Family Violence Intervention Within an Emergency Department: Achieving Change Requires Multifaceted Processes to Maximize Safety

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Introduction: Family violence is common with significant long-term negative health effects. Health professionals are recognised as key providers of family violence intervention. In 2002, the Hawke's Bay District Health Board launched a Family Violence Intervention Programme in its emergency department. The intervention programme involved staff training, the development of resources and routine questioning for partner abuse within the social history for all women 16 years and over. The aim was to identify the barriers and enablers to routine questioning one year after the programme was launched to inform programme improvements.

Methods: Evaluation research using semi-structured interviews; eleven staff participated in either a single or a group interview. Content and thematic analysis, with triangulation of findings was used.

Results: The interviews revealed that routine questioning for partner abuse is difficult in the emergency department. Some staff screened routinely while others only offered intervention when overt abuse was identified. Barriers, enablers and solutions revealed by participants were either personal or organisational; all had the common theme of safety.

Discussion: Routine questioning for partner abuse is challenging and its introduction into practice requires a systems approach to achieve change. Barriers to questioning exist and by simultaneously addressing these and implementing enablers, at an organisational and personal level, barriers are eliminated or at least minimised. A link was evident between nurses' level of comfort and their rate of questioning. A multifaceted approach focusing on safety of all concerned can support change resulting in implementation of family violence intervention in the health sector.

Key words: Family violence; Screening; Qualitative method

Family violence is a significant social policy issue that affects every person directly or indirectly. Direct impacts may occur if a person is victimized by violence or is a witness to violence; indirect effects may include an individual's inability to access health services because beds are occupied by victims of abuse or a funding request is declined because government/health authority funding is needed to address family violence.[1]

Family violence is defined as abuse of any type, perpetrated by one family member against another family member. It includes child abuse, partner abuse (PA), and elder abuse. PA is physical or sexual violence, psychological/emotional abuse, or threat of physical or sexual violence that occurs between intimate partners.[2]

The New Zealand Ministry of Health requires the health sector to actively address family violence because it affects the health and well-being of many New Zealanders.[2] The *Family Violence Intervention Guidelines: Child and Partner Abuse* (2002)[2] state that routine screening using questioning for PA should occur for all female patients aged 16 years or older when they are seeking services from the health sector, and assessments of men and children should

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Miranda Ritchie was a recipient of a Ministry of Health Postgraduate Primary Health Care Nursing Scholarship. Miranda Ritchie also received financial support from the Save the Children New Zealand Small Grant Fund.

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J Emerg Nurs 2009;35:97-104.

Available online 15 July 2008.

0099-1767/$36.00

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doi: 10.1016/j.jen.2008.05.004

occur if abuse is suspected. This screening can occur within the context of taking a social history. In accordance with this national directive, the Hawke's Bay District Health Board introduced its Family Violence Intervention Programme (FVIP) in 2002. The program was sequentially introduced into 3 areas over a 2-year period: emergency department, pediatrics, and maternity. The FVIP used a systems approach to implement screening for PA.[3-5] This included maximizing management support, amending documentation, developing a policy, training using evidence-based literature, establishing resources, and undertaking an ongoing evaluation. In the emergency department this program involved the introduction of routine screening for PA for all women. This screening was undertaken by nurses. Social workers had a role in the program as a referral resource and a support for the nurses.

This study is a component of the larger process and outcome evaluation undertaken while implementing the FVIP. The larger evaluation was designed to measure progress, support and inform implementation, and sustain change.[3-5] It consisted of clinical audits every three months in each area and staff interviews every six months to identify FVIP impacts on practice in each area.[5] This ED study is one aspect of this larger study. At the time this study commenced, no other emergency department in New Zealand had adopted PA screening.

Many studies have identified that significant provider barriers exist to implementing screening as a family violence intervention.[6-17] These barriers are based on a health professional's lack of knowledge and understanding about victimization. Although changing how health practitioners work with victims of abuse has been shown to be difficult, it is important that this change comes about, given the prevalence of abuse in society.

American prevalence rates of current (within 12 months) physical or sexual abuse in female patients presenting to the emergency department ranged from 11.7% to 14.4%, with the lifetime incidence for physical or emotional abuse being between 36.9% and 54.2%.[18-21] A New Zealand study suggested that 21% of women presenting to the emergency department reported current abuse,[22] with Australasian studies suggesting a lifetime incidence between 23% and 44%.[22-25] Battered women do seek care from emergency services on a regular basis.[22,26,27] Abuse effects may include trauma injuries,[26-29] physical health effects,[30,31] and mental health effects.[32] Abuse during pregnancy impacts the health of both the mother and the unborn child.[33-35]

The emergency department should be a place of safety for victims and should offer them confidential acute care.[22] People experiencing abuse who are not offered family violence intervention report negative experiences regarding their ED visit; they wanted the health professional to ask them about abuse, and they wanted to be offered information with options.[27,36] Although victims of PA may not volunteer a history of abuse,[18] if asked by a health professional, many disclose abuse.[37,38]

The purpose of this study was to explore the experiences of the emergency nurses 1 year after the launch of routine screening for PA. The research aimed to establish the impact of the implementation on staff practice, as well as the level of compliance with the policy, and to identify the barriers and enablers for implementing routine screening for PA in the emergency department.

Methods

The study used a qualitative descriptive design to capture individual staff members' stories, enabling in-depth understanding of the program's operation from a staff perspective. The approach used the 4 levels of evaluation described by McNamara.[39] These include reactions and feelings, learning (enhanced attitudes, perceptions, or knowledge), changes in skills, and effectiveness (improved performance because of enhanced behaviors).

STUDY DESIGN

The principal investigator (M.R.) conducted semistructured interviews during 2003, 12 months after program implementation, which allowed for the anxiety associated with the new initiative to settle. The regional ethics committee granted ethical approval for the study. The respect for and safety of the participants were the paramount concern of the study, and all participants were provided with information on how to access family violence counseling services. In addition, recruitment processes required staff to contact the principal investigator to ensure that there was no coercion to participate in the research.

All 35 permanent registered nurses and the 1 social worker who worked in the emergency department and who had attended the FVIP training or were scheduled to attend the training were eligible for the study. These included experienced and novice emergency staff. All float (casual) nurses were excluded because they had not undertaken the training and do not routinely work within the department. The medical staff were also excluded, as their role at the time of this evaluation did not include responsibility for the routine questioning. Recruitment processes included regular meetings held in the emergency department during which time the study was described and written information outlining the purpose and the structure of the study was distributed. The information was also forwarded to those not present to invite their participation.

Potential participants were offered a choice of a single or group interview. All participants signed informed consent forms before the interview.

The interviews included open- and closed-ended questions. A previous cycle of interviews conducted as part of the larger evaluation found that this method was effective in obtaining staff's perceptions and everyday experiences[40] with the FVIP program. The research team developed an interview schedule that covered 4 areas: (1) the participant's level of emergency nursing experience, degree of FVIP training, and involvement with program implementation; (2) the participant's level of comfort with routine questioning, as well as barriers to questioning and possible solutions to these barriers; (3) training and other enablers, including resources currently available and those considered necessary; and (4) questions on the proactive nature of the FVIP and job satisfaction. The semistructured interview schedule enabled the interviews to be thorough yet concise, recognizing that staff may have a variable level of comfort with screening for PA. The schedules varied slightly to accommodate the differing dynamics associated with group and single interviews. The researchers made it clear at the commencement of each interview that all perspectives were valued, as the focus was to obtain information that would inform the delivery of the FVIP.

Of the staff members, 11 (31%) participated in the interviews. Three single and two group interviews were held. Each interview lasted approximately 1 hour. Purposeful grouping[41] of the recruited participants shaped the membership of the groups; one group consisted of 4 senior emergency staff (3-12 years' emergency experience), and the other involved 4 emergency staff with a range of experience (1-14 years' emergency experience). Ground rules were established and agreed to at the outset of the group interviews and addressed issues such as respect for individual viewpoints and that group consensus was not required. Audiotaping, note-taking, and poster paper notes were used to record what participants said. The interview transcriptions/notes were returned to participants for review and to provide the opportunity for amendment. Because these member checks resulted in only minor changes, which expanded the content rather than amending it, the researchers are confident that all interviewees' perspectives were expressed.

The researchers analyzed the data individually and as a team in 3 phases.[42] This involved the researchers reviewing each interview transcript for content first. This review enabled key words from each question to be grouped, for example, barriers to change. Second, the themes and patterns from the content analysis across all interviews were grouped. At this point, the transcripts were reviewed again. The final phase involved the triangulation of findings from each question to establish whether there were any relationships among the findings. Although a small number of research participants were involved, the triangulation process of combining the findings from the 5 interviews showed a level of data saturation across several key themes. Because the participants had various levels of engagement with the program, the researchers are confident that the findings do not reflect the researchers' views of the FVIP.

Results

The 11 interviewees ranged in age, years of emergency department experience (1-14 years), and receptiveness to the FVIP (apprehensive to total commitment to the FVIP). The depth of experiences with conducting PA screening expressed by all participants during the interviews was considerable. All participants believed that the PA brief intervention model was an important identification, assessment, and referral process for the emergency department. There was a pattern to participant's frequency of questioning that related to their individual level of comfort. The participants who asked "all women"[43, p. 1] spoke of being comfortable with screening and actively sought opportunities to screen. Others asked when circumstances permitted, for example, "when they're on their own."[43, p. 1] One participant asked only on suspicion of abuse. Organizational factors that influenced participants' ability to question included lack of time, resources, and privacy.

For those who had attained a level of comfort with screening, the challenge was optimizing the opportunities to ask the screening questions. Those who were less comfortable viewed the intervention of screening as a challenge. One participant referred to the questions as the "bombshell,"[43, p. 2] a sentiment shared by another participant who said, "it is a big question to ask."[43, p. 5]

BARRIERS TO ROUTINE QUESTIONING

All participants described organizational barriers that impacted their ability to ask the screening question. Barriers included delay from training to implementation, lack of time, lack of privacy, and lack of training. Other barriers presented were of a personal nature, including an individual's level of comfort, forgetting, and perception of role.

ORGANIZATIONAL BARRIERS

It was stated that the long delay (9 months) some experienced between training and launching of the FVIP resulted in lost motivation. However, a participant noted, "having said that, we had that refresher course which I think has certainly helped with people that attended that as far as being enthusiastic."[43, p. 2]

Participants reported that the level of privacy available in the department is a key barrier that reduced their ability to screen for PA. Some rooms had doors, some had a curtain, and other areas involved a large room with curtain screening only between people. The other key privacy issue concerned the challenge of separating the woman and her family to create a safe environment for screening.

ED roles were another barrier for some participants who were in senior roles, such as being the shift coordinator or the triage nurse. Some suggested that they could not ask the questions because they lacked the necessary rapport or patient contact or because the pressures of the role meant that offering an immediate intervention if abuse was disclosed could be problematic; therefore they did not ask.

A comment expressed during both group interviews and 1 single interview was that there was often insufficient time to accommodate the questioning process. Both senior and junior nurses suggested that questioning was dropped when there was pressure on time available because of the acuity and volume of patients in the emergency department, with a perception that questioning takes time. "When you are really busy and you think can I do it? I've got eight other patients to look after."[43, p. 2] The acuity of patients was also a barrier. Senior and junior nurses suggested that their role requires them to prioritize the care; this prioritization often meant patients who were seriously ill or in pain had questioning omitted from the initial assessment. Another barrier included the location of the screening question in the ED documentation. It was suggested that having the screening question at the bottom of the page sometimes meant staff missed seeing it. The final major organizational barrier identified was that not all medical staff were trained in the FVIP, which meant they did not always understand the need for nurses to have the space for such questioning.

PERSONAL BARRIERS

Personal barriers include both personal practice issues and personal experiences that influence their practice. "There was certainly quite a lot of fear I suppose. And reluctance to start routine questioning. People, while they thought it was a good idea, were just still a little bit nervous about actually asking questions."[43, p. 1] The level of comfort appeared to decrease if a woman experiencing violence disclosed abuse. The fear associated with the yes response was evident in the following quote: "I find if you get a 'yes' then I start to get a bit unstuck really … I don't feel as confident … in dealing with it because I feel kind of qualified to ask the initial question, but … I don't really feel that … comfortable with dealing with that, that next bit. But … I do [usually ask]."[43, p. 19]

Participants in both group interviews admitted that sometimes they simply forgot to ask the question. A rapport between the nurse and the woman was essential for questioning to take place. Participants recognized the FVIP's focus on empowering women to decide. However, when a woman who had disclosed abuse declined the intervention or referral and returned to the current home situation, then there was some frustration for the nurse associated with this outcome. "I mean [it is] sometimes a little bit frustrating when they sort of won't do anything about it and you're nervous about what's going to happen when they do go home."[43, p. 4]

ENABLERS TO ROUTINE QUESTIONING

The enablers identified by the participants included their use of many components developed as part of the program, such as training, management support, supervision, documentation, resources, and redefining success. As health professionals, we like to "fix" issues, and family violence intervention is not a "quick fix"; a successful outcome includes asking the questions and offering information. Participants also suggested how these enablers could be modified to increase the use of the screening question. As with the barriers, these enablers were either organizational or personal.

ORGANIZATIONAL FACTORS THAT SUPPORT THE IMPLEMENTATION OF ROUTINE SCREENING

The training and policy were considered excellent resources; they both influenced the nurses to ask the question, as it was required practice. The refresher training offered was considered to be a useful resource that addressed the delay between training and launching the FVIP, and it reminded and refocused staff to the program.

The resources available within the emergency department were considered to be helpful, with information readily available as a resource for people experiencing abuse. Other resources cited include cue cards, senior staff support, reminder posters around the department, and information about community resources that women could use. One participant commented on the audit feedback and the targets set for screening; this was a motivational enabler.

Participants suggested enablers to address the barriers. For example, to address the lack of privacy, solutions included using opportunities such as asking in the x-ray room, using a vacant room, or asking in a quiet voice. Several participants identified that they ask the partner to leave to enable an examination or medical assessment to be completed. The suggestions for the barrier of time included having more prompts and reminders, such as the addition of a yellow dot sticker on the assessment form that stays

until the question is asked and moving the location of the question on the documentation form so that it appears with other screening questions, thereby increasing its visibility. Other suggestions included all medical staff attending training, increasing the management profile, increasing supervision training, increasing feedback on success of the program, and developing a safety plan resource.

PERSONAL ENABLERS

The personal enablers grouped into 6 main themes. They were an individual's level of comfort with asking, recognizing that the FVIP addresses a previous deficit in care, the initial implementation process, the epidemiology of family violence including child abuse, sense of empowerment, and personal commitment and determination.

Most participants suggested that the training and policy supported them to ask the question. They learned the skills and developed their own "patter," and many considered that the more they asked, the more comfortable they became. They were encouraged by the positive feedback they received from some women. "I think the feedback you get too because the number of times I've routinely questioned and more often than not, the woman's said I think that's really good what you're doing."[43, p. 18]

Participants identified that "it's empowering"[43, p. 26] for the staff to offer support and intervention for victims who in turn empower themselves to review their options. Participants' concern about the level of family violence was an enabler, as questioning was viewed as a strategy that addresses family violence. The recognition of the co-occurrence of child abuse and PA was recognized as an outcome of training that worked as a motivator.

Participants identified that a successful outcome for one victim was a motivator to include questioning about family violence. Even the potential for such an outcome was motivational. Some felt that the cost was too high not to question. "And I think it's the old thing of you know, if we can identify one woman you know out of the exercise it makes it worthwhile. That's what motivates me."[43, p. 18] One motivational factor for several participants was that questioning was a proactive and tangible way of addressing child abuse and PA.

Determination and commitment were required when the program began. "I was determined to do it so just went with it and that's got easier as it's gone really."[43, p. 1] Participants also liked the positive experience of questioning and that the FVIP was addressing a significant issue. The impression from the interviews was that all participants, whether they were asking all women or only those who cause concern, have a level of pride in what they were doing. "I think we can be proud that we're doing it."[43, p. 27] For some participants, routine questioning has impacted them positively by increasing their job satisfaction. For others, the impact was less or they felt that it was too early to have made any change.

Discussion

This research confirmed much of what is already understood related to screening for family violence[2,4]; however, previous research has not presented a comprehensive model for informing change. The barriers and enablers were examined in relation to the staff member and the victim. Figure 1 shows how grouping these create a model of barriers and enablers to ensure safety when routinely questioning for PA.[43] This model demonstrates the link from barriers and enablers to the staff member's professional and personal safety and the victim's safety.

Improving victims' safety was the primary motivation for staff in this program. Therefore, with victims central to the program, they are positioned at the innermost point of the model. The staff are next to the victim. This indicates their close relationship with the victim and identifies them as the link between the FVIP and the victim. The FVIP cannot reach the victim without the staff member offering the intervention that he or she accepted responsibility for delivering. All female patients aged 16 years or older could be placed at the center of the model; however, victims of abuse are at the center of the model because the impact of the barriers has a greater effect on victims of abuse. This also avoids gender-biased language and is inclusive of children and men who experience abuse.

The barriers and enablers are the outer processes. They impact directly on the nurse's ability to routinely screen. Safe practice is a fundamental requirement for all New Zealand registered nurses.[44] Nurses need to feel safe with the FVIP if they are to adopt screening for PA into their practice. The results suggested that nurses can feel safe to screen women if they are given the knowledge and skills and have appropriate and effective support processes in place. Their ability to screen and offer the appropriate intervention may increase the safety of victims. Routine screening also needs to be safe for the women; staff will not ask if they are not confident in their ability to respond in an appropriate environment with the privacy and time to offer the intervention.

Although it is known that comfort with the question influences the questioning process, the results from this study suggest that there is a correlation between the level of comfort with the questioning process.[5,43] Figure 2 illustrates the proposed link between the level of an individual's comfort with questioning and the extent to which he or

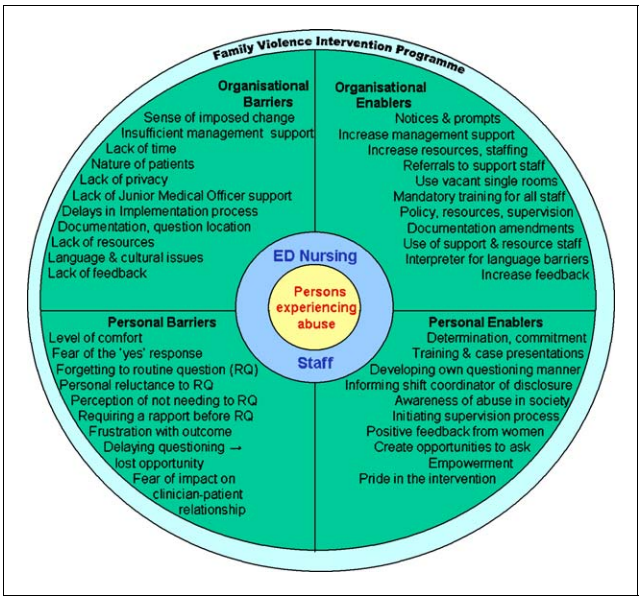

FIGURE 1

Model of barriers and enablers for routine questioning. (Copyright 2004, Miranda Ritchie.) This figure is available in color and as a full-page document at www.jenonline.org. *JMO* junior medical officers.

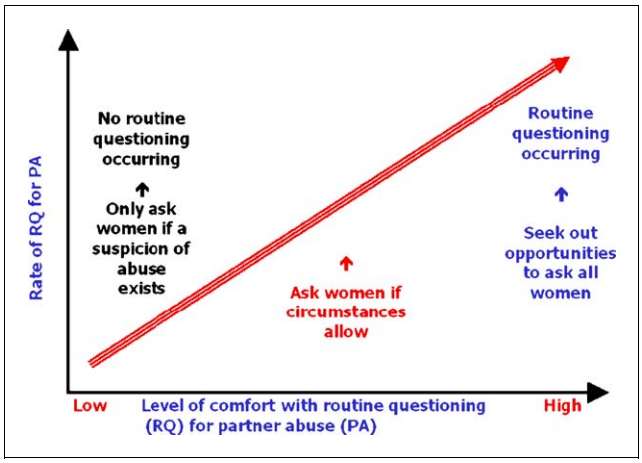

FIGURE 2

Level-of-comfort continuum for routine questioning for PA. (Reproduced with permission from Blackwell Publishing from Wills R, Ritchie M, Wilson M. Improving detection and quality of assessment of child abuse and partner abuse is achievable with a formal organisational change approach. J Paediatr Child Health 2008;44:92-8.) This figure is available in color and as a full-page document at www.jenonline.org.

she routinely questions for PA. Some participants had a high level of comfort with the questioning process, so they maximized opportunities to question, still recognizing the principles of safe questioning. The majority of the participants were routinely questioning when the enablers outweighed the barriers, ensuring that it was safe for the health professional and the victim. This placed them somewhere in the middle of the level-of-comfort continuum. The staff member who was still establishing a level of comfort or a sense of safety with the concept of routinely questioning all women is located toward the left side of the continuum. His or her perception of who should be screened appeared to influence his or her actions, in that he or she only asked women who appeared to be at risk from their presenting history or injuries. This reflected his or her relatively low level of comfort with the process. Encouragement was required to assist further expansion of the questioning process. Although it felt safe to ask on suspicion, the level of comfort did not extend to asking all women.

The findings are consistent with other studies on routine questioning for PA in the health sector.[6-17] Key barriers of time, privacy, and level of comfort were found in other studies with ED staff to identify barriers.[8,17] What this study adds is an enhanced understanding of the systems that support routine questioning. The findings have directly impacted the program where the study was undertaken; for example, the documentation form has been amended. The principle that the question is best placed with other social history questions may be useful to other emergency departments and other service areas. To our knowledge, the suggestion that safety underpins the barriers and strategies for health professionals is new, as is the model proposed. Future studies could consider the transferability of these findings (barriers and enablers, continuums of comfort, and safety) to other service environments.

Limitations

The study findings may reflect a selection bias, as only one third of staff invited to participate in the research consented to participate. Because respondents reported variable practice and differing views with screening, we do not consider that only those with a positive experience participated in the study. The sample represents most characteristics of the ED staff, including full- and part-time staff, senior and less experienced staff, and staff with varying levels of commitment to the FVIP. The study may also be limited by the lack of medical involvement in the research; the decision to exclude this group was made on the grounds of the screening being the responsibility of the nurses and not the medical profession.

Implications for Emergency Nurses

Family violence is common, and people experiencing abuse often seek help in the emergency department.[22,27,36] The implementation of family violence intervention, including

routine questioning for PA, requires commitment from emergency nurses and organizational support.[3-5] In addition to emergency nurses being supported to address personal concerns with family violence interventions, organizational support is needed for change. This support includes addressing barriers to intervention within the ED context, including acuity of patients and awareness of departmental processes such as documentation requirements and physical environment. By addressing safety issues of patients and of emergency nurses during the implementation phase, nurses can be supported to include routine questioning for PA within their patient assessments and contribute to the health services role in addressing family violence.

Conclusions

Introducing routine questioning requires a practice change; a multifaceted approach focusing on safety can assist staff to make this change. The approach includes management support, policy, resources, training, and evaluation. A key finding of this evaluation was the influence of safety during implementation of change. To achieve change, a program needs to focus on optimizing safety for all stakeholders. The barriers and enablers found within the FVIP were centered on this theme.

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