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Translating clinical experience into action: Developing an educational protocol to improve intimate partner violence screening by Emergency Department nurses

By Thea Herzog and Geoffrey Maina

Background

The World Health Organization (WHO) describes intimate partner violence (IPV) as “any behaviour within an intimate relationship that causes physical, psychological or sexual harm to those in the relationship.” IPV affects millions of people around the world. “Worldwide, almost one-third (30%) of women who have been in a relationship report that they have experienced some form of physical and/or sexual violence by their intimate partner in their lifetime” (World Health Organization [WHO], 2012, 2013). IPV is also associated with higher rates of chronic health issues such as PTSD, mental health problems, poor cancer outcomes, and increased risk to HIV infections (Beydoun, Williams, Beydoun, Eid, & Zonderman, 2017; Coker, Follingstad, Garcia, & Bush, 2017; Dillon, Hussain, Loxton, & Rahman, 2013). Additionally, risks of further victimization (e.g., sexual assault, and IPV in other relationships), and elder abuse (Teresi et al., 2016; Gerber, Wittenberg, Ganz, Williams, & McCloskey, 2008; Young-Wolff et al., 2013) challenge nurses working in emergency units to support IPV screening and stop the long-term impact of IPV.

Intimate partner violence is a major social and health issue in Canada. The Department of Justice estimates that the annual cost of caring for victims of IPV is \$7.4 billion (Zhang, Hoddenbagh, McDonald, & Scrim, 2013). In 2016, more than 93,000 cases of IPV were reported in Canada. Women are most affected by IPV and constitute 79% of the reported IPV cases. Further, 37% of violent crimes are acts of IPV (Andresen & Linning, 2014; Burczycka & Conroy, 2018). Women aged 25–34 years report the highest rates of IPV, at 650 per 100,000 (Sinha, 2013).

Saskatchewan has the fourth highest IPV rates in Canada, at more than twice the national average (Sinha, 2013). During 2005–2015, the province reported 57 domestic homicide victims from 48 events (Ministry of Justice, 2017). In 2018, the police service for Prince Albert, Saskatchewan’s third-largest city, received 2,614 “domestic calls for service” related to family disputes (C. Rudderham, personal communication, April 2, 2019). During the same year, Prince Albert police services responded to 278 calls for IPV-related assaults (T. Dunlop, personal communication, April 10, 2019).

The face of IPV in the Emergency Department

Victims of IPV have significantly higher rates of visits to the ED than the general population (Hofner et al., 2005). Between 18–25% of women presenting in the ED are victims of IPV (Robinson, 2010). They present with problems that are directly or indirectly related to IPV (Kothari & Rhodes, 2005; Rhodes et al., 2011). For example, they may have broken bones or bruises, but they may also have vague complaints that are not obviously associated with IPV, such as headaches or abdominal pain (Hoffman, 2013), or they may appear in distress or be flagged for having frequent visits to the ED.

Because victims of IPV often have their first contact with nurses and the healthcare system in an ED, this is an ideal setting for nurses to screen for IPV. However, many EDs across Canada, including Victoria Hospital in Prince Albert, do not mandate IPV screening. Also, healthcare providers are unable or resistant to screen for all the clients seeking care in the EDs. For example, Gutmanis and others found that nurses and physicians in Ontario screen only 5–25% of patients presenting to EDs for IPV (Gutmanis, Beynon, Tutty, Wathen, & MacMillan, 2007). This low IPV screening rate is attributed to nurses’ lack of time and to their feelings of inadequacy, helplessness or discomfort with how to manage IPV (Catallo, Jack, Ciliska, & MacMillan, 2013; DeBoer, Kothari, Kothari, Koestner, & Rohs, 2013). A lack of knowledge of or experience with caring for clients experiencing IPV can also impact their interactions with these clients (Gutmanis et al., 2007). Clients may also be in denial that they live in an abusive relationship. Therefore, healthcare provider screening can create awareness of the existence of partner violence in a client’s life (Giesbrecht, 2012).

Personal experience working as an RN in an ED

As a nurse working in the ED in Prince Albert for five years, I (T.H.) have cared for a significant number of women in crises who showed signs of experiencing IPV. Although women of all ages are affected by IPV, most of the clients I have cared for range from 16–29 years old. Most of these clients are not economically independent and feel trapped in a violent relationship. Others do not know the resources available within the city to support them, such as safe shelters or crisis services. Often, alcohol and substance use within a relationship is a significant factor that masks IPV in majority of women seeking care with symptoms of IPV. Therefore, correctly identifying and screening for IPV takes patience and diligence.

Currently, Victoria Hospital has no strategy for screening for IPV in the ED. Since screening for IPV is a sensitive endeavour for both nurses and clients, it is critical that ED teams are thoroughly equipped with knowledge and skills to identify, screen and intervene for vulnerable clients (Sundborg, Saleh-Stattin, Wändell, & Törnkvist, 2012). Because of the lack of resources and support, such as protocol and processes to screen for IPV, nurses feel frustrated and inadequate to provide safe care to these patients. In staff meetings, nurses have frequently voiced a need for capacity building to screen and intervene for IPV. In response to these identified needs, I decided to create an educational tool to aid in IPV screening in the ED.

Creating an educational poster for nurses working in ED setting

The creation of the IPV educational poster was grounded in critical social theory, allowing the gap between research and practice to be bridged (Sundborg et al., 2012). The following steps were used to create this poster.

Conducting a brief literature review and situational analysis of IPV in Prince Albert: The literature review provided information on the definition and manifestations of IPV and strategies for screening for it. Discussions with local partners and stakeholders involved in service provision and care, yielded statistics on the prevalence of IPV in the community.

Drafting of the poster: Information gathered from the literature review and situational analyses were summarized into key brief statements under the following subheadings: definition of IPV; local statistics; manifestation; and, intervention strategies. Copyright-free images representing IPV and ED settings were included to provide interest and a balance between text and graphics. IPV screening questions (Davis, Parks, Kaups, Bennink, & Bilello, 2003) were also included in the poster, and brief intervention steps were illustrated in a flow diagram.

Seeking and receiving feedback on the draft IPV educational poster: The draft poster was presented to 12 nurses working in the ED, including a unit nurse manager, a unit nurse educator, and nurses with diverse ED experiences. Nurses were initially surprised by the statistics on IPV in the city and appreciated the poster's utility in raising awareness about IPV. They commended the poster's simplicity and aesthetic properties, believing that it can act as a reminder to screen and intervene. They suggested that having community support services and contacts listed on the tool would help them connect clients to these valuable resources, especially during after-hour shifts. The nurses also suggested that the "community supports" section of the poster be bolded and summarized to be more concise. They encouraged introducing this tool to other hospital departments and printing it onto pocket cards for RN use.

Refining and launching the IPV educational tool: Following extensive consultation with the nurse manager, nurse educator, and front-line nurses in the ED, the tool was refined to include

the feedback provided. As per the RNs' suggestions, copies of the IPV educational tool were posted on the walls of the exam room, staff room and triage room to serve as constant reminders to the nurses to screen and intervene for clients suspected of experiencing IPV. During the launch of the tool, the nurse educator recommended that pocket-sized cards with information on local resources be printed and handed to clients suspected to be at risk for IPV (see Appendix 1 and 2 for the poster and pocket-sized cards respectively).

Discussion

Through personal experience, as a nurse in an ED in Prince Albert, and through numerous conversations with other RNs, it was determined that ED nurses frequently encounter clients suspected of being affected by IPV. However, no resources were available in the hospital to help nurses accurately screen or support these clients. Thus, this poster was developed as an easy-to-use educational resource to support nurses in providing effective IPV screening and care.

The process of developing this nursing intervention began with conducting a literature review and then a situational analysis with stakeholders providing services to victims of IPV. The literature review revealed that ED nurses feel inadequately prepared or supported to facilitate care of clients who disclose IPV (DeBoer et al., 2013). A lack of a private space in the ED and insufficient time to develop rapport with the clients were also identified as barriers to screening (Catallo et al., 2013). Conversations within the ED are ongoing to eliminate these barriers.

Information on common manifestations of IPV was obtained from the review and included in the educational poster. Local stakeholders provided statistics of IPV in the community. The use of local statistics on IPV made the resource contextually relevant and validated clinical observations that IPV was a major health issue likely affecting many clients presenting in the ED.

Seeking RNs' input in the development of the IPV educational tool ensured that it was informative, relevant, easy to use and appropriate for raising awareness and supporting RNs in the care of clients experiencing IPV (Fay-Hillier, 2016). Nurses identified with the assessment that there was a need to screen for IPV. They also expressed willingness to use this educational resource to screen their clients and to encourage the clients to use the available supports and services.

According to Ulbrich and Stockdale (2002), building self-efficacy of healthcare providers in screening for IPV and increasing their knowledge of community supports and referral processes help to address IPV within the healthcare setting and in the community. They also reported that increased comfort and awareness of staff last up to six months following educational intervention.

In this project, having the nurse educator provide feedback during the development phase was critical because she helped

with the design and offered to include the tool when orienting new RNs to the department. The nurse manager was supportive of the intervention, but senior nurses cautioned against making IPV screening a universal practice. They believed screening all clients would become tedious and time consuming and, thus, decrease staff morale and eventually reduce support for the intervention.

Despite the challenges ED nurses might face in caring for IPV victims, they have a duty to provide safe and compassionate care to all clients (Canadian Nurses Association, 2017). The Registered Nurses' Association of Ontario (2005) recommends that RNs screen "females 12 years of age and older" by asking cued questions such as, "Have you ever been hurt or threatened by someone?" (p. 9, 63). Where knowledge and skills deficits exist, RNs are expected to grow in competence and provide evidence-informed practice including identifying, screening, and intervening for victims (Canadian Nurses Association, 2017). In this project, while we recognize that men, too, can be victims of partner violence, screening for IPV among men was not within the scope of this project. The statistics reflect prevalence of IPV victims are females. When screening men, social and cultural climates require a degree of sensitivity. It is imperative to be aware of these realities.

Educating RNs to recognize signs of IPV and effectively screen for it are the first steps towards improving care for clients experiencing IPV (Ahmad, Ali, Rehman, Talpur, & Dhingra, 2017; Williams, Halstead, Salani, & Koermer, 2016). For the sustainability of the screening practice in the ED, it is important that the ED Manager and Nurse Educator provide support such as sharing statistics of partner violence screening on a regular basis.

Implications for emergency nursing practice

This project provides several practical lessons. First, the process of designing this educational tool showed that in settings where peer and managerial support exists, there is goodwill to implement desired changes to improve client outcomes. In our case, with nursing unit manager support, front-line workers advocated for the healthcare needs of clients experiencing IPV. Creating this educational poster is an example of nurses working collaboratively and drawing on their clinical experiences to identify and respond to clients' needs.

Secondly, this project shows that front-line nurses do not have to have leadership positions to initiate change in their workplace. In this case, nurses served as patient advocates by taking ownership of the issue and using therapeutic communication skills to screen for clients suspected of experiencing IPV. By encouraging front-line nurses to be problem solvers, nurse managers and leaders can create a culture of patient advocacy. When nurse managers foster a culture of collaboration and leadership with front-line nurses, nurse-client relationships are optimized (Canadian Nurses Association, 2017; Hegney et al., 2019).

Third, when front-line nurses are proactive by addressing gaps in care, they can affect broad and far-reaching changes in healthcare practice and policy. For example, in our situation, because victims of IPV present in various clinical settings, encouraging other hospital units to use the IPV education poster will likely lead to departmental collaboration and a re-examination/re-evaluation of treatment approaches and referral protocols. We, therefore, anticipate that new policy and referral protocols will be created to advance the needs of clients experiencing IPV.

Finally, this project demonstrates the importance of keeping current with the literature in order to enhance client outcomes. In our case, reviewing the literature on the challenges that RNs face when screening for IPV and presenting the findings to decision makers can lead to an evaluation of our approaches to care in the ED. For instance, studies have identified a lack of private spaces to interview clients as a barrier to screening for IPV. In order to create a safe space where clients can freely disclose their experiences to the RNs, our department has offered a private interview room for this purpose.

Conclusion

Additional research is needed to evaluate the success of this educational poster. The next steps include a two-pronged approach: 1) evaluating how often the education tool is used by RNs to screen for IPV, and for changes or client outcomes such as numbers of referrals to community agencies; and 2) expanding the IPV screening process to other units in Victoria Hospital.

Take-aways

- The purpose of this practice improvement project was to develop an intimate partner violence (IPV) education screening aid for nurses in ED.
- Nurses feel inadequately prepared to screen and care for IPV clients.
- The primary outcome for this practice improvement project was an IPV screening education tool for nurses working in ED.
- Key implications for emergency nursing practice from this project are: a) when ED nurses are involved in the co-creation of education tools for improving screening for intimate partner violence, ownership of the process and the product is enhanced; b) nurses are also keen to use the tool to improve screening and patient care.

About the author



Thea Herzog, MN, RN, completed her BSc Kin, BSN and MN at the University of Saskatchewan. This article was completed in partial fulfillment of her MN requirements. She currently works as an emergency nurse in Prince Albert, Saskatchewan. In addition to emergency nursing, Thea's topics of interest include domestic violence, women's health, rural nursing, and health prevention.

Screening for Intimate Partner Violence in the Emergency Department

What is Intimate Partner Violence (IPV)?

"It is any behavior within an intimate relationship that causes physical, psychological or sexual harm to those in the relationship" (WHO, 2012)

IPV 2018 Statistics in Prince Albert

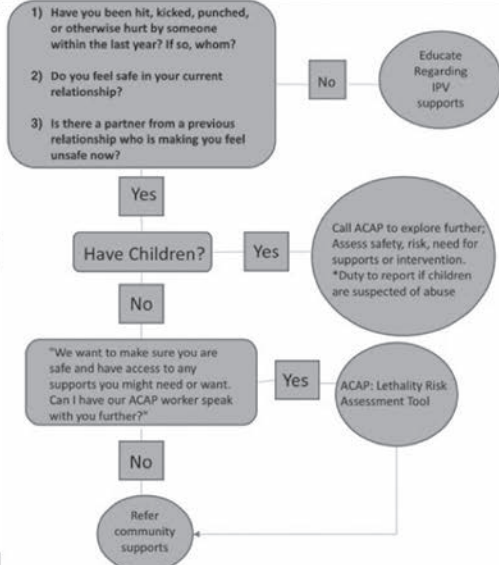
- Prince Albert police attended 2,614 domestic calls
- Prince Albert police attended 278 calls for assault related to IPV
- Punching, hitting, slapping, choking and suffocation are most common IPV complaints in PA

The Face of IPV in Emergency Department



- 18-25% of women who present to the ED experience IPV
- **Physical presentation:** Bruises, fractures, petechial hemorrhage, bloodshot eyes, raspy voice, headaches, vague abdominal pain
- **Psychological presentation:** Depression, Suicidal ideations

- Note:**
- Alcohol and substance abuse may be involved
 - IPV clients are frequent ED users, lack vital resources



(Adopted from Davis, Parks, Kaups, Bennink, & Bilello, 2003); Registered Nurses Association of Ontario (RNAO, 2015)

Communication Strategies

- Provide privacy and confidentiality
- Build Rapport and support
- Respect decisions and timing



Community Supports

- Call Mobile Crisis if the client is in crisis**
- Monday to Friday 4pm-8am, weekend 24 hr
 - Tel: (306) 764-1011 or 911
- Call Prince Albert Safe Shelter if you are concerned about client's safety (24hours/day)**
- Tel: (306) 764-7233
 - Address: 923 17 St Prince Albert
- Call YWCA Prince Albert if the client needs addiction support, shelter and other resources (24hours/day)**
- Tel: (306) 763-8571
 - Address: 1895 Central Ave

Appendix 1. IPV poster

Communication Strategies

- Provide privacy and confidentiality
- Build Rapport and support
- Respect decisions and timing

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Appendix 2. IPV pocket card

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