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Improving Intimate Partner Violence Screening Practices Among Postpartum Nurses

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Abstract

Background and Review of the Literature: Intimate partner violence (IPV) during pregnancy is a global public health issue that has negative outcomes on both an individual and a societal level. Health care providers play a pivotal role in providing services to women experiencing violence during pregnancy. Regardless of the setting, barriers to IPV screening exist among healthcare providers. Review of the literature examined the existing IPV screening practices and screening barriers among healthcare providers to better understand the relationship between barriers and frequency of screening for IPV. *Purpose:* The purpose of this DNP project was to enhance knowledge of IPV for postpartum nurses. *Methods:* Sixty-eight postpartum nurses employed at an inner city academic medical center were invited to complete the Barriers to Abuse Assessment Tool adapted for Postpartum Nurses (BAAT-PPN) followed by a DNP student created eLearning module. Fifteen nurses completed the BAAT-PPN aimed at identifying site specific barriers to IPV screening. Sixty-seven nurses completed the educational intervention focused on IPV in pregnancy and site resources. A pre/post intervention test was used to assess the nurses knowledge. *Results:* Systemic (50.00%) and knowledge (25.00%) barriers were identified as most important in IPV assessment. Outcome measures indicated an increase in nursing knowledge specifically in the areas of defining IPV (28.01%), frequency of IPV (26.52%), factors associated with IPV in pregnancy (14.71%), and resources available at the site (32.31%). *Conclusion:* Nurses consider IPV screening within their scope of practice but identified lack of training as a barrier. Raising awareness through education is an important facilitator in improving recognition of and response to IPV among nurses.

Keywords: domestic violence, intimate partner violence, pregnancy, postpartum, screening, nursing, and barriers.

Introduction

Intimate partner violence (IPV) against women is a significant public health issue that transcends all boundaries (Guillery, Benzies, Mannion, & Evans, 2012; World Health Organization [WHO], 2013). Regardless of cultural, religious, or socioeconomic grouping, the burden of IPV is carried primarily by women affecting up to 30% globally and 36% in the United States (Centers for Disease Control and Prevention [CDC], 2018; WHO, 2012). As many as 324,000 pregnant women are affected by IPV each year (Agency for Healthcare Research and Quality [AHRQ], 2015). In the United States, approximately one in six pregnant women are abused by their partner (US Preventive Services Task Force [USPSTF], 2018). IPV during pregnancy intensifies the risk of poor physical health, behavioral health, and socioeconomic outcomes for the woman, her unborn child, and her family (Health Resources and Service Administration, Office of Women's Health [HRSA], 2017).

Background

There is no single universal accepted term or definition for violence against women by a partner with domestic violence and IPV often being interchanged (O'Reilly & Peters, 2018). IPV is more focused as it refers to behavior within an intimate relationship versus domestic violence, which often refers to partner violence but can include any member of the household (WHO, 2012). The CDC (2018) defines IPV as acts by a present or past partner that include physical violence, sexual violence, stalking, and psychological aggression.

In the United States, IPV is a common but often undetected occurrence among women of childbearing age with factors such as exposure to violence as a child, young age, unemployment, substance abuse, marital difficulties, and economic hardship increasing the risk of IPV (USPSTF, 2018). In comparison to older women, women of childbearing age have a higher

incidence and prevalence of IPV (USPSTF, 2018). During a 12- month period, among women ages 18-24, 14.8% reported experiencing IPV in comparison to 8.7% of women ages 25-34 years, 7.3% of women ages 35-44 years, 4.1% of women ages 45 to 54 years, and 1.4% of women 55 years or older (USPSTF, 2018).

Pregnancy can trigger the initiation or increase the incidence of IPV (Guillery et al., 2012; O'Reilly & Peters, 2018). Experiencing IPV while pregnant inflates the potential for harmful consequences including abdominal trauma, sexually transmitted diseases, exacerbation of chronic health conditions, and death by homicide (HRSA, 2017). IPV during pregnancy is a risk factor for miscarriage, late entry into prenatal care, preterm birth, low-birth weight infants, neonatal death, maternal depression, and maternal substance use all which lead to poor outcomes and increased healthcare costs (O'Reilly, Beale, & Gillies, 2010; WHO, 2012).

Despite a lack of consensus on universal screening of women for IPV, many professional organizations including the American Nurses Association, the American Medical Association, and the American College of Obstetricians and Gynecologists support routine screening (MacMillan et al., 2009). While most healthcare providers acknowledge the importance of screening for IPV, the rates remain low (O'Doherty et al., 2015). Barriers to IPV screening among health care providers include lack of time, discomfort with the topic, lack of knowledge, low self-efficacy, unclear guidelines for screening practices, and lack of referral protocols (HRSA, 2017).

Victims of IPV often do not seek medical care due to control by a partner, shame, embarrassment, and fear (HRSA, 2017). Pregnancy is a time in a women's life where she accesses healthcare most often placing maternal child healthcare providers in prime position to screen for IPV (O'Reilly & Peters, 2018). Disclosure about incidences of abuse to a health care

provider makes a woman four times more likely to utilize an IPV intervention (HRSA, 2017). Clinical guidelines support IPV screening in women of childbearing age (AHRQ, 2014). Effective screening combined with interventions that includes referral to ongoing resources is associated with moderate health improvements through reduction of exposure to violence and abuse (AHRQ, 2014; USPSTF, 2018).

Problem Statement

Missed opportunities by postpartum nurses for screening of intimate partner violence (IPV) among pregnant women receiving postpartum nursing care is indicated by undetected IPV, lack of intervention/referral to resources, and increased risk of negative maternal and infant outcomes such as maternal depression, maternal substance abuse, and ineffective maternal and infant bonding.

Organizational “Gap” Analysis of Project Site

The population of interest consists of postpartum nurses on the inpatient Mother Baby Unit at an inner city academic teaching hospital. The minimum educational level at the selected site for inpatient nursing is a Registered Nurse preferably with a bachelor’s degree. Documentation for all nursing care is by electronic health record (EHR). The site utilizes EPIC as the EHR platform. An institutional expectation of staff nurses is to address and document that domestic violence education was completed prior to discharge. Currently, this documentation consists only of checking a box with no other indicator of actual task completion. At present, there is a lack of standards for screening, no screening tools, and no protocols for referral.

The HRSA Office of Women’s Health (HRSA) (2017), aligning with their mission to improve health and achieve health equity through access to quality services, a skilled workforce,

and innovative programs, developed a strategic plan to address IPV. HRSA (2017) identified the creation of culturally competent, evidenced-based, and trauma informed educational materials for health care providers as a priority within their objectives.

Review of the Literature

A comprehensive review of the literature for IPV, domestic partner violence, and screening included the following databases Cumulative Index of Nursing and Allied Health Literature (CINAHL), Cochrane, Psych INFO, PubMed, and Web of Science. The following medical subject headings (MeSH) were used for PubMed and CINAHL: *domestic violence, intimate partner violence, pregnancy, postpartum, screening, nursing, and barriers*. MeSH terms used in the Cochrane search were: *domestic violence, intimate partner violence, and screening*.

Fifty-two articles were retrieved searching the databases, CINAHL, Psych INFO, PUBMED, using the above MeSH terms and accessing the Cochrane Database of Systematic Reviews. Inclusion criteria included peer reviewed, English language, and full text. Due to the limited amount of literature, the initial publication time frame of ten years was extended to twelve. References from key articles were also retrieved and reviewed. On review of the articles, six were duplicates; twenty-eight were not reflective of the intended project purpose or population. In summary, of fifty-two articles, thirty-three were eliminated.

The selected nineteen articles included one RCT, one systematic review with meta-analysis, two systematic reviews, one RTC screening phase, eleven non-experimental studies, two literature reviews, and one expert opinion. Three studies assessed nurse barriers to IPV screening, six studies and one article evaluated screening practices, four studies addressed IPV education, three studies highlighted provider discomfort with IPV disclosure, and one study looked at partner presence during screening. The Johns Hopkins Nursing Evidenced-Based

Practice Rating Scale was utilized to level and grade the evidence (Newhouse, Dearholt, Poe, Pugh, & White, 2005).

Nurses and Barriers to IPV Screening

Guillery et al. (2012) identified the frequency of screening, the most important barriers to screening, and the relationship between barriers to screening and frequency of screening among 96 postpartum nurses. Frequency of screening rates varied by type of abuse, physical, sexual, or emotional. The majority of nurses reported they did not routinely screen for IPV although they considered it within their scope of practice. The most important barrier identified was lack of knowledge followed by systemic barriers that included lack of hospital protocols and screening tools. The strongest predictor of frequency of screening was language with lack of fluency in the patient's language being a major barrier. Results supported an inverse relationship between nurses' perception of barriers and screening rates. The researchers acknowledge that the generalizability of the study is limited due to the small sample size and rate of response.

In a cross-sectional study of 156 nurses conducted by DeBoer, Kothari, Kothari, Kostner, and Rohs (2013), 90% felt that screening was an important aspect of their nursing practice supporting the findings by Guillery et al. (2012). Traditionally, studies exploring barriers to screening have cited lack of time or opportunity as a primary barrier but that was not supported in this study. A finding of interest was despite an overall 1-year prevalence rate of 16% for hospital, the vast majority of nurses reported encountering two or less victims of IPV in the last year (DeBoer et al., 2013).

Furniss, McCaffery, Parnell, and Rovi (2007) surveyed 385 nurses from 10 states to identify IPV screening barriers. A major theme that emerged from the survey results was concern over privacy in family-centered practice settings such as maternity. Similar to findings by

Guillery et al. (2012), language and lack of protocols were identified as significant barriers. Training and the need for information on community resources were also strongly identified as barriers. Nurses felt they were not adequately trained to screen or handle a positive screen. Conflicting opinion on the appropriateness of IPV screening in the perinatal setting did arise from survey results.

Partner Presence During Screening for IPV

Lack of privacy during screening was a major barrier to IPV screening identified by Furniss et al. (2007) and DeBoer et al. (2013). Rollans et al. (2016) explored the challenges and complexities of inclusion of partners during psychosocial assessment, which includes IPV assessment, at two clinical sites with 34 women during their antenatal intake and following birth. The exclusion of partners during IPV screening was common in all settings. The authors caution that although this may be preferable to the provider, if IPV is present there can be negative consequences for women after the visit. This study highlights the complexities in IPV screening while encouraging partner involvement. The study recommendations reflect the consistent theme of education, training and support services for providers as well as the need for policies to guide practice.

Provider Discomfort

LoGiudice (2015) synthesized data from eight studies producing a sample of 142 women's health care providers to better understand the lack of universal IPV screening. Themes uncovered were consistent with those in current literature including partner presence, language barriers, inconsistent screening practices, lack of training, and discomfort with IPV disclosure. Inadequate ability to manage a disclosure of IPV was the most global theme extricated. Providers stated time constraints, lack of education, and limited knowledge on

community resources. Universal IPV screening can positively effect maternal outcomes but a gap exists between recommendations and practice due to existing barriers (LoGiudice, 2015). A novel finding of this study was the benefit of the centering model of pregnancy in facilitating and supporting a woman in disclosure of IPV.

Fostering an environment of disclosure is key in identifying and supporting victims of IPV (Alvarez, Debman, Clough, Alexander, & Glass, 2017). Seventeen health care workers representing seven unique practice sites were interviewed to identify current practices on IPV identification and disclosure management during a healthcare visit as well as to provide insight into the use of an interactive app in practice. The authors choose to explore the myPlan app developed as a safety decision aid by IPV researchers, practitioners, and survivors (Alvarez et al. 2017). Results did reveal opportunities to integrate this type of resource into practice but more importantly highlighted providers discomfort with responding to IPV disclosure related to lack of protocols, training, and knowledge of resources. Reflecting findings by LoGiudice (2015) that there is a gap between recommendations and practice, components of practice environments that facilitate optimal care were discussed. Elements that are essential in creating such an environment are knowledgeable providers, protocols guiding action, and screening friendly environments. Providers must have the ability to effectively screen and respond to IPV disclosure thereby empowering a woman to determine her individual solution. Response goes beyond referral to resources including harm reduction strategies and safety planning. A main limitation identified by the authors was a lack of patient perspective on the use of the myPlan app.

Pregnancy is a period of time when women frequently utilize healthcare on a regular basis making it an opportune time for IPV intervention (O'Reilly & Peters, 2008; Wadsworth,

Degesie, Kothari, & Moe, 2018). Wadsworth et al. (2018) analyzed data from a previous study on maternal depression. The parent study sample (n=40) was postpartum women from two delivery hospitals that met specific inclusion criteria. The second sample (n=20) was women who screened positive for IPV in pregnancy during the parent study. Participant interviews focused on healthcare experiences and suggestions for providers. Of major importance to the women in this study was the ability of providers to provide direct support and refer to local resources. Unfortunately, previous studies have shown that providers are often uncomfortable with IPV disclosure due to limited knowledge of available resources (Alvarez et al., 2017; LoGiudice, 2015).

IPV Education

A systematic review of 22 studies by Sprague et al. (2012) revealed findings consistent with previously reported barriers including time constraints, lack of knowledge, provider discomfort, and inadequate referral resources. Barriers were documented more among providers than patients. The authors concluded that this was a positive finding as these barriers are less difficult to address and can be positively impacted through education and training. Continuing education of health care providers can improve IPV screening practices and effective methods of education and screening should be the focus of future research.

Lee et al. (2019) implemented an intervention to assess the impact on provider readiness to screen for IPV. The intervention included the use of the Domestic Violence Health Care Provider Survey Scale (DVHCPSS), the Abuse Assessment Screen (ASS), and a business card resource line. Initially, participants completed the DVHCPSS then received education and training on IPV screening, use of screening tool, and appropriate response to IPV disclosure. Although pre and post DVHCPSS's were not matched, post intervention surveys revealed a significant

increase in the readiness of providers to screen for IPV. Evidence gained from this study revealed that IPV can be reduced and prevented through universal screening and referral to resources. Recommendations for best practice aligned with those of Sprague et al. (2012) combining provider education with a validated IPV screening tool.

Utilizing a different intervention than Lee et al. (2019), Bermele, Andresen, and Urbanski (2018) sought to evaluate the effectiveness of an evidence-based screening protocol on IPV screening practices among antepartum nurses. Abuse During Pregnancy: A Protocol for Prevention and Education developed by the March of Dimes was implemented with 35 nurses. The protocol is a continuing education program involving use of the Abuse Assessment Screen (AAS), the Danger Assessment (DA), safety planning, and referral to resources (Bermele et al., 2018). Implementation of the protocol did result in a significant increase in nursing knowledge, but screening rates were lower when compared to previous studies (Bermele et al., 2018). Consistently reported in the literature as a barrier, visitor presence during assessment affected the nurse's ability to effectively screen for IPV (Bermele et al., 2018, DeBoer et al., 2013, Furniss et al., 2007).

Themes emerging from in-depth interviews with 12 health care providers of female veterans reinforced findings from the previous studies by Lee et al. (2019) and Sprague et al. (2012) (Iverson, Wells, Wiltsey-Stirman, Vaughn, & Gerber, 2013). Participants expressed that IPV screening should be a routine practice, routine screening was part of their professional role, and that the main barriers were time and lack of education. In order to facilitate incorporation of IPV screening into routine practice by providers, a need exists for basic IPV education that addresses prevalence, risk factors, and health related consequences (Iverson et al., 2013). Iverson et al.'s (2013) research recommendations are homogeneous to prior studies suggesting

that strengthening providers comfort level with screening and disclosure response can be achieved through ongoing training associated with protocols.

Screening Practices/Effectiveness of Screening

Seven studies looked at either screening practices, or effectiveness of current screening practice, or both. O'Reilly and Peters (2018) identified screening practices among 40 health care providers caring for pregnant and postpartum women in a community setting. Survey results revealed findings consistent in the literature such as low screening rates (42% did not screen), acknowledgement that women should be screened for IPV, and the need for referral resources. Although cited as an under-reported barrier to screening, this study identified a lack of IPV policy as a barrier, which is consistent with previously reported results. A novel finding of this study was that among those providers that do screen, formalized tools were not the preferred screening method.

Connelly et al. (2013) described the relationship between perinatal depressive symptoms, IPV, and substance abuse among women receiving perinatal services in a community setting. Of the 1,868 culturally diverse pregnant women screened during this phase of an RCT, over one third had multiple issues. Results support screening for multiple risk factors to allow for individualized interventions to support successful management.

An RCT conducted by MacMillian et al (2009) sought to determine the effectiveness of IPV screening in improving health outcomes for women. After accounting for a large sample loss during follow-up, 43% of the original 6,743 participants, results did show modest improvement in quality of life and reduced depression scores among those screened for IPV compared to those not screened. However, this result was not clinically significant. Screening was performed using a self-administered screening tool. Concerns over adverse outcomes related

to screening have been raised in the literature but results did not indicate that IPV screening was associated with short-term harm.

In a systematic review of the literature, O'Reilly, Beal, and Gillies (2010) identified that routine screening can increase IPV identification, and the use of self-administered screening tools may increase reporting. When looking specifically at pregnant women, results show IPV screening to be effective, contrasting results from broader studies. The authors suggest that this may be due in part to the increased frequency of health care encounters during pregnancy.

O'Doherty et al. (2015) conducted a systematic review of eight RCT's with the purpose of identifying if routine screening for IPV in all women across various health care settings supports recognition of IPV support services. The authors sought to examine if this intervention would improve quality of life and not cause harm. Results were consistent with previously reported findings that among those screened by health care providers for IPV, it was more likely to be identified in pregnant women with no associated reports of short-term adverse outcomes due to IPV screening.

Williams, Halstead, Salini, and Koermer (2016) aimed to gain insight into existing barriers through exploration of different IPV screening practices. Semi-structured, in-depth interviews with eighteen healthcare providers, knowledgeable in current IPV screening practices, from sixteen independent healthcare facilities revealed consistent barriers. Regardless of screening method, personal feelings about IPV, lack of time, offending patient/loss of patient, lack of confidence, lack of standardized procedures, and lack of resources were identified challenges causing screening barriers. Interestingly, although nurse representation in this study was only sixteen percent (n=3), the authors highlighted that as nurses are rated the most trusted health care professional, they stand to make a significant difference in early IPV identification.

An expert review of IPV screening by Paterno and Draughton (2016) reiterated screening barriers such as provider discomfort, lack of training, and how to respond to a positive screen/disclosure. Best practices for addressing barriers impacting identification of IPV involve techniques such as provider training, routine protocols, screening scripts, validated screening tools, and considerations for privacy. A principal message was that therapeutic, non-judgmental communication by providers is pivotal in empowering women to access the help they need to enhance their safety.

In summary, the literature review revealed that IPV screening is considered within the scope of nursing practice, but barriers exist that prevent screening during pregnancy. Common barriers include provider discomfort, lack of privacy, language barriers, lack of written policy, disclosure discomfort, and lack of resources such as educational training and information on available resources. There is no gold standard for screening for IPV and support for routine screening is controversial in the literature. There is consensus that identification of IPV is crucial to improving maternal and infant outcomes.

Evidenced Based Practice: Verification of Chosen Option

The American Association of Colleges of Nursing (AACN) (2019) supports the belief that education significantly impacts knowledge and competency of clinical nursing practice. Based on the review of the literature, the evidence-based practice (EBP) that was chosen for this DNP project was implementation of an educational intervention aimed at increasing postpartum nurses' awareness of IPV.

Theoretical Framework

The AWARE framework provided a conceptual foundation for the DNP project (Bradbury-Jones, Clark, & Taylor, 2017) (See Appendix A). Awareness, recognition, and

empowerment are concepts within this framework that can support nursing practice in recognizing and responding to IPV (Bradbury-Jones et al., 2014; Bradbury-Jones et al., 2017). Comprised within the framework are three principal needs of women and three related key nursing requirements necessary to meet those needs (Bradbury-Jones et al., 2017).

Although nurses hold an optimal position to recognize and respond to IPV, many lack the education and training that promote awareness, recognition, and empowerment (Bradbury-Jones et al., 2017). Within this framework, awareness is defined as cognizance, consciousness, familiarity, knowledge, and understanding (Bradbury-Jones et al., 2017). Interpretation of awareness is based on a level of conceptualization and theorization that suggests although we may know something exists, we may not be able to recognize it (Bradbury-Jones et al., 2017). The concept of recognition is defined as detection, acknowledgement, and realization (Bradbury-Jones et al., 2017). Application of theoretical and conceptual knowledge and understanding to an individual person is the interpretation of recognition within the AWARE framework (Bradbury-Jones et al., 2017). Empowerment is defined as to enable or to act and is interpreted as enablement and sharing of power (Bradbury-Jones et al., 2017). Once nurses have moved from awareness through recognition to empowerment, they are confident in their knowledge of IPV, their ability to recognize that an individual may be a victim, and their ability to appropriately respond.

This DNP project focused on the concept of awareness as a primary step in improving nursing practice. Limited awareness has been identified as an issue among nurses in addressing IPV with female patients (Bradbury-Jones, Taylor, Kroll, & Duncan, 2014; Sundborg, Tornkvist, Saleh-Stattin, Wandell, & Hylander, 2105). Education and training are viewed as critical catalysts to advance clinical nursing around IPV (Bradbury-Jones et al., 2017). The AWARE

framework emphasizes awareness raising through education and training focused on meeting the needs of the nurse (Bradbury-Jones et al., 2014). By meeting this need, nurses are better prepared to meet the needs of the women they encounter in clinical practice.

Methods

This DNP Project was a quality improvement project implementing an educational intervention with the aim of increasing postpartum registered nurses' knowledge on barriers to IPV screening, significance of IPV screening in pregnancy, and awareness of IPV. An online survey was used to collect quantitative data identifying nurses' perceived barriers to IPV screening. A pre-posttest design was used to collect quantitative data related to the educational intervention.

Key components of the AWARE framework were used to guide implementation of this quality improvement project (Bradbury-Jones et al., 2017). Upon IRB approval in October 2019 (See Appendix B), this DNP student educated the site's Unit Based Council on the project to gain support from members. Informational flyers were placed on two designated communication boards within the unit. A current email list of postpartum nurses was obtained from the unit manager the second week of October 2019. Survey Monkey was used to format the Barriers to Abuse Assessment Tool for use with Postpartum Nurses survey (BAAT-PPN). The site's internal email platform was used for staff communication. An informational email containing the link to the BAAT-PPN survey was disseminated to all postpartum nurses on October 23, 2019. The survey link remained open for 2 weeks, closing on November 6, 2019. During the open period, reminder emails were sent at both the halfway point and two days prior to survey closing. Those who participated in the survey had the option of voluntarily entering a random drawing for a \$50 Amazon Gift Card. Results from the survey were collected and

analyzed after the survey closed. These results were used to identify areas of focus for the educational intervention.

At the time of project development, HealthStream was the preferred method of providing education for nurses at the site. The third week of December, an educational module created by this DNP student was disseminated to the current postpartum nursing staff through the eLearning management system, HealthStream. This module contained both the pretest and posttest, which were identical, as required by HealthStream. Participation was on a voluntary basis. The module remained open for one month. Data was collected and analyzed during February 2020. Results were disseminated to the site and presented at UMass Scholarship Day in the Spring of 2020.

Goals, Objectives, & Outcomes

The overall goals of this project were: 1) improve the postpartum nurses' knowledge of barriers to IPV screening and 2) improve the postpartum nurses' knowledge on the significance of IPV screening in pregnancy to positively impact screening practices and maternal and infant outcomes 3) improve the postpartum nurses' knowledge of available IPV resources. The DNP student:

Objective 1: Analyzed current barriers to IPV screening among postpartum nurses at BMC by administering BAAT-PPN in October 2019.

Objective 1a: Compared results from BAAT-PPN with current evidenced based literature in October 2019.

Objective 2: Conducted an educational intervention for postpartum nurses at BMC utilizing the online educational platform HealthStream in December 2019/January 2020.

Objective 2a: Analyzed the impact of an educational intervention for postpartum nurses at BMC to improve knowledge on IPV in pregnancy and the impact of effective screening on maternal and infant outcomes by comparing pre-post test scores in February 2020.

Objective 3: Evaluated the postpartum nurses' ability to identify institutional resources available to women who screen positive for IPV by comparing pre-post educational intervention test scores in February 2020.

Outcome 1: At least 75% of postpartum nurses will participate in the BAAT-PPN survey.

Outcome 2: At least 50% of postpartum nurses who participate in educational intervention will demonstrate increased knowledge about the significance of screening for IPV in pregnancy as evidenced by improvement in pre/post intervention test scores.

Outcome 3: At least 50% of postpartum nurses who participate in postpartum intervention will demonstrate increased knowledge of institutional resources for IPV as evidenced by improvement in pre/post intervention test scores.

Project Site and Population

The site was an inner city private, not-for-profit, 567-bed, academic medical center. Of the patients served, 57% are from under-served populations and 32% do not speak English as a primary language. The annual birth rate is 2810 births per year (Massachusetts Department of Public Health, 2018). The population was a convenience sample of postpartum registered nurses from the Mother Baby Unit. There were 68 registered nurses on staff. Although no formal demographics exist, the staff nurses are racially and culturally diverse. The majority of nurses both in the institution and on the postpartum unit work 12-hour shifts, 7a-7p or 7p -7a.

Measurement Instruments

Outcomes were measured utilizing the following instruments, BAAT-PPN (See Appendix C) and a DNP student created pre/post-test contained within the educational intervention (See Appendix D). The BAAT-PPN survey is a tool adapted from the Barriers to Abuse Assessment tool created for Labor and Delivery Nurse (BAAT). Request for permission to use this tool was granted (See Appendix E). The BAAT-PPN consists of 51 items grouped into six subscales. Each item is ranked on a 4-point Likert scale. The internal consistency reliability (Cronbach's Alpha) of the tool was .50 -.83 (Guillery et al., 2012). The second phase of this project involved dissemination of a DNP student created eLearning module which contained the pre/post-test. The module titled "Intimate Partner Violence in Pregnancy" was disseminated through the site's nursing education department utilizing the online learning management system HealthStream. The module remained open for one month. The pre/post tests were identical and consisted of six multiple choice questions to measure effectiveness of educational intervention.

Data Collection

Pre-intervention/principal needs of women. This DNP student: (a) performed a review of the literature on barriers to IPV screening related to health care providers, (b) identified evidence- based interventions to improve screening practices among health care providers specifically nurses caring for women during pregnancy, (c) discussed project with nurse manager and gain support (d) developed an online educational intervention (See Appendix D), (e) developed a pre/post intervention test utilizing multiple choice questions (See Appendix F). Upon IRB approval this DNP student: (a) recruited postpartum nurses by in-person informational sessions , email, and informational flyers placed on unit communication boards, (b) administered

the BAAT-PPN survey prior to the educational intervention via Survey Monkey, (c) analyzed results to identify barriers specific to the project site allowing for the modification of educational intervention to reflect the most significant challenges to IPV screening, (d) developed an IPV resource card specific to the site.

Intervention/principal needs of nurse. Upon IRB approval this DNP student: (a) recruited postpartum nurses by in-person information session, email, and informational flyers placed on unit communication boards, (b) presented an online educational intervention including identical pre/post-tests to postpartum nurses who voluntarily chose to participate, (c) provided a site specific IPV resource card.

Post-Intervention/practice outcomes. Upon completion of intervention, this DNP student: (a) assessed post-intervention IPV knowledge of postpartum nurses through pre/posttest analysis, (b) assessed effectiveness of educational intervention, (c) disseminated results to key stake holders.

Ethical Considerations

The University of Massachusetts, Amherst (UMass) Internal Review Board (IRB) approval was obtained prior to initiating the DNP Project. The official IRB Determination Form was submitted as soon as the proposal was approved. The project was an educational intervention aimed at improving IPV screening practices among postpartum nurses. No patient information was utilized. Participation was voluntary. All participants were identified by number and no real names were used to protect anonymity. Data collected for this project was utilized only by the DNP students and secured in a password protected file. Participants contributed to the practice of nursing by offering insight into barriers that exist in recognizing and responding to IPV. This is beneficial as it will be the catalyst for education and training

development aimed at improving IPV screening practices. There were no perceived risks to participants in this project. No compensation was given but upon completion of online survey participants could opt to be part of a raffle for a predetermined gift card (See Appendix G).

Results

Participants in this quality improvement project were postpartum nurses employed at a specific inner city academic medical center. The project was divided into two phases. Phase I ran for two weeks and phase II for one month. The overall time from approval to dissemination was eight months.

Phase 1 – BAAT-PPN

The BAAT-PPN survey was disseminated to all postpartum nurses (n=67) with a two week completion timeframe resulting in a 22.39% return rate (n=15). Descriptive statistics were compiled from the collective data. Participants ranged in age from 28 years to 64 years old with a mean age of 44.07 (SD=10.6) years. The majority (66.67%, n=10) reported being married while 33.33% (n=5) were single. The highest level of educational achievement for the majority of participants was a Bachelor's degree (73.33%, n=11). Table 1 depicts the sociodemographic information obtained.

Table 1

Socio-Demographic Characteristics of Postpartum Nurses (n=15)

| Characteristic | M (SD) |
|-------------------|--------------|
| Age (years) | 44.07 (10.6) |
| Years of Practice | 14.5 (11.09) |
| | % (n) |
| Marital Status | |
| Partnered | 66.67% (10) |
| Not Partnered | 33.33% (5) |
| Nursing Education | |

| | |
|-----------|-------------|
| Diploma | 13.33% (2) |
| Bachelors | 73.33% (11) |
| Masters | 13.34% (2) |

The majority (50%, n=7.67) of postpartum nurses reported screening for IPV often (20.00%, n=3) or sometimes (30%, n= 4.67). A minority of nurses reported that they never (16.67%, n=1.67) screen for IPV. The remainder of nurses reported always (33.37%, n= 5.6) screening for IPV. As IPV includes physical, sexual, and emotional abuse, the above percentages represent a mean for all three types of abuse screening among postpartum nurses. Physical abuse (100.00%, n =15) and emotional abuse (93.34%, n=14) were reported to be addressed more often than sexual abuse (77.33%, n=11).

The BAAT-PPN is composed of 31 items divided into six categories of barriers/subscales: Systemic, Ethical, Knowledge, Personal, Fear, and Nursing Role Barriers. Postpartum nurses were asked to identify which subscale had the most significant impact on their willingness to assess for abuse. Fifty percent (50.00%) reported that Systemic barriers most affected screening. One quarter (25.00%) reported Knowledge as the most important barrier. A few nurses reported the remaining subscales of Nursing Role (8.33%), Ethical (8.33%), Fear (8.33%), and Personal (0.00%) as important barriers (See Table 2).

Table 2

BAAT-PPN Subscale Scores (n=12)*

| Subscale (number of items) | % | n |
|----------------------------|--------|---|
| Systemic (9) | 50.00% | 6 |
| Knowledge (4) | 25.00% | 3 |
| Nursing Role (4) | 8.34% | 1 |
| Ethical (2) | 8.33% | 1 |
| Fear (6) | 8.33% | 1 |
| Personal (6) | 0.00% | 0 |

Note. *n = number of nurses who indicated subscale as most significantly impacting assessment

Phase 11 – Educational Intervention

The educational module was disseminated to all postpartum nurses (n=68) with a one month completion time resulting in an n=67. Statistical analysis was done through HealthStream with data reported on a group versus individual level. Data was collected to assess the effectiveness of the educational intervention by measuring pre/post scores (See Table 3).

Table 3

Post-Partum Nurses Pre and Post-Intervention Test Scores (n=67)

| Questions | Pretest % Correct | Posttest % Correct | Improvement in % Correct |
|------------------------|-------------------|--------------------|--------------------------|
| Q1 IPV Frequency | 64.18% | 92.19% | 28.01% |
| Q2 Definition of IPV | 65.67% | 92.19% | 26.52% |
| Q3 Associated Factors | 80.60% | 95.31% | 14.71% |
| Q4 Barriers to Leaving | 95.52% | 95.31% | -0.21% |
| Q5 Nurses Role | 94.03% | 95.31% | 1.28% |
| Q6 IPV Resources | 55.38% | 87.69% | 32.31% |

Four of the six questions demonstrated improvement in the postpartum nurses' knowledge around the topic of IPV in pregnancy. Question six, which addressed the nurses' knowledge of IPV resources at the site, had the largest difference in pre/post-test scores (32.31%). Question one addressed the percentage of women who have experienced IPV in the United States and had the second largest positive shift (28.01%). Improvement was also seen in Question 2, which assessed knowledge of the definition of IPV (26.52%) and Question 3, which focused on factors associated with IPV in pregnancy (14.71%). Question five, which related to the nurses role in IPV assessment (1.28%), and question 4, which assessed knowledge of barriers to leaving an abusive relationship (-0.21), showed minimal change. Percentage of missing data from pre to post test was less than 10% (4.48%).

Discussion

The project was comprised of two phases each fulfilling a separate project objective. Phase one offered postpartum nurses (PPN) the opportunity to participate in an online survey to assist in identifying site specific barriers to IPV screening among postpartum nurses. Phase two provided an online learning module to all postpartum nurses to increase knowledge about IPV in pregnancy as well as available site resources available to staff and patients.

Phase 1 – BAAT-PPN

The BAAT-PPN provided postpartum nurses an opportunity to share their beliefs about personal and site barriers that impact their IPV screening practices. Questions from the BAAT-PPN helped gain insight to the perceived barriers that exist at this specific site. Responses from the participating postpartum nurses (22%, n=15) indicated that systemic and knowledge barriers had the greatest impact on nursing practice. Among the top systemic barriers were uncondusive environment, lack of a screening tool, time, lack of follow up, and a lack of a hospital protocol. How to respond to IPV disclosure as well as overall understanding of the topic were identified as barriers related to knowledge gaps.

Although limited by the low response rate and small sample size, these findings were consistent with those in current literature. Guillery et al.(2012) administered the original BAAT-PPN and found that although postpartum nurses indicated that they considered screening within their scope of practice, most did not routinely screen. Most participants (93.33%, n=14) in this project agreed that screening is part of their role but differing from the previous study only a minority of nurses reported not routinely screening. Knowledge and systemic barriers were identified by both groups as most important to IPV screening.

In this project, barriers reported by participants as most important are consistent with those identified during the literature review. Lack of privacy and partner presence were identified as creating environmental barriers (Furniss et al, 2007; DeBoer et al., 2013, Alvarez et al, 2017). Lack of hospital protocols, screening tools, and time consistently appear in the literature as barriers to IPV identification and screening (LoGiudice, 2015; Paterno & Draughton, 2016). Discomfort in how to respond to an IPV disclosure was a significant barrier that emerged from this project and in the literature review (Alvarez et al, 2017, Lee et al, 2019: LoGiudice, 2015). This and other knowledge barriers can be reduced through educational training and identification of resources (Sprague et al., 2012; Iverson et al, 2013, Lee et al, 2019).

Phase 11 – Educational Intervention

The educational module was designed to enhance participants knowledge on the topic of IPV in pregnancy and site resources. The module was developed by the DNP student and the director of the site's domestic violence program. The intent of this module was to impart foundational knowledge. Participating nurses, 98.5% of project population, were presented with a pre/post-test built into the online learning module. Results indicated a positive impact on nursing knowledge specifically in the areas of defining IPV, frequency of IPV, factors associated with IPV in pregnancy, and resources available at the site.

Within the AWARE framework, education is seen as foundational for improving nurse awareness thereby advancing practice (Bradbury-Jones et al, 2014). The nurse may know that IPV exists but may not know how to recognize or respond to it. Nurse awareness in addressing IPV among female patients is limited (Bradbury-Jones, Taylor, Kroll, & Duncan, 2014; Sundborg, Tornkvist, Saleh-Stattin, Wandell, & Hylander, 2105). The intent of this educational module was to build foundational knowledge on the topic of IPV in pregnancy.

Ongoing education and training will be required to increase the ability of these postpartum nurses to recognize and appropriately respond to victims of IPV.

Facilitators and Barriers

A key facilitator for the implementation of the project is its alignment with the Acts of 2014, Chapter 260, An Act Relative to Domestic Violence, section 9 which mandated the Massachusetts Department of Public Health to develop training for health professionals on the topic of domestic and sexual violence. The Massachusetts Board of Nursing requires domestic and sexual violence training as a requirement for license renewal. Experts at the site's Domestic Violence Program have developed a Massachusetts Department of Public Health approved training program, which meets Chapter 260 requirements. The site's active stance on this topic facilitated the implementation of the DNP project. Main barriers included nurses' discomfort with the topic, perception of importance of the project, and perceived time constraints for project participation.

Limitations

The main limitation for phase I of this project was lack of participation by the postpartum nurses. Nurses were offered an incentive for participation. The low response rate could have been a result of the delivery method as well as the length of the tool.

Phase II limitations were primarily systemic. The delivery and dissemination of the learning module was impacted by the site's internal structures. The site's preferred method for nursing education is eLearning. The site's eLearning management system changed during the project causing a delay in uploading and dissemination. One individual at the site is tasked with managing this system. Although the DNP student communicated with this individual prior to and throughout project development, the institutional change impacted their ability to support the

DNP project. The module was disseminated through the outgoing system and was grouped with mandatory trainings. These trainings had a deadline for completion that fell at the projects midpoint. The high response rate is reflective of an assigned not a voluntary activity. Data collection was managed through the online system with results formatted on a group not individual level limiting analysis. Projects implemented in a large institution are impacted by institutional practices and structure.

Conclusion

Improving postpartum nurses' awareness of IPV can improve practice. Empowerment through education can enable nurses to respond more appropriately leading to more effective partnerships with women. The AACN (2019) states that knowledge and clinical nursing practice are elevated through education. With increased awareness and ongoing training, nurses can become more confident in supporting better outcomes for women experiencing IPV.

This project aimed to increase postpartum nurses' awareness of IPV in pregnancy. The identification of site specific barriers highlighted the nurses desire for guidance through education, systemic protocols, and screening tools. Postpartum nurses gained awareness by participating in the educational module. The intent of this project was not to create experts in IPV identification and response but to act as a catalyst for further discussion and education focused on enhancing nursing practice.

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Appendix A: AWARE Framework

AWARE “abused women, awareness, recognition, and empowerment”

Table 1

A practice Framework for improving nurses’ responses to intimate partner violence (IPV)

| Concept | Principal needs of women | Key requirements for nurses | Practice Outcomes | Public Health Outcomes |
|-------------|-----------------------------|--|--|--|
| Awareness | Naming the Abuse | Access to appropriate IPV education and training | Enhanced understanding of IPV; Increased confidence in recognizing IPV | Increased rates of IPV referral and reduction of IPV rates |
| Recognition | Support with disclosure | Support in having difficult conversations | Establishment of trusting relationship: Increased likelihood of disclosure | |
| Empowerment | Control over safety choices | Working in partnership for safety planning | Optimized safety | |



(Bradbury-Jones et al., 2017, p. 2497)

Appendix B: IRB Approval

Dear Robin,

Thank you for submitting the letter from the XXXXXXXX IRB. Our office accepts the determination made by the XXXXXXXX IRB and requires no further IRB review from UMass Amherst. You may begin your work.

If you have additional questions, please don't hesitate to contact me.

Thanks,

Iris

Iris L. Jenkins, Ph.D.

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Appendix C: Barriers to Abuse Assessment Tool (BAAT) Postpartum nurses (PPN)

Thank you for taking the time to consent to participate in this quality improvement project which will assist me in my DNP Capstone Project. Participation in this study is voluntary. If you consent to participate, please complete the questionnaire. Please note that all responses will be kept confidential and will be anonymous.

This study is concerned with your perceptions of barriers to assessment for intimate partner violence (IPV). I am interested to hear what **Postpartum Nurses** have to say about their perceptions of assessing for abuse in the postpartum practice setting.

Intimate Partner Violence, as defined by Health Canada (2002), may include any of the following types of abuse:

Physical abuse: includes beating, burning, slapping, choking, kicking, pushing, biting or use of a weapon to threaten or intimidate. Physical abuse and neglect can result in serious injuries or death.

Emotional or psychological abuse: may include yelling, screaming, name calling, insults, threats, humiliation or criticism, excessive jealousy or isolation tactics to keep away from family and friends.

Sexual abuse: includes unwanted sexual touching, rape, unsafe, degrading or offensive sexual activity. It may include controlling reproductive choices.

In this study, **abuse assessment** is defined as: asking women direct questions about abuse and nurse observations assessing for abuse.

| Sample question: | STRONGLY AGREE | AGREE | DISAGREE | STRONGLY DISAGREE |
|--|----------------|-------|----------|-------------------|
| Nurses who work on the Postpartum unit are warm, caring individuals. | X | | | |

In this sample, your response indicates you strongly agree with this statement.

FOR EACH BARRIER, PLEASE MARK ONE X IN THE BOX THAT MOST CLOSELY REFLECTS YOUR OPINION.

| SYSTEMIC BARRIERS | STRONGLY AGREE | AGREE | DIS-AGREE | STRONGLY DISAGREE |
|--|-----------------------|--------------|------------------|--------------------------|
| 1. Lack of a hospital protocol for abuse assessment | | | | |
| 2. Lack of a documentation form to record abuse assessment (i.e. screening tool) | | | | |
| 3. Inadequate administrative or management support | | | | |
| 4. Inadequate support from your professional association (i.e. NLN, ANA) | | | | |
| 5. Unconducive environment (e.g. lack of privacy from other patients, family, partner) | | | | |
| 6. Lack of follow-up services & places to refer women | | | | |
| 7. Inadequate staffing to devote time to assessing for abuse | | | | |
| 8. (a) Difficulty finding time if woman is postpartum | | | | |
| 8. (b) Nurses do not have opportunity to develop a trusting relationship with clients | | | | |
| ETHICAL BARRIERS | | | | |
| 9. I believe I should not assess for abuse if necessary supports and resources are lacking | | | | |
| 10. I do not want to be called to court to give testimony | | | | |

| KNOWLEDGE BARRIERS <i>I believe ...</i> | STRONGLY AGREE | AGREE | DIS-AGREE | STRONGLY DISAGREE |
|---|-----------------------|--------------|------------------|--------------------------|
| 11. I have inadequate knowledge about the phenomenon of pregnancy abuse | | | | |
| 12. I have inadequate knowledge about <i>how</i> and <i>when</i> to assess for pregnancy abuse | | | | |
| 13. I have inadequate knowledge about appropriate responses in the case of disclosures | | | | |
| 14. I am unable to 'fix' or stop the pregnancy abuse | | | | |
| FEAR BARRIERS <i>I am fearful...</i> | | | | |
| 15. ... of making a mistake (i.e. mislabeling, improper documentation) when assessing for abuse | | | | |
| 16. ...of retaliation by the partner that is directed towards me | | | | |
| 17. ... of asking sensitive information from someone of a different ethnic background | | | | |
| 18. ... that assessing increases risk to her and her baby | | | | |
| PERSONAL BARRIERS <i>I believe ...</i> | | | | |
| 19. ...that if there are no physical signs, there must not be abuse | | | | |

| | STRONGLY AGREE | AGREE | DIS-AGREE | STRONGLY DISAGREE |
|--|----------------|-------|-----------|-------------------|
| 20. ...that assessing doesn't make a difference (women don't leave anyway) – so why bother? | | | | |
| 21. ...that pregnancy abuse is a private problem | | | | |
| 22 ...that pregnancy abuse is uncommon | | | | |
| 23. ...it is embarrassing and uncomfortable to assess for pregnancy abuse | | | | |
| 24. ...abuse is not a health issue | | | | |
| NURSING ROLE BARRIERS <i>I believe ...</i> | | | | |
| 25. ... that the issue should be left to the 'experts' and is not in the domain of nursing practice | | | | |
| 26. ...that abuse assessment should be done at a different time – i.e. prenatally or community | | | | |
| 27. ...that it is not appropriate to ask about abuse when women are postpartum (not the priority at the moment) | | | | |
| 28. ... the focus of postpartum nursing should be post-delivery, rather than the life context after birth | | | | |
| 29. ...abuse assessment should be done by a professional with whom they have a continuing relationship | | | | |

| | STRONGLY AGREE | AGREE | DIS-AGREE | STRONGLY DISAGREE |
|--|----------------|-------|-----------|-------------------|
| NURSING ROLE | | | | |
| BARRIERS - Continued | | | | |
| 30. ...that it is inappropriate to assess for abuse unless there are clear indications of pregnancy abuse | | | | |

31. I do not assess a woman for abuse if she does not speak and understand a language in which I am fluent.

| STRONGLY AGREE | AGREE | DISAGREE | STRONGLY DISAGREE |
|----------------|-------|----------|-------------------|
| | | | |

32. (a) **OF ALL** the categories of barriers listed, please indicate which ONE is the most important/significant that affects your willingness to assess for abuse: (check one)

- Systemic
- Personal
- Ethical
- Fear
- Nursing Role
- Knowledge

(b) **OF ALL** the barriers listed previously (1 through 30), please indicate the three most important/significant barriers that affect YOUR willingness or ability to assess for abuse:

- a. # _____ (most significant)
- b. # _____ (next significant)
- c. # _____

33. Do you think there are other barriers to assessing for pregnancy abuse that we have not mentioned?
If your answer is yes, please write the other barriers here.

34. Please indicate how often you assess your patients for physical abuse?

ALWAYS _____ **OFTEN** _____ **SOMETIMES** _____ **NEVER** _____

35. Please indicate how often you assess your patients for sexual abuse?

ALWAYS _____ **OFTEN** _____ **SOMETIMES** _____ **NEVER** _____

36. Please indicate how often you assess patients for emotional abuse?

ALWAYS _____ **OFTEN** _____ **SOMETIMES** _____ **NEVER** _____

**To assist us in grouping your answers with others of similar background
please answer the following questions and tell us a little about yourself ...Recall that your answers
are confidential!**

37. Please put an X next to the highest level of post-secondary education that you have completed.
(select one only)

- _____ **DIPLOMA (RN)**
- _____ **ASSOCIATES DEGREE**
- _____ **BACHELORS DEGREE**
- _____ **MASTERS DEGREE**
- _____ **PhD (OR OTHER DOCTORATE)**

38. What year did you graduate from your NURSING program? _ _ _ _ (YEAR)

39. To the nearest full year, how many years have you been **practicing** as a nurse? (If less than one year, put <1 YEAR)

_____ **YEAR/S**

40. Please share your age. _____ **YEARS**

41. Please indicate your **CURRENT** marital status.

_____ **SINGLE**, _____ **MARRIED**, _____ **COMMON LAW**,
 _____ **DIVORCED**, _____ **WIDOWED**

42. Please indicate how often you have read journal articles about abuse and/or domestic violence in the past year? (Please check only one)

_____ **NEVER**
 _____ **less than or equal to ONCE A YEAR**
 _____ **2 – 6 TIMES A YEAR**
 _____ **7 OR MORE TIMES A YEAR**

Recalling that all responses are completely confidential and will not be shared with anyone in your workplace, respond to the following questions about your personal experiences:

43. Have you ever experienced **any type** of *professional* abuse?
NO _____ **YES** _____ → **If yes, specify type:**

44. Are you **presently** experiencing *professional* abuse?
NO _____ **YES** _____ → **If yes, specify type:**

45. Have you **previously** been in an abusive relationship with an intimate partner/ spouse?
NO _____ **YES** _____ →If yes, specify type:

46. Are you **presently** in an abusive relationship with an intimate partner/ spouse?
NO _____ **YES** _____ →If yes, specify type:

47. Do you know a close friend or family member who was **previously** in an abusive relationship?
NO _____ **YES** _____ →If yes, specify type:

48. Do you know a close friend or family member who is **presently** in an abusive relationship?
NO _____ **YES** _____

49. Thinking about your responses from items 42-47, how have these experiences influenced your assessment for abuse during the postpartum period?

50. Do you think the following factors **increase** the likelihood of abusive relationships in North America: (please circle one only)

Race: NO YES UNSURE NO RESPONSE

Socio-Economic Status: NO YES UNSURE NO RESPONSE

Age: NO YES UNSURE NO RESPONSE

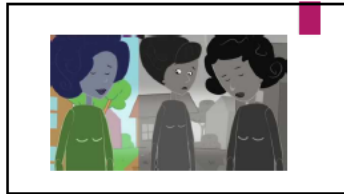
51. Please use the spaces below to provide **Additional Comments** about **assessing patients for Intimate Partner Violence:**

Thank you for completing the survey!

Appendix D: Educational Intervention



1



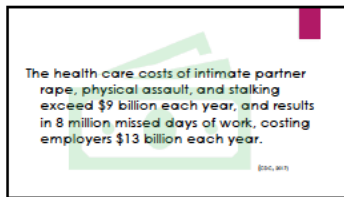
2



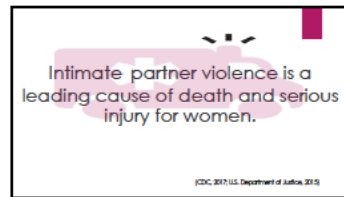
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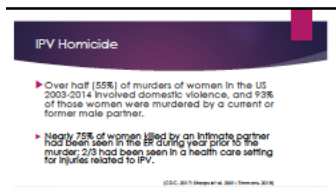
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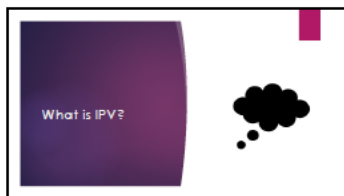
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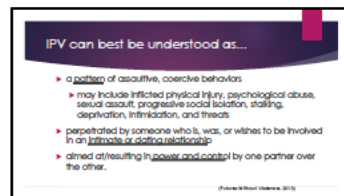
6



7



8



9

Women who experience physical violence are **3 X's** more likely to deliver a low birth weight infant

(Dixon et al., 2008 Perinatal Violence Research Fund, 2007)

19

Women who experience IPV around pregnancy are more likely to:

- Smoke tobacco
- Drink during pregnancy
- Use illicit drugs
- Experience depression, higher stress, and lower self esteem
- Attempt suicide
- Receive less emotional support from partners

(Peters-Walton, 2006)

20

Among women who were victims of abuse before and during pregnancy, the frequency of physical violence increased during the postpartum period.

(Peters-Walton, 2006)

21

Women with a controlling or threatening partner are **Six more likely** to experience on going symptoms of **postpartum maternal depression**.

(Dixon et al., 2008 Perinatal Violence Research Fund, 2007)

22

Women who experience physical violence around the time of pregnancy are:

- 35%-52%** less likely to breastfeed their infants
- 41%-71%** more likely to cease breastfeeding by 4 weeks postpartum

(Peters-Walton, 2006; Starnon et al., 2004)

23

Homicide has been reported as a leading cause of maternal mortality

Abuse during pregnancy is a risk factor associated with a woman being killed by her abusive partner

(Campbell, 2002; Tjebke, 2004; U.S. Department of Justice, 2005)

24

Barriers to leaving are numerous, complex, and different for everyone

- Abuser's control tactics**
 - Threatens to hurt or kill self, victim, babies or family members
 - Promotes to change, acts on bad behavior around others
 - Threatens to seek custody of children/leave victim
 - disparages/report her to DCF to the police or tell anyone
 - Threatening is the most dangerous time**
- Lack of support**
 - Little to no support of family, religious or cultural community
 - May end up homeless, unable to provide for children
 - May not be believed, abuser not held accountable
 - Abuse restraining orders or calling police won't work
- Post-partum**
 - Time around pregnancy and childbirth is high risk
 - Time of pregnancy while in hospital are extremely difficult
 - New or increased dependence on abuser/other parent
 - Medical or mental health complications

(Dixon, 2008)

25

Addressing IPV Postpartum?



26

Postpartum nurses have a unique opportunity to address IPV

Nursing role always includes



(Peters-Walton, 2006)

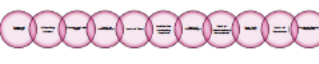
27

"The nurse doesn't have to have a solution for the patient; domestic violence survivors are incredibly resourceful and know their own situation and possibilities better than anyone else. Being there for a patient unconditionally is the goal."

(Powers Without Violence, 2010)

28


Barriers to addressing IPV in post-partum



(Simpson et al., 2013; Wilcox et al., 2013; Weaver et al., 2013; Fennell et al., 2013)

29

Barriers to addressing IPV post-partum
BMC Results



(Simpson et al., 2013; Wilcox et al., 2013; Weaver et al., 2013; Fennell et al., 2013)


30

How Can I Make A Difference?



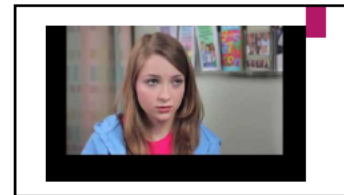
31

Educate all patients (when safe to do so) about IPV, its impact on health, and resources available.




(Powers Without Violence, 2010; Thomas, 2010)

32



33


Support patients who disclose abuse in a validating and non-judgmental way, not trying to fix it or tell them what to do.



(Powers Without Violence, 2010; Thomas, 2010)

34

Refer victims to appropriate resources for risk assessment, safety planning, consideration of options, advocacy, and support.



(Powers Without Violence, 2010; Thomas, 2010)

35

Where Do I Find Support?



36

Appendix E: Letter of Request

March 10, 2019

Dear Karen Benzies,

I am a doctoral of nursing practice student from the University of Massachusetts Amherst writing my Capstone Project tentatively titled “Improving Intimate Partner Violence Screening Among Post-Partum Nurses” under the direction of my Capstone Advisor Dr. Terri Black.

I would like your permission to reproduce to use the “Barriers to Abuse Assessment Tool for Use with Post-Partum Nurses” assessment tool in my project. I would like to use your survey under the following conditions:

- I will use this survey only for my project and will not sell or use it with any compensated or curriculum development activities.
- I will include the copyright statement on all copies of the instrument.
- I will send a copy of my project to you upon completion.

If these are acceptable terms and conditions, please indicate so by signing one copy of this letter and returning it to me through e-mail:

rhumphreys@umass.edu

Sincerely,

Robin Mills-Humphreys, Doctoral Candidate

Expected date of completion: 5/2020

Karen Benzies

Jun 13, 2019, 10:10 AM
(1 day ago)

to me

Hi Robin

Very sorry for delayed response.

Yes, you may use the BAAT-PPN for the purpose outlined below. Do you need a copy?

Karen

Appendix F: Pre/Post Test

- 1) In the United States, 1 in _____ women have experienced Intimate Partner Violence (IPV).
 - a) 2
 - b) 4
 - c) 6
 - d) 8

- 2) Intimate Partner Violence (IPV) is not:
 - a) The leading cause of death and serious injury for women
 - b) A major healthcare cost
 - c) A pattern of assaultive, coercive behaviors
 - d) Not related to power and control

- 3) Intimate Partner Violence (IPV) during pregnancy is associated with all the following except:
 - a) Decreased breastfeeding
 - b) Increased risk of preterm birth
 - c) Decrease in physical violence
 - d) Postpartum depression

- 4) Barriers to leaving an abusive relationship are:
 - a) Numerous
 - b) Complex
 - c) Different for everyone
 - d) Not related to safety

- 5) The role of the nurse in addressing Intimate Partner Violence (IPV) includes all of the following except:
 - a) Educate all patients
 - b) Support patients who disclose
 - c) Refer victims to appropriate resources
 - d) Offer solutions

- 6) How knowledgeable are you about Intimate Partner Violence (IPV) support services available at BMC?
 - a) I am unaware of the available resources
 - b) I am aware of the available resources but I do not know how to access them
 - c) I am aware of the resources and how to access them

Appendix G: Cost Analysis/Budget

Costs Analysis/Budget (Including direct and indirect costs)

| | | |
|--|-------------------|----------|
| Recruitment Costs: | | |
| Fact Sheet Copies – posted in 2 breakrooms and 1 locker room | 3 x .10 | .30 |
| Refreshments x1 day –each break room for 2 shifts | Coffee \$64 | \$64 |
| | Bagels \$60 | \$60 |
| Incentives: | | |
| Survey Participation | Gift Card | \$50 |
| Materials: | | |
| Survey – Upgraded Survey Monkey | \$34 per month x6 | \$204 |
| Pre/Post Test – HealthStream | 0 | \$0 |
| Educational PowerPoint - HealthStream | 0 | \$0 |
| Data Collection and Entry | 0 | \$0 |
| Travel Costs: | | |
| Participants: on-line | 0 | \$0 |
| DNP Student | 0 | \$0 |
| Time: | | |
| Development of educational intervention | 0 | \$0 |
| Mentor - Voluntary | 0 (Priceless) | \$0 |
| Participants – Voluntary | 0 (Priceless) | \$0 |
| Total | | \$274.30 |