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Comparison of Domestic Violence Outcomes Among Emergency Department Nurses

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Running head: DOMESTIC VIOLENCE OUTCOMES

Comparison of Domestic Violence Outcomes Among Emergency Department Nurses

Thesis

Submitted to the College of Nursing and Health Professions

In partial fulfillment for a Master of Science in Nursing

By

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Marshall University

College of Nursing and Health Care Professions

2002

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Abstract

Purpose: The purpose of this study was to examine the relationships between domestic violence education, organizational support, screening, danger assessment, safety planning, and referral practices among professional registered nurses in two ED settings.

Sample & Setting: A convenience sample of 63 professional registered nurses provided data from two EDs. An ED located in Kentucky where state mandated continuing education in domestic violence was required ($n = 33$) and an ED in West Virginia ($n = 30$) where mandated continuing education in domestic violence was not required was the setting for the study. The samples were separated based on nurses who had completed state mandatory continuing education and nurses who had not completed state mandatory continuing education in domestic violence.

Tool: The Domestic Violence Survey Tool, (DVST) a 26-item self-report survey was used to assess RN perceived adequacy for domestic violence education, organizational support, screening, danger assessment, safety planning, and referral practices.

Analysis: Descriptive statistics were utilized to describe the study samples ($N = 63$). Spearman rho was utilized to examine the relationships between the two groups for organizational support, screening, safety planning, danger assessment, and referral practices.

Conclusions: Registered nurses who completed mandatory continuing education in domestic violence reported completion of screenings, danger assessments, safety planning, and organizational support. Registered Nurses were more likely to provide assessment and interventions for domestic violence when provided both state mandatory continuing education and ongoing organizational support. These nurses screened more frequently, perceived a higher level of preparedness to screen both adolescents and adult female patients for domestic violence, performed more danger assessments, implemented safety planning, and referred patients to appropriate resources. Specifically, the organizational provisions of a domestic violence policy and procedure, written screening questions within the ED assessment form, safety planning tools, and ongoing domestic violence in-service training were associated with the desired healthcare responses to domestic violence.

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To my children, Zachary & Daniel, who have been a constant inspiration to me in my pursuit to fight domestic violence. May the world be a better place for you.

And finally, to the victim's of domestic violence who struggle to survive and maintain hope on a daily basis, you are not alone and your struggle is not in vain.

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Chapter One

Introduction

Domestic Violence is a pattern of assaultive and coercive behaviors, including physical, sexual, and psychological attacks, as well as economic coercion that adults or adolescents use against their intimate partners (Warshaw & Ganley, 1998). This abusive pattern increases in frequency and intensity with the progression of time and results in fear as well as physical and psychological harm to victims and their children (Warshaw & Ganley, 1998). Domestic violence crosses the developmental lifespan of victims from conception to death (Burgess, 2002), and affects women, men, children, adolescents and elders in current or past familial relationships whether the individuals are cohabitating or not, and includes dating relationships (American Association of Colleges of Nursing (AACN), 1999). The literature contained solid links between domestic violence and child abuse, and suggested the presence of domestic violence was associated with the presence of child abuse in 50% of cases and vice versa (Zuckerman, Augustyn, Groves, & Parker, 1995; McKibben, DeVos, & Newberger, 1989; Edleson, 2001).

Child Abuse and Domestic Violence

Witnessing violence directed toward the mother is now a recognized form of child abuse (Evans, 2001). The American Academy of Pediatrics on Child Abuse and Neglect (1998), on behalf of battered women, issued a policy statement reflecting the position to screen mothers for abuse in the pediatric setting as an active form of child abuse prevention. This resulted in another recommendation for all pediatricians to incorporate screening for domestic violence as a part of anticipatory guidance (American Academy of Pediatrics Committee on Child Abuse and Neglect, 1998).

Elder Abuse and Domestic Violence

Estimated prevalence of elder abuse occurs at a rate of one to two million per year using some form of abuse, neglect, or exploitation (Lachs & Pillener, 1995). According to the National Center on Elder Abuse (NCEA, 1998), in 90% of the cases for elder abuse and neglect the perpetrator was a family member. Two-thirds of the known perpetrators were found to be spouses or adult children. Elderly women were more frequently abused than men, and elders over 80 years of age were at greatest risk for abuse and neglect (NCEA, 1998).

Women and Domestic Violence

In 1998, the US Department of Justice (2000) estimated 15% of domestic violence abuse was directed toward men and the remaining 85% of victimization by intimate partners were committed against women. Among married and cohabitating women, in the National Surveys of Families and Households, higher rates of partner violence were found among those younger than 30 years of age (Sorenson, Upchurch, & Shen, 1996). Domestic violence, or intimate partner violence, is a public health crisis that affects one to four million women in the United States each year and is responsible for approximately 30% of female murders (Rennison & Welchans, 2000; Tjaden & Thoennes, 2000; American Medical Association, 1996), as well as, the majority of rapes (Littel, 2000). This study will focus on violence related to women because it is the most prevalent form of domestic abuse.

Background and Significance

Prevalence

Domestic violence threatens the lives, well-being, and foundation of families in global and epidemic proportions (John Hopkins School of Public Health, 1999). Around the world at least one woman in every three has been beaten, coerced into sex, or otherwise abused in her

lifetime (John Hopkins School of Public Health, 1999). In the United States, a woman was beaten every 12 seconds and some form of domestic violence was occurring in 60% of families (Morales & Sheafor, 1998). The National Violence Against Women's Survey (Tjaden & Thoennes, 2000) concludes that intimate partner violence was: (a) primarily violence against women, (b) a major public health and criminal justice concern, and (c) endemic to women due to the large number of rapes, physical assaults, and stalking victimizations committed against women each year in addition to the early age at which this begins for many women.

Prevalence in West Virginia. According to the Charleston Police (2002), West Virginia is ranked number one in domestic violence homicides, with one murder occurring every eight days. In fact, approximately one-third of all homicides in West Virginia, for the past 10 years, have been domestic violence homicides (Governor's Family Violence Coordinating Council of West Virginia, 2000). "Between July 1997 and June 1998, more than 21,000 adults and 4,500 children were provided services by licensed domestic violence programs in the state of West Virginia" (Governor's Family Violence Coordinating Council of West Virginia, 2000, p. 1). Law enforcement agencies reported they received a total of 10,397 complaints of domestic violence and that this total represented a 4.1% increase over 1997, with 35.9% of these complaints filed in a previous complaint (West Virginia State Police, 1998). According to the Silent Witness National Initiative (2002), West Virginia domestic violence homicide rates for women were 6.63 per one million population in 1999.

Prevalence in Kentucky. Domestic violence related calls received for the state of Kentucky were 28,168 (Burks, 2001). Between 1998-1999, the total number of people provided shelter by domestic violence shelters was 4,456 and the total number of people that were unable to be sheltered was 794 (Burks, 2001). The total number of non-residential people receiving

counseling, legal advocacy, and/or hospital advocacy was 21,611 (Burks, 2001). In 1978, the statute of the Adult Protection Act was expanded to include mandatory reporting and delivery of voluntary protective services to victims of spouse abuse. The total number of domestic violence allegations investigated was 20,848. Domestic violence allegations made up 73% of the total reported cases for adult abuse, self-neglect, caretaker neglect, and exploitation to Adult Protective Services. According to the Silent Witness National Initiative (2002), Kentucky domestic violence homicide rates for women were 1.01 per one million population in 1999.

Nurses and Domestic Violence

Since the 1970s, nursing has been involved in efforts to alleviate the problem of intimate partner abuse (Dracher, 2002). Nurses and other health care providers play a key role in domestic violence identification and intervention, and have been visible advocates for the prevention of domestic violence throughout the world. However, many healthcare professionals were forced to confront their own personal experiences with domestic violence as they attempted to help others (Dracher, 2002; Ellis, 1999). Ellis (1999) surveyed 40 registered nurses employed in a large emergency department and found that 57.5% reported a personal experience with domestic violence. While 35% reported having been hit, kicked, or punched, only 25% of this group identified these experiences as abuse. In another study by Moore, Zaccaro, & Parsons (1998), a survey of 275 nurses in perinatal practice revealed, 31% reported abuse of themselves or family members. Nurses who have experienced domestic violence in their own lives must be supported in their efforts to find understanding, safety, peace, and healing in their own lives. Nurse administrators can play an integral role in providing a safe work environment, support to employees through Employee Assistance Programs (EAP), and allowing time off to pursue prosecution for domestic violence crimes (Family Violence Prevention Violence (FVPPF), 2002).

Domestic Violence and Secondary Health Problems

Domestic violence has been linked to many serious health problems, both immediate and long-term. These healthcare consequences of domestic violence include physical injuries that sometimes lead to death or disability (Warshaw & Ganley, 1998; Wisner, Gilmer, Saltzman, & Zink, 1999), including head injury during a battering incident (Monahan & O'Leary, 1999). A variety of chronic physical conditions such as chronic pain syndrome, irritable bowel syndrome, gastrointestinal disorders, somatic complaints, and fibromyalgia were among the frequently noted secondary symptoms of abuse (Warshaw & Ganley, 1998; Wisner, et al., 1999; Resnick, et al., 2000). Mental health disorders, reproductive health problems, and unhealthy coping behavior such as drug abuse, smoking, and sexual-risk taking were also commonly observed (Warshaw & Ganley, 1998; Wisner, et al., 1999; Resnick, et al., 2000).

Healthcare Regulations

In the United States (US), the Joint Commission on Accreditation of Healthcare Organizations (JCAHO, 1997) evaluates emergency room policies and procedures for domestic violence protocols in its accreditation reviews. JCAHO (1997) maintains that hospitals should include criterion to: (a) identify victims of abuse, (b) make appropriate referrals, (c) gather evidence, and (d) outline appropriate documentation for the healthcare response to domestic violence. Despite the requirements that JACHO has instituted, many U.S. studies have found few health care facilities have complied with these requirements (Warshaw & Ganley, 1998; Nudelman & Trias, 1999). Nurse administrators must also be aware of laws surrounding the Occupational Safety & Health Act (OSHA), Family Medical Leave Act (FMLA), and American's With Disabilities Act (ADA) under which nurses with domestic violence issues may qualify for various levels of support (FVPF, 2002).

Professional and Organizational Liability

According to Nudelman & Trias, (1999), it is in the best interest of health care organizations, physicians, and nurses to implement routine screening to identify victims of domestic violence and to adopt protocols that define a comprehensive response for this patient population once identification is confirmed. Professional and organizational liability are conceivable outcomes if the physicians or nurses do not screen for obvious injuries, or accept implausible explanations for injuries, and the patient subsequently sustains additional injuries or becomes a victim of homicide at the hands of the abuser (Diloreto, 2001; Nudelman & Trias, 1999; FVPPF, 2002). Hospital administrator liability could also be extended to the employer who fails to provide a safe work environment once an employee discloses abuse victimization to the employer (FVPPF, 2002). If the employer fails to provide safety measures for the employee while at work and the employee becomes a homicide statistic, the employer could be cited for non-compliance with OSHA, and held liable for the subsequent death or injury of the employee (FVPPF, 2002).

Healthcare Response to Domestic Violence

Warshaw & Ganley (1998) found that although healthcare providers observe the manifestations of domestic violence on a regular basis, they may not connect a woman's symptoms to the abuse she is experiencing, know how to ask if she is being battered, or feel comfortable intervening if the woman confirms abuse. The consequence for not intervening with victims is of course a progression of the isolation, abuse, and secondary health complications associated with domestic violence that sometimes leads to death (Warshaw & Ganley, 1998; Nudelman & Trias, 1999; Resnick, et al., 2000). The health care provider's lack of recognition of domestic violence as the primary diagnosis also contributes to the escalating cost for medical

care (Wisner, et al., 1999). According to Littel (2001, p. 1) “those who work with sexual assault victims have long recognized that victims are often retraumatized when they come to hospital emergency departments for medical care and forensic evidence collection.” This retraumatization occurs due to the healthcare providers “lack of training and experience with sexual assault victims and in gathering forensic evidence” (Littel, 2001, p. 1).

Domestic Violence and the Emergency Department

Nurse researchers have documented 22% to 35% of women who seek treatment at hospital emergency departments do so for injuries related to domestic violence (Cambell, Pliska, Taylor, & Sheridan, 1994). The U.S. Department of Justice (1997) reported a current or former spouse, boyfriend, or girlfriend injured 37% of women who sought care in hospital emergency rooms for violence-related injuries. Intimate partner violence rates were best reduced by timely identification of affected women seeking healthcare treatment (Walton-Moss & Campbell, 2002; Warshaw & Ganley, 1998; FVPPF, 2002). The ED has been identified as a major focus area for initiating screening and reduction of domestic abuse because of the pervasive number of domestic violence victims being seen in this healthcare setting (Walton-Moss & Campbell, 2002). While many healthcare providers assume that domestic violence victims identified in the ED will present with an acute injury, a study of 11 EDs in Pennsylvania and California found that more than 33% of recently abused and 76% of women currently abused stated that they did not come to the ED for treatment of an injury related to abuse (Glass, Dearwater, Campbell, 2001).

Due to the prevalence of domestic violence victims seeking care in the ED, primary care, and mental health settings, healthcare providers need to be prepared to identify, assess, educate, and intervene to address the emergency issues related to sexual and physical assault

victimization (Resnick, Acierno, Holmes, Dammeyer, & Kirpatrick, 2000; Warshaw & Ganley, 1998). Emergency Department staff may not have an understanding of the long-term health care consequences or the predisposing risk factors for overlapping victimization of sexual assault (Littel, 2000) and domestic violence crime (Warshaw & Ganley, 1998). This lack of knowledge points to the critical need for healthcare professionals in the Emergency Department (ED) and other healthcare settings to understand the prevalence and typical characteristics for physical and sexual assault-related crime and realize the need for routine screening.

Domestic Violence Screening and Assessment in the Emergency Department

Universal Screening. According to the Family Violence Prevention Fund (FVPF, 1999), universal screening in emergency departments was justified due to the high prevalence of domestic violence and the severity of injuries observed with patients presenting in the ED. Walton-Moss & Campbell, (2002) stated that universal screening was also advocated to increase identification of patients partly because no demographic profile, pattern of injuries, or clinical illness reliably identifies women affected by intimate partner violence (IPV).

Screening is direct questioning of all female patients ≥ 14 years of age and ideally should be included as part of a written health questionnaire to identify the presence of physical, verbal, emotional, economic, or sexual abuse by a significant other or family member (FVPF, 1999). Screening should be completed at every emergency department visit for the presence of abuse over the past year (FVPV, 1999). Health care providers completing screenings should at a minimum be: (a) educated about the dynamics of domestic violence, safety planning, autonomy of abused patients, and cultural competency; (b) trained to provide screening and intervention strategies with identified victims; (c) instructed to complete interviews in a private setting; and (d) authorized to record in the main body of the patients medical record (FVPF, 1999).

Several nursing organizations have issued position statements acknowledging violence recognition, prevention, and intervention as health care priorities including: the American Association of Colleges of Nurses (AACN, 2001), the American Nurses' Association (ANA, 1991), the National Black Nurses' Association (NBNA, 1994), the American College of Nurse-Midwives (ACNM, 1997), and the Emergency Nurses Association (ENA, 1998). According to Walton-Moss & Campbell, (2002) one of the most important initiatives nurses can undertake to end domestic violence is to ask all women about domestic violence and to ensure that this screening process is completed in a private setting and during every patient contact in every healthcare setting. Screening should, at a minimum, be completed at least annually and/or anytime that intimate partner violence is suspected (Walton-Moss, & Campbell, 2002). Despite national initiatives for universal screening, Glass, et al., (2001) found less than 25% of women were asked about domestic abuse by the ED staff. Women presenting with acute trauma from abuse had higher than 39% screening rates compared to women reporting prior-year abuse (13%) (Glass, et al., 2001). Women reporting current abuse however, were significantly less likely to support routine screening (80% vs 89%) although the vast majority did (Glass, et al., 2001).

Danger Assessment. A danger assessment is completed by the healthcare professional to assess danger in relation to risk of future significant injury, homicide, or suicide due to domestic violence (Websdale, 2000). There were several danger/lethality assessment tools available to the healthcare professional to assist in this assessment in collaboration with the patient. According to Websdale (2000), who evaluated various lethality assessment tools, Campbell's (1986) tool was found useful to summarize the key risk factors identified by the majority of experts in the criminology field. These danger assessment risk factors were access to/ or ownership of guns, use of weapon in prior abusive incidents, threats of weapons, serious injury in prior abusive

incidents, threats of suicide, drug or alcohol abuse, forced sex of female partner, obsessive /extreme jealousy or extreme dominance.

The Danger Assessment Scale (DAS) was developed by Campbell (1986) to assess safety in relation to risk of future significant injury, homicide, or suicide due to domestic violence. The Danger Assessment Scale has no minimum score where lethality significantly increases but establishes a baseline for women to estimate risk based on their unique circumstances. This tool can be self-administered by the patient and should be evaluated by the nurse and the patient for risk of future harm.

Finally, Websdale (2002) found lethality instruments were not efficient lethality screens but instead were powerful dangerousness indicators and could be beneficial for combating domestic violence, developing effective safety plans, listening to battered women more carefully, reducing the incidence of serious injury, and in some cases preventing death.

SafetyPlanning. There were several safety planning tools available to assist the registered nurse in the development of a safety plan to prevent further harm to the victim of domestic abuse. Safety planning strategies were considered for both the victim leaving an abusive relationship and the victim returning to an abusive relationship. For the victim returning to an abusive relationship, safety planning strategies included efforts to assist the victim to identify the perpetrators behavioral cues in impending violent behavior, sources of help, how to avoid getting trapped in the house, and possible escape routes (Warshaw & Ganley, 1998). The victim should also be advised to memorize important phone numbers of friends and relatives who are willing to assist during a battering incident and teach children to call 911 (Warshaw & Ganley, 1998). If possible, the victim should consider opening a separate bank account and

providing a trusted neighbor or friend with a suitcase full of extra clothes and copies of important documentation should the victim need to leave immediately (Warshaw & Ganley, 1998).

If the victim is leaving or has left the relationship, the RN should instruct the victim to change the locks on the doors, install as many security devices as possible, and inform neighbors to contact police if the batterer is observed around the victims home (Warshaw & Ganley, 1998). The victim should also be advised to obtain a restraining order and to provide copies to police, employers, caregivers for the children (including schools), and friends and neighbors (Warshaw & Ganley, 1998). The victim should keep a copy of the restraining order on her person at all times, avoid frequenting familiar stores and businesses, and change patterns of behavior related to scheduled routine familiar to the batterer to decrease the opportunity for stalking (Warshaw & Ganley, 1998).

According to Tjaden & Thoennes (2000), authors of the National Violence Against Women's Survey, most victimizations were perpetrated against women by current or former intimate partners, and women were at increased risk for injury if the assailant was a current or former intimate partner. Therefore, violence prevention strategies for women that focus on how they can protect themselves from intimate partners are a needed intervention (Tjaden & Thoennes, 2000).

Sexual Assault Nurse Examiners (SANE)

A Sexual Assault Nurse Examiner (SANE) is a registered nurse who has advanced education and clinical preparation in the forensic examination of sexual assault victims (Littel, 2001). SANE nurses are forensic nurses and also conduct evidentiary exams in cases involving other types of interpersonal violence (domestic violence), public health and safety, emergencies or trauma, patient care facilities, police, and corrections custody (Littel, 2001). The sexual

assault nurse provides a victim-sensitive solution to the gaps in the medical-legal systems response to sexual assault victims (Littel, 2001). SANE nurses have been educated regarding the victimization issues and provide prompt compassionate care to the victims of sexual assault (Littel, 2001). SANEs are adept at identifying physical trauma and psychological needs, ensuring delivery of appropriate medical care, collecting forensic evidence, and documenting injuries that will assist prosecutors to establish lack of consent and criminal conviction of the perpetrator (Littel, 2001). In addition, SANEs also testify in court as expert witnesses regarding their forensic evaluations during the criminal prosecution of the sexual assault offender (Littel, 2001). Obviously, SANE's are more qualified to provide domestic violence screenings, danger assessments, safety planning, and referrals due to their knowledge and training. However, many emergency departments lack this expertise and state mandated continuing education to all nurses has been initiated to bridge the gap in the services to domestic violence victims.

Legislation and Health Policy Initiatives

West Virginia. A survey completed by the Governor's Family Violence Coordinating Council of West Virginia (2000), found that family and domestic violence was not covered in detail, if at all, during the preparation of professionals who were most likely to come into contact with victims, nor was it a required in-service topic for any professional. This lack of education perpetuates the cycle of violence to continue without intervention or prevention and results in misdiagnosis, a tendency to treat the symptoms, and not the abuse. To address this area of weakness, the Governor's Family Violence Coordinating Council of West Virginia (2000) has recommended the inclusion of domestic violence education within all professional education programs, offerings for continuing education to all professionals, provision of information about domestic violence to be provided to children, and the initiation of a public awareness program.

Although domestic violence continuing education has been mandated in several states across the nation, the literature review revealed a lack of research to assess the effectiveness of this mandate on the assessment and care of domestic violence victims within the healthcare setting.

Kentucky. House Bill 309 enacted state mandated continuing education in domestic violence for all professional registered nurses during the 1996 Regular Session of the Kentucky General Assembly (KBN, 2002). Registered nurses were allowed three years to obtain this CE requirement for compliance with licensure requirements, and all nurses licensed after the initiation of this bill were allowed three years within the date of initial licensure to obtain this required CE (KBN, 2002). Domestic Violence education courses were taught by KBN approved CE Providers who, at a minimum, included the model curriculum approved March 25, 1997 by the Domestic Violence Training Committee of the Governor's Commission on Domestic Violence (KBN, 2002). Beginning May 1998, all nursing graduates of Kentucky prelicensure nursing programs have had the domestic violence CE included within the program of nursing education (KBN, 2002). This course included the following components: dynamics of domestic violence, effects of domestic violence on adults and child victims, legal remedies for protection, lethality and risk issues, model protocols for addressing domestic violence, available community resources, victim services, and reporting requirements (KBN, 1997).

Purpose of the Study

The purpose of this research was to examine the effects of state mandated continuing education, as perceived by registered professional nurses, in the emergency department for (a) frequency of screening female patients for domestic violence, (b) safety planning for identified victims of domestic violence, (c) danger assessments for identified victims of domestic violence, (d) referrals for identified victims of domestic violence to resources, and (e) degree of

organizational support for domestic violence screenings and assessments. More specifically, the following five research questions guided this study.

Research Questions

1. What were the relationships, if any, between state mandated domestic violence continuing education and the frequency of screening for domestic violence?
2. What were the relationships, if any, between state mandated domestic violence continuing education and danger assessment practices for domestic violence?
3. What were the relationships, if any, between state mandated domestic violence continuing education and safety planning for domestic violence?
4. What were the relationships, if any, between state mandated domestic violence continuing education and referral practices for domestic violence?
5. What were the relationships, if any, between state mandated continuing education and organizational support for domestic violence?

Hypotheses

1. Nurses who received mandatory continuing education in domestic violence screened female patients for domestic violence more frequently than nurses who had not received mandatory continuing education in domestic violence.
2. Nurses who received mandatory continuing education in domestic violence were more likely to complete danger assessments for identified victims of domestic violence than nurses who had not received mandatory continuing education in domestic violence.
3. Nurses who received mandatory continuing education in domestic violence were more likely to complete safety planning for identified victims of domestic violence

than nurses who had not received mandatory continuing education in domestic violence.

4. Nurses who received mandatory continuing education in domestic violence were more likely to refer victims of domestic violence to resources than nurses who had not received mandatory continuing education in domestic violence.
5. Nurses who received mandated continuing education in domestic violence were more likely to perceive organizational support than nurses who had not received state mandated continuing education for domestic violence.

Definition of Terms

Voluntary domestic violence continuing education. Voluntary domestic violence continuing education was defined as any domestic violence education voluntarily sought by the registered professional nurse. Number of domestic violence continuing education courses obtained by registered professional nurses in the ED were measured by self-report on the nursing Domestic Violence Survey Tool (DVST).

Kentucky state mandated continuing education. Kentucky state mandated continuing education was a one-time requirement to earn three hours of Kentucky Board of Nursing (KBN) approved Domestic Violence CE (Kentucky Board of Nursing, KBN, 2002). Domestic violence continuing education obtained by registered professional nurses in the ED was measured by self-report on the nursing Domestic Violence Survey Tool (DVST).

Screening frequency. Screening frequency was defined as the frequency for screening all female patients ≥ 14 years of age for domestic violence. Screening frequency was measured by self-report on the DVST.

Screening thoroughness. Screening thoroughness was the frequency or percentage for all female patients both adolescent and adult that were screened for domestic violence in the ED. Screening thoroughness for domestic violence by registered professional nurses in the ED was measured by self-report on the DVST.

Screening preparedness. Screening preparedness was the level of preparedness that nurses perceived for completing screenings for domestic violence. Screening preparedness was measured by self-report on the DVST.

Danger assessment. Danger Assessment was defined as the use of the Danger Assessment Scale (DAS) developed by (Campbell, 1986) to assess safety in relation to risk for future significant injury, homicide, or suicide due to domestic violence. Frequency of Danger Assessments provided for identified victims of domestic violence by registered professional nurses in the ED was measured by self-report on the DVST.

Safety planning. Safety planning was assistance provided by the nurse to the identified victim of domestic violence to assess and develop a plan to decrease the risk of further abuse and was implemented if the woman was returning to the abusive relationship or attempting to leave (Warshaw & Ganley, 1998; Nudelman, & Trias, 1999; Walton-Moss & Campbell, 2002). Frequency of safety planning was measured by self-report on the DVST.

Organizational support. Organizational support was defined as support provided by nursing administration to the ED nursing staff to complete domestic violence assessments, interventions, forensic evidence collection, and documentation. A review of the literature (Warshaw & Ganley, 1998; Nudelman & Trias, 1999; Walton-Moss & Campbell, 2002) revealed Organizational Support consisted of the following components: presence of policy and procedure for screening, assessment, and intervention; availability of private room for screening;

observable pictures or posters in the facility depicting domestic violence; screening questions written into the admission assessment form; availability of screening tools that included body map, safety planning, danger/ lethality assessment, resource information for referrals, in-service training on domestic violence, and cameras for collection of evidence. Organizational support as perceived by registered professional nurses in the respective EDs was measured by self-report on the DVST.

Referral. Referral was defined as the referral of victims to shelters, counseling, victim advocates, police, and magistrates for further assistance and support. Referral by registered professional nurses in the ED was measured by self-report on the Nursing Survey Tool.

In summary, the independent variable for this study was state-mandated domestic violence continuing education. The independent variable was recorded by self-report on the DVST by registered professional nurses in the two EDs. The dependent variables were screening frequency, screening thoroughness, screening preparedness, danger assessment, safety planning, referral, and organizational support. The dependent variables were also measured by self-report on the DVST.

Implications for Nursing

Nursing Practice

Improving the healthcare response to domestic violence victims may improve the health outcomes of this patient population, and their children, and subsequently decrease the cost to the healthcare system. When victims of abuse are undetected by healthcare providers, the primary diagnosis is missed and the secondary symptoms associated with ongoing exposure to abuse continue to progress without intervention for the primary cause (Wisner, et al., 1999). The

victims of abuse average more surgeries, physician and pharmacy visits, hospital stays, and mental health consultations than other women (John Hopkins School of Public Health, 1999).

Findings from the National Violence Against Women Survey found that 35.6% of women injured during their most recent rape since age 18, and 30.2% of the women injured during their most recent physical assault since age 18, received some type of medical care (Tjaden & Thoennes, 2000). The majority of these female victims of rape and physical assault (81.9% and 61.4% respectively) used the hospital for treatment (Tjaden & Thoennes, 2000). Of those women treated within the hospital, the emergency room was the most commonly used site for assessment and treatment of rape (44%) and injury due to assault (61%) (Tjaden & Thoennes, 2000).

This research may assist practicing RNs to pursue the establishment of appropriate healthcare responses to domestic violence. Thereby, leading to improved care and health outcomes for patients experiencing domestic violence and seeking treatment within the healthcare setting.

Nursing Education

The healthcare system has been slow to respond to the epidemic of domestic violence despite the opportunities to intervene. Healthcare providers need to obtain skills in the assessment and intervention of domestic violence victims. This will require healthcare providers to obtain the necessary education to screen, identify, and educate the domestic violence client. Ten states (Alaska, California, Florida, Kentucky, New Hampshire, Ohio, Oklahoma, Pennsylvania, and Washington state) have begun to institute mandatory continuing education requirements for licensure or renewal of licensure for nurses (Family Violence Prevention Fund, FVVPF, 2002). West Virginia is currently considering this requirement for licensure.

If state mandated continuing education requirements were found to be effective in increasing the ED nurses' assessment, identification, and intervention with victims of domestic violence, establishing mandated domestic violence continuing education requirements for RN licensure and/or renewal would be justified by other states in their efforts to initiate a healthcare response to domestic violence. This research may also lead nursing educators to include domestic violence education within the nursing curriculum of all students.

Nursing Administration

Nurse Administrators must also be concerned with providing cost effective, quality care to the patients they serve. Medical care cost for battered women were estimated at approximately 1.8 million per year (Wisner et al., 1999). This cost does not take into account the healthcare cost of children witnessing or experiencing domestic violence (Wisner et al., 1999). Other factors that contributed indirectly to the cost of domestic violence included: days of missed work, decreased productivity due to emotional, psychiatric, injury, or medical sequelae of abuse, and the premature loss of young people from the workplace due to death or disability (Wisner et al., 1999). A study by Wisner et al. (1999), found women in a health plan identified through mental health records for referral of intimate partner violence (IPV) had significantly higher costs, were younger, utilized a higher rate of out-of-plan referrals, and utilized the emergency room equally when compared to women of the health plan population in general. The lower utilization of emergency room visits found in this study was attributed to the lack of apparent screening for domestic violence discovered upon review of the medical record (Wisner et al., 1999).

Research into this subject matter is relevant and important to Nurse Administrators who can play an integral part in incorporating hospital based domestic violence programs into their

organizations. Nurse Administrators must also be concerned with the implementation and compliance with JCAHO standards regarding policy and procedures for accreditation. Proper education and training of nursing and medical staff on the prevalence, identification, intervention, referral, and documentation of abuse is essential in addressing this national and community epidemic. The implementation of hospital based family violence programs could provide a solid opportunity for healthcare organizations to make an impact on the collective health of the communities they serve.

Summary

In summary, domestic violence is extremely pervasive throughout the world and the United States. Healthcare providers have been slow to respond to this epidemic of violence that predominately affects women and children and leads to poor health outcomes, increased utilization of the healthcare system, and destruction of lives. Finally, this study provides additional information to the limited body of research on the ability of domestic violence state mandated continuing education to improve the healthcare response provided by RNs to domestic violence victims presenting within the ED.

Chapter Two

Introduction

This chapter provides a literature review to support the purpose of this study. In addition, an overview of the Neuman System's Model (NSM) was outlined for the reader and utilized as the framework for completion of this research. Following a brief discussion of the NSM, the nursing interventions for the domestic violence client were incorporated through the lens of this theory.

Literature Review

Ellis (1999) completed a non-experimental study of 101 registered nurses (RN) utilizing a quantitative survey to examine barriers that contributed to the prevention of RNs screening for domestic violence in the emergency department. The five minute questionnaire assessed various demographics, previous attendance at domestic violence in-services, screening for domestic violence, and preparedness to perform: screenings, provide support, inform victims about legal options, identify warning signs of abuse, make appropriate referrals, and discuss options with a victim that discloses abuse (Ellis, 1999). Chi-squared analysis revealed no significant correlation for the variables of years in nursing, years in ED, or level of education (Ellis, 1999). However, a statistically significant relationship was seen between age and attendance at in-services $\chi^2 (n = 40) = 13.35, p \leq .01$ (Ellis, 1999). In conclusion, although 87% of the respondents had previous domestic violence education, only 45% completed routine screenings, and 42.5% felt they needed more education to improve their screening and intervention skills (Ellis, 1999). The lack of time and lack of privacy to complete screenings reflects a need for organizational change and support in order to improve the response of ED nurses to domestic violence victims (Ellis, 1999).

Roberts, Bus, Raphael, Lawrence, O'Toole, and O'Brien (1997) completed a quasi-experimental study of nurses and doctors in an Australian ED to measure the pre & post dependent variables of knowledge, attitude, and practice to determine the effects of the independent variable, a one-hour educational intervention. The educational session included a case presentation, literature about domestic violence, a poster on all department notice boards, and individual pocket cards (Roberts et al., 1997). Educational instructors included a social worker, a psychiatrist, and a police officer who presented information to: (a) increase the general knowledge about domestic violence, (b) increase knowledge of resources for victims, (c) increase knowledge of legal options for victims, (d) increase knowledge of mandatory reporting laws, and (e) change negative attitudes and practices toward victims by doctors and nurses (Roberts et al., 1997).

According to Roberts et al. (1997), the results indicated that both doctors and nurses had statistically significant changes in knowledge after the intervention of education, with nurses answering 71.5% of the questions correctly ($t = 6.63$, $df = 45$, $p = .0001$) and doctors answering 72.4% correct ($t = 2.66$, $df = 19$, $p = .015$). Female nurses had a significant increase in their total number of correct answers after education ($t = 5.28$, $df = 37$, $p = .0001$) (Roberts et al., 1997). Although attitude measurements were generally higher during pre-test measurement of all groups, results showed statistically significant improvement for female nurses ($t = -2.96$, $df = 39$, $p = .005$) (Roberts et al., 1997). There were also statistically significant changes noted in the knowledge of resources (McNemar's test, $p = 0.0009$) and the knowledge of legal aspects ($t = 4.48$, $df = 65$, $p = .0001$) by nurses (Roberts et al., 1997).

Other general conclusions that were noted included: (a) more nurses responded to the questionnaire; (b) both doctors and nurses felt that domestic violence was a behavioral pattern

that could be changed but nurses attitudes about being able to do something to intervene changed significantly after education; (c) education had more of an impact on nurses than doctors and that attitudes regarding domestic violence were a function of profession not gender; and (d) due to the low response from doctors on the questionnaire, doctors may still need to be convinced that domestic violence is a significant public health problem warranting intervention and treatment (Roberts et al., 1997).

A quasi-experimental study completed by Quillian (1996), utilizing a convenience sample of patients from a city/county health clinic at three different sites (family planning clinic, HIV testing and counseling site, and the sexually transmitted disease clinic) in the Western United States examined a screening study for spousal abuse. The procedural program included: (a) education regarding national and local statistics related to the prevalence of domestic violence; (b) a film about spousal abuse created by the March of Dimes; (c) an introduction of study objectives; (d) a discussion of protocol formats; (e) identification of key personnel to complete screenings; (f) community resources; (g) an establishment of time for data collection; and (f) the provision of monthly meetings to provide support and identify concerns of staff regarding the screening process (Quillian, 1996).

Although the incidence of abuse (8.8%) was low for this study, possible reasons for this finding were felt to be due to difficulty with screening exhibited and expressed by the staff with the reasons listed as follows: (a) personal experience with abuse; (b) lack of knowledge or understanding of the research project; (c) lack of understanding regarding domestic violence dynamics; and (d) fear of being involved with the law as a mandated reporter (Quillian, 1996). Implications of the study suggested an emphasis on continuing education regarding domestic

violence to assist healthcare providers to increase their understanding and comfort level in assessing and providing interventions and referrals to victims of abuse (Quillian, 1996).

Smith, Danis, & Helmick (1998) completed a non-experimental study on physicians and nurses that assessed the predisposing, enabling, and reinforcing factors associated with screening behavior prior to the implementation of an educational program. This educational program was designed to initiate clinical training to provide comprehensive coordinated healthcare response to victims of abuse through screening, assessment, management, referral, and counseling. The PRECEDE-PROCEDE framework for conceptualizing behavior change guided the data collection to assist in the preparation of the educational intervention phase in order to change pre-existing healthcare provider behaviors and attitudes toward domestic violence victims (Smith et al., 1998).

Multiple linear regression was used to analyze data that represented the different levels of thoroughness in screening. Bivariate analysis supported the theory that respondents who successfully screen at any of the three levels above the lowest level of thoroughness would screen at all lower levels of thoroughness and therefore, these behaviors were combined into a Guttman scale that tapped progressively higher levels of thoroughness (Smith et al., 1998). A Multistage approach to multiple regression analysis was utilized to determine which of the variables were associated in bivariate analysis with each of the four screening behaviors in addition to the Screening Thoroughness Scale and results were considered statistically significant at the $p < .05$ (Smith et al., 1998).

When assessing frequency of screening behavior, the most commonly reported behavior was “screening women that present with physical injuries” and this screening practice always occurred with 37% of the respondents and “often” by 26.7% of the respondents (Smith et al.,

1998). Universal screening of all female patients was the least common practice of the four possible behaviors noted at 5.1% and 5.8% for nurses and physicians respectively (Smith et al., 1998). However, most clinicians reported screening at higher levels of thoroughness (Smith et al., 1998).

When assessing knowledge level, the majority of the study population was exposed to some form of domestic violence continuing education or training but most clinicians indicated a lack of knowledge as a subsequent barrier to intervention for victims of abuse, surrounding legal issues (70%) and referral sources (58%) (Smith et al., 1998).

Bivariate analysis revealed that some of the beliefs about role behavior were significantly related to screening practices (Smith et al., 1998). Clinicians were more likely to engage in screening practices if their beliefs were maintained regarding: (a) screening women who exhibit nonspecific complaints, (b) routinely screen all women; (c) communicating concerns to abused women; (d) persuading women to leave abusive relationship; and (e) helping women to create safety plans (Smith et al., 1998). When assessing perceived competency of clinicians, the majority of clinicians felt: (a) prepared to ask women if they had been abused (65%); and (b) prepared to refer women to community resources (57%); but not prepared to: (a) counsel battered women (38%); (b) treat battered women (34%); or (c) assist battered women with safety planning (37%) (Smith et al., 1998). These variables both individually (measuring self-efficacy) and summative (measuring Perceived Competency) were significantly associated with all of the screening practices (Smith et al., 1998).

Reinforcing behaviors (factors that have an impact on whether clinicians would continue the screening behaviors) were assessed and the majority of clinicians agreed that asking about abuse helps clinicians to more effectively treat women. This factor was significantly related with

all screening behaviors (Smith et al., 1998). A belief by the clinician that all women should be screened as part of a routine history or physical exam and perceived competence emerged as a predictor for screening all women once ($F = 6.25, p < .05$ and $F = 6.71, p < .05$), and screening each woman at every visit ($F = 18.03, p < .05$ and $F = 9.63, p < .05$) (Smith et al., 1998).

This study reflected previous education concerning domestic violence and awareness of the importance of clinician involvement in identification, treatment, and referral of victims. One predisposing factor (belief that routine screening is an appropriate role behavior) emerged as significantly related to the likelihood of screening all women at least once or during each visit (Smith et al., 1998). However, this factor was not related to thoroughness in screening. The results of this study suggest that the clinicians that are more likely to screen and with increased thoroughness are those clinicians that feel they are professionally prepared to complete screenings for domestic violence.

Gagan (1998) completed a non-experimental, cross-sectional, descriptive, correlational study to identify diagnosis and intervention performance accuracy and the variables that influence performance accuracy of adult nurse practitioners (ANP) and family nurse practitioners (FNP). The researchers utilizing current literature, several experts in the area of domestic violence, and experiences of the researcher, developed the Nurse Practitioner Survey (NPS) and the Nurse Practitioner Performance Tool (NPPT). The NPPT contained 10 written vignettes designed to evaluate the ability of the NP to identify and intervene with victims of domestic violence.

Gagen (1998) found: (a) NPs had higher levels for formulating diagnosis than for interventions; and (b) three variables had a significant effect on the diagnosis performance accuracy of NPs. NPs taking a college course that included content in domestic violence, as well

as, a professional interest in domestic violence pursued on one's own time, increased diagnosis performance accuracy (Gagen, 1998). Gagen (1998) subsequently found a decrease in diagnosis performance accuracy for every one-year increase in experience as a NP.

Perrin, Boyett, & McDermott (2000) completed a non-experimental comparison study to determine the effectiveness of a mandatory 1-hour domestic violence continuing education training course on health care practitioners' awareness and identification of pregnant women involved in physically abusive relationships. The Florida Board of Professional Regulations began mandatory continuing education in 1993. The National Perinatal Association (NPA) Conference was held prior to this implementation and participants at this conference were distributed a 12-item questionnaire printed on a postage paid survey (Perrin et al., 2000). Therefore, this group was recognized as not having previous mandatory continuing education.

The survey asked practitioners to: (a) estimate the percentage of pregnant women younger than 18 years who are in abusive relationships; (b) estimate the percentage of pregnant women in their practice who were abused; (c) frequency with which pregnant women in their practice were asked about abuse as part of the routine history; and (d) whether their patients receive education about physically abusive relationships. The remaining questions pertained to the respondents' demographic data. Chi-square analysis revealed the only statistically significant difference between 1993 and 1997 survey responses was with regard to the availability of patient education materials provided to patients by healthcare providers ($\chi^2 = 22.003$, $n = 109$, $df = 5$, $p = .001$) (Perrin et al., 2000). Perrin et al. (2000) found that participants from both 1993 (84%, $n = 72$) and 1997 (79%, $n = 42$) reported an interest in further information on the topic of domestic violence and seminars were the preferred method of continuing education (47% and 38% respectively). Finally, 28% ($n = 21$) in 1993 and 17% ($n = 9$) in 1997 reported that they had

been in a physically abusive relationship (Perrin et al., 2000). Based on the results of this study, mandated continuing education did not improve the practitioners' perceptions regarding physically abusive relationships or the response to victims in the form of increased screening. Therefore, knowledge obtained from domestic violence mandated continuing education did not lead to the desired changes in clinical practice.

The research of Larkin, Rolniak, Hyman, MacLeod, & Savage (2000) identified the research problem as the difficulty experienced by healthcare providers in implementing widely advocated universal screenings for domestic violence victims. Previous research has sought to assess the provider barriers to screening but little research has been completed regarding interventions that seek to improve compliance with universal screening practices; and thereby overcome the noted provider barriers of time constraints, discomfort with domestic violence, expected futility of intervention, and perceived victim responsibility (Larkin, et al., 2000). The objective or purpose of this study was to expand on previous research regarding barriers to domestic violence screening and to measure the effects of an administrative intervention on health care provider compliance with universal domestic violence screening protocols.

Prior to the initiation of the administrative intervention, only 29% (483 of 1638) of the domestic violence screenings were completed (Larkin et al., 2000). However, post-administrative intervention the number of domestic violence screenings increased to 72.8% (Larkin et al., 2000). Despite the significant increase in screenings acknowledged, the change in the frequency in which providers actually identified victims through the screening process remained relatively small despite an overall increase from 5.3% (87 of 1638) to 8.0% (130 of 1617) or a 50% increase in odds of detection for this sample post-intervention (estimated $OR = 1.5$, 95% $CI = 1.2, 2.0$) (Larkin et al., 2000).

When comparing pre-intervention samples to post-intervention samples utilizing logistical analysis, patients admitted with a psychiatric complaint were less likely to be screened pre-administrative intervention when compared to patients admitted with a medical complaint (estimated $OR = 0.38$, 95% $CI = 0.16, 0.92$) and less likely to be screened when compared to patients with a trauma-related complaint (estimated $OR = .30$, 95% $CI = 0.12, 0.73$) (Larkin et al., 2000). This decrease in likelihood of screening during the pre-intervention stage was also noted in patients that presented closer to the initiation of the screening program (estimated $OR = 0.43$, 95% $CI = 0.35, 0.54$) and with those patients that presented to the ED between the hours of 11:00 PM and 7:00 AM (estimated $OR = 0.46$, 95% $CI = 0.31, 0.68$) (Larkin et al., 2000).

After the administrative intervention was implemented, the only predictor of screening bias that remained was that White Caucasian patients were still more likely to be screened for domestic violence than were non-White patients who were 99% African American (estimated $OR = 0.79$, 95% $CI = 0.63, 1.00$) (Larkin et al., 2000). All other previously noted pre-intervention predictors (psychiatric complaints, month, and night shift) were no longer significant for missed screenings (Larkin et al., 2000). Neither the gender of the nurse nor the insurance status of the patient was ever noted as significant predictors of non-screening in either the pre- or post-administrative intervention stages of the study (Larkin et al., 2000).

Loughlin, Spinola, Stewart, Fanslow, & Norton, (2000) completed a qualitative study on the responses of registered nurses in the ED to a five-step administrative protocol of care on partner abuse implemented in a public hospital. The protocol objectives were to increase the ED staff response to identify intimate partner violence, improve the acute management that women receive, and increase women's referral to appropriate support services through the use of a

protocol entitled OASIS (Observe for abuse, Ask, Assess, Intervene, and Support) (Loughlin, et al., 2000). A training session was provided regarding domestic violence and a cultural component for the patient populations served by this hospital. Implementation of the protocol was voluntary and varied between staff members and among the same staff members over time (Loughlin, et al., 2000). One month after the training, the protocol was suspended by the ED manager due to concerns expressed by the nursing staff regarding the universal screening of all females greater than 15 years of age. A revised protocol was introduced in which staff were directed to only ask women when they suspected abuse (Loughlin, et al., 2000). In addition, a protocol coordinator emerged to provide coordination within the emergency department, provide additional training sessions for medical staff and numerous one-on-one training sessions for new registered nurses, incorporate the OASIS protocol into the emergency department orientation handbook, and make contact with community support services (Loughlin, et al., 2000). Within 9 months, the protocol was perceived to be integrated into routine emergency department practices with implementation likely to continue. Nurses expressed increased understanding of the dynamics of domestic violence and the reasons why women don't leave due to lethality risks and acknowledgement of organizational support in the form of a private room for interviews, tools for assessment, and referral connections (Loughlin, et al., 2000). As an increased feeling of competency to assist victims of abuse occurred, the barrier of time diminished (Loughlin, et al., 2000).

Theoretical Framework

Betty Neuman's Systems Model (NSM) will be utilized as the theoretical framework for this research proposal due to the 'goodness of fit' in dealing with the healthcare response to domestic violence victims. The Neuman System's Model (NSM) is a system's approach model

to nursing (Neuman, 1989). The NSM is an open systems model that views nursing as being primarily concerned with defining appropriate action in stress-related situations or possible reactions of the client/client system; since environmental exchanges are reciprocal, both client and environment may be positively or negatively affected by each other (Neuman, 1989).

The client is viewed as multidimensional composed of physiological, psychological, sociocultural, developmental, and spiritual variables, which ultimately function harmoniously in response to both internal and external stressors (Neuman, 1989). This is a dynamic model because it is based on the continuous interaction of the client with the various environmental stressors (intrapersonal, interpersonal, and extrapersonal stressors), which have the potential for causing a symptomatic reaction to stress (Neuman, 1989). The system acts as a boundary to enable the defined client to maintain stability (Neuman, 1989). “Nursing functions to facilitate optimal wellness for the client through retention, attainment, or maintenance of the client system stability” (Neuman, 1989, p. 25).

The NSM is based on the theories of stress reaction and adaptation with the person being a multidimensional whole in “constant dynamic interaction with the environment” and the nurse providing primary, secondary, or tertiary prevention strategies for treatment to maintain or move the client toward the “optimal wellness level” (Neuman, 1989). Optimal means the best possible health state achievable at a given point in time to maintain the system stability whereby the nurse creates a linkage among the client, environment, health, and nursing.

Within the NSM, the client is represented by multiple concentric rings surrounding the core structure (Appendix C) (Neuman, 1989). These rings are the defense against environmental stressors. The Normal line of defense represents the usual wellness state of the client (Neuman, 1989). The flexible line of defense protects the normal line of defense and this prevents invasion

of environmental stressors (Neuman, 1989). This buffer like function of the flexible line of defense maintains the system stability, keeping the client system free of stressor reactions or symptoms (Neuman, 1989). However, when the normal line of defense is penetrated due to a failing flexible line of defense, symptomatology from stressors become apparent and illness results (Neuman, 1989).

The internal lines of resistance protect the system once invasion of the normal line of defense has by environmental stressors has occurred (Neuman, 1989). If the internal lines of resistance are effective in reversing the stressor reaction to allow reconstitution or return to stability, wellness is regained. However, if the lines of resistance are ineffective in reversing the stressor reaction, energy depletion occurs and eventually death results (Neuman, 1989). The point of entry into the healthcare system for both the client and the caregiver is either predominately at the primary level (before a reaction to stressors has occurred) at the secondary level (after a stressor has occurred) or at the tertiary prevention level (following treatment of a stressor reaction) (Neuman, 1989).

Neuman defined primary prevention as general knowledge that is applied to client assessment and intervention for identification and reduction of the mitigating risk factors associated with environmental stressors to prevent a possible stressor reaction (Neuman, 1989). In the case of domestic violence, the nurse must screen patients for domestic violence for identification and provide a basic understanding of the dynamics of domestic violence to the client in order to assist the client to prevent possible stress reactions to the endemic women's health issue of abuse.

Secondary prevention, according to Neuman, (1989) is instituted when symptomatology occurs for the client following a reaction to a stressor. The nurse must act to prioritize

interventions and treatment strategies to reduce the noxious effect of the stressor (Reed, 1993).

The nurse must observe the client for signs of abuse and screen for abuse to confirm identification. Once a client has been identified as a victim of abuse, the nurse must assess for safety and lethality; assist in safety planning, offer counseling, refer the client to available resources, provide legal options, and initiate appropriate documentation to assist the client to obtain a protection order and prosecution of the perpetrator if desired by the client.

Finally, tertiary prevention relates to the nurses' ability to assist adjustive processes taking place as reconstitution begins for the client and maintenance factors move the client back toward primary prevention (Neuman, 1989). This would involve the nurse assisting the client by providing: support, alternatives for the clients' adjustment to life away from the abuser, assistance to the client to move beyond the psychological trauma of abuse, and assistance to the client to understand the dynamics of abuse and possible cues to identify future abusers.

Summary

In summary, the literature review consistently revealed a need for further education to be provided to healthcare providers in an effort to increase the healthcare response to domestic violence. Ellis (1999), Smith et al., (1998), and Gagen (2000), found the majority of their sample respondents had previous education in domestic violence but a lack of knowledge related to legal issues and resources was the most frequently sighted barrier to screening. Smith et al., (1998) found clinicians improved ability to treat patients after questions are asked was the most common reinforcing variable for screening and perceived competence was the largest predictor of screening behavior by clinicians. Roberts et al., (1997) found that domestic violence education increased general knowledge, improved attitude toward victims, and increased knowledge of the available resources for victims. Quillian (1996) found the effects of screening

diminished secondary to nurses personal experience with abuse, lack of knowledge regarding domestic violence, and fear of legal involvement. Ellis (1999) noted the negative effects on screening behavior when organizational support was not present.

Larkin et al., (2000) noted that an organizational intervention initiated to increase compliance of registered nurses in the ED to complete universal screenings for domestic violence resulted in a statistically significant difference in screening practices from pre- to post-intervention (29% - 78%). According to Larkin et al., (2000), this disciplinary policy to increase compliance may have had a negative impact on the frequency of victim identification (nurses may have complied out of fear rather than with compassion for this patient population), which increased but remained low pre- to post-intervention (5.3% - 8.0%). Loughlin et al., (2000) found that the development of an organizational protocol for increasing identification, assessment, and treatment of domestic violence victims and the additional provision of organizational support (in the form of: staff education, a project coordinator, availability of assessment tools and referral networks, and finally the allowance of feedback from staff) resulted in adoption of the domestic violence protocol, increased competency level of nurses, and an increased response to domestic violence victims.

Before the nurse is able to assist the client with domestic violence issues, the nurse must have appropriate education and training in domestic violence. Education is at the heart of the nurses' ability to assist the client with domestic violence issues. In addition, the literature review and model protocols developed by the Family Violence Prevention Fund (2002) would suggest that organizational support available to the nurse to institute a healthcare response for victims is also necessary for successful implementation of the domestic violence protocols. The NSM was utilized as a framework for the implementation of primary, secondary, and tertiary healthcare

responses by registered nurses for victims of domestic violence. More specifically, the focus of this research was the examination of the adequacy of state mandated continuing education to positively affect organizational support, and the clinical practices of screening, danger assessment, safety planning, and referral for victims of domestic violence.

Chapter Three

Introduction

This chapter includes a description of the research design, the sample and setting of the population, instrument utilized for data collection, procedures for conducting the research, and the limitations of the study.

Methodology

Design

This study used a pre-experimental, comparison design. The effect of state mandated domestic violence continuing education on the perceived frequency of screening, danger assessment, safety planning, referral, and organizational support by registered professional nurses within the ED was examined in two hospitals and compared for differences. One hospital ED was selected from a state that requires domestic violence state mandated continuing education and one hospital ED was selected from a state that does not have mandated continuing education. Demographic information was evaluated for differences within the sample of registered professional nurses within the respective EDs using Spearman rho correlations.

Setting and Sample

The study took place in two hospitals EDs located in the states of Kentucky and West Virginia. These EDs were chosen for comparison due to the state mandated requirements for domestic violence continuing education in Kentucky and the absence of domestic violence state mandated education requirements in West Virginia. The target population for this study was professional registered nurses working within the EDs. A convenience sample of 30 nurses from each hospital was surveyed using the 26-item self-report Domestic Violence Survey Tool developed by the investigator. Inclusion criteria for the sample were (a) professional registered

nurses, (b) staff nurse within the ED in one of the respective hospitals chosen for this study, (c) worked more than 20 hours a week, and (d) completed the survey in its entirety. Exclusion criteria for the surveyed sample included (a) Licensed Practical Nurses (LPNs), (b) nursing aids, (c) paramedics, and (d) nurses who worked less than 20 hours a week in the respective ED. The researcher was only interested in ED staff nurses who completed admission assessments and nursing documentation within the medical record.

Instrument

The tool used for the evaluation of domestic violence education, organizational support, screening, danger assessment, safety planning, and referral was the 26-item, self-report, Domestic Violence Nursing Survey Tool (Appendix D). The survey tool was developed by the researcher, and was completed by the registered nurses within the two EDs. Content validity was established through review of the literature, submission to experts for review (thesis committee members and nursing faculty with a background in emergency nursing), and subsequent refinement of the tool based upon the recommendations of the panel. Reliability was examined by this pilot study using Chronbach's Alpha coefficient.

Procedure

The researcher obtained permission from the Marshall University Institutional Review Board (IRB) (Appendix B) and both hospital organizations (Appendix A) to complete this research project. No permission from the patient was needed since no direct contact with the patient was made nor review of any medical records. The researcher completed data collection through the use of a self-report survey distributed to the sample of registered professional nurses within the two EDs. The questionnaires were provided to both ED Directors to distribute to registered professional nurses in the ED by using an unmarked sealed envelope. The envelope

contained a cover letter included with the questionnaire that explained the purpose of the study (Appendix E). Completion and return of the questionnaire implied informed consent. The protection of respondent rights and complete anonymity were maintained by distribution of the questionnaires in a plain envelopes with no identifying information except the organizational name and was returned sealed by the respondent nurse to the respective ED Director. No names or identification will be used on any of the study material.

Limitations

A limitation of this study was the use of a pre-experimental design that weakens the results of this study because no initial data were completed to measure the equivalence of the two ED staff prior to the intervention of education. Attempts to overcome this weakness were undertaken by the collection of demographic variables such as education level, experience, age, number of years in nursing, and personal exposure to domestic violence. The lack of sample randomization was another identified limitation of this study that decreased the generalizability of the results. The use of self-report without a review of the medical record to validate findings creates another limitation to the internal validity of the results. Attempts to minimize self-report bias were undertaken by the use of anonymous reporting. Additionally, the use of convenience sampling and small sample size contributed to the limitations of this study since several other hospitals were in close vicinity to those chosen for this study. However, due to the time limitations surrounding this study, additional hospitals were not included. A small sample will limit the predictability of the findings to other settings.

Summary

In summary, this research used a pre-experimental design to assess the effects of the intervention of state mandated domestic violence continuing education on the organizational support and the healthcare response of emergency department professional registered nurses. Specifically a 26-item self-report survey was utilized to measure screening, safety planning, danger assessment, and referral practices of registered nurses in the ED who received state mandated continuing education compared to registered professional nurses in the ED who did not receive state mandated domestic violence continuing education.

Chapter Four

Introduction

The purpose of this chapter was to provide an explanation of the data analysis, results, implications, discussion, recommendations, and conclusions.

Data Analysis

Frequency distributions were utilized to describe and compare the two samples using the following variables (a) age, (b) educational degree, (c) number of years in nursing, (d) number of years practicing in the emergency department, (e) gender, (f) witnessing domestic violence of a family member or close friend, and (g) personal experience of domestic violence in a current or previous relationship. The convenience sample of emergency department (ED) nurses ($N = 63$) was divided into two groups based on the setting, and data were compared using the study variables.

When assessing the groups according to setting, Group A ($n = 33$) consisted of ED nurses working in Kentucky where state mandated continuing education was required, and Group B ($n = 30$) consisted of nurses working in West Virginia where state mandated continuing education was not a requirement. After assessing the two groups for the presence of required state mandated continuing education, Group A was found to have one nurse who had not received the required continuing education in domestic violence, and Group B was found to have two nurses who had received the state mandated continuing education course in Kentucky. This mixture was found because two nurses in West Virginia possessed dual RN licenses in both states. Therefore, the researcher divided the groups according to nurses who received state mandated continuing education in domestic violence (Group A: $n = 34$) and nurses who had not received state mandated continuing education in domestic violence (Group B: $n = 29$).

Data were analyzed using frequency distributions and Spearman rho correlation Coefficients. Content analysis of the Domestic violence Survey Tool (DVST) was established by review of the literature for concept inclusion and submission to a panel of seven experts for content review. Content refinement of the tool was made based upon the critical comments from the panel of experts. Psychometric analysis using Cronbach Coefficient Alpha was used to establish reliability estimates for the 26-item Domestic Violence Survey Tool (DVST). Data were analyzed using the Statistical Processor for Social Sciences (SPSS) version 11.0 (SPSS for Windows, 2001).

Results

Sociodemographic Characteristics of the Samples

Group A: RNs with State Mandated Continuing Education in Domestic Violence. The sample ($n = 34$) consisted of 31 females (91%) and 3 males (9%) with the majority ($n = 19$, 56%) of the subjects between the ages of 18-25 years. The majority of nurses held an Associate Degree in Nursing ($n = 29$, 79%), practiced nursing for more than six years ($n = 21$, 62%), practiced in the ED for less than five years ($n = 21$, 62%) and practiced primarily in Kentucky ($n = 32$, 94%). Fifty percent ($n = 17$) of nurses reported witnessing domestic violence of a family member or close friend and 32% ($n = 11$) reported personally experiencing domestic violence in a current or former intimate relationship.

Group B: RNs Without State Mandated Continuing Education in Domestic Violence. This sample ($n = 29$) consisted of 20 females (69%) and 9 males (31%), with the majority ($n = 21$, 72%) between the ages of 36-55 years. The majority of nurses held either a Diploma or a Baccalaureate of Science in nursing degree ($n = 17$, 59%), practiced nursing for more than six years ($n = 25$, 83%), practiced in the ED for more than six years ($n = 24$, 83%) and the majority

practiced in West Virginia ($n = 28, 97\%$). When assessing the frequency of witnessing domestic violence of a family member or close friend, 38% ($n = 11$) reported this experience and 17% ($n = 5$) reported personally experiencing domestic violence in a current or former intimate relationship (Appendix F).

Further examination of the sociodemographic variables of the RNs samples revealed the following associations. RNs who completed the mandatory domestic violence education were younger, less educated professionally, had fewer years of experience as a nurse, and practicing in the ED. RNs in both samples reported feeling prepared to screen in relation to their years of experience in nursing ($r_s = .25, p = .05$) and made referrals related to their years of experience in the ED ($r_s = .27, p = .03$).

Study Questions

Study Question One: What were the relationships, if any, between state mandated domestic violence continuing education and the frequency of screening for domestic violence? A significant relationship was found between state mandated continuing education of RNs and frequency for screening of domestic violence ($r_s = .39, p = .002$), indicating ED nurses who had state mandatory continuing education were more likely to screen for domestic violence in patients. No significant relationships were found between state mandated continuing education of RNs and preparedness for screening ($r_s = .05, p = .73$), or screening thoroughness ($r_s = -.22, p = .09$).

Study Question Two: What were the relationships, if any, between state mandated domestic violence continuing education and danger assessment practices for domestic violence? A significant relationship was found between RNs having state mandated continuing education and the completion of danger assessments ($r_s = .28, p = .03$), indicating RNs who had state

mandated continuing education in domestic violence identified the need for provisions of danger assessment for victims of domestic violence.

Study Question Three: What were the relationships, if any, between state mandated domestic violence continuing education and safety planning for domestic violence? A significant relationship was found between RNs who completed state mandated continuing education and safety planning for domestic violence victims ($r_s = .39, p = .002$), indicating RNs who completed state mandated domestic violence continuing education identified the need for the provision of safety planning for victims of domestic violence.

Study Question Four: What were the relationships, if any, between state mandated domestic violence continuing education and referral practices for domestic violence? No significant relationship was found between RN state mandated continuing education for domestic violence and referral practices ($r_s = .09, p = .506$), indicating RNs who received the mandatory continuing education do not refer victims of domestic violence to social or legal services for additional support.

Study Question Five: What were the relationships, if any, between state mandated continuing education and organizational support for domestic violence? A significant relationship was found between RN state mandated continuing education and total score for organizational support ($r_s = .42, p = .001$), indicating RNs who completed mandatory continuing education felt the ED had the necessary resources to care for domestic violence victims. See Appendix E for the results of the previously discussed relationships.

Analysis by Study Variables

The following analyses provide further examination of the interrelations of the dependent study variables.

RN Frequency of Screening. A Significant relationship was found between frequency of screening patients and RNs feelings of preparedness to screen patients for domestic violence ($r_s = .35, p = .004$), indicating RNs who screen more frequently report feeling more prepared to do so. A Significant relationship was also found between frequencies of screening patients for domestic violence and screening thoroughness of RNs ($r_s = .54, p < .001$) indicating RNs who screen more frequently also report screening both adolescent and adult patients for the presence of domestic violence. A significant relationship was found between frequency of screening patients and ability of RNs to complete danger assessments ($r_s = .34, p = .006$) and collaborate with victims to develop safety plans to prevent further harm ($r_s = .44, p < .001$), indicating that RNs who screen more frequently for domestic violence in patients complete danger assessments and safety planning with identified victims of domestic violence. Finally, a significant relationship was found between frequency of screening patients and number of referral services made by RNs ($r_s = .40, p = .001$), indicating RNs who screen more frequently for domestic violence provide more referrals for identified victims to social and legal resources. Frequency of RN screening was moderately correlated with feeling prepared to screen, screening thoroughness, danger assessment completion, provision of safety planning, and referral of domestic violence victims.

RN Preparedness and Thoroughness. A significant relationship was found between RNs preparedness to screen and screening thoroughness of patients ($r_s = .35, p = .005$), indicating nurses who reported being prepared to screen patients for the presence of domestic violence were more likely to screen both adolescent and adult female patients for domestic violence.

RN Thoroughness. Significant relationships were also found when examining for relationships between screening thoroughness and danger assessment ($r_s = .44, p < .001$), safety

planning ($r_s = .42, p = .001$), and referrals ($r_s = .38, p = .002$) for identified victims of domestic violence. Those nurses who reported screening a higher percentage of both adolescent and adult patients for domestic violence also provided danger assessment, safety planning, and referrals for victims of domestic violence.

RN Danger Assessment and Safety Planning. A statistically significant relationship was found between danger assessment completion and the provision of safety planning ($r_s = .64, p < .001$) for domestic violence victims. This finding suggests those nurses who completed danger assessments also completed safety planning with patients who experienced domestic violence and came to the ED.

RN Safety Planning and Referrals. A significant relationship was found between safety planning for patients and referrals made ($r_s = .33, p = .01$). This finding suggests those nurses who completed safety planning also provided referrals for victims of domestic violence who came to the ED.

Mandated Domestic Violence Continuing Education (MDVCE) and Organizational Support

These analyses were completed by comparing Hospital A to Hospital B. Hospital A consisted of a nurse manager and RNs who completed the DV education and Hospital B consisted of a nurse manager and RNs who did not complete the domestic violence education. When examining the relationships of RN mandatory continuing education and the individual components of the Organizational support subscale, the following results were noted.

MDVCE and Domestic violence policy & procedure. There was a significant relationship found between DV Policy & Procedures and RNs completing the mandatory continuing education ($r_s = .37, p = .003$), indicating nurse administrators who received mandatory

continuing education provided Domestic Violence Policy & Procedures for the assessment and intervention of the ED patient as perceived by the RN staff.

MDVCE and Domestic violence in-services. A significant relationship was found between Domestic Violence In-services provided by the organization and RNs completing mandatory continuing education ($r_s = .37, p = .003$), indicating nurse administrators who received mandatory continuing education provided ongoing domestic violence in-services as perceived by the RN staff.

MDVCE and On-site domestic violence expert. There was a significant relationship found between mandatory domestic violence continuing education and the provision of a DV Expert on-site, ($r_s = .30, p = .02$), indicating nurse administrators who received mandatory continuing education provided a domestic violence expert on-site to enhance the organizational support for the treatment of domestic violence victims as perceived by the RN staff.

MDVCE and Cameras for collection of evidence. A significant inverse relationship was found between RN mandated continuing education and the availability of cameras within the ED for collection of forensic evidence ($r_s = -.37, p = .003$), indicating RNs employed in Hospital B (State without mandated continuing education in domestic violence) reported the provision of cameras for collection of forensic evidence as an organizational support for the care of domestic violence victims as opposed to those RNs employed in Hospital A (State with mandated continuing education in domestic violence).

MDVCE and Safety Planning Literature. A significant relationship was found between RN mandated continuing education for domestic violence and the provision of safety planning literature ($r_s = .45, p < .001$), indicating RNs employed in Hospital A (State with mandated RN

continuing education in domestic violence) reported the availability of safety planning literature to assist in the development of an individualized plan of safety for the victim.

MDVCE and Lethality Tool. A significant relationship was found between RN mandated continuing education and the provision of a lethality tool ($r_s = .31, p = .01$), indicating RNs employed in Hospital A (State with mandated RN continuing education in domestic violence) reported the provision of a lethality tool to complete danger assessments for victims of domestic violence.

MDVCE and Employment Assistance Program (EAP). A significant relationship was found between RN mandatory continuing education and the availability of EAP ($r_s = .42, p = .001$), indicating RNs employed in Hospital A (State with mandated RN continuing education in domestic violence) report the provision of EAP for employees experiencing domestic violence.

Individual Components of Organizational Support and the Dependent Study Variables

These analyses were completed by comparing the individual components of the Organizational Support subscale to screening frequency, screening thoroughness, screening preparedness, danger assessment, safety planning, and referrals. All significant relationships were reported.

Individual Components of Organizational Support and Screening Frequency. A significant relationship was found between the organizational implementation of policy and procedures and frequency of RNs screening for domestic violence ($r_s = .29, p = .02$), indicating RNs who reported the presence of policy and procedures for the assessment and intervention of domestic violence screen were more likely to screen patients for domestic violence.

A significant relationship was found between the organizational implementation of written domestic violence screening questions in the ED assessment form and frequency of RNs screening for domestic violence ($r_s = .37, p = .003$), indicating RNs who reported the presence of written domestic violence screening questions within the ED assessment form were more likely to screen patients for domestic violence.

A significant relationship was found between the organizational implementation of domestic violence in-services and frequency of RNs screening for domestic violence ($r_s = .27, p = .03$), indicating RNs who reported the provision of domestic violence in-services were more likely to screen patients for domestic violence.

A significant relationship was found between the organizational provision of a safety planning tool and frequency of RNs screening for domestic violence ($r_s = .42, p = .001$), indicating RNs who reported the presence of a safety planning tool were more likely to screen patients for domestic violence.

Individual Components of Organizational Support and Screening Thoroughness. A significant relationship was found between the organizational provision of a policy and procedure for the screening and care of the domestic violence patient and thoroughness of RNs screening for domestic violence ($r_s = .28, p = .03$), indicating RNs who reported the presence of a domestic violence policy and procedure were more likely to screen both adolescent and adult patients for domestic violence.

A significant relationship was found between the organizational implementation of written domestic violence screening questions in the ED assessment form and screening thoroughness implemented by RNs ($r_s = .28, p = .03$), indicating RNs who reported the presence

of written domestic violence screening questions within the ED assessment form were more likely to screen both adolescent and adult female patients for domestic violence.

A significant relationship was found between the organizational implementation of domestic violence in-services and RN screening thoroughness for domestic violence ($r_s = .25$, $p = .05$), indicating RNs who reported the provision of domestic violence in-services were more likely to screen both adolescent and adult female patients for domestic violence.

Individual Components of Organizational Support and Preparedness. A significant relationship was found between the organizational implementation of domestic violence in-services and RN preparedness to screen for domestic violence ($r_s = .27$, $p = .03$), indicating RNs who reported the provision of domestic violence in-services felt more prepared to screen patients for the presence of domestic violence.

Individual Components of Organizational Support and Danger Assessment. A significant relationship was found between the organizational implementation of domestic violence in-services and RN completion of danger assessments ($r_s = .26$, $p = .04$), indicating RNs who reported the provision of domestic violence in-services completed danger assessments with victims of domestic violence in the ED.

A significant relationship was found between the organizational provision of a safety planning tool and completion of danger assessments by RNs ($r_s = .28$, $p = .03$), indicating RNs who reported the presence of a safety planning tool danger assessments for victims of domestic violence to assess the risk for further harm.

Individual Components of Organizational Support and Safety Planning. A significant relationship was found between the organizational implementation of policy and procedures and the provision of safety planning by RNs ($r_s = .41$, $p = .001$), indicating RNs who reported the

presence of domestic violence policy and procedures completed safety planning for domestic violence victims treated within the ED.

A significant relationship was found between the organizational implementation of domestic violence in-services and RN completion of safety planning ($r_s = .26, p = .03$), indicating RNs who reported the provision of domestic violence in-services completed safety planning with victims of domestic violence in the ED.

A significant relationship was found between the organizational provision of a safety planning tool and completion of safety planning by RNs ($r_s = .43, p = .001$), indicating RNs who reported the presence of a safety planning tool assisted domestic violence patients to develop safety plans in an effort to prevent further harm to victims and their children.

Individual Components of Organizational Support and Referrals. A significant relationship was found between the organizational provision of a policy and procedure for the screening and RN provision of referrals for domestic violence victims ($r_s = .35, p = .005$), indicating RNs who reported the presence of a domestic violence policy and procedure made referrals to social and legal resources for these patients to increase support systems and further continuity of care.

Reliability of DVST Organizational Subscale

Reliability was assessed using Cronbach's coefficient alpha (Cronbach, 1951). The reliability estimate for the 11-item subscale for Organizational Support on the Domestic Violence Survey Tool yielded an alpha = .75.

Implications

The National Violence Against Women Survey found the majority of women who experienced rape or physical assault utilized the hospital ED for treatment (Tjaden & Thoennes,

2000). However, the emergency department has been cited as a place of retraumatization for many victims of domestic violence due to the lack of response or inappropriate response of healthcare providers (Warshaw & Ganley, 1998). This outcome has led domestic violence advocates to seek educational methods for improving healthcare provider knowledge and subsequent provision of interventions for victims of domestic violence who seek treatment within the ED. The continued examination of the effectiveness of domestic violence continuing education will lead to improved educational programs and result in better provision of care to victims by increasing intervention and prevention strategies, and thereby, decreasing healthcare dollars spent from the lack of these interventions.

These findings suggest RNs who completed mandatory continuing education to improve care for patients experiencing domestic violence frequently screened for domestic violence, completed danger assessments, provided safety planning, and increased provisions of organizational support to complete screenings, assessments, and interventions within the target population. Therefore, healthcare policy that mandates domestic violence continuing education for all registered professional nurses with emphasis on RNs and NPs who work in women's health, primary care, and pediatrics, should be considered as a possibility to increase the response to domestic violence within the healthcare setting. Nurse educators should consider including the dynamics of domestic violence and the provision of culturally sensitive care and intervention strategies within all nursing curriculums.

Nurse Administrators play an integral part in incorporating hospital based domestic violence programs into their organizations and must be concerned with the implementation and compliance with JACHO standards regarding policy and procedures for accreditation. Proper education and training of healthcare staff on the prevalence, identification, intervention, referral,

and documentation of abuse is essential in addressing this national and community epidemic that utilizes healthcare dollars, affects the lives of women and children, and leads to senseless death.

Organizational support findings suggest RNs who were provided in-services, policy and procedures, screening questions, and safety planning tools reported increased preparedness, thoroughness, and frequency in screening practices, performed danger assessments, safety planning, and referrals for victims. Nurse administrators should consider the implementation of organizational support to improve the healthcare response to victims, as well as, increase the support systems for RNs in abusive relationships in an effort to retain nursing staff and maintain a safe working environment.

Discussion and Recommendations

These results must be viewed in light of the limitations of the design and sample. The use of a pre-experimental cross-sectional design disallowed the assessment of the two ED groups for equality pre-intervention. Convenience sampling, lack of randomization, as well as, the small sample size contributed to the weaknesses of this study. Thus these findings cannot be generalized beyond the setting. Additionally, the use of a self-report tool without validation by review of the medical record must be considered a limitation to the validity of these results.

No other studies have used the DVST, so this study was important because it served as a validation sample for instrument reliability and validity. The findings of this pilot study found the DVST to be reliable and valid with this sample. This tool may provide nursing administration a means of identifying strengths and weaknesses to mandated domestic violence continuing education, organizational support, and the healthcare response to domestic violence within the ED.

Smith et al., (1998) found the most reinforcing variable for domestic violence screening was the RNs increased ability to implement treatment strategies for this patient population. The findings of this study suggest frequency in screening was significantly related to RNs (a) reporting higher levels of preparedness to screen, (b) screening both adolescents and adult female patients, (c) performing danger assessments (d) developing safety plans to diminish the risk of further harm, and (e) referring victims to appropriate resources. These results support the effectiveness of RNs who have received domestic violence education and ongoing organizational support.

Smith et al., (1998) reported perceived competency was the greatest predictor of screening patients for the presence of domestic violence by physicians and nurses. This study examined RN level of preparedness to complete patient screenings. RN preparedness to screen (perceived competency) was moderately correlated with frequency in screening ($r_s = .35$, $p = .004$) and screening thoroughness ($r_s = .35$, $p = .005$). The study findings suggest those nurses who reported higher levels of preparedness were more likely to screen both adolescent and adult patients for domestic violence and perform screenings at higher levels of frequency.

Roberts et al., (1997) found domestic violence education increased general knowledge, improved attitudes toward victims of abuse, and increased knowledge about available resources for this patient population. While the current study did not directly examine RN knowledge, findings suggest knowledge increased for those RNs who received mandatory continuing education based on the significant associations with screening frequency, danger assessment, safety planning and organizational support when compared with RNs who did not obtain domestic violence education. This study also found nurses with increased experience in the emergency department were more likely to refer victims of domestic violence to resources

($r_s = .27, p = .03$), indicating training and experience in the ED were important attributes in caring for these patients.

Ellis (1999) noted the negative effects on screening behavior when organizational support was not present. The findings of this study suggest mandatory continuing education and organizational support were needed interventions to develop an appropriate healthcare response within the ED for domestic violence victims.

Previous research by Larkin et al., (2000) indicated organizational interventions initiated to increase compliance of registered nurses in the ED to complete universal screenings for domestic violence resulted in a significant difference in screening practices from pre- to post-intervention (29% - 78% respectively). Loughlin et al., (2000) found the development of organizational support and the provision of protocols for increasing identification, assessment, and treatment of domestic violence victims resulted in adoption of the domestic violence protocol, increased competency of nurses, and increased response to domestic violence victims. The findings of this study support the findings of Larkin, Loughlin and colleagues. Organizational support was associated with increased RN frequency for screening, increased RN perceived preparedness to screen, and increased RN perceived thoroughness in screening patients for the presence of domestic violence. Organizational support was also associated with RN provision of danger assessments, safety planning, and referrals for victims of domestic violence.

Recommendations for Future Research

This study established a baseline measurement for the effectiveness of mandated continuing education and organizational support on the healthcare response provided by RNs within the ED. Future research should include replication of this study with Nurse Practitioners in primary healthcare settings and Obstetrical/gynecological nurses. Future research should

include replication of this study with a larger sample size and inclusion of sample randomization to increase the generalizability of results. Future research should also include further examination for the effects of organizational support based on the organizational subscale measurement within this study. A time-series experimental study that implements a pretest/post-test approach with each implemented measure would provide invaluable information to further nursing administrations successful implementation of organizational support for the care of the domestic violence victim. Further utilization of the DVST should be implemented to examine tool reliability and validity in other samples. Future research should also include a qualitative study to examine the perceived effects of Kentucky mandated reporting for adult victims of domestic violence on the resultant healthcare response by RNs.

Conclusions

Registered nurses who completed mandatory continuing education in domestic violence reported completion of screenings, danger assessments, safety planning, and organizational support. Registered Nurses were more likely to provide assessment and interventions for domestic violence when provided both state mandatory continuing education and ongoing organizational support. These nurses screened more frequently, perceived a higher level of preparedness to screen both adolescents and adult female patients for domestic violence, performed more danger assessments, implemented safety planning, and referred patients to appropriate resources. Specifically, the organizational provisions of a domestic violence policy and procedure, written screening questions within the ED assessment form, safety planning tools, and ongoing domestic violence in-service training were associated with the desired healthcare responses for domestic violence.

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Appendix A: Organizational Permission Letters



CABELL HUNTINGTON HOSPITAL

April 8, 2002

**Pamela S Neal, RN BSN
2 Lakeview Terrace
Barboursville, WV 25504**

Dear Pam,

Your request for permission to distribute the anonymous survey tool, “Domestic Violence: Nursing Survey Tool”, has been considered and approved by the Nursing Research Committee at Cabell Huntington Hospital I understand that the survey will be distributed to nurses who staff the Emergency Department at Cabell Huntington Hospital

Sincerely,

A handwritten signature in black ink that reads "Diana Griffin". The signature is written in a cursive style.

Diana Griffin RNC MSN

Cabell Huntington Hospital
Nursing Research Application Form

Date: April 4, 2002

Title of Study: The Relationships of Domestic Violence Education, Organizational Support, Screening, Danger Assessment, Safety Planning and Referral by Professional Registered Nurses in the Emergency Department


Principle Investigator: Pam Neal
Position: Nursing student, Masters Program
Agency: Marshall University

Description of Research by the Investigator~	Acceptable	Not Acceptable	Does Not Apply
1. Statement of the problem	✓		
2. Statement of the purpose	✓		
3. Statement of significance for nursing and benefits	✓		
4. Brief description of supporting literature	✓		
5. Brief description of research question	✓		
6. Description of the tools/instruments; include reliability and validity	✓		
7. Explanation of procedure to be used	✓		
8. Description of the research design	✓		
9. Description of sample and size	✓		
10. Include copy of human subject consent form			✓
11. Description of how the results will be used	✓		

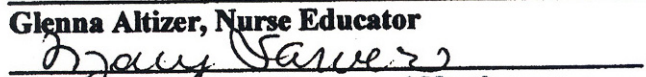
Application Approved

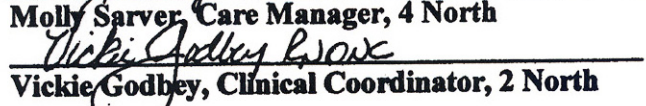
Application Approved:


Paul Lageman, Nurse Manager, Emergency Department


Diana Griffin, Nurse Manager, Education Department

Glenna Altizer, Nurse Educator


Molly Sarver, Care Manager, 4 North


Vickie Godbey, Clinical Coordinator, 2 North

**KING'S DAUGHTERS MEDICAL CENTER
EMERGENCY DEPARTMENT
MEMORANDUM**

TO: Pamela S. Neal, RN, BSN

FROM: Tom Thomas RN, BSN, SANE
Director of Emergency Services



DATE: 4/3/02

RE: Research Project

Pursuant to our discussion, I have reviewed your research project, The Relationships of Domestic Violence Education, Organizational Support, Screening, Danger Assessment, Safety Planning, and Referral by Professional Registered Nurses in the Emergency Department. I have also reviewed the data collection tool you plan to use in the ED.

Please feel free to implement the data collection questionnaire at you convenience. I am available to assist you in any way I can.

Appendix B: IRB Approval Letter

Marshall University
Institutional Review Board
Cabell Huntington Hospital
Institutional Review Board

**Department of
Veterans Affairs**
Human Studies Subcommittee

St. Mary's Hospital
Institutional Review Board

Domestic Violence 67
COORDINATOR
1542 Spring Valley Drive
Huntington, West Virginia
25704
(304) 696-7320
Fax: (304) 896-7391

April 4~ 2002

Pamela S. Neal, RN, BSN
2 Lakeview Terrace
Barboursville, West Virginia 25504

**Re: Proposed Student Study - Exempt IRB No. EXO2-0053 - The Relationships
Of Domestic Violence Education, Organizational Support, Screening, Danger
Assessment, Safety Planning, and Referral by Professional Registered
Nurses in the Emergency Department.**

Thank you for the submission of the above proposed non-risk study. The purpose of the research is to study the effects of state mandated continuing education as perceived by registered professional nurses in the emergency department for (a) organizational support, (b) frequency of screening female patients for domestic violence, (c) frequency of safety planning, and (d) perceived frequency of referral of identified victims to resources. Also, a comparison of the difference in perceptions of nurses receiving state mandated continuing education and nurses not receiving state mandated continuing education will be done.

The data will be collected by an anonymous survey to be distributed at 2 area emergency rooms. Written authorization must be obtained prior to conducting the survey.

The study as submitted would be exempt from IRS review and approval in accordance with 45 CFR 46.101 b.

Sincerely yours.


Henry K. Driscoll, M.D.
IRS chairperson

Nealexemptapr02

Appendix C: NSM

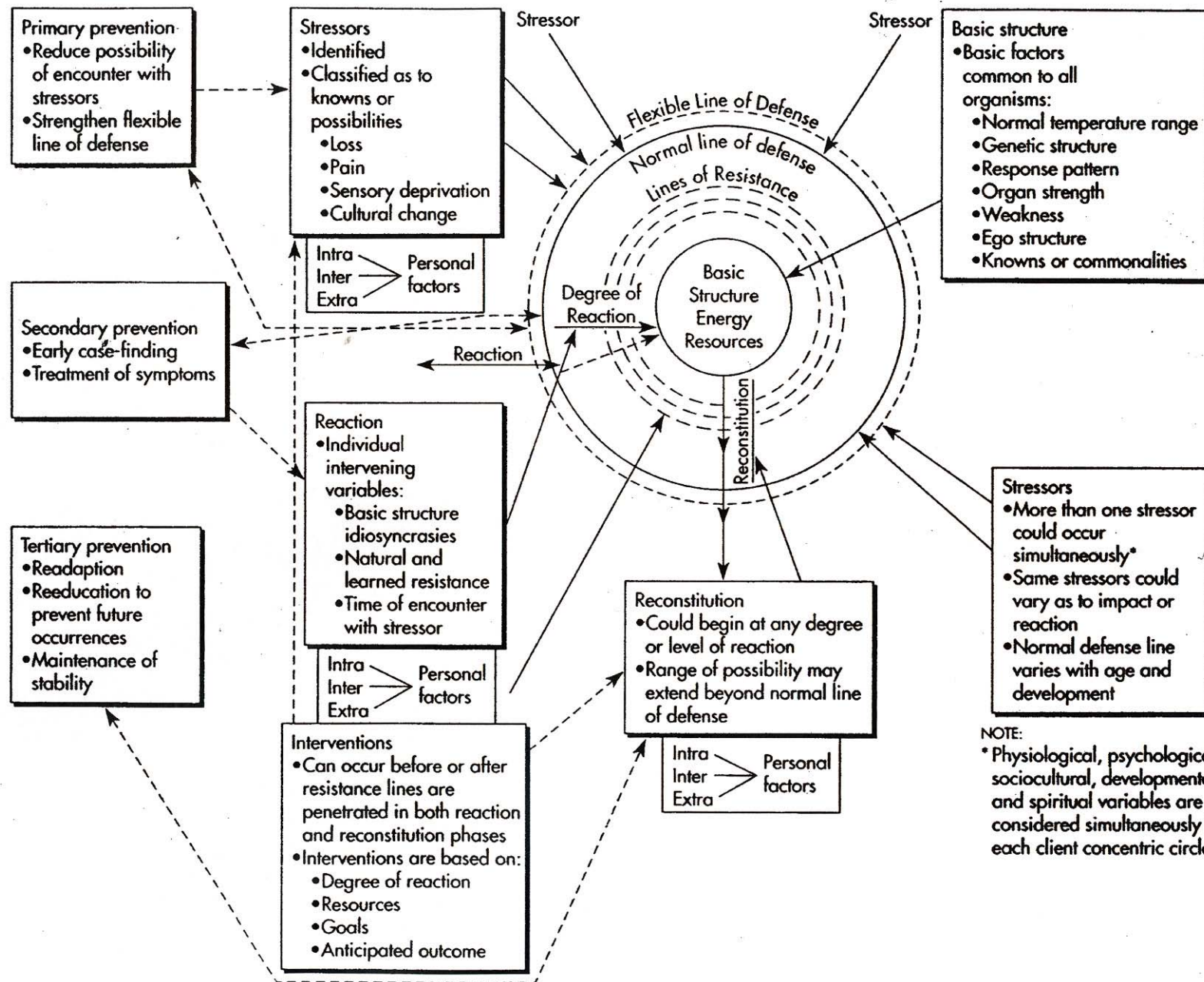


Fig. 19-1 The Neuman Systems Model. Original copyright 1970, © by Betty Neuman. Used with permission.

Appendix D: Domestic Violence Survey Tool

Domestic Violence Survey Tool

1. Age: 18-25___ 26-35___ 36-45___ 46-55___ ≥56___
2. Educational Degree: ASN ___ Diploma ___ BSN ___ MSN ___ APN ___
3. Number of years in nursing: 0-2___ 3-5___ 6-10___ 11+___
4. Number of years in the Emergency Department: 0-1___ 2-5___ 6-10___ 11+___
5. Gender: Male ___ Female ___
6. Have you received State Mandated continuing education? Yes ___ No ___
7. Number of voluntarily sought continuing education sessions on domestic violence? 0___ 1-2___ 3-4___ ≥5___
8. How often do you screen all female patients ≥ 14 years of age for domestic violence?
1. Never ___ 2. Occasionally ___ 3. Usually ___ 4. Always ___
9. On a scale of 0-10 with 10 feeling the most prepared and 0 feeling no preparedness, how prepared do you feel to complete screenings for domestic violence?
0___ 1___ 2___ 3___ 4___ 5___ 6___ 7___ 8___ 9___ 10___
10. Of the following levels of domestic violence screening, which answers best describes your screening practices for both adolescent & adult female patients?

	All	Most	Few	Rarely
1. Screen all female patients (both adolescents & adults)	___	___	___	___
2. Screen all female adult patients	___	___	___	___
3. Screen all female adolescent patients	___	___	___	___
11. After the patient confirms the presence of domestic violence, how frequently do you complete a Danger Assessment (Future homicide/suicide risk)?
1. Never ___ 2. Occasionally ___ 3. Usually ___ 4. Always ___
12. How frequently do you complete a safety plan with the patient to decrease the risk of further abuse?
1. Never ___ 2. Occasionally ___ 3. Usually ___ 4. Always ___
13. How many referral services do you use for identified victims of domestic violence? 0-2___ 3-5___ 6-10___ 11+___

Does your organization provide the following: Circle your answer for each question.

14. A written policy and procedure for the screening, safety planning, referral, & of documentation for victims of domestic violence? Yes No Don't Know

15. Educational information in the waiting areas or within the ED depicting domestic violence as a healthcare issue.	Yes	No	Don't Know
16. Domestic Violence Screening questions written into the admission assessment form?	Yes	No	Don't Know
17. In-service training on domestic violence?	Yes	No	Don't Know
18. In-house domestic violence expert?	Yes	No	Don't Know
19. Cameras for collection of forensic evidence?	Yes	No	Don't Know
20. Body Map: to document injuries?	Yes	No	Don't Know
21. Safety Planning Literature?	Yes	No	Don't Know
22. Lethality Assessment Tool: to evaluate future risk?	Yes	No	Don't Know
23. Domestic violence referral list for patients?	Yes	No	Don't Know
24. Employee Assistance Program for victim's of domestic violence?	Yes	No	Don't Know

25. Have you ever been exposed to or witnessed domestic violence through a family member or close friend? Yes ___ No ___

26. Have you personally experience domestic violence in a current or previous intimate relationship? Yes ___ No ___

Thank you for completing this survey. Do not provide any identifying information on the survey. Place the completed survey into the sealed envelope and return it to your ED Nurse Manager.

Appendix E: Cover Letter

Cover Letter

Dear Research Participant:

I am a fellow nursing colleague from Marshall University in Huntington, West Virginia. I am completing a research project for the completion of my graduate study requirements. The purpose of this research is to study the effects of state mandated continuing education on (a.) the screening of all female patients for presence of domestic violence, (b.) the safety planning of victims of domestic violence (c.) the referral of identified victims to resources and (d.) the organizational support supplied to professional registered nurses within the ED setting to respond to the healthcare issue of domestic violence.

You have been selected for inclusion in this study because professional registered nurses within the emergency department treat potential victims of domestic violence on a daily basis. The questionnaire will take approximately 5-10 minutes to complete and will greatly assist in the interpretation of the results to this study. All information will be anonymous. Please do not put your name anywhere on the questionnaire.

Results of this study will only be shared with the study participants and my advisor at Marshall University. Participation is voluntary and consent is implied by completion of the questionnaire. After completion of the questionnaire, please return in the sealed envelope to your Department Manager. You will receive one reminder notice within two weeks to complete the questionnaire. If you would like to receive a copy of the results for this study, please complete the enclosed card and return it to your Department Manager. If you have any questions, please contact me at your earliest convenience. Thank you for your time and assistance in this matter to further the development of the healthcare response to domestic violence victims.

Sincerely,

Pamela S. Neal, RN, BSN
Email: neal20@marshall.edu
Home Phone: (304) 736-7078
Cell Phone: (304) 634-7685
Thesis Chair: Dr. Lynn Welch
Phone: (304) 696-2616
Chair of IRB: Dr. Leonard Deutsch

Appendix F: Tables

Table 1.

Frequencies and Percentages of Mandated Continuing Education and Sociodemographic Characteristics of the Study Sample (N=63) for Groups A and B

Characteristic	Group	
	RNs in Hospital A: Kentucky: <u>n=33</u> <u>n(%)</u>	RNs in Hospital B: West Virginia: <u>n=30</u> <u>n(%)</u>
State Mandated Continuing Education in Domestic Violence		
Yes	32 (97.0)	2 (10.0)
No	1 (3.0)	28 (90.0)
Age		
18 to 25 years	5 (15.2)	1 (3.3)
26 to 35 years	14 (42.4)	7 (23.3)
36 to 45 years	12 (36.4)	12 (40.0)
46 to 55 years	2 (6.1)	10 (33.3)
≥ 56 years	0 (0)	0 (0)
Sex		
Female	31 (93.9)	20 (66.7)
Male	2 (6.1)	10 (33.3)
Educational Degree		
Associate of Science Nursing	26 (78.8)	13 (43.3)
Diploma Nursing	2 (6.1)	8 (26.7)
Baccalaureate of Science Nursing	5 (15.2)	9 (30.0)
Master's of Science Nursing	0 (0)	0 (0)
Advanced Practice Nurse	0 (0)	0 (0)
Number of Years Practicing Nursing		
0 to 2 years	5 (15.2)	0 (0)
3 to 5 years	8 (24.2)	5 (16.7)
6 to 10 years	12 (36.4)	7 (23.3)
≥ 11 years	8 (24.2)	18 (60.0)
Number of Years Practicing in the Emergency Department		
0 to 2 years	5 (15.2)	2 (6.7)
3 to 5 years	16 (48.5)	5 (16.7)
6 to 10 years	6 (18.2)	8 (26.7)
≥ 11 years	6 (18.2)	15 (50.0)

Table 2.

Frequencies and Percentages of Mandated Continuing Education and Sociodemographic Characteristics of the Study Sample (N=63) for Groups C and D

Characteristic	Group	
	Group A RNs with State Mandated Continuing Education in Domestic Violence <i>n</i> = 34 <i>n</i> (%)	Group B RNs without State Mandated Continuing Education in Domestic Violence <i>n</i> = 29 <i>n</i> (%)
Hospital A: Kentucky	32 (94)	1 (3)
Hospital B: West Virginia	2 (6)	28 (97)
Age		
18 to 25 years	5 (15)	1 (4)
26 to 35 years	14 (41)	7 (24)
36 to 45 years	11 (32)	13 (45)
46 to 55 years	4 (12)	8 (27)
≥ 56 years	0 (0)	0 (0)
Sex		
Female	31 (91)	20 (69)
Male	3 (9)	9 (31)
Educational Degree		
Associate of Science Nursing	27 (79)	12 (41)
Diploma Nursing	2 (6)	8 (28)
Baccalaureate of Science Nursing	5 (15)	9 (31)
Master's of Science Nursing	0 (0)	0 (0)
Advanced Practice Nurse	0 (0)	0 (0)
Number of Years Practicing Nursing		
0 to 2 years	5 (15)	0 (0)
3 to 5 years	8 (24)	5 (17)
6 to 10 years	11 (32)	8 (28)
≥ 11 years	10 (29)	16 (55)
Number of Years Practicing in the Emergency Department		
0 to 2 years	5 (15)	2 (7)
3 to 5 years	16 (47)	5 (17)
6 to 10 years	5 (15)	9 (31)
≥ 11 years	8 (23)	13 (45)

Table 3.
Spearman rho Correlational Matrix for Examining Relationships

Variable	Mandatory Cont. Ed. In Domestic Violence	Frequency of Screening	Preparedness to Screen	Screening Thoroughness	Danger Assessment	Safety Planning	Referrals for Assistance
Mandatory Cont.Ed. in Domestic Violence	1.00						
Frequency of Screening	.34**	1.00					
Preparedness to Screen	.05	.35**	1.00				
Screening Thoroughness	-.22	.54**	.35**	1.00			
Danger Assessment	.28*	.34**	.11	.44**	1.00		
Safety Planning	.39**	.44**	.22	.42**	.64**	1.00	
Number of Referrals for Assistance	.09	.40**	.24	.38**	.12	.33**	1.00
Organizational Support Total Score	.42**	.37**	.25	.33**	.21	.37**	.29*

* $p < .05$, ** $p < .01$