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Cultural Identity of Labor and Delivery Nurses In the Assessment of Pregnant Patients For Interpersonal Violence

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The project and manuscript have been successfully completed and meet the standards of the School of Nursing at San Jose State University. The project demonstrates the application of professional knowledge, clinical expertise, and scholarly thinking. An abstract of the project and two copies of the manuscript are attached.

Irene Gonzalez 5/17/06
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Dr. Barbara Willard 5/17/06
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Cultural Identity of Labor and Delivery Nurses In the Assessment of Pregnant Patients For Interpersonal Violence

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Abstract

Objective: Identification of barriers to assessment of interpersonal violence (IPV) in pregnant women.

Design: An exploratory descriptive study

Setting: The labor and delivery department of a public county hospital

Participants: 34 nurses, representing 8 cultures and 13 native languages, completed the survey, and 34 laboring patient's medical records were reviewed.

Main Outcome Measures: Any specific barriers, identified by nurses, to assessing for IPV in laboring patients

Results: Medical record review revealed 50% assessment rate in labor triage patients. Survey results revealed that cultural identity (85 %) was not a significant barrier. Approximately 65% of nurses agreed that in their culture it was acceptable to ask patients about IPV. Over 88% of nurses stated their culture strongly supported asking about IPV. Over 50% of nurses identified language as the single most prevalent barrier in both US and non-US born nurses.

Conclusion: Labor nurse's cultural identity, in itself, was not a barrier to the assessment for IPV. A nurse's inability to speak the same language as the patient emerged as the single most significant barrier in the assessment for IPV in this study.

Keywords: interpersonal violence-IPV, cultural identity, abuse in pregnancy, assessment barriers

Callouts (3)

1. Inability to communicate in the patient's language emerged as the most significant barrier for labor nurses, whether US or non-US born. (should appear in barriers to assessment)
2. To increase screening of pregnant women for IPV, we must understand the influence of language as a primary barrier. (should appear in discussion)
3. Conflict of languages presents a quality of care challenge as nurses are imported to fill staff shortages and increased immigration of non-English speaking patients continues. (should appear in implications for practice)

Interpersonal violence (IPV) directed at women is epidemic world wide. In the United States, we commonly hear the term, *Domestic Violence* (DV), in describing the destructive effects on women and their children. Yet, the definition of DV limits the abuser to an intimate partner. Often the abuser is not the father or the current partner, but may be any other person(s) in the mother's life. This study on interpersonal violence, did not limit data to a specific circumstance of abuse, therefore included those situations defined within "Domestic Violence".

Women who are pregnant have an increased risk of becoming victims of violence. AWHONN has supported routine education for nurses in the identification and treatment for IPV (Schoening, Greenwood, McNichols, Heermann, and Agrawal, 2004). It is known that abuse of women and children is as clearly linked to alcohol abuse as are major motor vehicle accidents. The rate of abuse rises 15 times higher in household where husbands are often drunk than homes where the husband does not drink (Health and Healthcare 2010, 2003).

It is estimated that between 9% and 25% of pregnant women are abused (Giardino, 1999; Cox 2003). Using the most modest estimate of only 4-5%, interpersonal violence in the prenatal period remains more common than diabetes and preeclampsia, which are routinely screened for during pregnancy (Parsons, Goodwin & Petersen, 2000). Outcomes of pregnancies affected by IPV include complications of first and second trimester bleeding, miscarriage, preterm labor,

low birth weight infants, substance abuse, sexually transmitted diseases, and urinary tract infections (McGrath, Hogan & Peipert, 1998; Cox, 2003).

Upon admission to a labor and delivery service, assessing pregnant patients for risk factors is clearly defined and standardized. This assessment consistently includes screening for possible IPV.

Barriers to assessment for IPV include lack of formal training, lack of privacy, feeling of helplessness to change the situation, and the personal belief system of the specific nurse. Ellis (1999) reported lack of privacy and time constraints as primary barriers in 40 RN's in a large trauma center. Additional studies have reported a rate of IPV in the personal experience of nurses to be as high as 58% (Ellis, 1999; Cox, 2003; Denham, 2003).

Conceptual Framework

Theory Description

The Theory of Planned Behavior (TPB) provided the framework for this study (Ajzen & Fishbein, 1980). The central factor in TPB is the *intention* to perform an identified behavior. In truth, the theory does not address the actual control a person has, but the perceived behavior control. Though a person may be willing to perform a certain behavior, realistic barriers may exist in their perception of the ability to do so.

Application of the TPB to assessment for interpersonal violence would have individual nurses show intent to screen when they approached it confidently,

felt that others, important to them, thought they should do so, and believed the act of intervention was under their control.

In the actual interaction of asking any woman about her safety and well-being, there could have been a perceived ease or difficulty of performing the action. Research on what impacted the ease or the difficulty would aid in the future goal of increasing compliance with laws and policy

When looking at health care, behavioral intention was the willingness on the part of the nurse to perform a specific behavior; how much they were willing to try to do it. This intention to perform the behavior or the action was rooted in the attitude, subjective norms, and perceived behavioral control (Ajzen, 1988). Therefore, it followed that if a willing intention could be provoked, then action of the desired behavior would follow. The intervention that would affect one nurse's behavior would not necessarily trigger action in another.

In this study, the desired behavior was the act of the nurse asking questions of the pregnant patient regarding past or current interpersonal violence. Without the core concepts resulting in the intention to perform the assessment, there would be little hope of success. Yet even with the intention, the individual nurse needed to make the concerted effort to perform the act.

Literature Review

Barriers to Assessment

Despite the knowledge of the need for assessment of the pregnant woman for violence, assessments are missed. The multiple barriers have been identified in the literature, yet ability to speak of the language of the patient has not been identified to date as a significant factor (Ellis, 1999; Thompson, Rivara, Thompson, Barlow, Sugg, and Maiuro, 2000). In a major review of 24 studies that examined health care provider barriers, lack of time and lack of training were the most often cited barriers (Parsons, Goodwin & Petersen, 2000).

Partner and Non-partner Abuse

Khosla, Dua, Devi and Sud published a study in the Indian Journal of Medical Sciences in 2005 focused on the prevalence of domestic violence aimed at pregnant North Indian women. The notion of non-partner abuse is revealed by the statistics of abuse by other members of the husband's family in 52% of the cases studied. Abuse by the husband and his mother constituted the majority of the cases, with many women having multiple abusers (Khosla, 2005).

Certainly nurses practicing in the US and who identify with the North Indian culture may find it difficult to comply with regulations of assessment for violence. Yet, conversely, the nurse may actually be a stronger advocate for the patient due to this cultural experience.

Training and Success

Parsons, Goodwin and Petersen reported in 2000 that staff attendance at didactic training programs alone did not change screening behavior for the long term. In fact, training programs that combined instruction with institutional supports, such as a violence resource nurse, had greater success (Parsons, Goodwin, and Petersen, 2000). Certainly a referral to a nurse who speaks the same primary language as the client was essential.

Clinical Decision Making

Bakalis and Watson (2005) studied the clinical decisions nurses made in specific health care settings. No decision-making theories were applied. The aim of the study was to determine if decision-making varied based on the specialty of the nurse practice area. In conclusion, the authors posed an interest in knowing if nurses showed particular aptitudes for the different levels/or types of decision-making. Additionally, did the personality, education, or experience in nursing have any influence? Culture of origin of the nurse was not discussed or referenced in this study of 60 registered nurses (Bakalis & Watson, 2005).

Method

Research Design

An exploratory, descriptive study was used to measure the self assigned cultural identity of labor and deliver nurses and the perceived barriers to assessing for interpersonal violence in their patients. Training had been provided and

mandatory requirements for screening all women admitted to the triage area of labor and delivery is well known. This descriptive study provided no treatment or manipulation.

A literature search did not reveal a tool for assessment of the performance of the mandatory screening with regard for the cultural identity of the nurse. An instrument was developed specifically for this study by the Principal Investigator. Demographics gathered the cultural factors of the participants, as well as the perceived barriers to assessment for IPV.

The Smith Multicultural Questionnaire (SMQ) attempted to elicit information about how cultural identity might influence the intent to assess for IPV. The questionnaire was designed to inquire into three areas of influence. First, how did the nurse's attitude, beliefs, and perceived outcomes influence the intent to assess for IPV? Secondly, in what way did the influence of subjective norms, or the social pressure to ask or not ask questions, influence clinical decision-making about IPV? Thirdly, how did the perceived behavior control, or the perception of the ease or difficulty of asking questions about IPV, influence intent to assess?

The instrument was reviewed by two doctoral nursing faculty members at San Jose State University, San Jose, CA; and three doctoral candidates from University of California, San Francisco, CA for analysis of structure, validity, and themes. Changes were made upon recommendations of the faculty. A pilot study

was completed using labor and delivery nurses at a Community Hospital located northern California.

Participants

The participants represented a self-selected sub sample from a convenience sample comprised of 75 labor and delivery nurses. All participants were registered nurses, participation was voluntary, and no incentives were provided. Thirty four nurses completed the SMQ, which represented 45% of the pool. Age of nurses ranged from 21 to 60 years of age (mean range 41-45 $\pm$ 1.8) (see Figure 1). The majority of the nurses had completed their baccalaureate degree; had between eleven to fifteen years of registered nursing experience; and were predominantly U. S. born (see Figures 2, 3, and 4).

Setting and Sample

The study was conducted in a busy labor and delivery department of a 524-bed public hospital owned and operated by a county in Northern California. The total number of labor and delivery patient triage assessments in 2005 was 11,203. Of this number, 5887 were admitted for care and 5560 delivered their pregnancy or a rate of approximately 463 births per month. The patients were given prenatal care at 23 separate clinic sites who deliver at the study hospital.

Patients were primarily of Hispanic descent (74 %) and most were monolingual Spanish Speaking. The next largest group was Caucasian women at 13%. The remaining patients were Black (African or African American) 5%,

Asian 2%, Filipino 1%, Arab 1%, Vietnamese 1%, Indochinese .23%, Pacific Islander .16% American Indian .05%, and other or unknown 4%.

The 75 nurses in labor and delivery represented twelve cultural identity groups. The eight cultural identity groups represented by the 34 voluntary participants (45 %) included: Caucasian, Chinese, East Indian, Egyptian, Filipino, Korean, Latina-Hispanic, and Nigerian (see Figure 4).

Measures

Nurse cultural identity was determined within the SMQ by direct question "What culture do you identify with?" Twelve options and "other" were possible responses. Place of birth did not necessarily indicate the nurses' individual sense of her culture. Although several participants stated they were born in Canada, two claimed "Caucasian" as their culture and not Canadian.

Barriers from the literature were introduced and reflected in the study survey. Options that would represent family and culture as a barrier were added. Cultural barriers included language spoken and family and/or cultural approval of asking personal questions about relationships. The participants chose the one most important barrier; and then any others that applied.

Research Procedure

Approval from two review boards (IRB) for the protection of human subjects was obtained. Over a 4 week period of time, each nurse who agreed to participate completed a consent form and a Smith Multicultural Questionnaire.

The survey did not contain any identifying information to ensure the anonymity of the participants.

A 24 hour/one day data collection of the triage intake forms from patient medical record was conducted from the same study institution. The goal was to detect the percentage of forms that included, or did not include, the required assessment for IPV with the quality care standard set at 100%.

The SMQ tool was introduced to the labor and delivery registered nursing staff. Any qualified nurse participated by completing a consent and a survey. No compensation was given for voluntary participation and the data remained anonymous. All surveys were shredded following data collection by an independent statistician.

Results

Medical Record Review

Thirty six admissions to labor and delivery triage took place within the target 24 hours. Two were seen twice, giving the total number of patients at 34. Of the 34, (n=18) or 50% were asked about current or past interpersonal violence: all responses were "no", as evidenced by notation in the medical record. Gestational age of the pregnancy on admission was from 15 weeks (motor vehicle accident) to 41+2 weeks. Additional, only 50% of the 34 patients had documentation of screening for IPV during prenatal care.

Upon evaluation of the medical records of the 34 patients, positive findings for IPV were documented in 33% (n=6) of the patients who were actually screened (n=18) in the prenatal period. The languages spoken by the patients with IPV history were: English, Spanish, limited English, Spanish only, and Korean only. The nurse participants spoke a total of 13 languages (see Table 1).

Barriers to Assessment

The initial assumption that a nurse's cultural identity would somehow be a barrier was disproved. Interestingly, 85% of the participants stated that they disagree that their culture would not approve of the nurse asking questions about IPV with a significant level of p=.013. Only 9% (n=3) agreed that their culture would not support their asking the IPV questions with one participant US born and two were non-US born.

Additionally, 65% of the nurses agreed that in their culture it was acceptable to ask questions about IPV. As for family approval of the nurses asking the questions, 88% felt supported to do so.

Barriers to assessment were evaluated from the perspective of US born and non-US born nurses. Both groups reported that inability to speak the patient's language was the primary barrier for both US and non-US born nurses. Inability to speak the patient's language was reported as the primary barrier by 50% of nurses with current or past abuse and 58% of the nurses without personal experience of IPV.

Clearly, when the language of the nurses varied from that of the patients; barriers to care existed. A total of 80% of nurses reported language as a primary or secondary barrier. Results of the current study departed from prior research in that the issue of language was neither studied nor identified as a barrier to IPV assessment.

Discussion

The labor and delivery nurses self reported that only 73% screen routinely for IPV in their patients, yet the actual documented assessment was only 50% in the medical record review. These findings are consistent with the literature as Ellis (1999) reported 45% of the nurses stated they routine screen all their patients and only 9% of the charts reflected it was done. Alarmingly, with only half of the patients being assessed in the prenatal period, the labor triage visit might have been the only opportunity for intervention in several of the patients.

A nurse's inability to speak the same language as the patient emerged as the most significant barrier in the assessment for IPV (see Table 2). Despite the unique cultural environment at the study institution, we have begun to see this trend of language barrier nationwide due to our importation of RN workforce and increased immigration of non-English speaking patients,

Limitations

Limitations of the study include the small convenience sample size. The unique cultural diversity of the nurses at the institution studied may not be similar

to other labor and delivery departments in institutions of similar size. Yet, this complex diversity of cultural identity may represent the future of nursing in the United States.

Implications for Practice

Despite the multicultural diversity in the nursing staff studied, it did not match the client diversity in culture or language. The answer may not be in language education, but perhaps in the development of non-verbal tools similar to the Wong-Baker Pain Scale we use routinely for pain assessment. Provision of a screening tool for nurses, nurse practitioners and physicians would allow initial screening. Follow up with a translator in the event of positive findings would be indicated

Research is lacking in the area of identification and study of the impact of culture and language in the practice of nursing. Xu reports that the typical internationally educated nurses are recruited from the Philippines, Canada, India or the United Kingdom, yet language was not mentioned in the article on the economics of dealing with the nursing shortage (Xu, 2005).

Hospitals, whose patients speak different languages, are responsible to their patients by providing resources in the form of translators and translating systems. These resources are not standardized and are less than sufficient to meet patient needs. This study adds to the body of knowledge further showing how important it to have nurses available who can speak different languages,

251 especially the primary languages spoken by the local patient community. This
252 study further supports the premise of how inadequate and, yet vital, language
253 translation resources are for the safety and optimal care of patients.

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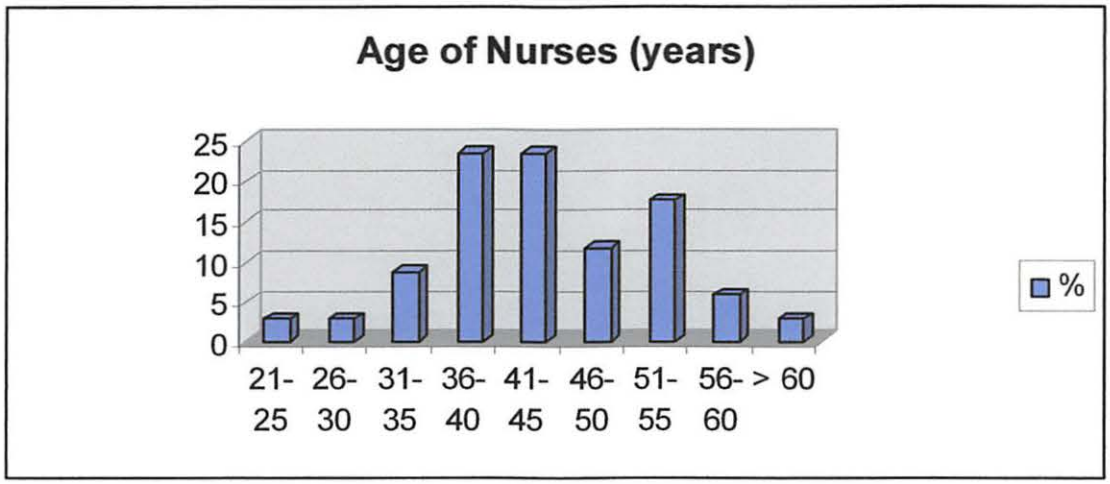

Figure 1. Characteristics of Nurse Participants: Age (n=34)

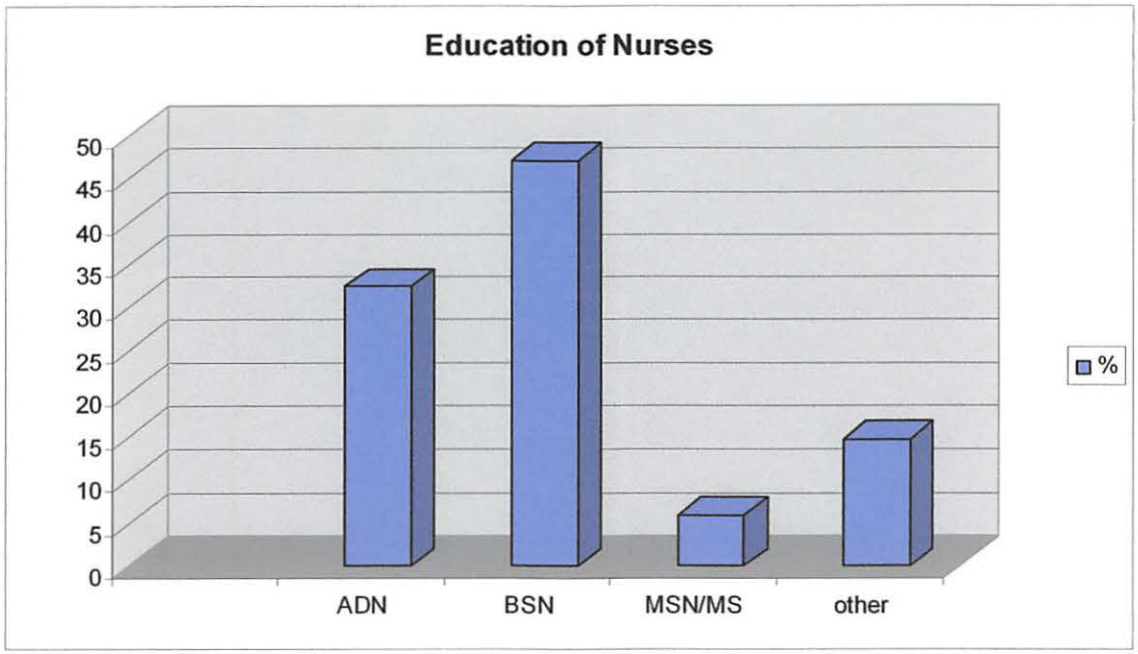

Figure 2. Characteristics of Nurse Participants: Education (n=34)
ADN = Associate degree in nursing
BSN = Baccalaureate degree in nursing
MSN/MS = Master's degree in nursing or other related field
Other = Non-nursing associate and baccalaureate degree

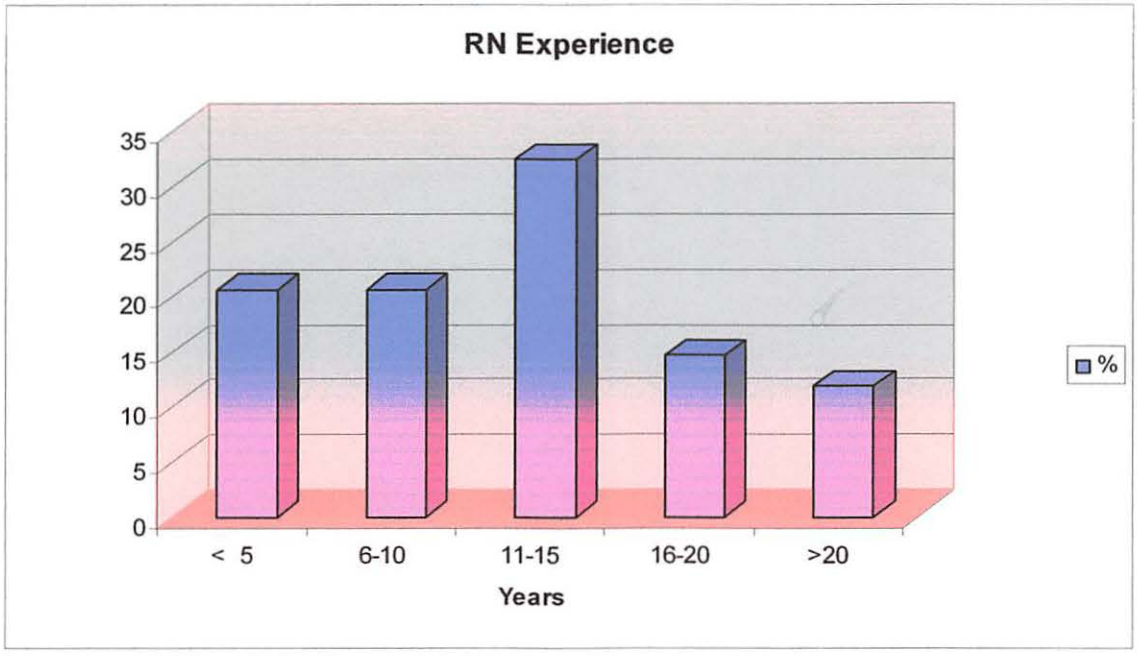

Figure 3. Characteristics of Nurse Participants: Years of Experience (n=34)

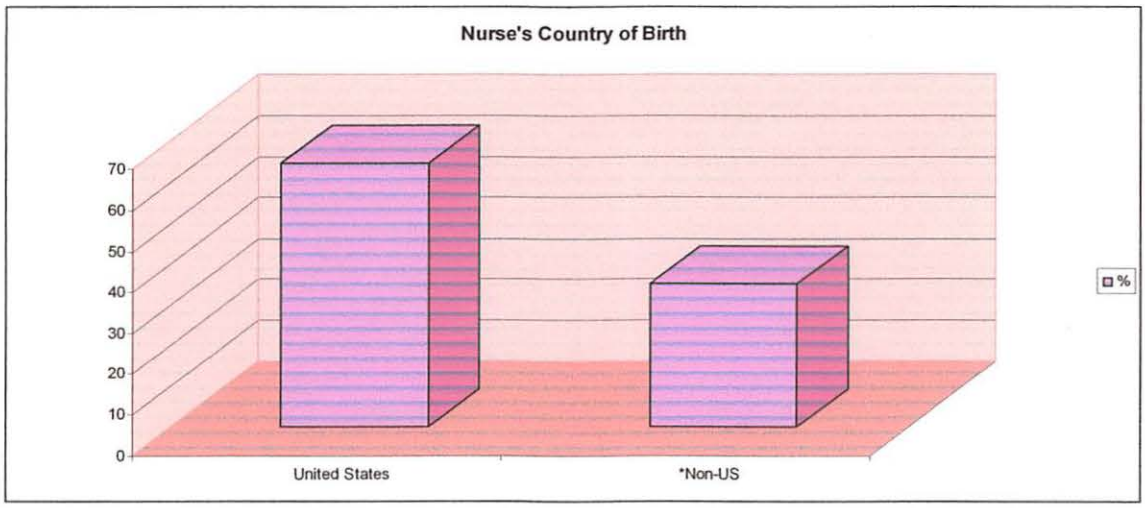

Figure 4. Characteristics of Nurse Participants: Nurse's Country of Birth (n=34)
*Cambodia, Canada, Chile, Egypt, India, Korea, Nigeria, Philippines

Table 1

Comparisons of Nurse's and Patient's Language

	Nurses (n=34)		Patients (n=34)	
Language Spoken	n	%	n	%
English	34	100	6	17.6
Spanish + English	16	47	4	11.8
Spanish only	0	0	22	64.7
Korean + English	1	2.9	0	0
Korean only	0	0	1	12.9
Arabic	1	2.9	0	0
*Bini	1	2.9	0	0
Chinese	1	2.9	0	0
Filipino/Tagalog	2	5.9	1	2.9
French	4	11.8	0	0
Hindi	1	2.9	0	0
**Igbo	1	12.9	0	0
†Punjabi	2	5.9	0	0
**Yoruba	2	5.9	0	0
Vietnamese	1	12.9	0	0

Note. *Bini, Igbo and Yoruba are languages spoken in Nigeria, †Punjabi is a language of the Punjab regions of India and Pakistan.

Table 2

Barriers to Screening for Interpersonal Violence Identified by Nurses (n=34)

Barrier Description (based on survey questions)	Primary		Additional	
	n	%	N	%
1. Area on form not conveniently located	0	0	3	8.8
2. I don't feel it is really my job to screen	0	0	3	8.8
3. There is lack of privacy for screening in my heath care setting	10	29.4	10	29.4
4. I don't know what to do if the answer if yes	1	2.9	5	14.7
5. I don't feel I have the support from nursing management	0	0	1	2.9
6. I do not speak the patient's language well enough to ask sensitive questions	18	52.9	9	26.5
7. I feel the patient will stay with the abuser anyway	0	0	4	11.8
8. I feel uncomfortable asking the questions	0	0	2	5.9
9. A woman must try to deal privately with abuse in her own way	0	0	3	8.8
10. I don't know enough about the issues of interpersonal violence to assess for it	0	0	1	2.9
11. I cannot fix the problem anyway	1	2.9	2	5.9
12. I have been abused and do not feel can bring up the issue with my patients	0	0	2	5.9
*13. I don't feel I have support from my colleagues	0	0	0	0
14. In my culture it is not acceptable to ask about the relationships in this way	1	2.9	0	0
15. I do not have adequate training in this area	3	8.8	3	8.8

Note. *Based on data, nurses do think they have support from colleagues.