve attitudinal and organisational change
Standards / Aspects (Indicators) of Care Tested: *Identifies XXDHB policy/ protocol / guideline, standard(s), clinical indicators or defined best practice where references are possible.*	The XDHB Violence Intervention Programme IPV policy(ies) *(specify)* mandate that staff trained in VIP will include IPV within clinical practice. The Ministry of Health Family Violence Assessment and Intervention Guideline; Child abuse and intimate partner violence (2016) indicate best practice regarding violence intervention. The recommended intervention includes routine enquiry for IPV. If abuse is disclosed, validation and support is provided, followed by a health and risk assessment, safety planning, and referral to appropriate services, including specialist community agencies) and follow-up and documentation. VIP service specifications require DHBs to report on the level of routine enquiry being undertaken in designated services (ref Ministry of Health VIP service specification; 6.5). Designated services include mental health, alcohol and drug, emergency department, child health (including school and home visiting services and tertiary paediatric services), maternity and sexual health.
QIA/Audit Scope: *Defines the extent and boundaries of the audit: What/who is being audited, where & when: e.g. All staff working in Unit A on dd/mm/yy*	The population that provides the audit sample includes all female patients within the care of the trained designated service (as defined above) during the timeframe under review (usually one month).

e.g. 20 health records of patients discharged from "Unit X" with a diagnosis of "x" during the period dd/mm/yy – dd/ mm/yy	All services who have launched routine enquiry for IPV will be audited quarterly. A standardised template (excel spreadsheet) is used to record clinical audit data.
QIA/Audit Procedure: *Describes the audit sample (include no. of cases in sample);* *Describes how the audit sample was identified/selected;* *Identifies data collection methods (e.g. interview, observation, documentation review):* *Identifies method of data analysis (e.g. compliance rating);* *Describes how confidentiality is to be protected.*	Process: The procedure may vary depending on the service being audited, because the health record management process may vary with some services having electronic records while others rely on paper files. Data source: Patient chart reviews are the information source. Charts are selected by random sample or consecutive notes taken during the allotted timeframe, depending on the service audited. Sample: A pragmatic sample size may be used (provides reliable finding within the resource available). The random sample should be representative of the population, with all shifts and days of the week included in the study, thereby reducing any risk for bias. Data: The data gathered includes patient demographic details, presentation details and routine enquiry profile. When violence has been disclosed, the IPV documentation form is used to gather data on the standard of assessment, intervention and referral based on the documentation. The data is entered into a Microsoft Excel programme. Data analysis: The data is analysed and a report of the findings is completed. Percentages are calculated with analysis comparing enquiry rates within population groups (e.g. ethnic group). Simple proportions only will be calculated. Confidentiality: No patient is identifiable as names are not recorded – NHI numbers are recorded until a study number is allocated. All information is stored in locked filing cabinets or in password-protected computer programmes.
Report Procedure & Due Date: *Identifies who will receive the audit report, and identifies how the report will be communicated to key stakeholders.* *Draft report usually required within 2 weeks of audit and circulated for feedback. Final report usually completed within 3-4 weeks of audit and incorporates feedback where appropriate.*	Audit reports are forwarded to the VIP senior manager and the department service manager within two weeks of the audit being completed. *(The report may be copied to the quality and risk team depending on DHB process)*. The findings are reported to the VIP Steering Group within the VIP Coordinators' reporting process. The findings will be reported both formally (i.e., in monthly and biannual MoH reports) and informally (i.e., at staff meetings and in the form of feedback during refresher training). Issues identified from the audit (e.g. low routine enquiry rates, insufficient documentation of disclosures) will be managed in collaboration with the VIP team including senior manager/programme sponsor, department service manager and steering group (including community agency representatives) as indicated.
Resources Required: *Approximate resources required for QIA/audit: Personnel / Time / Cost*	A standardised spreadsheet for gathering the data is used. The resource required is the time taken for the auditor to collect and analyse the data.
Risks / Barriers: *Identifies any actual/potential risks to completing the audit* *e.g. inability to access accurate data; restricted time resource for the auditor/sponsor; and health record inaccessibility*	There are two potential risks. The first is that health record management processes impact on the VIP Coordinator(s) ability to conduct the audit. The second is that the VIP Coordinator(s) do not have sufficient resource (time) to complete the audit process. If such QIA activities are not undertaken at sufficient intervals, early identification of VIP implementation issues may be missed and the quality of the programme and its effectiveness may be affected. The risk can be minimised by ensuring the VIP Steering Group endorse both the QIA plan including allocation of resources for such activities.
Risk Management Plan: *Record proposed actions for overcoming the risk(s) identified above*	Regular review of QIA plan and reporting on actions/outcomes via VIP Steering Group and reporting processes should enable early identification of issues and the development of a mutually agreeable recovery plan.
Protected Quality Assurance Activity (PQAA): *Auditors must register the audit as a 'PQAA' if it meets the scope of the*	*Please answer the questions/ follow prompts below:* **Q.1. Does this audit assesses the health services provided by XXDHB health practitioners?** Yes *(delete one)* **Q.2. Is this audit activity covered under our PQAA notice?**

quality assurance activities that are covered under XXDHB's protection notice (Protected Quality Assurance Activity policy XXDHB/OPM/038). The declaration affords civil liability protection to participating practitioners where the terms of the policy are fulfilled.	Yes ↓ If yes, please comply with the policy which includes a requirement to have the following statement on all documentation/ records relating to this activity: *"XX District Health Board: Confidential document. This document is produced for the purposes of a 'Protected Quality Assurance Activity' under health Practitioners' (Quality Assurance Activity: XX District Health board) Notice 2005."*

TOR submitted by:	
Position title:	
Department/ Service:	
Date:	

Approved by sponsor (signature)	
Date:	

Please register your audit with the Quality & Risk Service by following u*sual DHB process.*