Translating Evaluation into Action
A Northern Territory (NT) wide change management initiative across the hospital and community sectors

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Abstract

The introduction of the routine use of a domestic/family violence screening tool in all Northern Territory Public Hospitals is a key change management initiative of the NT Department of Health & Community Services. This initiative was announced as a Priority Action as part of the Northern Territory whole of Government Domestic & Aboriginal Family Violence Strategy 2003 – 2007.

This initiative was instigated in response to the high rate of hospital admission for assault in the Northern Territory and violence, especially domestic and family violence is the single greatest cause of hospital admissions for injury among Aboriginal women in the Northern Territory. In response to this, a three-month pilot of a domestic/family violence screening tool was conducted from September – November 2002 at two NT Public Hospital locations. Evaluation of this pilot between January and April 2003 showed there was broad client and staff support for domestic/family violence screening. Significantly one in four patients screened throughout the pilot disclosed D/FV and 36.3% of those patients screened and disclosing D/FV asked for immediate help.

The key recommendation from the Pilot Evaluation Report of May 2003 was to extend routine D/FV screening in all NT Public Hospitals. This presentation will outline the key steps and strategies utilised to translate the evaluation recommendations into action. It also presents the issues involved with engaging key stakeholders from the hospital, government and community sectors in this process.

The Author and presenter was brought into this project at the pilot evaluation stage and is now project managing the implementation stage which includes setting up a monitoring and evaluation framework. This presentation will cover all the conference themes.

Introduction

The introduction of the routine use of a domestic violence screening tool in all Northern Territory Public Hospitals is a key change management initiative of the Northern Territory Department of Health & Community Services. This initiative was

announced as a Priority Action as part of a whole of Government "*Domestic & Aboriginal Family Violence Strategy for 2003 – 2007"*.

The initiative was instigated in response to the fact that the Northern Territory has the highest rate of hospital admission for assault in the country[i], and violence, especially domestic and family violence, is the single greatest cause of hospital admissions for injury among Aboriginal women in the Northern Territory. A three-month pilot to test acceptance and use of a domestic/family violence screening tool was conducted at two NT Public Hospital locations – Royal Darwin Hospital Emergency Department and Katherine Hospital Antenatal Department between September and November 2002. Evaluation of this pilot (January-April 2003) showed there was broad patient, staff and community agency support for domestic violence screening. The evaluation showed that one in four patients screened throughout the pilot disclosed domestic/family violence and 36.3% of those patients screened and disclosing domestic/family violence asked for immediate help.

The key recommendation from the pilot evaluation report of May 2003 was to extend routine D/FV screening to all NT Public Hospital Antenatal and Emergency Departments. This paper outlines the key steps and strategies utilised to translate the evaluation recommendations into action. It also presents the issues involved with engaging key stakeholders from the hospital, government and community sectors in this process.

Implementation process

The first step in the implementation process was for the Health Minister to publicly announce the initiative in June 2003 and to report this in all NT Newspapers. An NT-wide implementation Taskforce was set up immediately to action the recommendations from the pilot evaluation.

A key component to successful implementation of domestic/family violence screening is staff training and information to hospital staff and external domestic violence referral agencies about the use of the screening tool. Community referral agencies, as well as hospital staff, need to be involved in the training on the use of the screening tool and to be aware there may be an increase in referrals after commencement of screening. Audits were carried out at all five Northern Territory Public Hospital Emergency and Antenatal Departments (Darwin, Gove District, Katherine, Tennant Creek and Alice Spring) and key domestic violence community referral agencies during September/October 2003. The audits were to ascertain hospital readiness to screen and community capacity to accept referrals from hospitals at each NT location. Domestic violence referral agencies included Police Domestic Violence Units, Crisis Accommodation and Shelters, Domestic Violence Legal Support Agencies and Domestic Violence Counselling Services.

The audit highlighted that all hospitals felt the introduction of the tool in their Antenatal Departments would be easier than in the Emergency Departments. Emergency Departments felt that screening would stretch staff resources and their physical layouts were not adequate for the level of privacy required to use the screening tool. Most community agencies stated they would welcome an increase in appropriate domestic/family violence referrals from hospitals.

At the start of phase two of this initiative each Northern Territory Public Hospital was at a different stage of readiness to introduce screening. Katherine Hospital had continued with use of the tool in their Antenatal Department since completion of the pilot project in 2002. Tennant Creek Hospital had undertaken some training in the use of the screening tool with the assistance of their local Domestic Violence and Sexual Assault Training and Support Workers in early 2003 but had not commenced using the screening tool. Darwin, Alice Springs and Gove District Hospital Antenatal staff had received no training in the use of the screening tool. Royal Darwin Hospital Emergency Department had decided not to continue with use of the screening tool since the pilot. Although the Director of this Emergency Department stated he was fully supportive of the initiative he had identified the need for three further nursing shifts to implement screening. However this estimate did not take into consideration the reduced time spent dealing with repeat violence.

The results of the audits were relayed back to hospitals in each location via representatives attending monthly Implementation Taskforce Teleconference Meetings. However the Women's Health Strategy Unit Project Management Team responsible for project implementation were concerned that information about the project was not reaching hospital workers, other staff working in the policy areas of Acute Care, or the General-Managers of each hospital. To assist with alleviating this problem monthly one page flyers were produced and distributed via email to Departmental Executives, Program Managers and all hospital staff. An extensive email distribution list was also developed for distribution to community organisations working in the domestic/family violence and related fields at each hospital location.

Performance targets

A set of performance targets were devised for the initiative. These were:

- Use of the screening tool at all Public Hospital Antenatal and Emergency Departments.
- Ongoing training systems in place at each hospital location.
- Effective referrals between Public Hospitals and domestic violence referral agencies.
- Awareness and acceptance of the screening tool amongst hospital staff, patients and community referral agencies.

These targets are critical to guiding implementation of the evaluation results and providing a monitoring benchmark for how implementation is going.

Risk management

The implementation of this initiative held certain risks. A risk management plan was drawn up to identify possible risks to the success of the initiative and to ensure successful implementation.

The risks identified were:

1. Current funding covered salary of project manager for one year. Risk of inadequate funding available in 2004/05.
2. Lack of training and inadequate knowledge about the screening tool.
3. High hospital staff turnover therefore difficult to retain appropriately trained staff.
4. Inadequate resources to deal with disclosed domestic violence arising from screening, and
5. Resistance to implementation including professional silence.

To counter these risks a number of risk minimisation strategies were put in place. These included:

1. Active contribution to PHOFA renegotiation and exploration of other funding partnership possibilities.
2. Regular training and up-to-date resource materials available at each hospital location.
3. "Train the Trainer" focus needed for training so that new staf are adequately trained.
4. Develop an information dissemination strategy.
5. Identify positive outcomes arising from screening for domestic/family violence through opportunities such as in-services to private General Practitioners and hospital staff.

Project management

The Project management aspect of this initiative had several components. The Project Sponsors were the two Assistant Secretaries of Health Services and Acute Care within the Department of Health & Community Services. A Project Management Team within the Women's Health Strategy Unit (WHSU) was set up and consisted of the Project Manager, the Women's Health Advisor and a Project Support Administration Officer (shared amongst a number of WHSU projects). An NT-wide Implementation Taskforce was set up and included representation from each NT Public Hospital and key domestic violence agencies at each location. Local implementation working parties at each Public Hospital location also need to play an active role to ensure good communication within each hospital as well as between hospital and community sectors. This is gradually occurring at each hospital location and critical to the success of implementation.

Key stakeholders

There were multiple stakeholders identified as playing an important role in successful implementation of the initiative. These were identified as including:

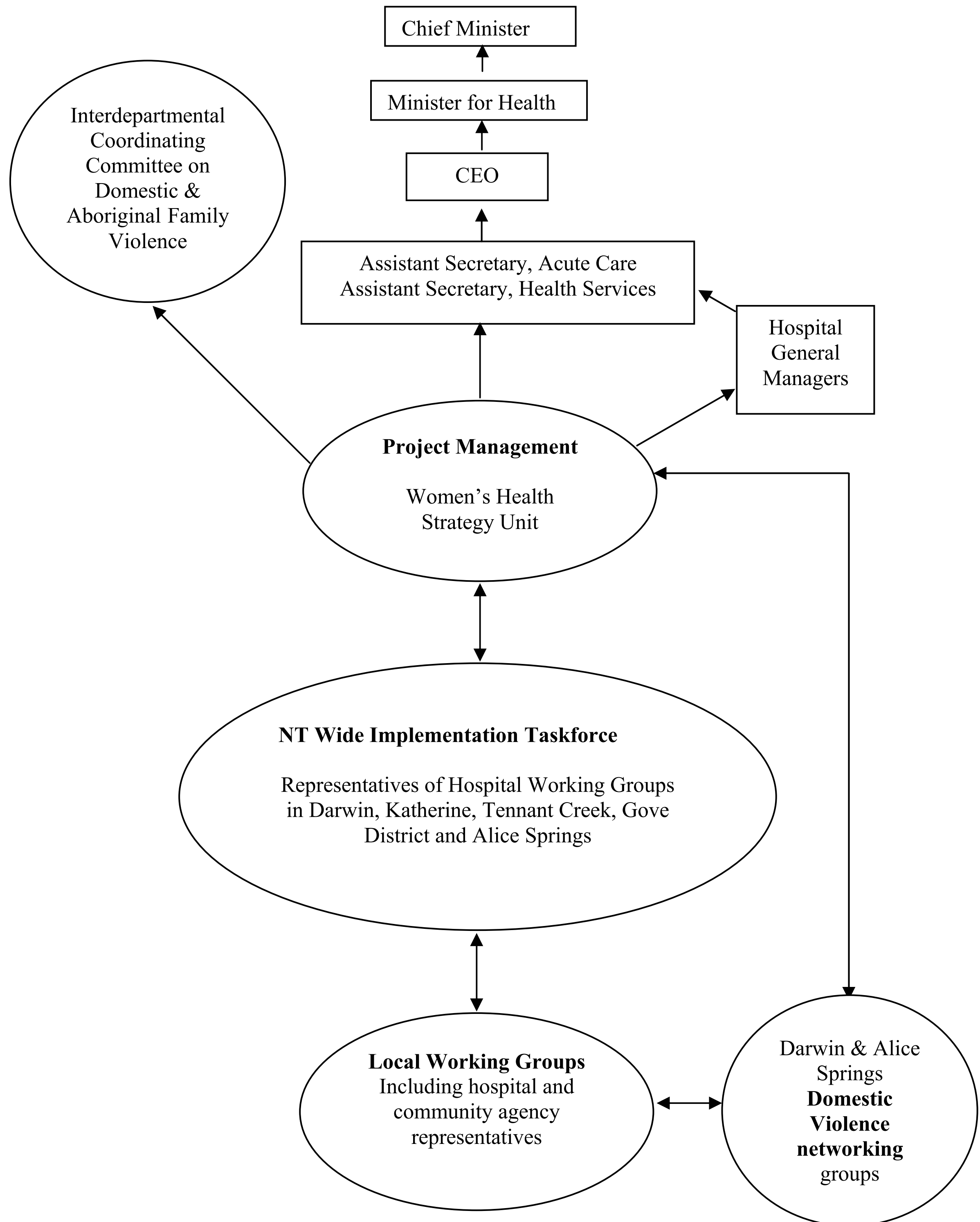
- All Northern Territory women, men and children
- NT Public Hospital staff
- Domestic/family violence community referral agencies
- Allied health service providers
- General Practitioners
- Police Domestic Violence Unit officers
- The Department of Health & Community Services
- The Ministers for Health and Community Services
- The Chief Minister

The Project Manager has taken account of these multiple stakeholders in developing the communication strategy for this initiative. Dissemination of the monthly information flyers across the Northern Territory has led to a vast range of health professionals having access to information about the initiative. One example of the benefits of this strategy has been through the Nurse Educators at Katherine Hospital reading the September 2004 information flyer and contacting the Project Manager to discuss resources for offering further training and in-services about the screening tool to a wider range of staff at Katherine Hospital.

Diagram 1 shows the complex communication and reporting structure for all key stakeholders involved in this initiative.

Diagram 1 - NT Public Hospital Domestic/Family Violence Screening - Communication and Reporting Structure Flowchart.

Key Stakeholders: Hospital Clients/Patients, Hospital Staff, Community Referral Agencies, Health Department staff in Acute Care and Health Services areas, the CEO, the Minister and the Public.



On-going evaluation

As well as the Pilot Evaluation for stage one of the initiative, an on-going evaluation mechanism has been set up to monitor and evaluate the success of the initiative. The evaluation method includes quarterly monitoring through the NT-wide Implementation Taskforce Meetings, and a formal in-house process and impact evaluation to be conducted two years after commencement of implementation. A suitable length of time is required between initial implementation and evaluation to ensure that implementation has been fully effective and its proper impact able to be measured. It is anticipated that the long-term expected outcome of reduced domestic/family violence in the community will be difficult to measure within this time period, but available evidence will be used to determine any changes.

Implementation plan

An Implementation Plan was drawn up. It reflected each identified stage of the project that needed to be developed and completed for the initiative to be a success. This plan has ten key steps, the last three of which are on going.

For Immediate Implementation

1. Assess adequacy to Screen at each location
2. Refine domestic/family violence screening tool
3. Organise 'Train the Trainer' sessions at each location
4. Develop evaluation framework
5. Develop Pamphlet on restraining order options
6. Develop information strategy
7. Launch at each hospital site

Ongoing

1. Regular information sharing
2. Develop and implement mechanisms for monitoring
3. Formal evaluation

Discussion

Evaluation during the pilot phase showed that such a change management initiative relies heavily on cross program collaboration across the hospital and community services sectors. For widespread implementation this means collaboration within each hospital and across the department, as the Acute Care and Health Services Divisions are located in different sections of the department, as well as funded differently. Communication about the initiative needs to occur at all levels across the department – to hospital staff about to introduce screening, to hospital General Managers and Policy Officers in the Acute Services area and to the range of domestic violence community referral agencies across the Northern Territory. The Management Team identified that communication needs to take many forms ranging from monthly information flyers distributed to all stakeholders, to information briefings across several NT Government departments at the quarterly Interdepartmental Committee Meetings on Domestic and Aboriginal Family Violence. This also entailed feedback from each location at the quarterly Implementation Taskforce meetings and feedback at local domestic violence networking meetings.

Evaluation of the pilot showed that screening to assist with identification and appropriate referral for domestic violence may be viewed apprehensively by staff in a busy hospital setting. Some staff may have their own fears about asking patients questions about what they may view as a highly personal subject. Others may not wish to broach the subject with people known to them in a small community. The Northern Territory has a large Aboriginal population and a large percentage of hospital patients are Aboriginal. Aboriginal interpreters are employed within the hospital system as well as Aboriginal Liaison Officers and Aboriginal Health Workers. Feedback during the evaluation of the pilot from the Royal Darwin Hospital Aboriginal Liaison Officer revealed that the use of the screening tool with Aboriginal patients opened up avenues for disclosure that otherwise may not have occurred. These issues have all been raised through the 'Train the Trainer' workshops held at each hospital location prior to commencement of screening at each location.

For an extensive change management strategy such as this it is important that as many stakeholders are involved in its implementation as possible. The Project Manager attends bi-monthly Domestic Violence Networking Meetings and quarterly Interdepartmental Domestic & Aboriginal Family Violence Committee Meetings to update a range of stakeholders on each stage of the implementation process. The Project Manager also chairs the NT-Wide Implementation Taskforce (met monthly for first 6 months now quarterly) and has encouraged key DV representatives external to the hospital sector to attend from each location. Input from General Practitioners has been through consultation with the GP/Hospital Liaison Program Manager with the Top End Division of GPs and a presentation at the Top End Division of GPs. The Project Manager has also provided information and training to Women's Health Educators throughout the NT.

Hospital staff who have attended the initial 'train the trainer' workshops are encouraged to provide on-going training for new staff. This has occurred at each hospital location and is the key to the success of the initiative. As of July 2004 each NT Public Hospital Antenatal Department has come "on board" for this initiative. It

has been a fine line between ensuring each hospital takes ownership of the change process and providing direction and uniformity to the introduction of this initiative.

Reaching agreement amongst stakeholders at each hospital location on key implementation decisions has been a challenge. Agreement needed to be reached in terms of a standard domestic/family violence screening form to be used across the Northern Territory. All key stakeholders needed to have input to the process. Feedback from focus groups during the Pilot Evaluation informed the process but as staff turnover in the hospital and community sectors is high, the Project Manager became aware of new players needing to be included in the decision-making process all the time. Implementation Taskforce meetings were held monthly for the first six months so as to "keep the momentum up" on decision making required of each representative, particularly in relation to the choice of wording on the screening form. Approval also needed to be sought from the Hospital Forms Committee to ensure standards were met even in terms of the colour of the form.

Another key issue requiring local hospital decision-making was the putting in place of procedures for filing the original completed green screening form in the patient's medical record and for collection of the yellow duplicate form (with no patient identifying features on it) on the ward and forwarding it to the Women's Health Strategy Unit in Darwin. Here the data is collated then sent back to each hospital as a means of informing hospitals on numbers screened, numbers disclosing DV, numbers seeking help and what kind of assistance is being provided. Some hospitals are still ironing out issues as to how the form is collected on the ward but these operational issues are gradually being addressed. The Project Manager has found trips to each hospital location useful in ironing out some of these procedural issues. It has highlighted the large number of people involved in making this initiative work in a complex hospital environment.

Now that the key NT–wide decisions have been made in relation to the implementation of this initiative the Implementation Taskforce meetings are held quarterly instead of monthly. Each NT Public Hospital is expected to report at these meetings on any on-going issues in relation to implementation and how they are addressing barriers identified in the original audits to screening.

Where to from here?

All Northern Territory Public Hospitals have now received initial 'train the trainer' training in the use of the screening tool and all NT Public Hospital Antenatal Departments have commenced using the screening tool. A monitoring process has been set up using Business Objects to obtain reports to feed back to each hospital data information gathered from the screening forms. The form however is designed not to be time consuming for the health professional. The training stresses the importance of making the person feel at ease and the health professionals asking the questions in their own words if possible.

To counter the barriers to screening in Emergency Departments a number of developments are occurring. Tennant Creek Hospital has now walled in the Triage Nurse's station so there is a private area in which to screen for domestic/family violence while the person is triaged. Local domestic violence community referral

agencies are arranging to hold in-services for Registered Medical Officers and Registrars at the Emergency Department of Royal Darwin Hospital. This is a start to improving communication and referrals between the Emergency Department and domestic violence referral agencies regardless of whether screening takes place or not.

Evaluation feedback during the training at each location and at other presentations has raised questions about use of the screening tool at remote health clinics and other health settings. The screening tool can be adapted for use in any health setting or by GPs in their practices. The Resource Kit for Health Professionals contains useful information on responding to domestic violence and key contacts throughout the NT for referrals. A training video titled *'Hidden Wounds'* was produced during phase one of the project and this has proved so useful that the Body Shop used segments from it, with permission from the department, to develop an Australia wide training package for all their staff. This initiative covers all the conference themes. It responds to the culturally diverse nature of the Northern Territory, it responds to stakeholder diversity, it uses a range of evaluation methodologies and it is a response to the need for inter-sectoral collaboration across the hospital and community sectors to respond to a complex issue – that is, the high rate of domestic/family violence in our community and the high rate of presentation for domestic/family violence related incidents at all Northern Territory Public Hospitals.

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[i] Williams, G., Chaboyer W., and Schulter P., 2002. Assault-related admissions to hospital in Central Australia. Medical Journal of Australia; 177 (6): 300 – 304.