Spring 2023

Why Doesn't She Just Leave? Improving Identification and Response to Victims of Intimate Partner Violence in the Emergency Room

Elizabeth Berry
Gardner-Webb University, eberry2@gardner-webb.edu

Why Doesn't She Just Leave? Improving Identification and Response to Victims of Intimate Partner Violence in the Emergency Room

by

Elizabeth Danielle Berry

A project submitted to the faculty of
Gardner-Webb University Hunt School of Nursing
in partial fulfillment of the requirements for the degree of
Doctor of Nursing Practice

Boiling Springs, NC

2023

Submitted by:	Approved by:
Elizabeth Danielle Berry	Kathy Williams
Elizabeth Danielle Berry	Kathy Williams, DNP, RN
04/13/2023	04/13/2023
Date	Date

Acknowledgements

This project would not have been possible without my Project Chair, Dr. Kathy Williams. She motivated me to complete each step in this process. She encouraged me to take breaks when life got hard. She listened to me process my trials and struggles, and she validated my feelings. She prayed for me and my family through challenging times. I know that Dr. Williams was sent to me for this purpose.

This whole endeavor would not have been possible without my husband, Thomas Richards. He has been willing and more than capable of completely orchestrating the chaos of a full-time doctorate student, four children, one dog, two guinea pigs, three fish, and a full-time job. He has never once complained and has tirelessly supported me with words of wisdom, acts of kindness, and his unique sense of humor. He grounds me but he always supports my big ideas and for that, I am eternally grateful. I will never be able to repay him for his devotion to our family, nor would he allow me to.

To my children, my inspiration. Thank you for being patient and understanding of the many nights and weekends I spent pouring over books and computers. Zander, I hope you use your endless potential to change the world for the better. Girls, I hope you three grow to be strong, independent women and know that you are more than capable of any dream you have. Sullivan, your kindness and love for others are true gifts. Harper, I know your imagination and creativity will serve you well. Ripley, you are headstrong and determined, do not ever let your spirit be broken.

I am also grateful to the members of my Psychiatric Mental Health cohort who encouraged me and at times carried me through these past three years. Dr. Yvonne Smith, you are such a blessing, and I am so thankful for the times you showed me grace. You are the leader I aspire to be.

Abstract

The purpose of this project was to improve identification and response to victims of intimate partner violence (IPV) presenting to the emergency department. Project participants completed a pre-education questionnaire prior to the project leader providing intimate partner violence educational materials and a presentation entitled *Recognizing and Responding to Victims of Intimate Partner Violence in the Emergency Room*. The project participants then completed a mirrored post-education questionnaire. Evaluation of the project included a comparison of the participant's responses to the mirrored questionnaires.

Project participants reported an increase in the:

- recognition of the prevalence of intimate partner violence among their patients,
- self-reported confidence in the ability to identify patients at high risk for intimate partner violence,
- self-reported confidence in the ability to identify patients currently experiencing intimate partner violence,
- self-reported confidence using EMR screening tools for intimate partner violence,
- self-reported confidence in communicating empathetically and effectively with patients experiencing intimate partner violence,
- self-reported confidence in knowing what to do if a patient discloses intimate partner violence,
- self-reported confidence in the ability to assess patients presenting with intimate partner violence complaints,
- awareness of both community and hospital resources for patients experiencing intimate partner violence, and

- awareness of barriers for patients experiencing intimate partner violence to access safety.

Keywords: intimate partner violence, emergency department, domestic violence, education

Table of Contents

Problem Recognition 9

Identified Need 9

Problem Statement 11

Literature Review and Synthesis 11

Intimate Partner Violence in Emergency Department 11

Screening for Intimate Partner Violence 12

Identifying At-Risk Patients 13

Referral to Hospital and Community Resources 13

Emergency Department Educational Needs 14

Forensic Nursing 14

Needs Assessment 15

Sponsors and Stakeholders 15

SWOT Analysis 16

Available Resources 18

Desired and Expected Outcomes 19

Team Selection 19

Cost/Benefit Analysis 19

Scope of the Project 20

Goals, Objectives, & Mission Statement 21

Goals 21

Objectives 21

Mission Statement 21

Theoretical Framework 22

Nursing Theory 22

Nola Pender's Theory of Health Promotion 22

Intimate Partner Violence and Pender's Model 23

Work Planning 25

Timeline 25

Budget and Resources 26

Evaluation Planning 26

Project Implementation 29

Threats and Barriers 29

Implementation and Monitoring 30

Project Closure 31

Data Interpretation 32

Quantitative Data 32

Project Outcomes 33

Project Sustainability 39

Conclusion 39

References 41

List of Tables

Table 1: Sponsors and Stakeholders 16

List of Figures

Figure 1: Comparison of Participant Pre-Questionnaire and Post-Questionnaire Responses on the Recognition of Prevalence 33

Figure 2: Comparison of Participant Pre-Questionnaire and Post-Questionnaire Responses on Identifying High-Risk Patients 34

Figure 3: Comparison of Participant Pre-Questionnaire and Post-Questionnaire Responses on Identifying Patients Currently Experiencing IPV 34

Figure 4: Comparison of Participant Pre-Questionnaire and Post-Questionnaire Responses on Using EMR Screening Tools 35

Figure 5: Comparison of Participant Pre-Questionnaire and Post-Questionnaire Responses on Communicating with Patients Experiencing IPV 35

Figure 6: Comparison of Participant Pre-Questionnaire and Post-Questionnaire Responses on Knowing What to Do if a Patient Discloses IPV 36

Figure 7: Comparison of Participant Pre-Questionnaire and Post-Questionnaire Responses on Assessing Patients Experiencing IPV 36

Figure 8: Comparison of Participant Pre-Questionnaire and Post-Questionnaire Responses on Awareness of Community Resources 37

Figure 9: Comparison of Participant Pre-Questionnaire and Post-Questionnaire Responses on Awareness of Hospital Resources 37

Figure 10: Comparison of Participant Pre-Questionnaire and Post-Questionnaire Responses on Awareness of Barriers to Access Safety 38

Problem Recognition

Identified Need

At 10.6%, South Carolina has the highest percentage in the United States of women experiencing contact sexual violence, physical violence, or stalking victimization by an intimate partner within 12 months (Ramaswamy et al., 2019). Furthermore, 42% of South Carolina women will experience intimate partner violence in their lifetime (National Intimate Partner and Sexual Violence Survey (NISVS), 2017). The year 2020 was the first year in the 23-year history of the Violence Policy Center (2020) study that South Carolina was not in the top 10 for women killed by their domestic partners. In 2020, South Carolina was number 11.

Due to the prevalence of intimate partner violence in the state, South Carolina emergency department nurses will encounter victims of intimate partner violence frequently. Emergency departments are used as primary healthcare settings by the people most at risk for intimate partner violence. Hoelle et al. (2015) found that 83% of high-risk women who presented for medical care 1 ½ years prior to an incident of intimate partner violence did so in an emergency department. Between 2% and 14% of women presenting to emergency departments are there because of an injury or illness caused by intimate partner violence and between 5% and 38% have experienced intimate partner violence within the last year (Plichta, 2007). Given these statistics, emergency department nurses play an integral role in recognizing and responding to intimate partner violence.

A 2022 survey of Emergency Nurses Association members found that 95.2% of emergency nurses responding to their survey *either somewhat* or *strongly agreed* that recognition of violence is critical to the care of emergency department patients (Wolf et al., 2022). Though emergency department nurses care for victims of intimate partner violence frequently, only 14.6% of these same emergency nurses self-reported feeling extremely

confident in caring for patient populations experiencing intimate partner violence (Wolf et al., 2022). These nurses reported forensic nurses to be a valuable resource for patients and staff and a need for expanded forensic education and additional resources for emergency department nurses to identify and care for this vulnerable population (Wolf et al., 2022). Another 2018 review of the literature found that nurses lack confidence in caring for victims of intimate partner violence and do not receive adequate training on the identification and care of victims of intimate partner violence (Alshammari et al., 2018).

The United States Preventive Services Task Force (2019) recommends screening for intimate partner violence in all women of reproductive age. Ideally, emergency department nurses should screen all women of reproductive age for intimate partner violence, however, nurses report barriers to screening to include high patient volumes, absence of electronic prompts, and lack of opportunity for privacy (Spangaro et al., 2020). In addition, the COVID-19 pandemic has created unpredictably high volumes of patients in the nation's emergency departments, further complicating screenings. Despite the United States Preventive Services Task Force recommendations, routine screening is not performed at the project site. In the absence of routine screening, emergency department nurses should be educated on the prevalence of intimate partner violence, risk factors for it, recognition of the signs and symptoms of intimate partner violence, and proper screening techniques for intimate partner violence. Emergency nurses should feel comfortable assessing patients for intimate partner violence and communicating with patients who disclose. Emergency nurses should be knowledgeable of both community and hospital resources available to patients disclosing intimate partner violence.

Problem Statement

Emergency department nurses at the project site frequently care for victims of intimate partner violence. The hospital's forensic team consulted over 600 patients experiencing sexual assault, intimate partner violence, and child/elder abuse or neglect in 2021 and over 700 patients in 2022. Emergency department nurses are in a unique position to identify potential victims of intimate partner violence, respond to their disclosures appropriately, and refer patients to appropriate hospital and community resources. Emergency department nurses at the project site were not comfortable identifying victims of intimate partner violence, screening patients for intimate partner violence, communicating with patients experiencing intimate partner violence, and exhibiting knowledge deficits regarding community and hospital resources for these patients.

Literature Review and Synthesis

Intimate Partner Violence in Emergency Department

Intimate partner violence is common. Those experiencing intimate partner violence are at a higher risk for poor health outcomes and frequent interactions with healthcare systems. Victims of intimate partner violence present to emergency departments frequently, though not necessarily for direct complaints of intimate partner violence. Emergency department nurses are in a unique position to interact with patients experiencing intimate partner violence during emergent/acute care visits, identify these patients, and provide them with appropriate community and hospital resources.

The purpose of this literature review was to explore effective ways to increase the identification of victims of intimate partner violence in emergency departments and to facilitate early intervention through the hospital and community resources. This literature review provided:

- an overview of the recommendations for screening for intimate partner violence,
- the barriers to screening emergency patients for intimate partner violence,
- other methods for identifying patients experiencing intimate partner violence,
- education needs for nurses regarding intimate partner violence,
- the importance of community and hospital referrals for those disclosing intimate partner violence, and
- the role of forensic nurses in caring for patients presenting for intimate partner violence.

Screening for Intimate Partner Violence

Plichta (2007) asserts that victims of intimate partner violence interact in the healthcare system but will not be identified without active screening. Through a review of the literature, Plichta (2007) found multiple barriers to screening patients for intimate partner violence including a lack of ability (in both confidence and training), lack of resources (time, effective interventions, resources for victims, and other clinical priorities), and other factors related to intimate partner violence like the presence of a partner/child during an assessment, concern with offending the patient being screened, perceived patient noncompliance/nonresponse, victim-blaming attitudes, and nurses' beliefs that they did not have victims within their patient populations. A multi-site feasibility study asserted that it is both possible and relevant, with 18% disclosure rates noted, to screen women for intimate partner violence and provide a psycho-social response within 1 hour (Spangaro et al., 2020). Barriers to screening, specific to the emergency department, included high patient volumes, absence of electronic prompts, and lack of privacy needed for screening (Spangaro et al., 2020). Furthermore, Rodriguez and Mandich (2019) studied intimate partner violence patient experiences in emergency departments and found screening was not routinely being performed on patients with suspicious injuries,

screening was being done with others in the room (family or law enforcement) and screening was rarely done by physicians. Emergency department nurses need to be educated on the complexities of intimate partner violence, the prevalence of intimate partner violence within their patient populations, appropriate screening methods for patients, how to screen patients, and hospital and community resources available for these patient populations. Systems need to address barriers to intimate partner violence screening in emergency departments and assist nurses with resources to provide early intervention in this vulnerable patient population.

Identifying At-Risk Patients

Emergency nurses interact with patients experiencing intimate partner violence frequently and play a critical role in identifying these patients. For patients experiencing intimate partner violence, emergency department visits increase in frequency before the occurrence of violent physical offenses (Hoelle et al., 2015). Hoelle et al. (2015) noted that those experiencing intimate partner violence presented to emergency rooms with obstetrics-gynecology-related visits 28.7% of the time, infection-related visits 18.9% of the time, and trauma-related visits 16.3% of the time. Furthermore, Muelleman and Liewer (2008) noted that women seeking treatment in an emergency department for non-intimate partner-related complaints often returned later with intimate partner violence-related injuries. Early identification of patients experiencing intimate partner violence is critical to timely refer to community and hospital resources.

Referral to Hospital and Community Resources

Screening patients for intimate partner violence may not always lead to appropriate interventions for those screening positive. One study noted that only 50% of women who disclosed intimate partner violence in various healthcare settings received direct intervention or services as a result (McCloskey et al., 2005). It is essential that nursing staff have administrative

support and the resources needed to provide proper care and referrals to patients experiencing intimate partner violence. For proper care and referrals emergency department nurses should be educated on both hospital and community resources available for patients experiencing intimate partner violence.

Emergency Department Educational Needs

Nurses reported a lack of confidence in caring for patients experiencing intimate partner violence due to limited training, education, and experience (Alshammari et al., 2018). Wolf et al., (2022) noted emergency nursing education guidelines regarding intimate partner violence should be expanded to include awareness of the range of patient presentations, typical injury patterns associated with intimate partner violence, appropriate documentation, and use of appropriate reporting and referral tools. Keeling and Fisher (2014) concluded that professionals caring for victims of intimate partner violence must be knowledgeable of the dynamics of intimate partner violence and perpetrator behaviors so they can respond to disclosures appropriately and without re-traumatization of the patient. Through a review of the literature, Hinsliff-Smith and McGarry (2017) asserted that “having knowledgeable and supportive emergency department staff can have a positive benefit for the longer-term health of the domestic violence and abuse survivor who seeks help” (p. 4013). Patients experiencing intimate partner violence require specialized nursing services. Emergency nurses require specialized knowledge and education to effectively care for patient populations experiencing intimate partner violence.

Forensic Nursing

Forensic nursing is the practice of nursing where the health and legal systems intersect (International Association of Forensic Nurses (IAFN), 2022). Forensic nurses are registered nurses who have received specialized training in caring for patients who have been victimized or

have been accused of victimization (IAFN, 2022). According to the IAFN (2022), forensic nurses work in a variety of fields including sexual assault, domestic violence, child abuse/neglect, elder abuse/neglect, vulnerable adult abuse/neglect, death investigations, corrections, and disasters. These specially trained nurses work within the healthcare and community systems to provide consultation and assessment to patients experiencing acute or chronic victimization, evidence collection, and consultation and testimony for legal proceedings. Forensic nurses work in a variety of healthcare and community settings including hospitals, community programs, coroner and medical examiner offices, correction institutions, and psychiatric hospitals (IAFN, 2022). The IAFN (2022) notes that forensic nurses are a critical resource in the care of victims of violence and for violence prevention efforts. Emergency department nurses viewed forensic nurses as an invaluable resource for engaging patients in conversations regarding intimate partner violence and providing support to patients, families, and staff (Wolf et al., 2022).

Needs Assessment

Victims of intimate partner violence are frequently cared for in emergency departments. Emergency nurses are in a unique position to identify and respond appropriately to patients experiencing intimate partner violence. Victims of intimate partner violence are frequently cared for in emergency departments. Emergency departments provide a venue to identify patients experiencing intimate partner violence and refer them to hospital and community resources. Emergency department nurses must be educated in recognition of, communication with, and facility protocol for the treatment of victims who disclose intimate partner violence.

Sponsors and Stakeholders

Sponsors and stakeholders are important to the success of any project. Sponsors are leading members of the organization who help champion and support the project whereas, stakeholders are others who may not actively be involved in the project but can be just as

influential to the project's success or failure. Stakeholders may also have a personal interest or disinterest in the project as it affects them. In larger organizations, like hospital systems, it is important to have influential sponsors as advocates for the project. Active advocates for the project can ensure the success of the project within the system. Table 1 provides a list of sponsors and stakeholders.

Table 1

Sponsors and Stakeholders

High Power, Low Interest	High Power, High Interest	Low Power, Low Interest	Low Power, High Interest
• Emergency staff nurses • Emergency technicians • Emergency ancillary staff • Facility IRB • University IRB	• Emergency Department Director • Forensic Nursing Coordinator • Emergency Department Manager • Manager of Staff Development and Process Improvement • Nursing Research Council • Hospital Legal Department		• Patients who are victims of domestic violence

SWOT Analysis

Every project brings unique challenges for the project leader. Depending on the dynamics of the project site, the proposed project participants, and the project design, the project leader will need to anticipate and assess strengths, weaknesses, opportunities, and

threats (SWOT) to a successful project. Project strengths are factors that can contribute to the success of the project. The project strengths included the project facility being a large academic hospital system with access to specialists and resources. The hospital system has a 24-hour-a-day, 7-day-a-week on-call forensic nursing team consulting on victims of intimate partner violence with visible injuries, patients reporting strangulation by an intimate partner, and those in need of emergency shelter due to intimate partner violence. The hospital system has a written protocol for referring patients to the forensic nursing team. The forensic nursing team has a memorandum of agreement with the local sexual assault and domestic violence advocacy agency to provide advocacy services to victims of intimate partner violence. These services may include legal aid, counseling, hospital accompaniment, emergency shelter, court accompaniment, etc. The forensic program receives grant funding from the hospital, state, and federal programs to maintain 24/7 forensic nursing service coverage.

Project weaknesses are factors that could inhibit the success of the project. Weaknesses of the project site included critical hospital staffing shortages, staff turnover, and the COVID-19 pandemic. The project site also had a high number of travel nurses with little to no investment in the community. The project also involved education to nursing staff which could be difficult given staffing needs and the ability of the administration to allow time for education.

Project opportunities are factors that can be harnessed to add to the project's success. The project site had a mandatory education program established for emergency nurses with less than 1 year of bedside experience. Project opportunities included the opportunity to increase the knowledge and education of new emergency nursing staff. The project leader had an established relationship with the management team, forensic coordinator, and quality manager. This established relationship could be used to recruit sponsors to advocate for the project.

Project threats are factors that could inhibit the success of the project. Threats to the project included staff buy-in, staff turnover, and demands of the forensic team. Staff buy-in is essential to the success of the project. Emergency nurses have so many certifications they must ensure are current to perform their job. Adding education that is not an absolute job requirement takes time and resources. The project site also requires full Institutional Review Board (IRB) approval, which can be timely, thus postponing the project's implementation.

Available Resources

The hospital system has a 24-hour-a-day, 7-day-a-week on-call forensic team available to consult patients presenting for forensic complaints at all hospitals and facilities within the system. The current process includes forensic nursing consults for all patients presenting for intimate partner violence with visible injuries, patients complaining of intimate partner violence with reports of strangulation, and patients presenting for intimate partner violence who need emergency shelter. The forensic team consults on patients complaining of other forensic complaints such as adult patients presenting for acute sexual assault (within 96 hours), all pediatric patients presenting for sexual assault, patients with suspected child abuse/neglect, and patients with suspected elder or vulnerable adult abuse/neglect. The on-call forensic nurse is also available to answer any other staff questions regarding forensic complaints or mandated reporting. The team refers victims of intimate partner violence to the county’s sexual assault and domestic violence advocacy agency for emergency shelter and aftercare advocacy services.

The hospital system has a memorandum of agreement with a domestic violence and sexual assault advocacy agency to provide advocacy services to victims of intimate partner violence. The hospital’s partnering advocacy agency is a non-profit organization that provides an array of advocacy services including legal aid, court accompaniment, counseling services, and emergency shelter to victims of intimate partner violence. The hospital's forensic team is

hospital, state, and federal grant funded. The hospital's partnering advocacy agency is state, federal, and private donor funding.

Desired and Expected Outcomes

Desired and expected outcomes of the project included an increase in emergency department nurses' knowledge of the prevalence of intimate partner violence and the intricacies of intimate partner violence. After the project implementation, new emergency department nurses should feel comfortable having conversations with their patients about intimate partner violence and using electronic medical record tools to screen patients for intimate partner violence. These nurses should report an increase in knowledge of both hospital and community resources for patients experiencing intimate partner violence. With an increase in education about hospital and community resources, it is possible that the forensic team will see more consults and that there will be more referrals to community resources.

Team Selection

The hospital Forensic Coordinator served as the practice partner. The practice partner has over a decade of experience working with pediatric, adolescent, and adult forensic patients. The practice partner holds a master's degree in forensic nursing and certifications in both adult and pediatric sexual assault nurse examiner and an intimate partner violence nurse examiner certificate. The project leader will develop, implement, and evaluate the project. The project chair will provide support and oversite of the project.

Cost/Benefit Analysis

The costs of the project included time spent to develop visual education material for the staff education session, time spent developing education materials and resources for the staff resources packet, the cost of printing education visuals for staff, and time spent preparing education for staff. Training of staff will not require any extra time from staff and will occur

during their regularly scheduled education sessions during new nurse residency programs. The on-call forensic nurse will continue to respond to patients disclosing intimate partner violence with visible injuries, reports of strangulation, and those who request emergency shelter or request to speak with a forensic nurse.

It is difficult to measure the benefits of violence disclosure, identification, and referral to appropriate services for victims of intimate partner violence. Intimate partner violence is implicated in worsening physical and mental health; another potential consequence of intimate partner violence is death. Early identification and intervention may help mitigate the long-term costs and consequences for patients who have been victimized.

Scope of the Project

This project aimed to increase the competency of emergency department staff in the identification of and providing evidence-based care to patients who disclose intimate partner violence. To increase the identification of those experiencing intimate partner violence in the emergency department, education materials were developed by the project leader. Education materials developed included a Canva presentation for new-hire nurses with less than 1 year of experience. The Canva presentation detailed the prevalence of intimate partner violence, the patients most at risk for intimate partner violence, the types of intimate partner violence, and the cycle of intimate partner violence. The presentation then discussed how to communicate with patients experiencing intimate partner violence, hospital protocol for responding to disclosures, and community resources available to victims of intimate partner violence. Education materials were distributed to new emergency room nurses with less than 1 year of experience participating in the emergency department's nurse residency program.

Goals, Objectives, & Mission Statement

Goals

The purpose of this project was to improve the identification and response of victims of intimate partner violence in the emergency room. Increasing awareness of the complexities of intimate partner violence and its prevalence, and providing a systematic approach to communicating with patients and responding to disclosures, will provide emergency room nurses with the resources to effectively care for patients experiencing intimate partner violence.

Objectives

The outcome objectives of this project included

- Educating emergency nurses on the prevalence of intimate partner violence among patients presenting to the emergency department.
- Educating emergency nurses on patients most at risk for intimate partner violence.
- Educating emergency department nurses on the complexities of intimate partner violence including the power and control wheel and the cycle of intimate partner violence.
- Educating emergency nursing staff on IPV screening tools currently available within the electronic medical record.
- Educating emergency nursing staff on communication with patients experiencing intimate partner violence.
- Increasing emergency nurses' awareness of community and hospital resources available to patients who are victims of interpersonal violence.

Mission Statement

Intimate partner violence is common. Emergency departments are safety nets for many communities. Those experiencing intimate partner violence frequently present to emergency

rooms for a variety of medical complaints. Emergency department nurses interact with those experiencing intimate partner violence frequently. The mission of this project was to increase emergency nurses' knowledge of intimate partner violence and community and hospital resources available to patients experiencing intimate partner violence. Emergency department nurses must be knowledgeable of the prevalence of intimate partner violence, risk factors for intimate partner violence, identification of patients experiencing intimate partner violence, communication with those patients, community resources available for patients experiencing intimate partner violence, and hospital resource available to victims of intimate partner violence. This foundational knowledge will allow emergency nurses to identify those experiencing intimate partner violence and provide a more competent, trauma-informed response to positive screening and disclosures of intimate partner violence.

Theoretical Framework

Nursing Theory

Theory guides practice in a multitude of disciplines. Nursing theory provides direction and understanding of complex relationships that exist within the healthcare system. Theory provides a framework for understanding concepts prevalent in the nurse-patient-systems relationship. Nurses have many roles and responsibilities to both their patients and the systems they serve. Nurses are motivators and have the power to drive positive health outcomes within their patient populations. Because of this, nurses need to understand the concepts surrounding a patient's willingness or perceived lack thereof to participate in health-seeking behaviors.

Nola Pender’s Theory of Health Promotion

Nurses are champions of health promotion and can be effective motivators of change. What motivates patients to take steps toward improving their health? Pender’s Model of Health Promotion, developed by Nola Pender, first appeared in 1982 and was revised in 1996 (Pender

et al., 2011). Pender's (2011) theory asserts that health is more than just the absence of disease but an overall positive dynamic state. The theory uses a holistic lens to explore and understand patient behaviors that either hinder or contribute to health promotion. Pender focuses on three areas: (a) individual characteristics and experiences, (b) behavior-specific cognitions and affect, and (c) behavioral outcomes. The theory is based on seven assumptions and provides 14 theoretical statements to provide a basis for health-seeking behaviors (Pender et al., 2011).

Individual characteristics and experiences are determined by patient-specific factors like age, prior behaviors, personality, race, ethnicity, and socioeconomic status. Behavior-specific cognitions and affect examine personal influences like perceived benefits and barriers to the change, perceived self-efficacy (self-confidence in the ability to initiate changes), activity-related affect, interpersonal influences like social norms, social support, and role models, and situational influences like options. Behavioral-specific cognitions also explore commitment to the plan through goal setting and competing demands and preferences to include unanticipated difficulties. Ongoing evaluation determines if the plan is effective or if the plan needs readjustment. The final component of the model, behavioral outcome, refers to the desired outcome of health-decision making and preparation for action (Pender et al., 2011).

Intimate Partner Violence and Pender's Model

Pender's model can be used to examine health-promoting behaviors associated with intimate partner violence and the nursing response to patient disclosure. As we explored throughout this project those experiencing intimate partner violence frequently present to emergency departments and are at an increased risk for poor health outcomes. Intimate partner violence is incredibly complex and involves power and control dynamics between the abuser and the victim. Those presenting for healthcare services may not disclose the victimization or they may disclose to the healthcare system but choose not to involve law enforcement or other

community systems. Depending on individual state-mandated reporting laws, victims may be able to seek medical care and community resources without involving law enforcement.

Nurses must understand the relationship between individual characteristics and experiences and health-seeking behaviors. For example, patients of color may not want to involve law enforcement due to previous experiences with the judicial system and systemic oppression. Male victims may not seek help from either healthcare services or law enforcement due to social stigmas surrounding gender and intimate partner violence. Furthermore, high-profile victims or those of higher socioeconomic status may not seek help due to social stigmas regarding what they feel a victim is supposed to look like.

When we examine Pender's concepts of individual characteristics and experiences and the behavior-specific cognitions of those experiencing intimate partner violence nurses must understand that not all patients experiencing intimate partner violence will choose to disclose. Even further, not all patients who disclose will choose to involve law enforcement. Many factors, including social stigmas and perceptions about those experiencing intimate partner violence, may prevent victims from disclosing abuse and reporting it to law enforcement.

Victims may also choose to seek out healthcare and community services but decide not to leave the abuser. Those experiencing intimate partner violence may choose to stay with the abuser for many individual reasons including safety concerns, religious or personal beliefs, stigma related to identifying as a victim, financial concerns, etc. Nurses must provide options to both patients who decide to leave and to patients who decide to stay with abusive partners. Nurses must understand the barriers patients face when leaving violent relationships. Nurses must not be judgmental of individual decisions, and they must understand that patients experiencing intimate partner violence may still be working on making small changes to improve their health outcomes despite not leaving the abuser immediately. Pender's model explains

both aspects of this dynamic by exploring the patient's history, environment, attitudes, and beliefs regarding leaving or potential to, social support or lack thereof, and barriers to change. Nurses can use these concepts to help patients develop realistic goals and a course of action for change the patient is comfortable with to improve overall health and positive outcomes.

Pender's theory provides greater clarity and understanding of the barriers that patients experiencing intimate partner violence encounter when deciding to disclose, seeking help from hospital and community services, and trying to leave abusive situations. When nurses understand patients' individual characteristics and experiences and behavior-specific cognitions and affect they are better able to understand patient behaviors. Emergency nurses' understanding of patients' experiences with intimate partner violence and hospital and community resources will improve response. This understanding should ultimately lead to more health-seeking behaviors, better outcomes for patients, and more trauma-informed nursing care.

Work Planning

Timeline

The project problem recognition, needs assessment, literature review, development of project goals and objectives, and mission statement were developed in the spring of 2022. The theoretical underpinnings were completed in the summer of 2022. The project leader developed the project materials in August 2022. The School of Nursing Evidence-Based Practice and Research Council application was completed and submitted in September 2022. The project was given preliminary approval by the School of Nursing Evidence-Based Practice and Research Council in October 2022. The project also required project site Institutional Review Board (IRB) approval. Project site approval was obtained in November of 2022. The School of Nursing Evidence-Based Practice and Research Council gave final approval of the project in December 2022. The project

leader implemented the project in December 2022. Data collection and data analysis was performed by the project leader in February 2023. The project will have expected completion by April 2023. The project will be disseminated in April 2023 in both written and presentation formats.

Budget and Resources

There were no additional costs for salaries and wages for staff as education occurred during one of the nurse residency program's 12 monthly education sessions. The project site provided the education accommodations and facilities at no additional cost to the project leader. The cost for the resource folders was $50 for 50 folders. The cost of the paper used to print surveys was $50. The project leader utilized the project site for printing resources at no additional cost to the project leader. The project leader, in collaboration with the practice partner, developed brochures detailing community resources. The project leader provided water and a light snack for the 19 project participants for $75. The total cost of the project was $175.

Evaluation Planning

The purpose of this project was to improve the identification and response to victims of intimate partner violence in the emergency room. The project leader identified opportunities for improvement in the identification and care of patients experiencing intimate partner violence presenting to the project site’s emergency department through evidence-based education. Project outcomes included increasing the ability of the emergency department nurse to understand the prevalence and intricacies of intimate partner violence, increasing the ability of the emergency nurse to recognize signs and symptoms of intimate partner violence and patients at high risk, and increasing the ability of the nurse to assess for intimate partner violence and

refer patients disclosing intimate partner violence to appropriate hospital and community resources.

This project involved educating new hire staff emergency nurses with less than 1 year of experience in nursing on identifying and responding to intimate partner violence in the emergency department. The participants were asked to take a mirrored pre-education and post-education questionnaire prior to the project presentation and after the project presentation. The project leader predicted that the participants of the education would report the following:

- an increase in recognition of the prevalence of intimate partner violence,
- an increase in self-report of ability to identify patients at high risk for intimate partner violence,
- an increase in self-report of ability to identify patients currently experiencing intimate partner violence,
- an increase in self-report of confidence using electronic medical record screening tools to screen patients for intimate partner violence,
- an increase in self-report of knowing what to do if a patient discloses intimate partner violence,
- an increase in self-report of ability to assess a patient experiencing intimate partner violence,
- an increase in knowledge of both hospital and community resources for those experiencing intimate partner violence, and
- an increase in understanding of why some patients may choose to stay in relationships that include intimate partner violence.

The project utilized the project leader's expertise in caring for victims of intimate partner violence, educational materials developed by the project leader, a resource packet

including the informed consent, a pre-education questionnaire developed by the project leader, a copy of the presentation slides developed by the project leader, a community resources brochure developed by the project leader and the practice partner, and a mirrored post-education questionnaire developed by the project leader. The education session consisted of a 2-hour session for a group of newly hired emergency center nurses with less than 1 year of clinical experience. These nurses participated in monthly required education sessions as part of their employment agreement. The nurse supervising the program agreed to allow the education as one of the monthly sessions. The education materials were developed by the project leader in conjunction with the practice partner and project chair. The education materials included a face-to-face verbal and visual Canva presentation and a resource packet including brochures for community resources, hospital resources, and the criteria and process for hospital forensic nursing consultation.

The education session was mandatory per department policy for new-hire nurses with less than 1 year of experience however participation in the pre and post questionnaires was voluntary. On the day of the presentation, the project leader greeted all participants and introduced herself and her credentials. The project leader reviewed the informed consent form and participants were provided a copy but in order to protect participant confidentiality they were not instructed to sign the consent. The participants were informed that participation was voluntary, and they could withdraw from the project at any time by leaving the presentation. The project leader then invited the participants to complete the voluntary pre-questionnaire. The participants were instructed not to place any identifying information on the questionnaires both verbally and in the questionnaire instructions. The participants were also instructed that they could leave the entire questionnaire or any question blank that they preferred not to answer. All questionnaires were instructed to be returned to the bin. The project leader then

provided a content warning regarding the nature of the presentation and explained the objectives of the project. The project leader then presented the Canva presentation to the new-hire nurses and fielded questions from the participants. The participants were then invited to complete the voluntary post-questionnaire. The participants were again instructed not to place any identifying information on the questionnaire both verbally and in the questionnaire instructions. The participants were again instructed that they could leave the entire questionnaire or any question blank that they preferred not to answer. Participants were instructed to return all questionnaires to the bin.

The questionnaire used to evaluate the participants' pre and post education responses was developed by the project leader and project chair and included 10 questions using a 6-point Likert scale. To maintain the confidentiality of the participants no identifying information was requested. The participants were instructed not to place any identifying information on the questionnaires. The data from the questionnaires were then used to evaluate the outcomes of the project presentation. The data was analyzed, and the results were reported to the project chair, project partner, and project site.

Project Implementation

Threats and Barriers

Anticipated threats and barriers to the project included reduced interest in the project over time. The planning of the project began in January of 2022 therefore the project leader had to keep stakeholders engaged in the project throughout the whole project planning process. This process lasted 1 year. Potential threats during that time included changes in administrative staff in the emergency department and unforeseen barriers to project implementation such as an increase in the number of patients admitted to the hospital for both influenza and COVID. It was critical for the project to be able to be implemented in December 2022 as the Eclipse

courses were moving to a different format in 2023 and this could require modifications to the IRB application already submitted. An unanticipated threat to the project being implemented in December of 2022 included the lengthy facility IRB approval process. The project had to both be approved by the facility and get final approval by the School of Nursing Evidence-Based Practice and Research Council prior to the end of the fall semester to be implemented in December of 2022.

Implementation and Monitoring

After both the University's and the project facility's approval, the project leader implemented the project in December 2022. At the request of the Emergency Department Nurse Residency Director, the project leader implemented the project on two separate days to accommodate all participants of the emergency department nurse residency program. On the day of the presentation, the project leader greeted all project participants, introduced herself, and welcomed participants to the project presentation. The project leader provided light refreshments (water and snacks) to the project participants. Participants were presented with a packet to include the informed consent, a copy of the pre-education questionnaire, a copy of the slides to be used in the presentation, a copy of the post-education questionnaire, and the Domestic Violence and Sexual Assault Resources Brochure. Project participants were asked to reference the informed consent located in their folders. Project participants were allowed time to read the informed consent and ask questions regarding the information. The project participants were informed that they could withdraw at any time without consequence and in order to withdraw they could simply leave the room without penalty or consequence. Participants were then invited to complete the pre-education questionnaire located in the packet provided. Participants were verbally instructed not to place any identifying information on the questionnaire. Participants were informed that they could choose not to complete the

questionnaire or leave any item they did not wish to answer blank. All participants regardless of whether they chose to complete the questionnaire, were instructed to return the pre-education questionnaire to the bin. The project leader left the room while participants completed the pre-education questionnaire.

After completion of the questionnaire, the project leader returned to the room to conduct the presentation using the slide show presentation. Participants were encouraged to ask questions during the presentation and following the presentation. After completion of the project presentation, the participants were invited to complete the post-education questionnaire. The participants were again instructed not to place any identifying information on the questionnaire. Participants were again informed that they could choose not to complete the questionnaire as well as leave any item they did not wish to answer blank. All participants, regardless of whether they chose to complete the questionnaire, were again instructed to return the post-education questionnaire to the bin. The project leader left the room. The project leader thanked each participant as they left the project facility. The project leader gathered all questionnaires from the collection bin and secured them in a locked box.

Project Closure

The project leader met with the practice partner to discuss the project implementation and project closure. The practice partner and the director of the Eclipse program were informed by the project leader that the project participants were engaged and asked appropriate questions during the project. The project leader provided the practice partner and the director of the Eclipse program with a summary of the project results. Both the practice partner and the director of the Eclipse program acknowledged the importance of this education to the Eclipse students and the project materials will be made available to future Eclipse residency program students. The project data will be interpreted and presented to the Nursing Research Council in

the summer of 2023. The project leader thanked the practice partner and the director of the Eclipse program for their time and dedication to the successful implementation of the project.

Data Interpretation

Quantitative Data

The project used a mirrored pre-education questionnaire and a post-education questionnaire to collect data from the 19 (n=19) project participants before and after the participants was provided with the Domestic Violence and Sexual Assault Resources Brochure and participated in the project leader's slideshow presentation. Participants were comprised of emergency department nurses with less than 1 year of clinical experience participating in the hospital's emergency nurse residency program. Quantitative data was collected from the *Recognizing and Responding to Intimate Partner Violence in the Emergency Department* pre-education questionnaire and post-education questionnaire. The questionnaire was developed by the project leader and reviewed by the project chair for face validity. The pre-education questionnaire and the post-education questionnaire consisted of the same 10 items. The items were scored via Likert-scaled ordinal values with six responses from (1) strongly agree, (2) agree, (3) somewhat agree, (4) somewhat disagree, (5) disagree, and (6) strongly disagree. The aggregate data from the participant responses to the pre-education questionnaire items were compared to the aggregate data from the participant responses from the post-education questionnaire items.

All project participants opted to complete the pre and post questionnaire and all participants responded to all 10 questions on the pre-and post-questionnaire. The participants' responses to both the pre and post questionnaires were entered into Microsoft Excel for Windows 2020. Microsoft Excel for Windows was used to analyze the data and provide

percentages for each ordinal Likert scale response to each question. Stacked column charts were made for each question for optimal data visualization.

Project Outcomes

Figures 1-10 depict the pre-questionnaire and post-questionnaire response percentages compiled from 19 emergency department nurses with less than 1 year of experience who were participating in the emergency center's residency program. Project participants were invited to complete a pre-questionnaire including 10 questions regarding how they thought or felt personally about topics related to intimate partner violence. The data was compiled into stacked column charts showing pre and post data for each question. The percentage values of each Likert-scale response to each pre-questionnaire question are represented in the pre horizontal axis. Project participants were then provided with resources and education regarding recognizing and responding to intimate partner violence. After the presentation, project participants were invited to complete the mirrored post-education questionnaire. The percentage values of each Likert-scale response to each post-questionnaire question are represented in the post horizontal axis.

Figure 1

Comparison of Participant Pre-Questionnaire and Post-Questionnaire Responses on the Recognition of Prevalence

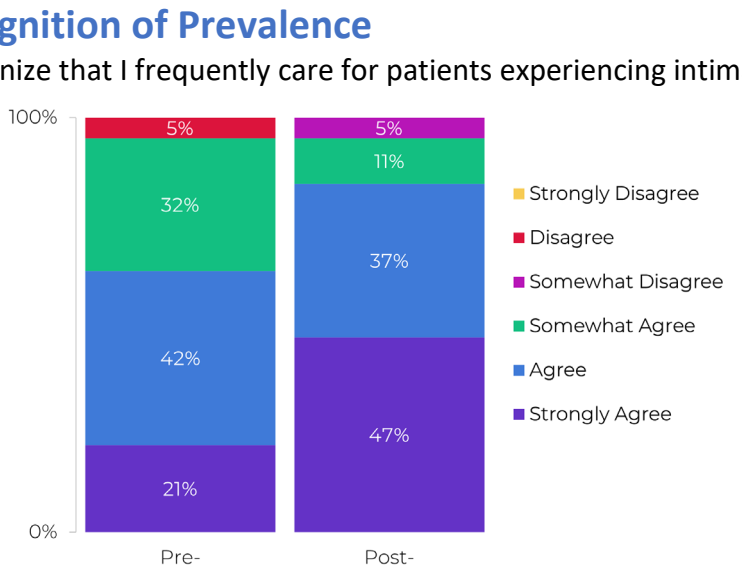


Figure 2

Comparison of Participant Pre-Questionnaire and Post-Questionnaire Responses on Identifying High-Risk Patients

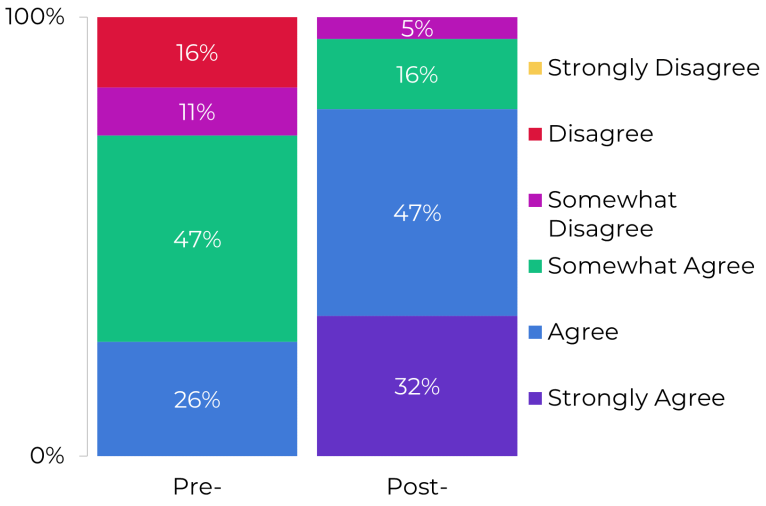


Figure 3

Comparison of Participant Pre-Questionnaire and Post-Questionnaire Responses on Identifying Patients Currently Experiencing IPV

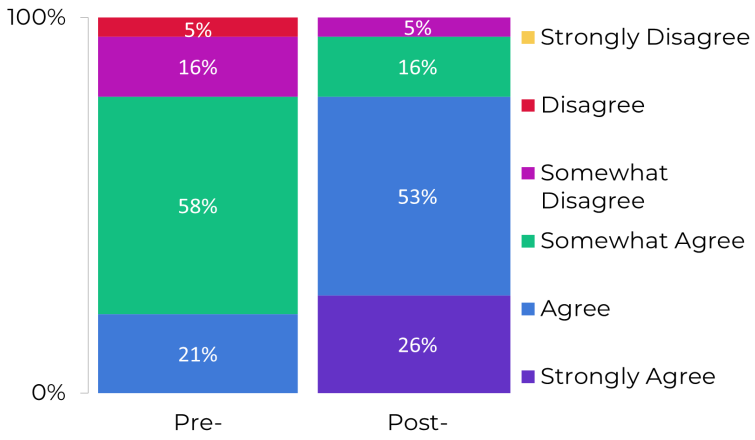


Figure 4

Comparison of Participant Pre-Questionnaire and Post-Questionnaire Responses on Using EMR Screening Tools

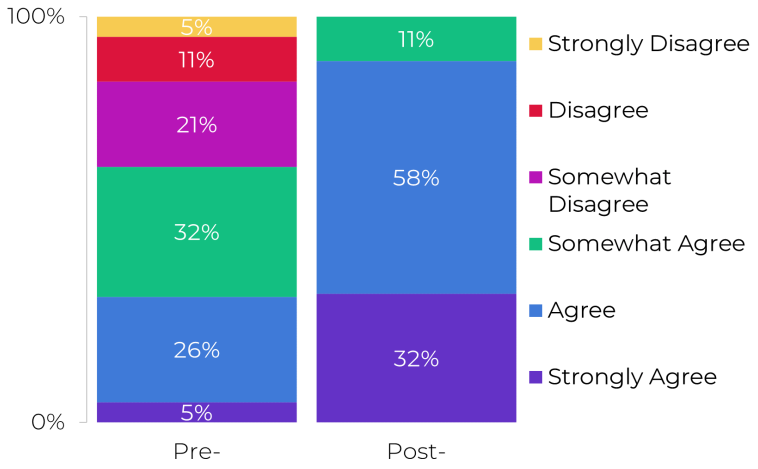


Figure 5

Comparison of Participant Pre-Questionnaire and Post-Questionnaire Responses on Communicating with Patients Experiencing IPV

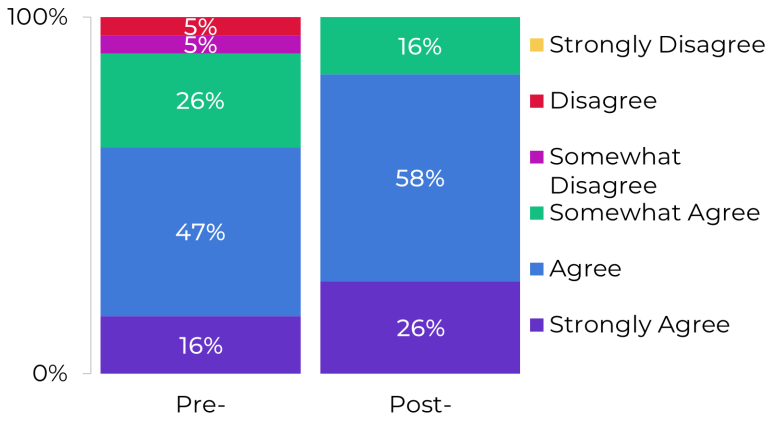


Figure 6

Comparison of Participant Pre-Questionnaire and Post-Questionnaire Responses on Knowing What to Do if a Patient Discloses IPV

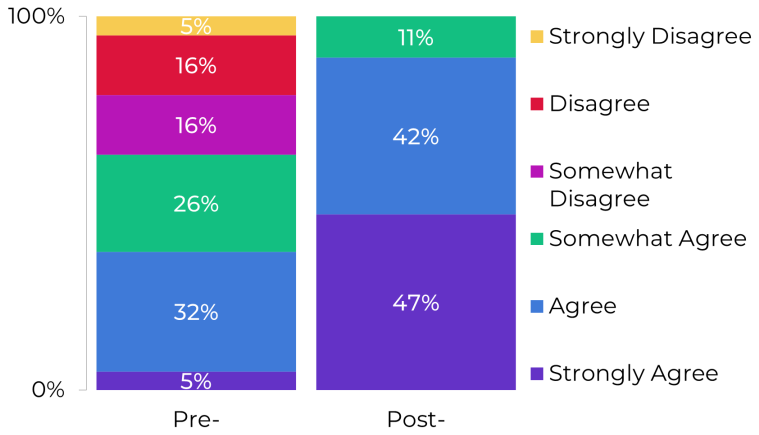


Figure 7

Comparison of Participant Pre-Questionnaire and Post-Questionnaire Responses on Assessing Patients Experiencing IPV

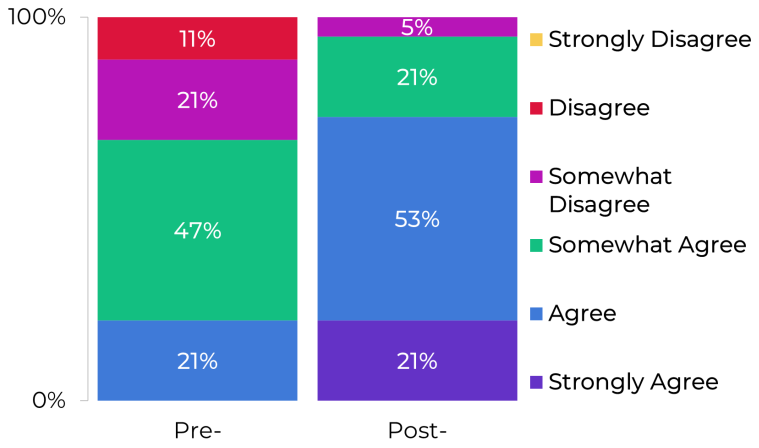


Figure 8

Comparison of Participant Pre-Questionnaire and Post-Questionnaire Responses on Awareness of Community Resources

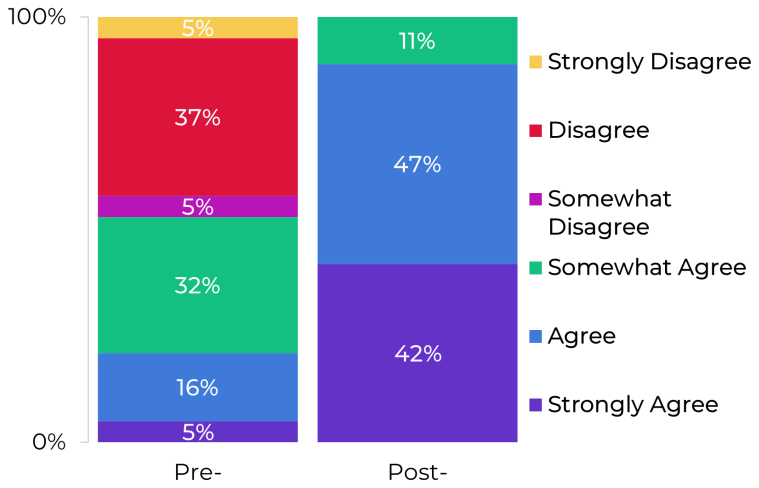


Figure 9

Comparison of Participant Pre-Questionnaire and Post-Questionnaire Responses on Awareness of Hospital Resources

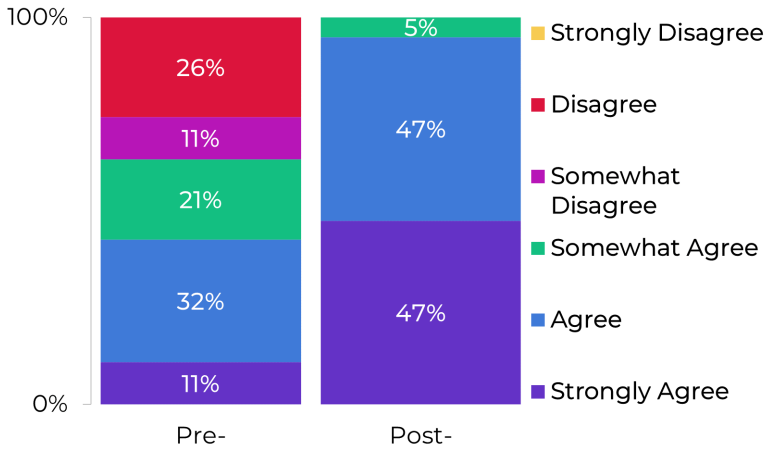
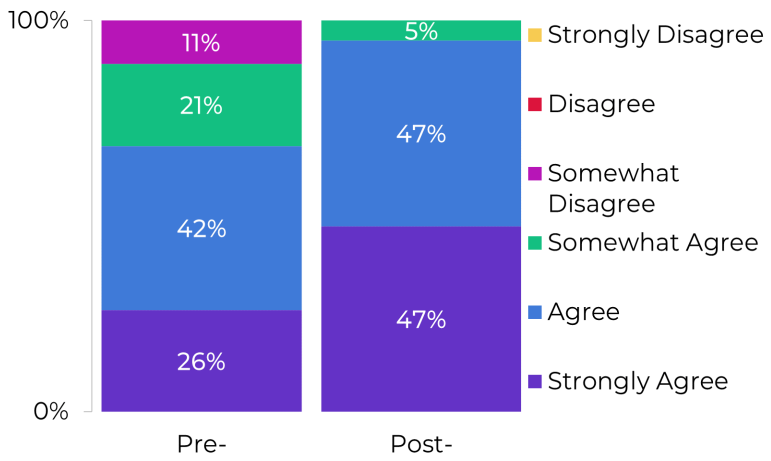


Figure 10

Comparison of Participant Pre-Questionnaire and Post-Questionnaire Responses on Awareness of Barriers to Access Safety



Project participants reported an increase in the:

- recognition of the prevalence of intimate partner violence among their patients,
- self-reported confidence in the ability to identify patients at high risk for intimate partner violence,
- self-reported confidence in the ability to identify patients currently experiencing intimate partner violence,
- self-reported confidence using EMR screening tools for intimate partner violence,
- self-reported confidence in communicating empathetically and effectively with patients experiencing intimate partner violence,
- self-reported confidence in knowing what to do if a patient discloses intimate partner violence,

- self-reported confidence in the ability to assess patients presenting with intimate partner violence complaints,
- awareness of both community and hospital resources for patients experiencing intimate partner violence, and
- awareness of barriers for patients experiencing intimate partner violence to access safety.

Project Sustainability

Emergency nurses frequently care for victims of intimate partner violence. Due to the high numbers of patients experiencing intimate partner violence seeking care in emergency departments emergency nurses must be able to identify high-risk patients, screen patients for intimate partner violence, and respond effectively to patients disclosing intimate partner violence. In order to effectively care for patients experiencing intimate partner violence emergency nurses must be adequately educated. The project increased self-reported knowledge in every category for new emergency nurses. The results of the project will be used to justify permanently adding education regarding intimate partner violence to the project site's emergency nurse residency program. The project site employs a forensic coordinator and full-time forensic nursing staff who would be available to continue yearly education regarding intimate partner violence.

Conclusion

Intimate partner violence is common among patients presenting to emergency departments. Emergency departments should prepare nurses for encounters with patients experiencing intimate partner violence through comprehensive education efforts. Comprehensive intimate partner violence education for emergency nurses should include:

- prevalence of intimate partner violence among patients visiting the emergency department,
- awareness of patient populations at high risk for intimate partner violence,
- signs and symptoms consistent with intimate partner violence,
- assessment of patients experiencing intimate partner violence,
- available EMR tools and methods of screening for intimate partner violence,
- hospital/jurisdictional protocol for disclosures of intimate partner violence,
- aspects of the power and control dynamics seen in intimate partner violence,
- long-term health consequences and risks associated with intimate partner violence,
- communicating with patients disclosing intimate partner violence,
- potential for re-traumatization of patients by professionals, and
- hospital and community resources available for patients experiencing intimate partner violence.

Intimate partner violence-specific education provided to emergency nurses is an effective way to increase self-reported confidence and knowledge of these special patient populations among emergency nurses.

References

Alshammari, K. F., McGarry, J., & Higginbottom, G. M. A. (2018). Nurse education and understanding related to domestic violence and abuse against women: An integrative review of the literature. *Nursing Open*, 5:237– 253. https://doi.org/10.1002/nop2.133

Hinsliff-Smith, K., & McGarry, J. (2017). Understanding management and support for domestic violence and abuse within emergency departments: A systematic literature review from 2000-2015. *Journal of Clinical Nursing, 26*(23-24), 4013-4027. https://onlinelibrary-wiley-com.ezproxy.gardner-webb.edu/doi/pdf/10.1111/jocn.13849

Hoelle, R. M., Elie, M.-C., Weeks, E., Hardt, N., Hou, W., Yan, H., & Carden, D. (2015). Evaluation of healthcare use trends of high-risk female intimate partner violence victims. *Western Journal of Emergency Medicine, 16*(1), *107 – 113.* https://doi.org/10.5811/westjem.2014.12.22866

International Association of Forensic Nurses (IAFN). (2022). *Forensic nursing.* https://www.forensicnurses.org/page/WhatisFN

Keeling, J., & Fisher, C. (2014). Health professionals' responses to women's disclosure of domestic violence. *Journal of Interpersonal Violence*, *30*(13), 2363–2378. https://doi.org/10.1177/0886260514552449

McCloskey, L. A., Lichter, E., Ganz, M. L., Williams, C. M., Gerber, M. R., & Sege, R. (2005). Intimate partner violence and patient screening across medical specialties. *Academic Emergency Medicine*, *12*(8), 712-722. https://doi.org/10.1197/j.aem.2005.03.529

Muelleman, R. L. & Liewer, J. D. (1998). How often do women in the emergency department without intimate violence injuries return with such injuries? *Academic Emergency Medicine*, 5: 982-985. https://doi-org.ezproxy.gardner-webb.edu/10.1111/j.1553-2712.1998.tb02775.x

National Intimate Partner and Sexual Violence Survey (NISVS). (2017). *National Intimate Partner and Sexual Violence Survey: 2010-2012 State Report.* https://www.cdc.gov/violenceprevention/pdf/nisvs-statereportbook.pdf

Pender, N. J., Murdaugh, C. L., & Parsons, M. A. (2011). Health Promotion in Nursing Practice (6th Edition). Boston, MA: Pearson.

Plichta, S. B. (2007). Interactions between victims of intimate partner violence against women and the health care system: Policy and practice implications. *Trauma, Violence, & Abuse*, *8*(2), 226–239. https://doi.org/10.1177/1524838007301220

Ramaswamy, A., Ranji, U., & Salganicoff, A. (2019, December 2). *Intimate partner violence (IPV) screening and counseling services in clinical settings.* Kaiser Family Foundation (KFF). https://www.kff.org/womens-health-policy/issue-brief/intimate-partner-violence-ipv-screening-and-counseling-services-in-clinical-settings/#:~:text=Both%20USPSTF%20and%20WPSI%20recommend,to%20women%20of%20reproductive%20age

Rodriguez, B., & Mandich, M. (2019). What victims of domestic violence experience in emergency departments; a cross sectional study. *Archives of Academic Emergency Medicine*, *7*(1), 1–6. https://pubmed.ncbi.nlm.nih.gov/32021979/

Spangaro, J., Vajda, J., Klineberg, E., Lin, S., Griffiths, C., Saberi, E., Field, E., Miller, A., & McNamara, L. (2020). Intimate partner violence screening and response in New South Wales emergency departments: A multi-site feasibility study. *Emergency Medicine Australasia*, *32*(4), 548–555. https://doi.org/10.1111/1742-6723.13452

United States Preventive Services Task Force. (2019). Screening for intimate partner violence, elder abuse, and abuse of vulnerable adults: Recommendation statement. *American Family Physician, 99*(10), 648A-648F. https://www.aafp.org/dam/brand/aafp/pubs/afp/issues/2019/0515/od1.pdf

Violence Policy Center. (2020). South Carolina ranks #11 in rate of women murdered by men – First time in 23-year history of VPC study the state has not ranked among the 10 states with the highest rates. https://vpc.org/press/south-carolina-ranks-11-in-rate-of-women-murdered-by-men-first-time-in-23-year-history-of-vpc-study-the-state-has-not-ranked-among-the-10-states-with-the-highest-rates/

Wolf, L. A., Perhats, C., & Delao, A. (2022). Educational needs of U.S. emergency nurses related to forensic nursing processes. *Journal of Trauma Nursing*, *29*(1), 12–20. https://doi.org/10.1097/JTN.0000000000000627