

Running head: INTIMATE PARTNER VIOLENCE/ABUSE SCREENING

Intimate Partner Violence/Abuse Screening Education

Joyce Bailey, Audrey Falk, Heidi Ritting, Ashley Roberts, and Amber Skipworth

Pacific Lutheran University

Abstract

Intimate partner violence/abuse, or IPV/A, is an unfortunate common occurrence in today's society. Healthcare's role in screening is significant, since hospitals/clinics are generally where the victims typically are first seen and recognized. Proper screening and response by healthcare providers may help to break the cycle of violence and be the difference between life and death. As future healthcare providers, the ability to recognize, identify and respond to an abused patient is vital in the teaching of the nursing profession. The purpose of our project was to raise awareness of the knowledge deficit that exists among nursing students at Pacific Lutheran University. This paper illustrates the results of our assessment: the need for further education within the School of Nursing at Pacific Lutheran University concerning how to correctly identify possible IPV/A situations.

Intimate Partner Violence/Abuse Screening Education

Due to the high prevalence of intimate partner violence/abuse (from now referred as IPV/A), it is recommended that new patients be screened for abuse upon entering a healthcare facility. Despite these incentives, there appears to be apprehension among healthcare personnel to perform these screenings. It is our group's experience that if the screenings are not being avoided all together, healthcare providers' implementation of the screening is at times awkward and prevents further elaboration. It also is our feeling as senior nursing students that some are not yet equipped with all the skills necessary to react properly in an IPV/A situation. Therefore, the intent of our assessment was to identify whether or not this deficit exists at Pacific Lutheran University's School of Nursing. This assessment was accomplished via objective (research) and subjective (key informant interviews, student survey) data.

Definitions

For the purpose of this paper, IPV/A is defined as an act(s) of assaultive and/or coercive behaviors, including but not limited to physical, sexual, and psychological attacks, that adults or adolescents use against their intimate partners. Our Conceptual definition of an intimate partner relationship includes, but is not limited to, married couples, same sex couples, parents and children, dating couples and elderly and their caregivers.

Objective Data

Health consequences of IPV/A.

Intimate partners commit 30 % of homicides of females and 5 % of homicides of males (U.S. Department of Justice,2007). According to the *Western Journal of Medicine*, of 218 women presenting to an emergency department with injuries due to domestic violence, 28 % of these women required hospital admission, 13 % needed significant medical intervention, and 40% had required medical care in the past resulting from abuse (Berrios, D.C. & Grady, D.,

1991). The number of people seeking healthcare due to IPV/A related problems burdens an already overwhelmed emergency department and healthcare system. Depending on the injuries sustained victims may require ongoing, long term and repeated care. Providing routine assessment through screening provides an opportunity to reduce healthcare burden and increase the quality of life for many.

“According to an analysis of the National Crime Victimization Survey from 1987-91, intimates commit an annual average of 621,015 rapes, robberies or assaults representing over 13% of all of these violent victimizations.” (U.S. Department of Justice, 1994).

Healthcare's role in screening.

According to the U.S. department of Justice, 37 % of all women who sought care in hospital emergency rooms required care for violence-related injuries, and usually were injured by a current or former spouse, boyfriend or girlfriend (U.S. Department of Justice, 1997). In addition, it has been found that 77 % of women seen in an emergency department for non-trauma complaints had been victims of domestic violence, but that only 13% were screened for domestic abuse (Abbott, Johnson, Koziol-Mclain, & Lowenstein, 1995). These results demonstrate it is not only direct violence we should be looking for. Not everyone will have visible clues to IPV/A.

In a study evaluating the implementation of domestic violence screening protocol in an oncology clinic, 63 % of the charts reviewed had a domestic violence screening papers present, yet only 12 % of the charts had documentation of the screen being performed(Owen-Smith, Hathaway, Roche, Gioiella, Whall-Strojwas, & Silverman, 2008). IPV/A screenings should be performed anytime a patient is admitted or evaluated, regardless of what department they enter through. Not everyone will present in the emergency room and everyone is at risk for IPV/A.

Barriers to domestic violence screening in health care settings.

According to recent research on the barriers of screening for IPV/A in emergency departments, it was found that the most significant deterrent of screening was lack of education and instruction on how to ask questions about abuse, language barriers between nurses and patients, a personal family history of abuse, and time constraints of nurses (Yonaka, Yoder, Darrow, & Sherck, 2007). This research demonstrates the need to increase training, provide a quick reference guide, and perhaps role play to provide an opportunity to learn the correct way to interact with patients. An emphasis on the proper language or alternative ways to approach the question, such as avoiding the use of jargon, better word choice or restating questions, may help eliminate language barriers. Even forgetting to use open-ended questions can be a language barrier.

Research has noted that if the screenings are not being avoided all together, provider response to the disclosure is awkward and sometimes discouraging to further disclosure. Often healthcare personnel fail to acknowledge the patients response or simple check the box and then move on, thus preventing further affirmation by the patient. (Yonaka, et. al 2007). Some examples of awkward questioning is to simply ask “You are not a victim are you?” Another example is to not provide privacy, frequently patients are questioned in the presence of the significant other or child.

Subjective Data

Key informant interviews.

Mindy Schaffner, PhD and assistant professor for Mental Health Nursing 350, was interviewed for her thoughts on nursing students’ preparedness to screen for IPV/A. Nursing 350 is the class in which information about IPV/A is covered. She indicated that the course does not go into as much depth about IPV/A as she would like and there are many topics she would like to

cover in more depth. So much in fact that there could be several separate courses implemented dedicated to certain mental health subjects. She stated many of her students that had yet to take the Nursing 350 course are less likely to appropriately screen, detect, or handle an IPV/A situation and believes many of her students who have taken the course are better able to screen and respond to the issue, yet there are still significant gaps in their knowledge. She maintained that experience was the key to effective screenings. Dr. Schaffner acknowledged the time constraints of today's nurses, and how because of these constraints, the patient's mental health issues are much more likely to be ignored. She felt that further education, resources, and/or role-playing would benefit her students and make them more comfortable screening patients for IPV/A. She proposed making videos to show the students how to screen and therefore increase their familiarity with these types of screenings.

Brenda Frank, a clinical instructor for the obstetric clinical rotation, was interviewed about her perceptions of students' IPV/A screening knowledge. This interview was significant because by the time nursing students are in the clinical rotation for obstetrics, they have already taken the mental health course that addresses IPV/A. Instructor Frank stated she did not feel her students were at all prepared to screen and noted that it also takes practice to feel comfortable. She declared that her nursing students are apprehensive to talk to patients altogether, let alone screening them for IPV/A. Instructor Frank encourages her students to ask the IPV/A screening questions at Madigan Army Medical Center and expressed how important it is to screen while the patient is alone. She agreed that further practice, knowledge, and resource information would benefit her students greatly.

Dr. MaryAnn Carr RN, MSN, PhD, clinical instructor for the medical-surgical rotations, was interviewed for her perceptions of students' preparedness to perform IPV/A screenings. She felt, even as an experience nurse, she was unprepared to perform an IPV/A screening. Dr. Carr

agrees that most students are unprepared to ask questions of such an intimate nature. As Brenda Frank mentioned earlier, students are nervous enough doing a general assessment and speaking with patients about everyday matters that students are not prepared ask questions related to intimate partner violence. Dr. Carr does state practicing or witnessing positive and negative techniques may improve student comfortability with performing screening but experience is the best teacher.

We also interviewed Janet Dubois, MSN, RN, clinical and didactic instructor for medical-surgical, about her perceptions of students' preparedness to perform IPV/A screening. She stated she has not spoken to students about IPV/A screenings and, in fact, she learned about the screening in a nursing meeting at the hospital where she works. Instructor Dubois felt that students are not prepared to respond appropriately to a positive response during a screening. She also stated the subject has never been brought up at a post clinical conference to trigger a discussion with students. She suggests maybe an introduction in nursing 220 would be a good start but a workshop might be too much of a commitment for students. If it is added to the curriculum she thought a good area would be to include it into the assessment class. Instructor Dubois felt an appropriate method would be how to "tie" things together and not focus so much on performing the screening questions. Learning verbal clues from the patient after a relationship has developed would be a better use of time. She does believe a role playing course would be beneficial, however the part of the respondent should be played by a person trained in the program, making the responses more realistic. She also suggested students learn to group sensitive questions and clarify answers once family or visitors have left the room and some relationship has been built. She also states this is a skill that will develop over time similarly to other clinical skills.

Systems Analysis

The systems analysis of IPV/A knowledge and education takes place in the PLU nursing school environment which includes clinical sites. The inputs are students, time, faculty, money, and patients. Throughput is the progression through the school of nursing. The throughput is a progression through clinical sites patient interactions and transitioning through clinical and didactic courses. The progression through the PLU nursing school throughput culminates in the production of nurses. Recent research illustrates that when time does not allow for further education concerning IPV/A, the output becomes nurses who do not perform adequate IPV/A screenings.

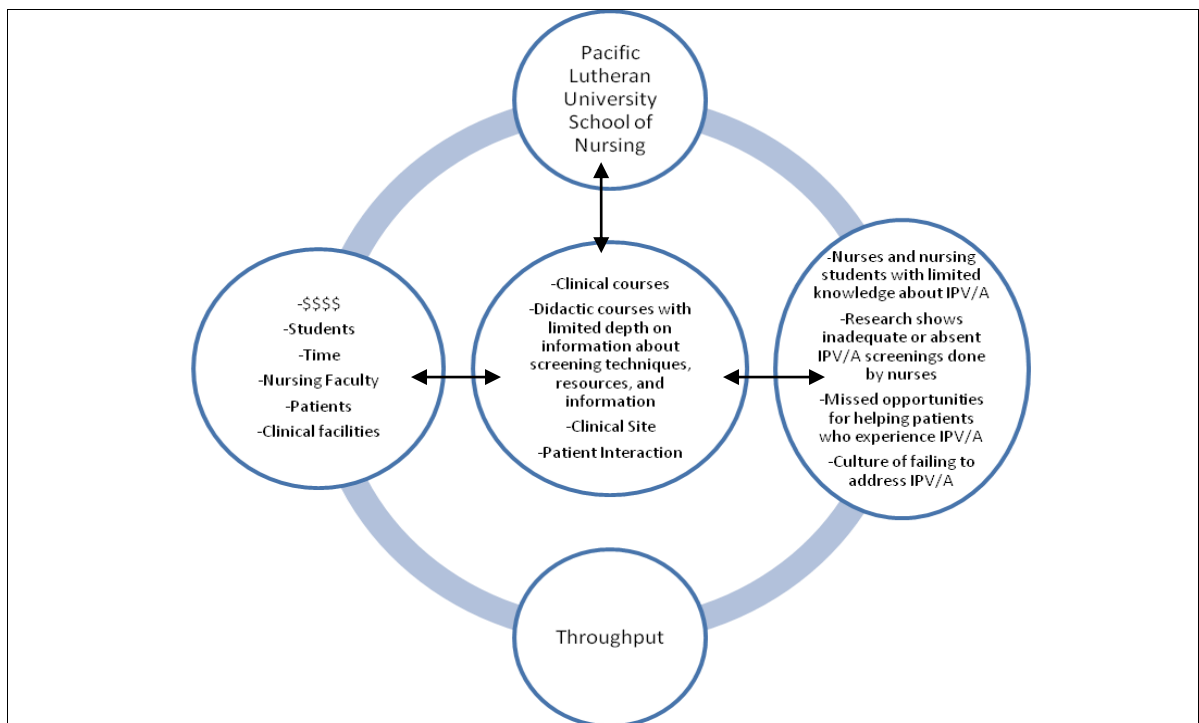


Figure 1: Systems Theory as applied to IPV/A screening education

Analysis

The ability to recognize, identify and respond to a patient victimized by IPV/A is vital in the nursing profession. Healthcare’s role in screening is significant, since hospitals/clinics are where the victims often go for treatment. Proper screening and response by healthcare providers may help break the cycle of violence and be the difference between life and death. According to

the U.S. Department of Justice, intimate partners commit 30% of homicides of females and 5% of homicides of males (U.S. Department of Justice, 2007).

The themes of recent research on IPV/A screenings explain that either the subject matter is being ignored or the screenings are not being done effectively. Studies have shown the most significant deterrent of screening is a lack of education and training on how to ask questions about abuse. Education increases the probability of addressing and meeting the needs of patients. The general opinion from key informants in the PLU School of Nursing was further education could be implemented and would be beneficial to nursing students. The more education and preparation nursing students have on IPV/A situations will increase the likelihood of more effective screenings in their future nursing practices. Also expressed by the informants was the idea that familiarity would decrease the awkwardness of asking personal questions about IPV/A. The more information and examples of proper screenings will likely increase the comfort level of these future nurses.

Survey Results

We surveyed a total of 87 students currently enrolled in PLU's School of Nursing. Broken down into cohort year we had: 16 sophomore II, 13 junior I, 19 junior II, 17 senior I, 6 senior II and 16 entry level master's (ELM) students respond to our survey. The survey was composed of seven questions related to comfort level and familiarity with IPV/A screenings and resources. All questions were answered using a five point Likert scale. See appendix A for the survey and cover letter.

The first question on the survey asked: "How comfortable would you feel asking a patient/client IPV/A screening questions?" Responses to question one varied between "very comfortable" and "somewhat comfortable". 43.8 % of sophomore II's and 46.2% of junior I's responding to the survey stated they felt "somewhat comfortable" asking IPV/A screening

questions. 36.8 % of junior II's , 41.2% senior I's, and 43.8% of ELM's responding stated they felt “comfortable” asking screening questions. Senior II's were the only group that felt “very comfortable” asking screening questions, with 66.7% stating this response. There was a significant difference in the response of sophomore II and junior II students ($p=0.018$), between sophomore II and senior II students ($p=0.008$), between junior I and senior II students ($p=0.023$), and between senior I and senior II students ($p=0.027$). It appears comfortability increases with progression through the nursing program.

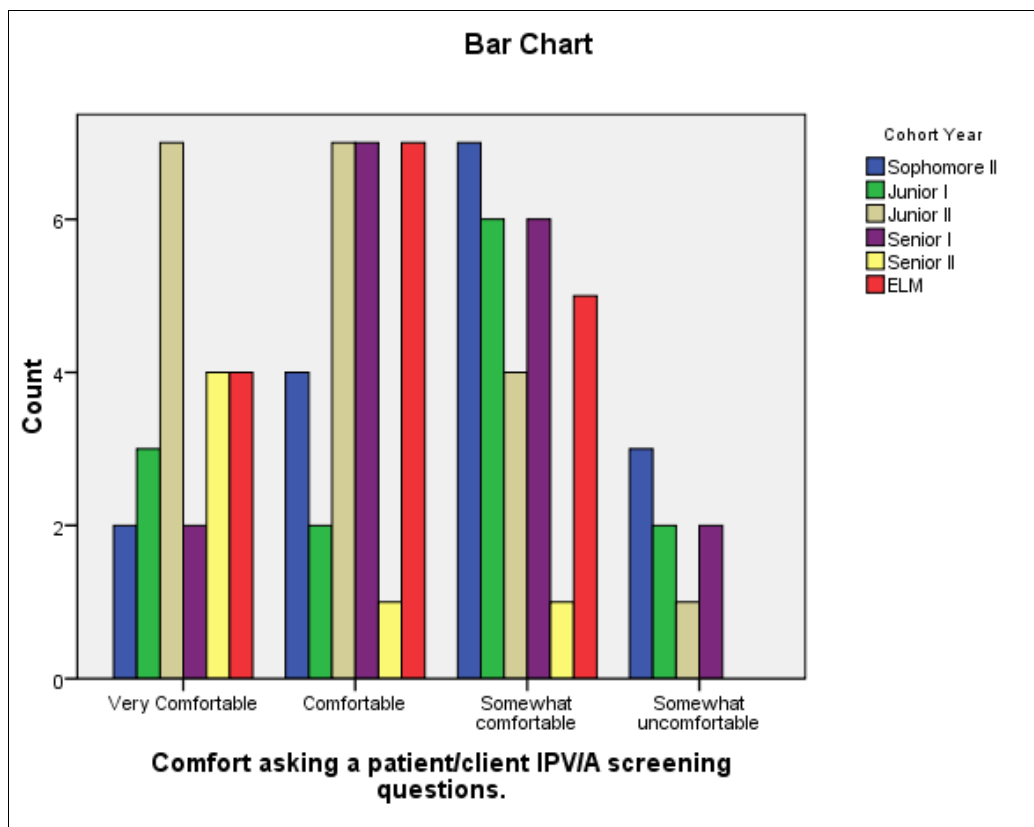


Figure 1: Survey question one results

Question two on the survey asked: “How familiar are you with what to do if a patient/client answers yes to IPA/V screening questions?” Responses varied from “somewhat unfamiliar” to “very familiar”. Sophomore II, junior I, senior I and ELM stated they were “somewhat unfamiliar” with rates of 56.2%, 53.8%, 47.1% and 56.2% respectively. Junior II students

responded they were “somewhat familiar” with responding to a positive screening at a rate of 42.1%. Senior II students were evenly spaced between “very familiar” and “somewhat unfamiliar” at a rate of 33.3% each. There were significant differences between sophomore II and senior II student responses ($p=0.031$) and between junior I and senior II student responses ($p=0.03$). There seems to be greater variety in responses to this question and may be related to personal experiences with patient/clients either in clinical or outside school.

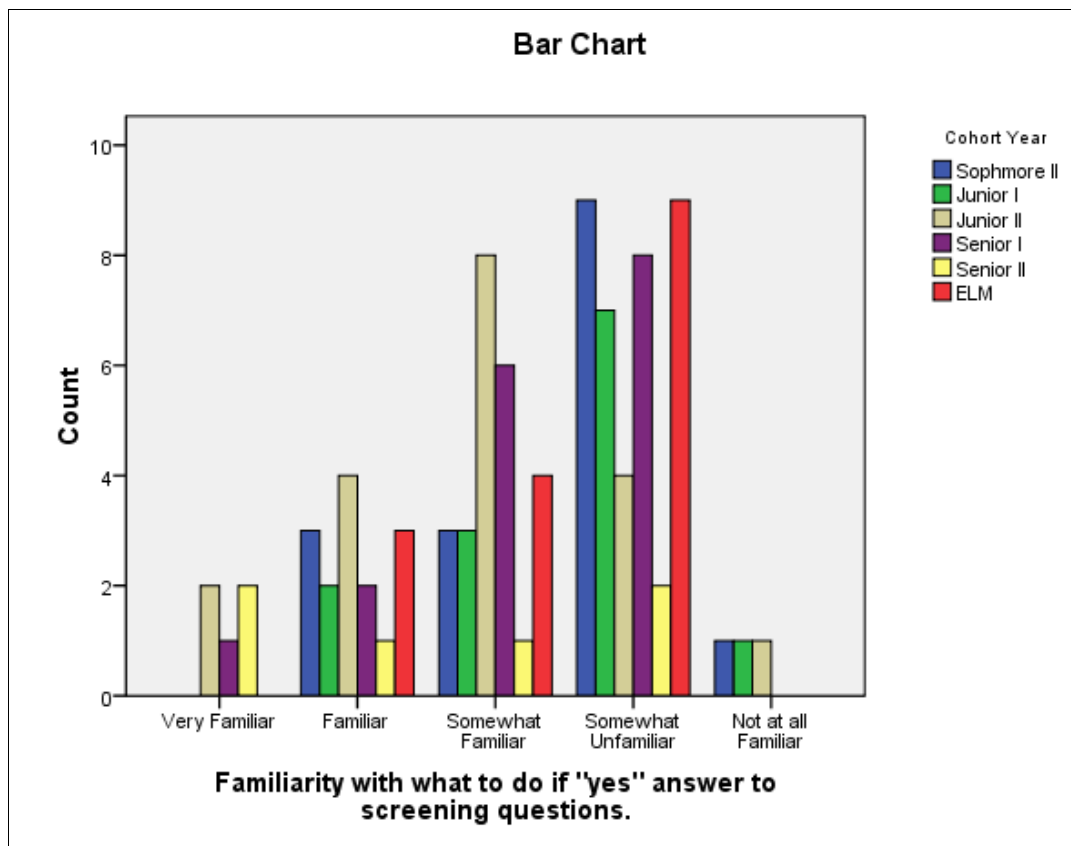


Figure 2: Survey question two results

The next question was regarding familiarity with the signs and symptoms of IPV/A. Sophomore II, junior II, and senior I all stated they were “somewhat familiar” with the signs and symptoms with a rate of 62.5%, 42.1% and 42.1% respectively. Interestingly, another 42.1% of junior II’s responded that they were “familiar”. Both ELM and senior II students responded they are “familiar” with the signs and symptoms at a rate 50% each. Junior I were the only group to

state they were “somewhat unfamiliar” at a rate 38.5%. There were significant differences between sophomore II and senior II student responses ($p=0.012$) and between junior I and senior II student responses ($p=0.011$). Suggesting an increase in familiarity of signs and symptoms of IPV/A from first semester of the junior year to the final semester senior year.

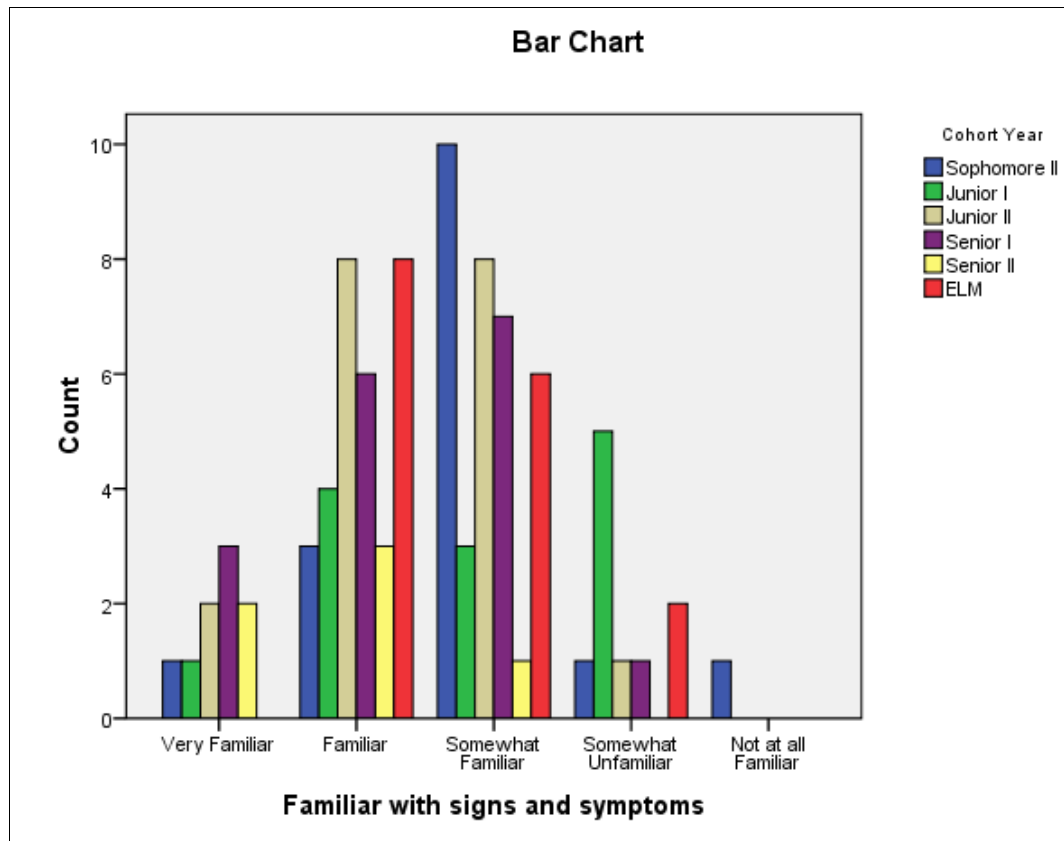


Figure 3: Survey question three results

The fourth question on the survey followed up on the signs and symptoms by asking how familiar students were with responding to signs and symptoms of IPV/A. Sophomore II, junior I, senior I, all stated they were “somewhat unfamiliar” with responding to signs and symptoms at a rate of 50%, 53.8%, and 35.3% respectively. Senior I were also divided with 35.5% stating they felt “familiar” with responding to signs and symptoms of IPV/A. Senior II responses were divided evenly between three responses at a rate of 33.3% each of “very familiar”, “familiar” and

“somewhat familiar”. ELM students, 43.8%, felt “somewhat familiar”. There were significant differences between most of the groups. Sophomore II student responses were significantly different than junior II students’ ($p=0.003$) and senior II students’ ($p=0.001$). Junior I student responses were significantly different from junior II students’ ($p=0.026$) and from senior II students’ ($p=0.004$). Senior I student responses were significantly different from senior II students’ ($p=0.021$) and senior II student responses were significantly different from ELM students’ ($p=0.015$). There was a wide range of response between and within groups to this question. This may also relate to experiences obtained from clinical or outside school.

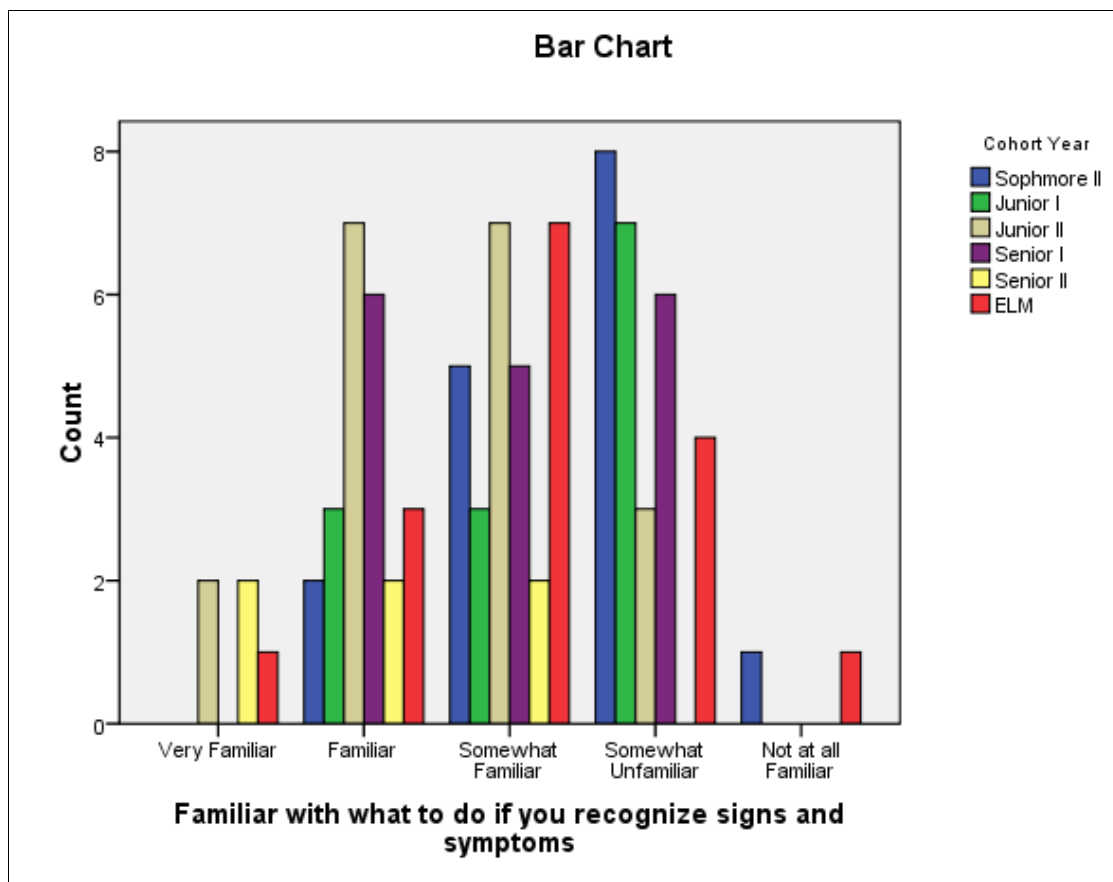


Figure 4: Survey question four results

Question five was very similar to the previous question. It asked students how familiar they are with the next step after identification of signs and symptoms of IPV/A. Again

sophomore II, junior I and senior I students stated they were “somewhat unfamiliar” with what to do at rates of 60%, 61.5% and 52.7% respectively. Junior II and ELM students felt they were “somewhat familiar” with what to do at rates of 36.8% and 50%. 50% of senior II students felt “very familiar”. There were significant differences between most of the groups in response to this question. Sophomore II student responses were significantly different from junior II students’ ($p=0.001$) and from senior II students’ ($p=0.002$). Junior I student responses were significantly different from junior II students’ ($p=0.001$) and from senior II students’ ($p=0.001$). Junior II student responses were significantly different from senior II students’ ($p=0.013$) and from ELM students’ ($p=0.012$). Senior I student responses were significantly different than senior II students’ ($p=0.01$) and senior II student responses were significantly different from ELM students’ ($p=0.009$). There was a wide range of response between groups to this question, similar to the previous question. This may relate to experiences obtained from clinical or outside school.

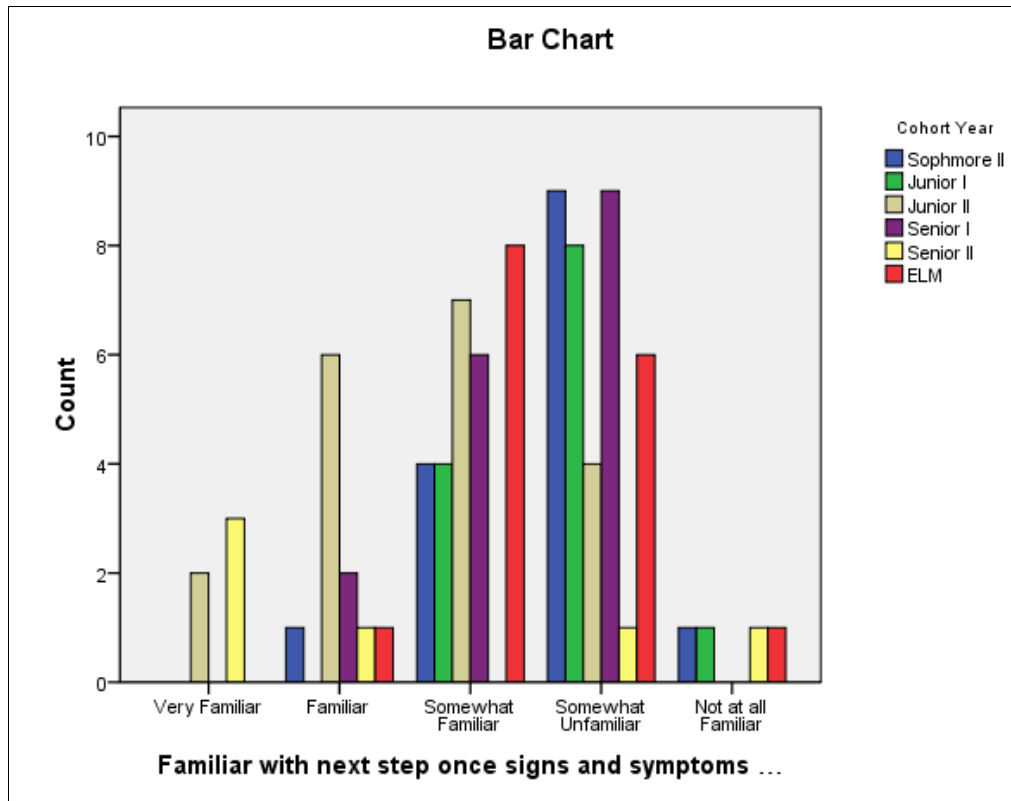


Figure 5: Survey question five results

Question six asked student how familiar they are with available resources for IPV/A victims. Sophomore II students were divided between “somewhat familiar” and “somewhat unfamiliar” at rates of 37.5% each. Junior I and senior I students both stated they felt “somewhat familiar” with available resources at rate of 41.7% and 41.2% respectively. 50% of senior II students felt “very familiar” with available resources and 43.8% of ELM students felt “somewhat unfamiliar”. Junior II students felt “familiar” at a rate of 47.4%. There were significant differences between the groups with this question. Sophomore II student responses were significantly different from junior II students’ ($p=0.005$) and from senior II ($p=0.015$). Junior I student responses were significantly different from junior II students’ ($p=0.048$) and from ELM students ($p=0.003$). Senior II student responses were significantly different from ELM student responses ($p=0.011$). There were significant differences between several groups in response to

this question. Sophomore II student responses were significantly different from junior II students' ($p=0.005$) and from senior II students' ($p=0.015$). Junior I student responses were significantly different from junior II students' ($p=0.048$) and ELM students' ($p=0.003$). Senior II student responses were significantly different from ELM students ($p=0.011$). There were differences between groups and within groups in response to this question. This suggests that there may be an experience factor, either through clinical or outside of school situations.

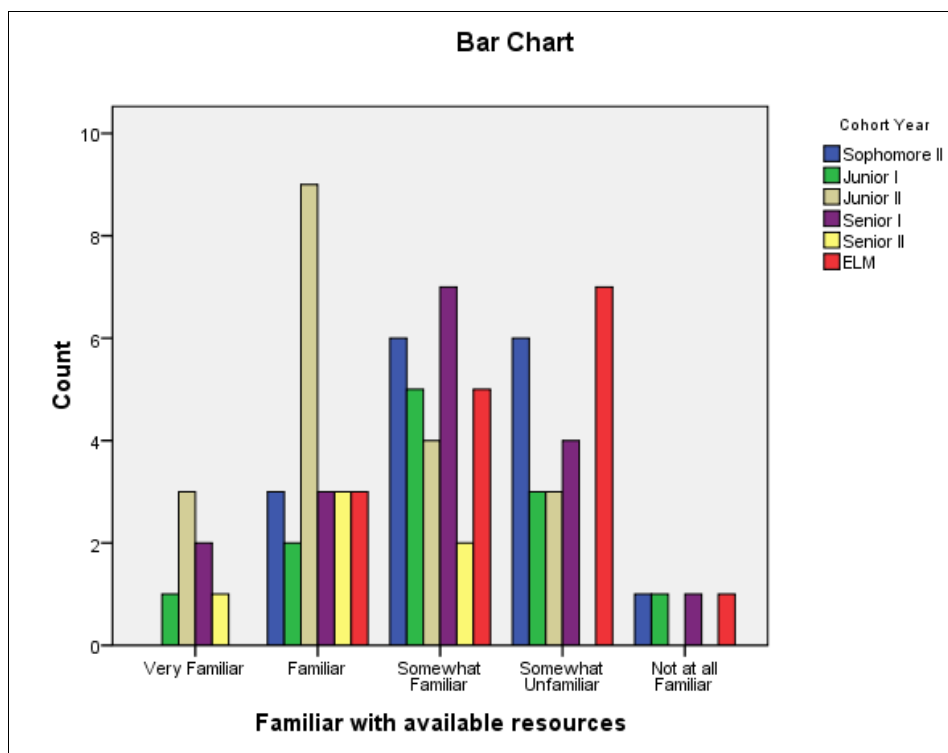


Figure 6: Survey question six results

The final question wanted to know how much interest there is in a “quick” resource guide. All groups had high levels of “very interested” students. Sophomore II – 68.8%, junior I – 76.9%, junior II – 73.7%, senior I – 50%, senior II – 100% and 81.2% of ELM all stated they were “very interested” in having a quick reference guide. There was only a significant difference

between senior I and senior II student responses ($p=0.03$). Suggesting there is little difference, regardless of placement in the program, in interest in a reference guide between groups.

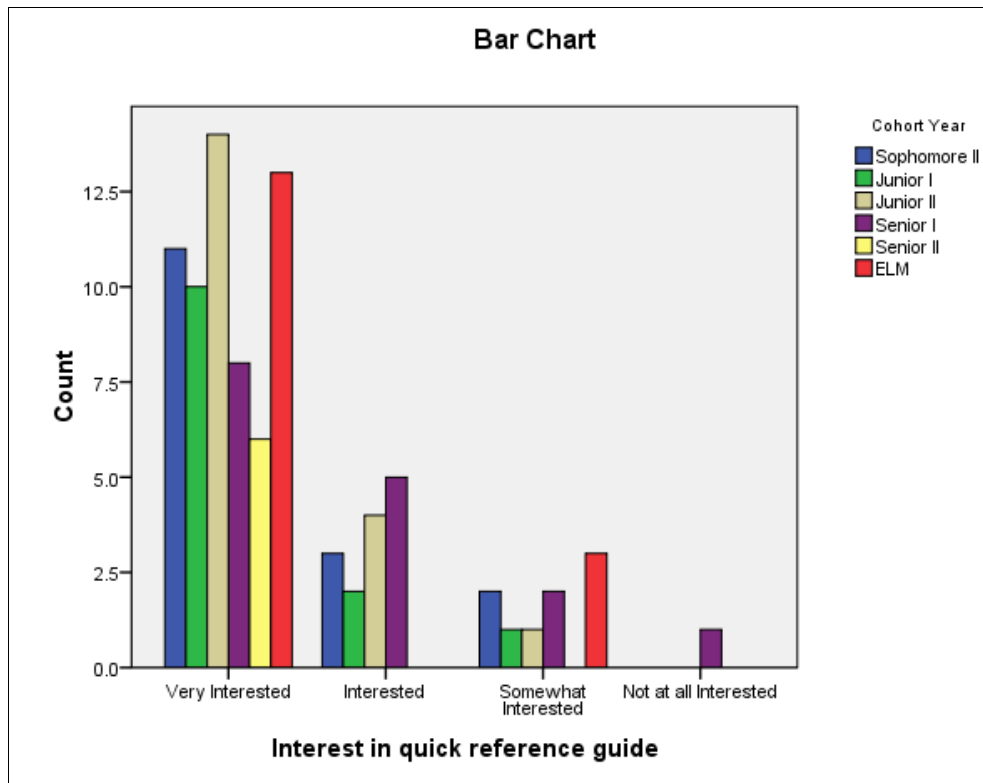


Figure 7: Survey question seven results

Overall, this survey indicates a variety of answers. It shows there is an interest in obtaining a quick reference guide to help in situations of suspected or admitted IPV/A. The greatest variety in answers came when asking about familiarity with resources and what to do when a patient gives a positive response to IPV/A screening questions. Considering all data gathered, it can be inferred that there is a need to address a knowledge deficit among PLU nursing students regarding issues of IPV/A. This is supported by the recent research stating current nurses are ill-prepared for these situations. If the issue can be discussed in an educational setting, it could better prepare new graduates for IPV/A situations and therefore decrease the percentage of undetected and unaddressed incidents of abuse.

Concerns and Strengths

Strengths.

Research supports lack of knowledge in nurses. Survey results show some comfort with asking questions but not much familiarity with resources or what to do when a patient/client answers positively or has signs and symptoms of IPV/A. PLU environment is an optimal environment for further education and/or training. Students are already here to learn and incorporation into the curriculum would be advantageous to students, future employers and most of all patients. Faculty support the idea of increased training related to IPV/A screenings, signs and symptoms and how to communicate with patients regarding available resources, and students responding to our survey state an interest in a quick reference guide on IPV/A.

Concerns.

The time constraints both in and outside the classroom greatly impacted our assessment. HPRB review took much longer than we anticipated and we were unable to survey all class levels within the school of nursing. It is reportedly very difficult to make any curriculum alterations. We are concerned whether the culmination of efforts will result in increased education or simply more work for all involved. Perhaps the problem really comes down to awareness that nurses avoid doing the assessment, gaining experience in all nursing skills, and dealing with the issue in “real” life situations. In addition, there is concern the survey results are not as accurate as wanted since we were unable to survey the sophomore I class and only surveyed six senior II students.

Causal Relationship

There is no direct causal relationship between lack of education or training and avoidance or ineffective IPV/A screenings. However, lack of comfortability and education or training are the most frequently stated reasons for not completing the screening, or for improperly performing the assessment. Yonaka, Yoder, Darrow & Sharp (2007) and Buck & Collins (2007)

both state the most significant barrier to screening is the lack of education and instruction on how to ask the questions. This statement was regardless of degree level. Many providers state they are open for further education and training (Yonaka et al, 2007).

Deming's 14 points

W. Edwards Deming developed fourteen points relating to improving management and overall customer satisfaction and total quality management (TQM). These points, originally targeted at business organizations can be used in a variety of applications, including healthcare. Three of his points in particular relate to this project, all relating to education and self-improvement.

In this time of using Hospital Care Assurance Programs' (HCAPS) to evaluate performance and payment levels, point five of Deming's fourteen points becomes important. Point five states "improve constantly and forever the system of production and service" with the overall goals to increase quality (Stanhope & Lancaster, 2008). By being innovative and self aware we can identify areas to improve upon.

Healthcare itself is constantly changing in the hopes to improve services which in turn improve outcomes. With only a reported 12-14% of IPV/A victims being screened in the hospital but 70-80% of patients wanting to be screened demonstrates this is an area lending itself to quality improvement (Bhandari, Sprague, Tornetta, D'Aurora, Schemitsch, Shearer, Brink, Mathews, & Dosanjih, 2008). Hilmer & Karney (1997) state this point is management's responsibility and only management has the authority to change a common cause of problems, in this case variation in screening techniques or the non-performance of IPV/A screenings. Throughout Deming's fourteen points there is a continuous thread to reduce variation in all forms (Castellano & Roehm, 1995).

Deming's sixth point recommends organizations institute training. The training instituted needs to meet that specific organization's needs and goals and use their available resources (Kiesow, 1995). This point ties into the previous need to improve constantly by reducing variation on how all staff performs the same tasks.

In IPV/A screening there is a wide variety of approaches to ask the questions and provide resources. By instituting a training program that is site specific, staff learns the preferred methods and available resources the specific organization or even department might have access to use. The emergency department is more likely to have a social worker readily available than a medical surgical department since women who are abused frequently seek treatment in the emergency room (Rhodes, Frank, Levinthal, Prenoveau, Bailey, & Levinson, 2007).

This point is focused more on building technical skill. Techniques for asking questions, such as who should be present while the screening is happening, and knowing resources, should be the focus of this kind of training. The training should also happen on a regular basis, such as on skills days, to keep the information fresh and increase comfortability with the screening process.

Focusing on broader knowledge is the purpose behind Deming's thirteenth point. This point states "encourage education and self-improvement for everyone" (Castellano & Roehm, 1995). Tying back to the fifth point of continuous improvement it is only through keeping up with current practices and constant quality improvement that all processes can improve (Kiesow, 1995).

Offering a broader educational program in communication techniques and in responding to requests for resources related to IPV/A will increase staff confidence in themselves and their ability, in turn increasing quality and patient satisfaction. By offering a broader view, of the subject we can increase staff knowledge of the impact IPV/A has on

healthcare. This would be a good time to role play, practice open ended questioning and demonstrate positive and negative interviewing techniques.

By increasing the knowledge base of staff we increase the quality of the service or product we offer to the community and as quality increases so does the number of people wanting your services. If your institution has a reputation of helping people in IPV/A situations more people may come forward and seek help at your site therefore increasing your impact on the community you serve and, in the long term, perhaps reducing some burden on the healthcare system, never mind the individual's life you have helped.

Management diagnosis for the system of the school of nursing and our group may include:

- Ineffective time management related to lack of planning, as evidenced by faculty stating time restraints in curriculum, faculty stating little information about IPV/A education, students surveys indicating further need of educational resources.

Planning

Nursing diagnoses with objectives and goals:

1. Risk for knowledge deficit of intimate partner violence screenings among nursing students related to lack of exposure, and unfamiliarity with information as evidenced by instructors detecting discomfort in students, Mental Health course time constraints, student surveys and professional nursing research.

Long term goal: Reduce injuries, disabilities and deaths due to unintentional injuries and violence per Healthy People 2010.

○ Objectives:

1. Reduce maltreatment and maltreatment fatalities of children by the year 2010.

2. Reduce the rate of physical assault by current or former intimate partners by the year 2010.
3. Reduce the number of physical assaults by the year 2010.
4. Reduce hospital emergency department visits caused by injuries by the year 2010.

The long term goal and objectives come directly from Healthy People 2010 and they are the umbrella under which we work. The best way we, as nurses and students, can reach these is to improve screening performance. The more people we are able to remove from potentially violent and fatal situations the greater the reduction in people suffering from disability or death from violence. By assuring graduating nursing students are comfortable and aware of local resources, we promote awareness of the problem of IPV/A, therefore leading to the reduction of victims.

Short term goal: Reveal knowledge deficit and decreased comfort level among nursing students related to IPV/A screenings.

- Objectives:
 1. Nursing students will indicate via survey current comfort level of screening for IPV/A by December 1, 2008.
 2. Nursing students will indicate via survey current familiarity of IPV/A resources by December 1, 2008.

We need to identify if there is a need among students for greater instruction in the performance of IPV/A screenings. By surveying students self perceptions we will be able to better pinpoint areas that need improvement. There may be a knowledge deficit in what resources are available compared to what students know about the signs and symptoms. If there

is a need for increased comfortability, not necessarily knowledge, by asking questions we can develop a program strengthening comfortability such as role-play.

A seven question survey was developed using a Likert scale. The questions delve into students' comfortability asking the screening questions and familiarity with signs, symptoms and resources available. Surveys are a great assessment tool. They help clarify or identify a problem and gather information (Redding, 1997). Surveys provide information from which improvement plans can be developed and implemented (Redding, 1997). Surveys are also a good tool for organizations to assess areas within their systems that need improvement and implement change (Cohen, 2005). Please see appendix for survey.

We requested time from several professors asking for about ten minutes of class time to administer the survey. Ideally we wanted at least ten surveys from every class level. Unfortunately, we were unable to survey the sophomore I class due to scheduling conflicts, both on them and us, and the length of time it took for the survey to pass HBRP. In addition, some instructors either did not respond or were unwilling to lose class time for our project. As a result we were only able to survey six senior II students.

Survey results suggest there is a need for knowing what to do in situations rather than increased comfortability, although responses maybe misleading since they are self-reported. There was a greater variety in response to questions on familiarity of resources and actions than comfortability asking screening questions.

Short term goal: Correct potential knowledge deficit among nursing students.

- Objectives;
 1. Work with the Women's center on campus to develop a workshop or seminar or use a currently provided program to increase students'

awareness and comfortability with IPV/A screenings by start of fall semester, September 2009.

2. Prepare a video of correct and incorrect techniques for performing an IPV/A screening by August 1, 2009.

By using programs already available we can reduce the amount of time needed to implement the change. In collaborating with other organizations, we gain from their experience. We can also reduce costs by utilizing existing programs.

If students prepare and perform a video that will be used to instruct their peers they gain a greater knowledge of the problems being demonstrated. The peer group learning from the video can place themselves in the situation easier when they witness someone they can relate to, someone in the same situation. Demonstrating incorrect ways to perform IPV/A screenings allow students to identify what is wrong and how they would do things differently, and then show a correct way to validate their ideas and thoughts (Holschneider, 2007). The education provided should focus on improving healthcare provider communication skills and responses to abuse disclosures (Rhoden, Frankel, Prenoveau, Bailey and Levinson, 2007).

Second nursing diagnosis:

2. Risk for avoidance of IPV/A screenings questions among nursing students and new graduates related to discomfort with IPV/A related questions as evidenced by nursing instructors and students stating a need for more knowledge, and a feeling of unpreparedness.

Short term goal: Increase nursing students' preparedness to deal with performing IPV/A screening and how to respond to a positive response to screening questions.

- Objectives:

1. Develop a “quick” reference guide with common signs and symptoms of IPV/A and generally available resources by the start of fall semester, September 2009.
2. Prepare a program or use a currently available program such as “In Her Shoes” for students to develop familiarity with IPV/A screenings by March 1, 2009.

Simulating real life situations allow students the opportunity to actively participate in their own learning and “assume ownership of a learning task” (Hildenrand, 1997). By participating in situations they may encounter it allows students the chance to apply classroom theory such as therapeutic communication, establishing a relationship with patients, and the chance to learn from others’ viewpoints (Hildenrand, 1997). Simulations can also help students understand the negative impacts of improper performance of screening. Many patients state insensitivity, lack of confidentiality and a “joking” manner prevent them from possible revelations of IPV/A (Rhoden, et al, 2007).

One complaint among patients who did identify themselves as victims of IPV/A was the failure of healthcare workers to link them with available resources (Rhoden, et al, 2007). By having a quick reference guide readily available to students and new graduates we can advance towards eliminating this problem. The guide can let them know what a good follow up question would be if a patient voluntarily expresses concern about IPV/A since patients are more likely to respond to screenings if at least one follow up question is asked (Rhoden, et al, 2007).

Alternatives

We went into this project with a specific outcome – the building of a quick reference guide and adding an IPV/A workshop or training session to the curriculum. We had no alternatives considered to make a decision matrix. Unfortunately, it took several weeks for our survey to be

approved by HBRP which meant we did not have data to support our theory in time to implement it. Due to this delay we were unable to move forward with the making of a quick reference guide, since we did not know what information would be best to use as reference material. We were able to find a card available from the Family Violence Prevention Fund to use as a template to customize a quick reference guide. Refer to appendix B for an example.

Force Field Analysis

During the analysis of the data, many motivating forces emerged along with some resisting forces. The encouraging and motivating forces for the change in IPV/A screening education include the recent research that supports our idea that further education is needed. The PLU faculty members interviewed also support the need for further education. Also influential in the force for change is the amount of contact IPV/A victims have with future nurses. This provides an abundance of opportunities to assist our patients in the future. Of course the most important driving force is our patients' welfare.

Some barriers that have come up while implementing our project are the time constraints of one semester to prepare the project, and the lack of previous experience with the HPRB process. Along with time issues, the large amount of information in the mental health curriculum limits the amount IPV/A education. Another barrier is the matter of finding the time to provide more information, which may need to be provided outside of class time. The personal barriers of providing more education on IPV/A are often feelings of discomfort in asking personal questions and being uncomfortable with unfamiliar situations.

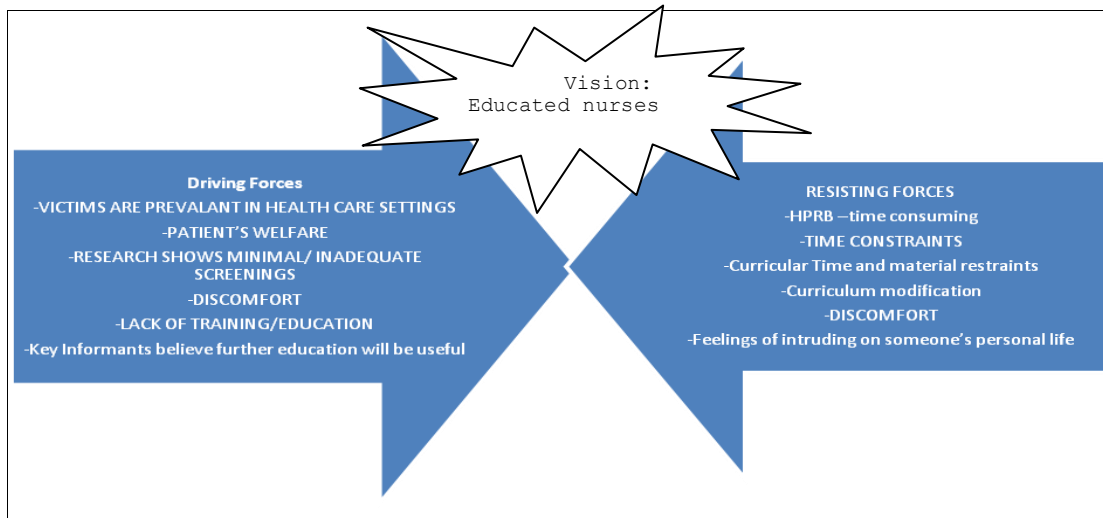


Figure 8: Force field analysis

Chaos Theory

The chaos theory, a form of nonlinear change, is a “theoretical construct defining the random-appearing, yet deterministic, characteristics of complex organizations” (Yoder-Wise, 2007). This theory can be used to describe how we accomplished our continuous quality improvement project of potentially creating a quick reference card of IPV/A screening questions for nursing students at PLU. Pacific Lutheran University’s School of Nursing is certainly a complex organization to penetrate for the purpose of quality improvement, and the way our project fell into place could appear random but had purpose. Though we initially created a plan for this project, we knew that did not guarantee implementation.

The most common example used to explain chaos theory is whether or not the flap of a butterfly’s wings in Africa will cause a hurricane in South America. The meat of the chaos theory simply asks the question, “Does one’s actions affect the outcome of another?” In regards to this project, the answer is yes. Any amount of raised awareness of a situation contributes to the decrease in occurrence of that situation. In other words, the more people are aware of the

prevalence of IPV/A and their own lack of knowledge of screening of IPV/A, the more they will focus on it and address it.

Implementation

Orlando's Nursing Process Theory

The implementation of our project was closely modeled after Orlando's Nursing Process Theory. This theory combines the nursing process with a theoretical framework to guide nursing practice. Orlando believed that "processing observations as specified in the theory led to effective nursing practice and good outcomes" (Chitty, 2005). When applied to our continuous quality improvement project, this theory explains both the purpose and results of our assessment. As student nurses in the clinical setting, we have observed the improper use of IPV/A screening materials/techniques. From this observation, we inferred the source of this negligence was a result of the lack of education and training of IPV/A screening. This hypothesis led us to our assessment of PLU nursing students. As a result of this assessment, we were able to confirm our hypothesis and determine an appropriate course of action to address it. The theory can also be applied to our potential interventions to treat this deficit. For example, the training would include role-playing during which certain behaviors someone in an IPV/A situation may exhibit would be displayed and observation of that behavior would then lead the nurse to asking more direct questions.

Situational-Contingency Theory

In the management of our project, our group was guided by the situation-contingency theory. There are five members of our group, and each of us has varying qualities. This allowed us to not only match skill sets, but also to come together and achieve productive brainstorming as a group. We were able to find different tasks that fit with each member of the group. We were all also flexible with group members by being able to meet at specific times on weekends, by giving

members who were in clinical less work at the start, by giving those who were not in clinical the more time consuming tasks, and switching at the mid-semester point.

Within the group there is a lot of trust and respect among each of the members. We have all gotten to know each other pretty well by having all of the same classes together for three years. The dynamics of our group meshed well, and we experienced no problems with agreeing upon assignments or due dates, and there was no tension between any group members.

The leadership style fits most well with our group is the Situational-Contingency Theory, "...the leadership effectiveness depends on the relationship among 1.) the leader's task at hand, 2.) his or her interpersonal skills, and 3.) the favorableness of the work situation" (Yoder-Wise, 11). Not only were the leaders of the group flexible, but the followers of the group were flexible as well. According to Hersey and Blanchard's contingency-situational theory, the group's success depends on two things: the leader's maturity level and the subordinate's maturity level (Patterson & Stone 2005). Our group was strong in both of these areas, with the right task given to the person with the best capabilities.

Evaluation

Regardless of time constraints prohibiting us from implementing our ultimate goal, we still made a contribution to the perpetuation of continuous quality improvement. Once our group unanimously decided on the subject of our project we began the process of research immediately. This was our biggest strength as a group; we collaboratively strived to accomplish as much as we could in a timely and efficient manner. However, we did encounter problems once we submitted our proposal to HPRB. The proposal was submitted within the first few weeks of our meetings, but due to the nature of the topic, a full board review was recommended. The review took roughly one week to approve, but required stipulations to be addressed before we could distribute our survey. At this point, three weeks were left to finish the project which left us little

time to gather and analyze data to determine whether or not a quick reference guide to IPV/A screening would be beneficial to PLU nursing students. Therefore, as a result, our project will require extended implementation.

This project is primed for further development by another change group. We have identified a knowledge deficit among nursing students that is being seen among mature nurses within the community as current research demonstrates. Having identified the need, interventions need to be developed. We started this project with the idea of developing a quick reference guide to disseminate to students and potentially starting a workshop in conjunction with the Women's Center on campus, however we were only able to identify the need for these things. A future group would be welcomed to develop an actual quick reference guide and working with the chair of the Curriculum, Instruction and Evaluation Committee, currently Dr. Carolyn Schultz, to develop other educational aspects such as workshops or student lead video demonstrations.

Formative Evaluation

Our short-term goal of revealing a knowledge deficit and decreased comfort level among nursing students related to IPV/A screenings has been met. We were able to distribute our survey to the majority of the cohorts in the School of Nursing to screen nursing students at various stages in their curriculum to identify the need for further instruction on IPV/A screening.

Summative Evaluation

Since we were unable to implement our intervention, we cannot evaluate our long-term goal. Therefore, our long-term goal cannot be met at this time. It is our hope that with light being shed on this issue, the faculty will be able to incorporate more training on IPV/A screening into courses throughout the nursing program. According to our key informants, this would be a valuable change to the curriculum.

If our intervention had been implemented, we would be able to go to hospitals throughout Pierce County and get an updated report from the hospitals on the number of effective screenings, or the number of reported IPV/A incidents because of the effective screening. We would hand off the project to the Head Nurse of the hospital to check the progress of our intervention yearly.

We have learned a tremendous amount from this project which is summarized below as follows:

- HPRB takes a lot longer than we thought it would. It took a third of the semester just for the approval.
- PLU nursing students feel unprepared to screen for IPV/A.
- There has been several recent research articles published on IPV/A screening, but not much has been done about the need for an intervention.
- An intervention is completely necessary. Nursing students and new graduates are going out into the field unprepared; creating what can be a dangerous or awkward environment for the patient and their families.
- We need to be advocates for change, and be part of the change process wherever we are. Implementing change and being part of the change process means continuously bettering our field for ourselves, future nurses, and our clients.

The following is a list of things we could improve upon in the future:

- We would have gone through the paper guidelines on the very first meeting.
- Knowing the guidelines of the paper, and what each section entails, we would have been able to split work up more evenly in the beginning, not leaving one member of the group

doing an unfair amount of work. If it turned out that one person got more work than the rest, we would have had time to change it.

- Going through the guidelines first would also have informed us of what could be done before our HPRB approval.
- Due to the lengthy wait for our HPRB approval, our group lost motivation around mid-semester. We would have kept the ball rolling instead of taking the time that we were waiting for our HPRB approval off.

Some skills that would be helpful in allowing us to function as change agents are better technical skills with the HPRB process, better research skills, and more experience over all. Obviously, the experience piece is important. With more knowledge and experience in anything, we will be better. More experience with HPRB, more experience with writing surveys, more experience with giving surveys, more experience with key informant interviews, and more experience with finding research articles would have made our project run much more smoothly and efficiently. If we were to do our project over again, things would be much different, and probably much better.

References

- Abbott, J., Johnson, R., Koziol-McLain, J., & Lowenstein, S. R. (1995). Domestic violence against women: incidence and prevalence in an emergency department population. *Journal of the American Medical Association, 273*(22), 1763.
- Berrios, D. C., & Grady, D. (1991). Domestic violence risk factors and outcomes. *Western Journal of Medicine, 155*(2), 133-135.
- Bhandari, M., Sprague, S., Tornetta, P., Aurora, V., Schemitsch, E., Shearer, H., et al. (2008). (Mis) Perceptions about intimate partner violence in women presenting for orthopedic care: A survey of Canadian orthopedic surgeons. *Journal of Bone and Joint Surgery, 90A*(7), 1590-1597.]
- Buck, L., & Collens, S. (2007). Why don't midwives ask about domestic violence? *British Journal of Midwifery, 15*(12), 753-758.
- Bureau Of Justice Statistics . (1994, November). Selected Findings. In *Violence between intimates*. Retrieved September 22, 2008, from U.S. Department of Justice Web Site: <http://www.ojp.usdoj.gov/bjs/pub/pdf/vbi.pdf>
- Bureau of Justice Statistics. (2007). *Intimate Partner Violence in the U.S.* Retrieved September 22, 2008, from U.S Department of Justice Web Site: <http://www.ojp.gov/bjs/intimate/report.htm>
- Castellano, J. & Roehm, H. (1995). The Deming philosophy. *CMA Magazine, 69*(1), 25.
Retrieved 11/14/08 from Business Source Premier database.
- Chitty, K., K. (2005). *Professional nursing: Concepts and challenges*. St. Louis, Missouri: Elsevier, Inc.
- Erlingsson, C (2007). Searching for elder abuse: A systematic review of database citations. *Journal of Elder Abuse & Neglect, 19*(3/4), 59-77.

- Fulmer, T., Paveza, G., Abraham, I., & Fairchild, S. (2000). Elder neglect assessment in the emergency department. *Journal of Emergency Nursing, 26*(5), 436-443.
- Hildenrand, J. E. (1997). The company division meeting: a business communication simulation. *Business Communication Quarterly, 60*(3), 1997.
- Hilmer, S. & Karney, D. (1997). Towards understanding the foundations of Deming's theory of management. *Journal of Quality Management, 2*(2), 171. Retrieved 11/14/08 from Business Source Premier database.
- Holtschneider, M. E. (2007). Nursing Management. *Better communication, better care through high-fidelity simulation, May, 55-57*
- Kiesow, P. (1995). Fourteen points stress employee well-being. *Ceramic*
- Owen-Smith, A., Hathaway, J., Roche, M., Gioiella, M. E., Whall-Strojwas, D., & Silverman, J. (2008). Screening for domestic violence in an oncology clinic: Barriers and potential solutions. *Oncology Nursing Forum, 35*(4), 625-633.
- Redding, J. (1997). Hardwiring the learning organization. *Training and Development, August, 61-67*.
- Rhodes, K. V., Frankle, R. M., Lavinthal, N., Prenoveau, E., Bailey, J., & Levinson, W. (2007). Improving patient care "You're not a victim of domestic violence, are you?" Provider-patient communication about domestic violence. *Annals of Internal Medicine, 147*(9), 620-627.
- Sayles-Cross, S. (1988). Profile of familial elder abuse: A selected review of the literature. *Journal of Community Health Nursing, 5*(4), 209-219.
- Stanhope, M. & Lancaster, J. (2008). *Public health nursing: Population centered healthcare in the community* (7th ed.). St. Louis, Missouri: Mosby.

U.S. Department of Justice. (1997, August). *Violence-related injuries treated in hospital emergency departments*. Rand, R. R. Bureau of Justice Statistics.

Yonaka , L., Yoder, M. K., Darrow, J. B., & Sherck, J. P. (2007). Barriers to screening for domestic violence in the emergency department. *The Journal of Continuing Education in Nursing, 38*(1), 37-45.

Appendix A

SURVEY COVER LETTER

INTRODUCTION: You are invited to participate in a research study conducted at Pacific Lutheran University in the School of Nursing. The main investigators of the study are Audrey Falk, Joyce Bailey, Amber Skipworth, Heidi Ritting, and Ashley Roberts, all of whom are Senior I Nursing students. You were chosen to participate in the study because currently enrolled in the School of Nursing at PLU. Approximately 50 participants will be enrolled in this study. Participation should require about 15 minutes of your time. Participation is entirely voluntary; you may withdraw from the study at any time without consequences.

PURPOSE: The purpose of the study is to investigate whether or not there is a need for educating nursing students at PLU on issues related to Intimate Partner Abuse/Violence. Results of the study will be summarized and presented in a class assignment. Responses will be completely anonymous; your identity will not be linked to this survey in any way.

PROCEDURES: If you decide to participate in the study, you will be given a one-page questionnaire containing questions regarding your knowledge of Intimate Partner Abuse/Violence in the health care setting. If you do not wish to participate, simply discard the questionnaire.

RISKS, INCONVENIENCES, AND DISCOMFORTS: Some of the questions on the survey may cause emotional discomfort. If so feel free to contact Women's Center (253-535-8759) or Domestic Abuse hotline (1-888-743-5754) with further questions or if you feel you need to talk to someone.

POTENTIAL BENEFITS: There are no major benefits to you for your participation, but a potential benefit may be the information provided to you about Intimate Partner Abuse/Violence or the experience of participating in research.

ANONYMITY: Records of information that you provide for the research study and your personally identifying information (name or other characteristics) will not be linked in any way. It will not be possible to identify you as the person who provided any specific information for the study.

You are encouraged to ask any questions, at any time, that will help you to understand how this study will be performed and/or how it will affect you. **You may contact the principal investigator, Audrey Falk at falkam@plu.edu or the investigator's faculty advisor, Carolyn Schultz at (253) 535-7699 or schultcw@plu.edu .** If you have any questions or concerns about this study or your rights as a study participant, you may contact the Human Participants Review Board, Pacific Lutheran University through the Provost's Office at (253) 535-7126.

Completing and returning the questionnaire constitutes your consent to participate.

Please keep this letter for your records.

Appendix B
Survey Questions

Appendix C

Division of group labor:

Change project proposal- Audrey Falk
HPRB proposal- everyone
HPRB revisions- Joyce Bailey, Heidi Ritting
Annotated Bibliography-Heidi Ritting, Audrey Falk
Assessment- Heidi Ritting
Key Informant interviews Mindy Schaffner- Heidi Ritting, Amber Skipworth
Key Informant interview Brenda Frank- Heidi Ritting
Key Informant Dr. Carr interview - Joyce Bailey, Audrey Falk
Key Informant interview Janet Dubois – Joyce Bailey, Ashley Roberts
Systems analysis- Heidi Ritting
Force Field Analysis-Heidi Ritting
Analysis- Joyce Bailey, with assistance of Heidi Ritting
Survey – Joyce Bailey, Audrey Falk
Survey Analysis – Joyce Bailey
Planning- Joyce Bailey, with assistance of Heidi Ritting
Nursing Diagnosis- everyone
Management Diagnosis – Heidi Ritting
Objectives- everyone
Goals- everyone
Evaluation- Ashley Roberts
Implementation- Audrey Falk, Amber Skipworth