INTIMATE PARTNER VIOLENCE ASSESSMENT PROGRAM EVALUATION FINAL PROJECT DEFENSE

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"On my honor as a student, I have neither
given nor received inappropriate aid on this assignment."

UVA | SCHOOL of NURSING

1. Introduction and Background
2. Review of Literature
3. Purpose
4. Design
5. Results
6. Conclusion / Recommendations
7. Summary

What is Intimate Partner Violence (IPV)?

- Violence or patterns of abusive behaviors between intimate partners
- Domestic violence / wife battery
- IPV is the most current term
- Heterosexual & homosexual relationships
- Women can be perpetrators, not just men
- Survivor is the most current term for IPV victims

PREVALENCE

- 17% of men and 33 % women (Ahmed et al., 2017)
- 54 % of women / 5 % of men in the ED are IPV survivors
- 14 % male trauma patients screen positive (Zakrison et al., 2018)
- Only 5 % identified by health care professionals (Ahmad et al., 2017)
- About half of all IPV survivors present with head, neck, and face injuries

IMPORTANCE OF SCREENING

- Ineffective identification can lead to future fatal injuries (Aboutanos et al., 2019)
  - ❖ 16 % of homicides are a result of IPV
  - ❖ 50 % of women killed by intimate partner were seen by provider within 1 year of death
- Routine screening increases identification of IPV
  - ❖ Leads to interventions
  - ❖ Improve social and clinical outcomes for IPV survivors

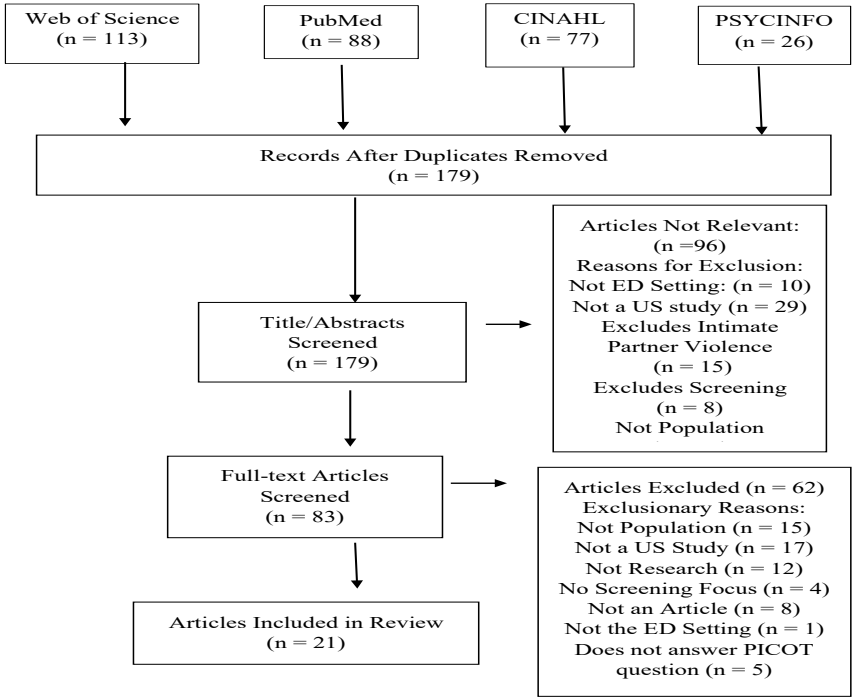
COMPLIANCE

- The Joint Commission (TJC) requires policies for identification, evaluation, management, early identification, and referral for survivors of IPV (Burnett, 2018)
- Only 66 % of hospitals screen for IPV in their EDs across the US (Delgado et al., 2011)
  - ❖ Low awareness IPV screening importance
- IPV screens increased when championed by nurse leaders (Scribano et al., 2011)

BARRIERS TO SCREENING

- Lack of standardized IPV detection training for ED staff
- Discomfort with IPV
- Lack of time
- Futility of intervention (Perciaccante, & Susarla, et al., 2010)
  - ❖Perception that IPV survivors choose not to leave abusive relationship

Review of Literature: Prisma Flow Diagram



LEVELS OF EVIDENCE

- Literature evaluated using the Johns Hopkins Nursing Evidence-Based Practice criteria (Dang & Dearholt, 2017)
- Level II (quasi-experimental)
  - ❖ 7 studies
    - 6 studies high (A) quality / 1 study good (B) quality
    - Quantitative
- Level III (non-experimental / qualitative)
  - ❖ 14 studies
    - Most high (A) quality
    - 11 quantitative
    - 3 qualitative

Johns Hopkins Nursing Evidence-Based Practice
Appendix C: Evidence Level and Quality Guide

Evidence Levels	Quality Guides
Level I Experimental study, randomized controlled trial (RCT) Systematic review of RCTs, with or without meta-analysis	**A** **High quality:** Consistent, generalizable results; sufficient sample size for the study design; adequate control; definitive conclusions; consistent recommendations based on comprehensive literature review that includes thorough reference to scientific evidence
Level II Quasi-experimental study Systematic review of a combination of RCTs and quasi-experimental, or quasi-experimental studies only, with or without meta-analysis	**B** **Good quality:** Reasonably consistent results; sufficient sample size for the study design; some control, fairly definitive conclusions; reasonably consistent recommendations based on fairly comprehensive literature review that includes some reference to scientific evidence
Level III Non-experimental study Systematic review of a combination of RCTs, quasi-experimental and non-experimental studies, or non-experimental studies only, with or without meta-analysis Qualitative study or systematic review with or without a meta-synthesis	**C** **Low quality or major flaws:** Little evidence with inconsistent results; insufficient sample size for the study design; conclusions cannot be drawn

STRONG EVIDENCE FOR INCREASED COMPLIANCE

- Dual method approach (DiVietro et al., 2018, Perciaccante & Carey, et al., 2010, Perciaccante, & Susarla, et al., 2010)
  - ❖ Injury location with in-person screening
  - ❖ Computerized screening method with face-to-face screening
    - ➢ Establishes trust and rapport
- Education (Chapin et al.,2011, Hugl-Wajek et al., 2012, Robinson, 2010, Wolff et al., 2017, Zakrison et al., 2018, Choo, & Nicolaidis, et al., 2012)
  - ❖ Health care professionals lack confidence / education with how to conduct IPV screening (Hugl-Wajek et al., 2012, Robinson, 2010, Williams et al., 2016)

HITS TOOL

HITS

Likert scale:
never (1) to frequently (5)
(Score range: 5-20)

Scores classified as victimized:
≥ 10 (females)
≥ 11 (males)
(Basile et al., 2007, p 42)

Sensitivity: 30%–100% (population dependent, lowest in men)
Specificity: 86%– 99%
(Rabin et al., 2009)

- **H**URT
  - How often does your partner physically hurt you?
- **I**NSULT
  - How often does your partner insult or talk down to you?
- **T**HREATEN
  - How often does your partner threaten you with physical harm?
- **S**CREAM
  - How often does you partner scream or curse at you?

PURPOSE

- Conduct a systematic program evaluation of the IPV screening program currently being utilized in the ED of an academic medical center
- Why?
  - ❖ Prevalence of IPV
  - ❖ Impact of IPV on patient's safety / quality of life
  - ❖ Unknown adherence to TJC, American College of Surgeons (ACS) guidelines, policy # 0213
  - ❖ Undisclosed barriers / facilitators to IPV screening at site
  - ❖ Rates of IPV are high in the military

DESIGN:
SYSTEMATIC PROGRAM EVALUATION / FORMATIVE APPROACH

Program evaluation implementation framework

- **Agency for Clinical Innovation (ACI)** framework:
  - 3 approaches: Formative, process, or summative (NSW Agency for Clinical Innovation [ACI], 2013)

- **Formative Evaluation is best fit:**
  - Assesses program design
  - Initiated before the implementation of a program / pilot program
  - Builds case for change, needs assessments, gap analysis, and / or review of best practice

PRACTICE SITE INSTITUTIONAL ASSESSMENT

- 600-bed Level 1 trauma center & academic medical center
- Mid-Atlantic region / serves a rural population
- 70-bed ED
  - 60,000 patients / year
  - Nursing: 77 open positions / **70 % turnover**
    - 39 Full-time / 5 Part-time: 6-week orientation
    - 65 travel nurses: 2-day orientation
  - 12 Social workers
  - 30 Full-time physicians / 3 part-time physicians
  - 1 Nurse practitioner
  - No formal education on IPV screening
  - No systematic evaluation of IPV screening program conducted

IPV SCREENING AT PRACTICE SITE

- Hospital policy HR # 0213
  - Health care professionals "screen all patients for abuse and neglect and shall refer all suspected cases to Social Work" (Hall, 2020, p. 1)
- Unknown adherence to TJC, ACS guideline, hospital policy # 0213
- IPV assessment at the site
  - ED nurse responsibility
  - Social work notified with positive assessments
  - Social workers refer to community resources
- Concerns
  - Tools: difficult to locate in the EHR
  - No alert trigger / hard stop

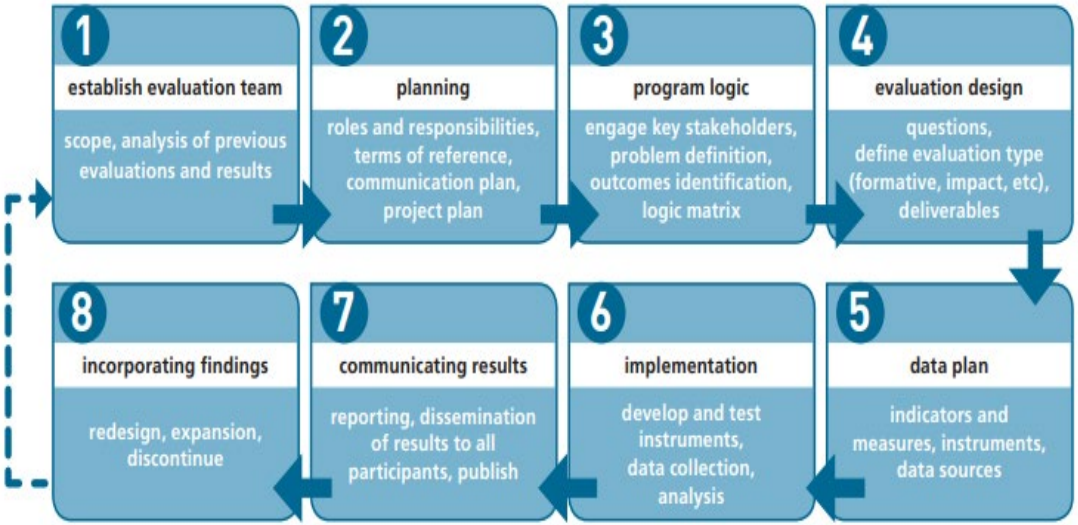
SCREENING TOOLS AT PRACTICE SITE

- HARK
- Abuse Screening Tool
- HITS
  - **Tool implemented in EHR in early 2021**
    - Goal to increase compliance with TJC / ACS standards
    - ED social workers trained to use tool
  - Tested in emergency room populations
  - Validated for use in men
  - Good internal consistency / construct validity (Zakrison et al., 2018)
  - ACS Trauma Quality Programs (TQP) Best Practice as the primary screening tool in a trauma center (Bonne et al., 2019)

THE EVALUATION CYCLE

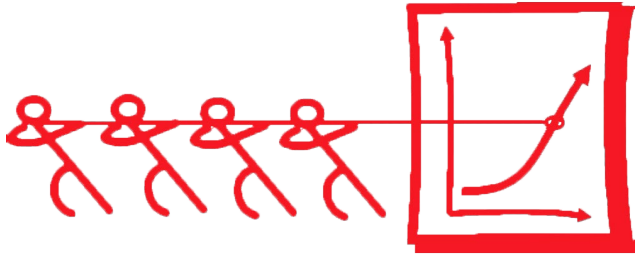
8 steps in the evaluation process:

1. Establish evaluation team
2. Planning
3. Program logic
4. Evaluation design
5. Data plan
6. Implementation
7. Communicating results, and
8. Incorporating findings (NSW Agency for Clinical Innovation [ACI], 2013)



STEP 1: EVALUATION TEAM

- Doctoral student
- Practice mentor (injury prevention coordinator)
- Social work ED supervisor
- Forensics nurse examiner (FNE)
- ED nurse
- ED nurse educator
- Interim ED nursing director
- ED nurse manager
- Analytics specialist at practice site
- Department of emergency medicine and ED's medical director were invited
- Challenges:
  - ❖ COVID 19 / Nursing turnover rate 70 %



STEP 2: PLANNING

- Evaluation plan:
  - ❖ Evaluation design
  - ❖ Data plan
  - ❖ Communication
    - ○ Meetings / emails used to disseminate results / reports
  - ❖ Roles and responsibilities and terms of reference determined
  - ❖ Plan how to engage stakeholders
    - ➢ Stakeholders:
      - ○ ED nurse
      - ○ ED interim nursing director/nurse manager*
      - ○ ED nurse educator
      - ○ ED social workers
      - ○ FNE team
      - ○ ED providers

STEP 3: PROGRAM LOGIC (4 PARTS)

Aim: evaluate ED's IPV screening program and advise the best practice for IPV screening to improve screening compliance.

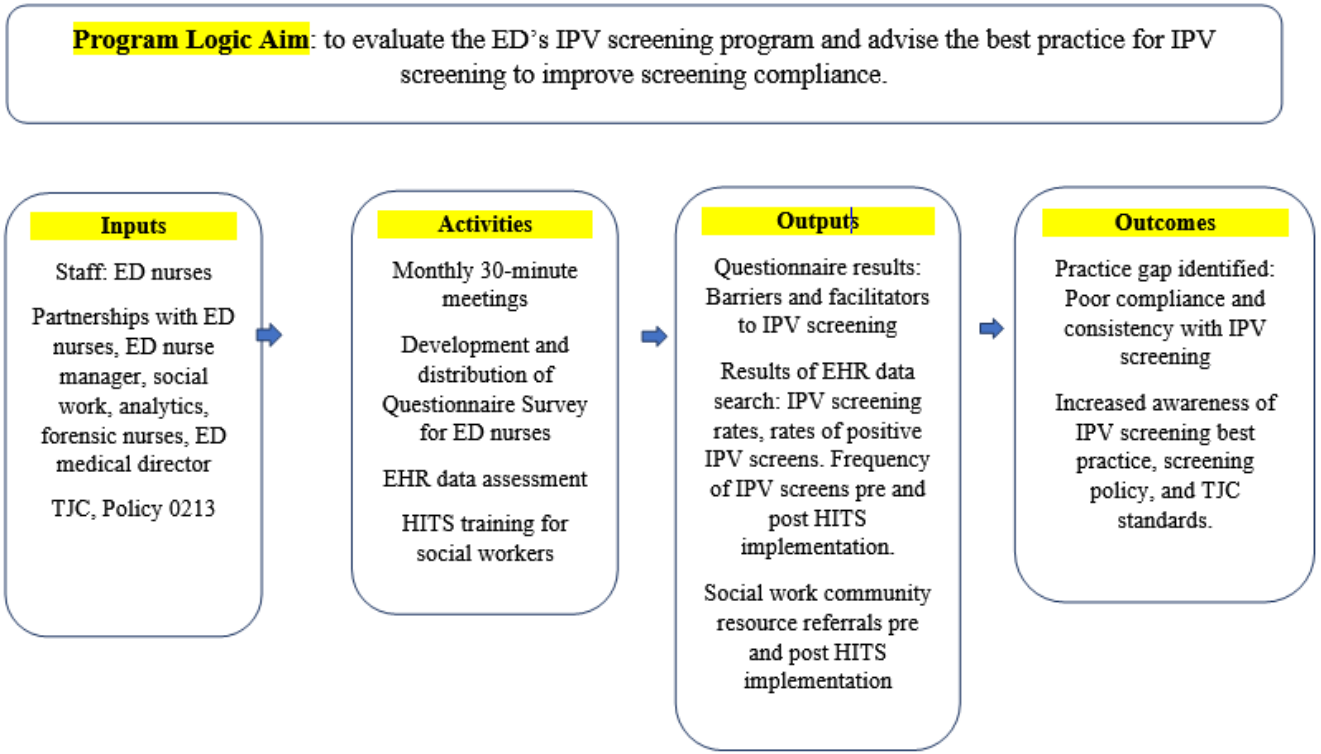
1. Inputs: Partnerships / resources needed / policy & TJC standard

2. Activities: Actions necessary to complete a program evaluation

- Questionnaire
- organizational assessment

3. Outputs: activity results

4. Outcomes (of the results): Identification of practice gap, awareness of screening importance



STEP 4: EVALUATION DESIGN

- **Formative Evaluation**
  - ❖ Questions:
    - ➢ What do we know about the problem that the program will address?
    - ➢ What is the accepted best practice?
    - ➢ What does the research and evidence tell us about this problem?

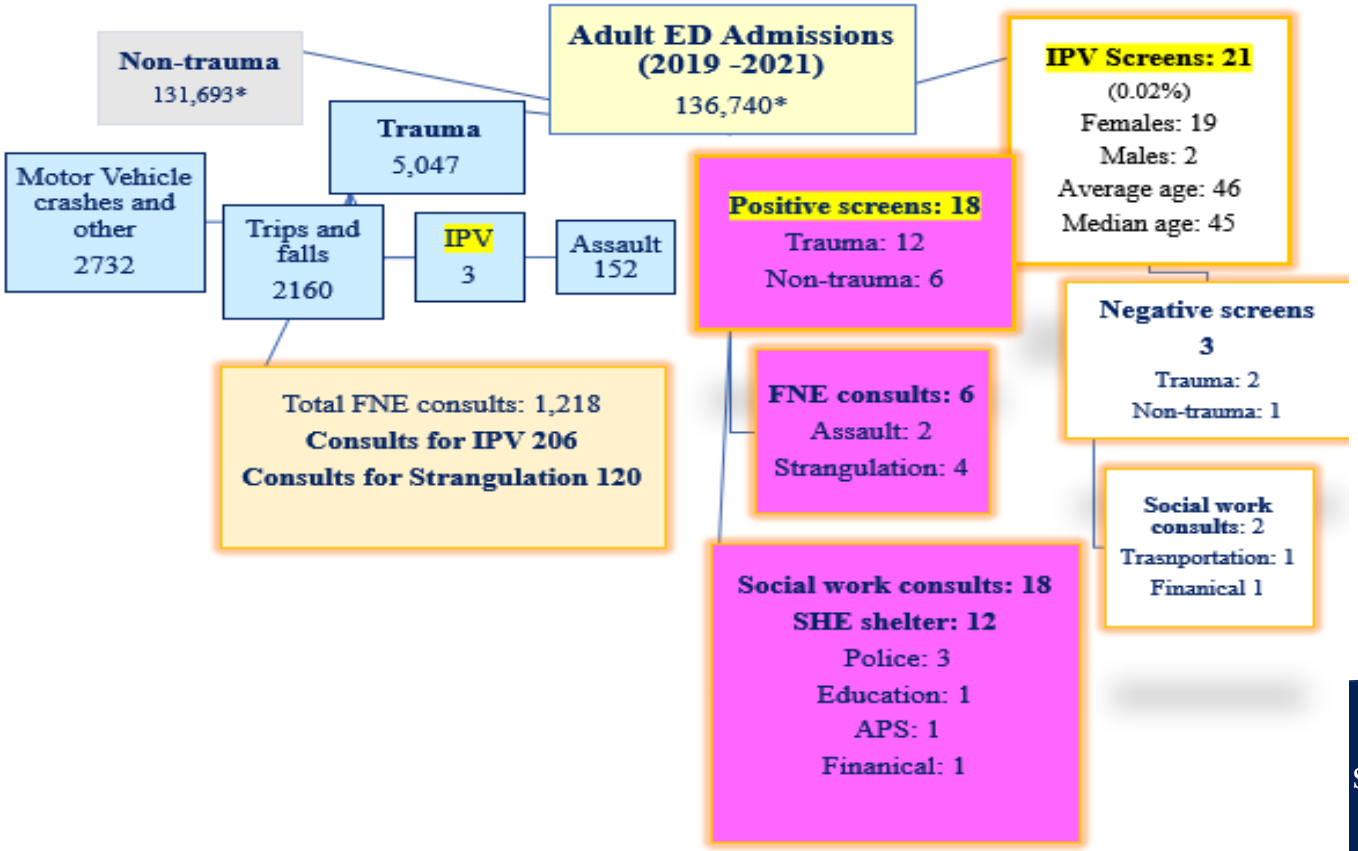
STEP 5: DATA PLAN

- Determines if program outcomes improved or worsened
- Quantitative and qualitative methods (Yeaton et al., 1997)
- Questionnaire Survey for ED personnel
  - ❖ Barriers and facilitators to IPV screening
- Baseline data
  - ❖ 2019 (extended due to 1 screen located in EHR)
  - ❖ 2019-2020 ED census, trauma and non-trauma patient data
  - ❖ 2019-2020 IPV screening rates
    - ❖ 2 screens completed (1 HARK, 1 Abuse Screening Tool)
- Comparison data
  - ❖ 2021 ED census
  - ❖ 2021 IPV screening rates (HITS tool implemented in early 2021)

STEP 6 / 7: IMPLEMENTATION / RESULTS

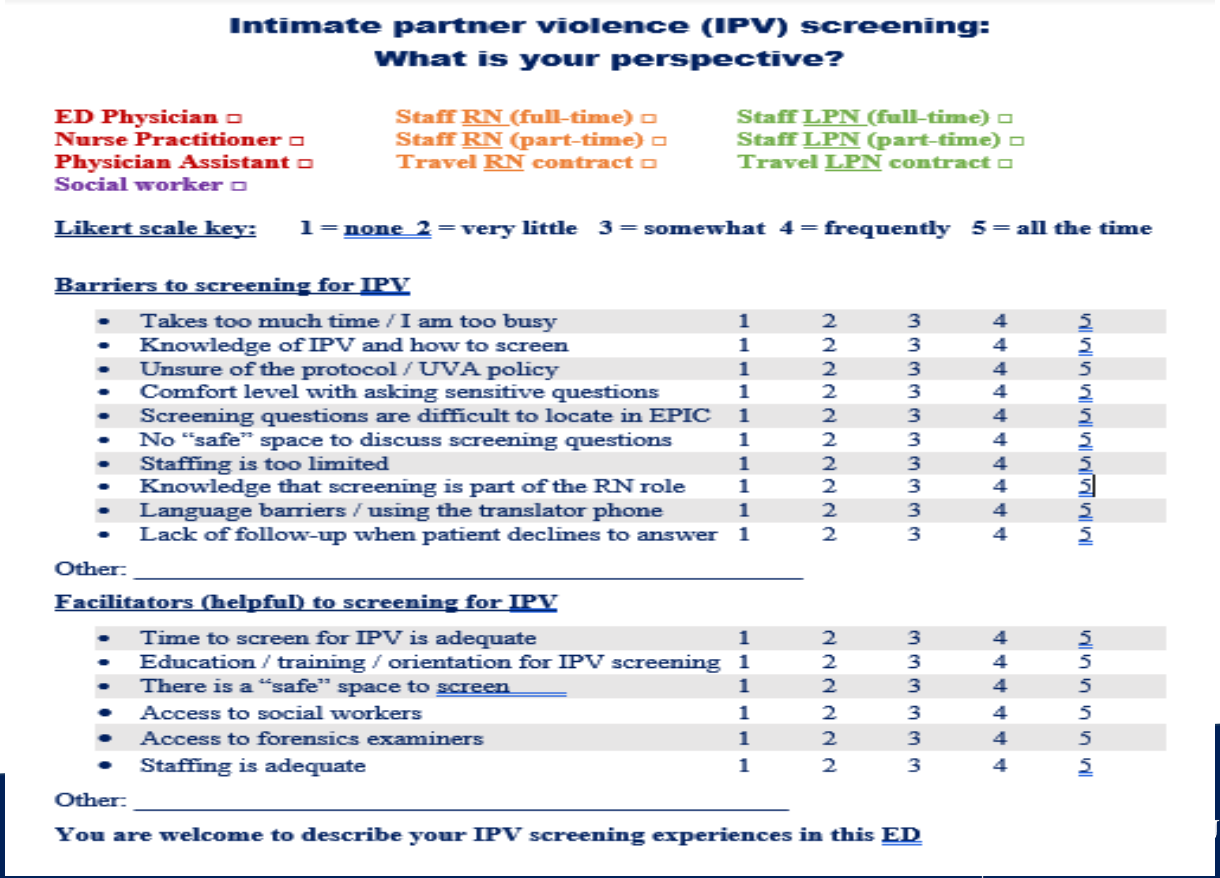
- IRB determined project to be quality improvement in nature
- All data kept confidential and stored in a locked space
- Distribution of results via email and meetings

IPV SCREEN RATES
(2019 – 2021)



17 ITEM PAPER / PENCIL IPV SCREENING QUESTIONNAIRE

Questionnaire administered August 2021: to identify barriers and facilitators to IPV screening in the ED



Intimate partner violence (IPV) screening: What is your perspective?

ED Physician ☐ **Staff RN (full-time)** ☐ **Staff LPN (full-time)** ☐
Nurse Practitioner ☐ **Staff RN (part-time)** ☐ **Staff LPN (part-time)** ☐
Physician Assistant ☐ **Travel RN contract** ☐ **Travel LPN contract** ☐
Social worker ☐

Likert scale key: 1 = none 2 = very little 3 = somewhat 4 = frequently 5 = all the time

Barriers to screening for IPV

• Takes too much time / I am too busy	1	2	3	4	5
• Knowledge of IPV and how to screen	1	2	3	4	5
• Unsure of the protocol / UVA policy	1	2	3	4	5
• Comfort level with asking sensitive questions	1	2	3	4	5
• Screening questions are difficult to locate in EPIC	1	2	3	4	5
• No "safe" space to discuss screening questions	1	2	3	4	5
• Staffing is too limited	1	2	3	4	5
• Knowledge that screening is part of the RN role	1	2	3	4	5
• Language barriers / using the translator phone	1	2	3	4	5
• Lack of follow-up when patient declines to answer	1	2	3	4	5

Other: _____

Facilitators (helpful) to screening for IPV

• Time to screen for IPV is adequate	1	2	3	4	5
• Education / training / orientation for IPV screening	1	2	3	4	5
• There is a "safe" space to screen	1	2	3	4	5
• Access to social workers	1	2	3	4	5
• Access to forensics examiners	1	2	3	4	5
• Staffing is adequate	1	2	3	4	5

Other: _____

You are welcome to describe your IPV screening experiences in this ED

QUESTIONNAIRE

Administration

- ED change of shift (2 day / 2 nights in same week)
- 1-minute summary to staff
- Approx 5 minutes to complete
- Forms placed in secure box

Good Response

49 respondents:

- 28 of 39 full-time nurses
- 3 of 5 part-time nurses
- 6 of 65 travel nurses
- 6 unidentified
- 4 of 30 ED physicians
- 2 of 12 social workers
- 1 EMT

QUESTIONNAIRE RESULTS

Barriers

- Lack of knowledge (74 %)
- Lack of follow-up (70 %)
- Unawareness IPV screening is RN responsibility (68.8 %)

Facilitators

- Safe spaces to screen (70 %)
- Access to social workers (66 %)
- Access to FNEs (66 %)

Barrier most identified within the 16 comments

- Lack of education and training

STEP 8: INCORPORATING FINDINGS

- Compliance with hospital policy and TJC standards was 0.015 %
- Recommendations for implementation
  - ❖ Submitted to ED team via executive summary
  - ❖ Addressed practice gaps
  - ❖ Based on the outcomes of the program evaluation and the review of literature
  - ❖ Team implemented recommendations per their discretion

RECOMMENDATIONS

1. Embed HITS tool in nursing adult assessment form

2. "Hard stop" for HITS screen: every adult patient screened

3. Option of "screening not done at this time"
Drop-down menu list of reasons for deferment

4. Score HITS modified screening question (0 to 4)

- New score range = 0 - 16
  - ❖ Modification of tool improves usability
  - ❖ Permission gained from tool developer
- Label tool as modified
- Caution: modifying the HITS tool may limit future multi-site research participation

5. Automatic consult order in EHR

- HITS ≥ 1 = Social worker consult
- HITS ≥ 6 = Social workers and FNEs consult

6. Secure triage flagging system visible in EHR to ED personnel

- Flag if abuse suspected
- Private area can be prepared

7. Include IPV screening training / HITS-modified tool in multidisciplinary ED unit orientation

- How, where, and when to screen

8. Annual evaluation of IPV screening

- Trauma and non-trauma patients admitted to ED

PLAN FOR SUSTAINABILITY

- Include IPV screening in nursing orientation
- “Domestic Violence” Social Worker in the ED ensures continuity and sustainability
- IPV screening tool easily accessible in EHR
- Annual evaluation of the IPV screening program in ED
  - ❖ Compliance with policy 0213 and TJC standard

PRODUCTS OF SCHOLARLY PROJECT

- **Executive summary** presented to team
- Submit manuscript to **Journal of Emergency Nursing**
    - ❖ Once sharing of proprietary data is approved by compliance officer at the practice site
- Plan to present an abstract for a podium presentation at the September 2023 **Emergency Nursing Association (ENA) annual conference** in San Diego

SUMMARY

- **Prevalence of IPV**
  - 54 % of women that report to ED are IPV survivors
  - 5 % of men in the ED are IPV survivors
  - 50 % of women killed by intimate partner were seen by their provider within 1 year of their death
- **IPV screening is important**
  - IPV is prevalent in our society
  - Routine IPV screening required by TJC standards and hospital policy for every adult ED admission
  - Program evaluation found 21 IPV in the EHR in 3 years / low compliance rate
- **Main barrier to IPV screening**:
  - Lack of knowledge (74 %)
- **Main facilitator to IPV screening**:
  - Safe space to screen (70 %)
- **8 recommendations** presented to the team
  - Recommendation to annually evaluate this program due to prevalence / importance of IPV screening
- **Outcomes**:
  - Domestic violence social worker contracted for ED based on this program evaluation to ensure sustainability
  - Engagement and awareness of IPV screening

THANK YOU FOR YOUR TIME & ATTENTION!

This concludes my presentation

Any Questions?

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STEP 3: PROGRAM LOGIC (PART 2) ACTIVITIES ORGANIZATIONAL ASSESSMENT

- Monthly team meetings
- Organizational assessment
- Distribution of IPV questionnaire survey
- HITS training for 11 social workers in early March

IMPACT OF COVID-19 ON IPV

- 9 metropolitan cities in the US reported 20 - 30 % increase IPV calls (Kofman and Garfin, 2020)
- Assault at home was strong indicator of IPV-related assault (Yau et al., 2013)
- Hotlines: increased calls; decreased calls; both tell an unsettling story
  - ❖ Close proximity of abuser makes utilizing hotlines difficult

HARK TOOL

HARK

(1 point for every yes answer)

Sensitivity: 81%
Specificity 95%
Positive predictive value: 83%
Negative predictive value 94%
(Sohal et al., 2007, p 3)

HUMILIATION
Within the last year, have you been humiliated or emotionally abused in other ways by your partner or your ex-partner?

AFRAID
Within the last year, have you been afraid of your partner or ex-partner?

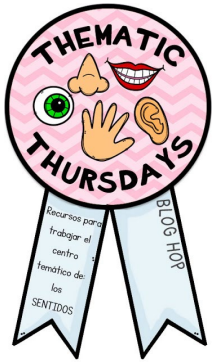
RAPE
Within the last year, have you been raped or forced to have any kind of sexual activity by your partner or ex-partner?

KICK
Within the last year, have you been kicked, hit, slapped or otherwise physically hurt by your partner or ex-partner?

SCREENING TOOLS

- 33 IPV screening tools (Ahmad et al., 2017)
- Commonly used screening tools for IPV include:
  - ❖ HITS: Hurt, Insult, Threaten, and Scream (Zakrison et al., 2018)
  - ❖ PVS: Partner Violence Screen (Perciaccante, & Susarla, et al., 2010)
  - ❖ SAVE: Screen, Ask, Validate, and Evaluate (Zakrison et al., 2018)
  - ❖ WAST: Woman Abuse Screening Tool (Perciaccante, & Susarla, et al., 2010)
  - ❖ HARK: Humiliation, Afraid, Rape, Kick (Sohal et al., 2007)

THEMATIC APPROACH



- Face-to-face screening
- Computer-based screening
- Identification through ED presentation and injury location
- Dual approach
- Education

STEP 5: DATA PLAN
DATA ELEMENTS

ADULT ED PATIENTS 2019-2021

- Number of admissions
- Trauma and non-trauma
- Demographics
- Types of trauma / mechanisms of injuries (MOIs)
- Forensic nurse examiner consults
- Number of patients screened/Role of clinician/Tool used

POSITIVE SCREENS 2019-2021

- Trauma and non-trauma
- Social work referrals
- What type of community agencies
- Forensic nurse examiner consults
- Barriers and facilitators to IPV screening

Analysis plan: Descriptive (describing a data set)

17 ITEM PAPER / PENCIL IPV SCREENING QUESTIONNAIRE

Intimate partner violence (IPV) screening:
What is your perspective?

ED Physician ☐ Staff RN (full-time) ☐ Staff LPN (full-time) ☐
Nurse Practitioner ☐ Staff RN (part-time) ☐ Staff LPN (part-time) ☐
Physician Assistant ☐ Travel RN contract ☐ Travel LPN contract ☐
Social worker ☐

Likert scale key: 1 = none 2 = very little 3 = somewhat 4 = frequently 5 = all the time

Barriers to screening for IPV

• Takes too much time / I am too busy	1	2	3	4	5
• Knowledge of IPV and how to screen	1	2	3	4	5
• Unsure of the protocol / UVA policy	1	2	3	4	5
• Comfort level with asking sensitive questions	1	2	3	4	5
• Screening questions are difficult to locate in EPIC	1	2	3	4	5
• No "safe" space to discuss screening questions	1	2	3	4	5
• Staffing is too limited	1	2	3	4	5
• Knowledge that screening is part of the RN role	1	2	3	4	5
• Language barriers / using the translator phone	1	2	3	4	5
• Lack of follow-up when patient declines to answer	1	2	3	4	5

Other: _____

Facilitators (helpful) to screening for IPV

• Time to screen for IPV is adequate	1	2	3	4	5
• Education / training / orientation for IPV screening	1	2	3	4	5
• There is a "safe" space to screen	1	2	3	4	5
• Access to social workers	1	2	3	4	5
• Access to forensics examiners	1	2	3	4	5
• Staffing is adequate	1	2	3	4	5

Other: _____

You are welcome to describe your IPV screening experiences in this ED

- Barriers: 10 questions
- Facilitators: 6 questions
- Comment section welcomed participants to describe IPV screening experiences

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