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A Program Evaluation of Domestic Violence Screening at A Large Urban Hospital

by

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Abstract

Domestic violence has been deemed a direct invasion and violation of human rights by the World Health Organization (2021). Due to the continuous rise in cases of domestic violence, national organizations like the United States Preventative Services Task Force (USPSTF) have recommended that healthcare providers screen patients for this abuse. The purpose of this study was to reinforce the current screening procedure and protocol to ensure that each patient was screened for domestic violence before being discharged from the hospital. This study evaluated a quality improvement project formed to promote the completion of a preexisting domestic violence screening form that can provide resources to the survivors. A Plan-Do-Study-Act approach was implemented to analyze research and provide education to nurses on how to properly screen patients for domestic violence and why it should be completed before discharge. After the completion of the educational intervention, six weeks of post-intervention data were analyzed using descriptive statistics.

Keywords: domestic violence, intimate partner violence, screening

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A Program Evaluation of Domestic Violence Screening at A Large Urban Hospital

In the United States, an average of 20 people per minute are abused by a domestic partner or intimate partner (Black et al., 2011). 1 in 3 women and 1 in 4 men will suffer from some form of intimate partner violence in their lifetime (Black et al., 2011). In 2020, only 34% of the victims of domestic violence received medical care for their injuries (Truman & Morgan, 2014). Domestic violence, interchangeable with intimate partner violence, is defined as a relationship in which one person is exhibiting behaviors to assert power or dominance over the other person (Kaur & Garg, 2008). The behaviors include physical assault, sexual assault, verbal assault, willful intimidation, and other abusive actions that one person forces upon another in an intimate relationship. In 2021, The World Health Organization released statistics specifically about domestic abuse against women that supported their stance that intimate partner violence is a critical health problem and an invasion and violation of human rights (2021).

The continuous rise in victims of domestic violence urged the United States Preventative Services Task Force (USPSTF) along with the Women Preventative Service Initiative (WPSI) to recommend providers screen women for violence (Ramaswamy et al., 2019). In the Women's Health Policy brief, the USPSTF and WPSI concluded that healthcare providers have a pivotal and frontline role in both preventing domestic violence and recognizing its victims. Their recommendations also included that screening and counseling should be mandatory allowing for the identification of more vulnerable people or victims that could be in a potentially unsafe relationship. When patients are successfully screened, they can access resources such as; forensic nurse examiners, physical and mental health treatment, social workers, and ultimately the tools they need to end their own cycle of abuse. The Center for Women and Families, Kentuckiana's lead rape crisis and domestic violence center, has provided advocacy and support to over 727

survivors of both sexual assault and intimate partner violence (*Year in Review: 2021*). When patients at the University of Louisville Hospital answer "yes" to the domestic violence screening form an advocate for the Center for Women and Families is automatically called. According to Louisville Metro Police Department statistics in 2020, there were two homicides caused by domestic violence, in 2021 there were five but in 2022 there were 20 (*Louisville Metro Pd, Ky*, 2022).

Setting

The setting for this project was two inpatient units located in a level one trauma and academic hospital in Louisville, Kentucky. The hospital sees over 3,000 patients a year and has a comprehensive stroke center and the only dedicated burn unit in the state of Kentucky. The two specific units at this level one trauma hospital are 8East and 8South which are both medical-surgical progressive care units spanning from 15 to 26 beds.

Site Specific Problem

Currently there is a policy in place for domestic violence and a screening tool currently exists. Upon admission to the ER patients are screened for a current or past unsafe relationship. In 2005 the institution introduced a new service called "SAFE Services" which stands for sexual assault forensic examiner, this provides the patient with advocates, access to law enforcement, and forensic exams (*Safe Services*, 2022). The program first started only providing services to sexual assault victims but after a grant in 2015, the SAFE Services were extended to domestic violence victims at the University of Louisville Hospital. Although the grant was only intended to cover a year of domestic violence services, the need continued to increase and the domestic violence program is now a permanent service. From the time that S.A.F.E. Services started

seeing victims of domestic violence in 2015 through the year 2017 University of Louisville provided services to 274 patients.

After interviewing the managers of S.A.F.E. Services and nurses from both the emergency department and the inpatient units several consistent themes emerged. The managers of S.A.F.E. Services expressed that there is a time constraint for the nurses working in the emergency room, also that a lot of the nurses don't feel comfortable asking questions on the domestic violence screening form (A. Corzine, personal communication, 2022) The staff nurses in the emergency department shared that limited time and high priority patients took precedence over the screening form. When patients presented with injury related to domestic violence the screening form was completed and the sexual assault forensic nurse examiner was called. However, if the injury was not related to domestic abuse the form was often left incomplete. When patients are admitted to the floor, most floor nurses assumed the form had been completed in the emergency room and did not check for completion. In addition, nurses also stated the admission flow sheet does not currently contain the domestic violence screening form.

Screening patients for domestic violence is mentioned in the emergency department workflow criteria. Completing the domestic violence screening form should be completed by the triage nurse upon the patient's arrival at the hospital. Due to barriers in the emergency room, some patients will transfer up to the floors without being screened, this is where more education is needed. At a level one trauma hospital patients will commonly present medically, physically, or mentally unstable making the patient unable to screen; others arrive intubated from the scene. There is a disconnect between the emergency department nurses and the floor nurses because floor nurses have the assumption that the domestic violence screening from has already been completed in the ER implying that floor nurses don't need to confirm completion or complete the

screening themselves. . The patients that arrive intubated go straight to the intensive care unit where they spend several days, when they downgrade to the floors their domestic violence screening form often remains incomplete. Education is needed here for the floor nurses to ensure that they understand for some patients this is their last chance to get help before returning to a domestic violence situation.

Stakeholders

The stakeholders in this project include the patients, the nurses, the managers of S.A.F.E. services, and the chief financial officer. The most critical players in this intervention are the nurses because they have the unique opportunity to screen and intervene on behalf of patients that are admitted to the hospital.

The managers of S.A.F.E. Services are invested in compliance with screening for domestic violence because that form triggers services and activates a response from the sexual assault forensic nurse examiner. If the patient answers “yes” to any of the questions on the domestic violence screening form, it orders an automatic consult with the S.A.F.E. Services social worker.

In 2003, the CDC reported that the average annual cost of domestic violence on the healthcare system is 4.1 billion spent on medical and mental healthcare costs for the victims (Arias, 2003). For the average female who received one medical service and one mental health service, it cost 816$ compared to the price of follow-up treatment which cost 3,682$ (Centers for Disease Control and Prevention, 2009). A victim of domestic abuse is averaged to be revictimized 3.4 times a year presenting three opportunities for the patient to be screened and offered resources to end their cycle of abuse. The chief financial officer would be concerned with

the long-term aftereffects that domestic violence causes, and which services would be reimbursed at a public university.

Context

A literature review was completed to analyze evidence-based interventions that would contribute to domestic violence screening for patients admitted to the hospital setting.

Literature Review

Intervention

Screener

Many reviewed articles suggested that the person in the optimal position to screen the potential victims of domestic violence is the bedside nurse, however, other articles suggested that patients can be screened by case management, advocates, or physicians. A study by Roberts et al. assessed the victims' perception of who in the healthcare field was the most helpful participant in their medical care. Doctors ranked the least helpful in the eyes of the survivors of domestic violence (1996). Another article by Day et al. noted that social workers were the designated caregiver to screen patients in the inpatient facility. At the facility referenced in this article, the trauma social workers saw every patient that is admitted to the emergency room. (2015). At a level one trauma center in Philadelphia, a group of medical professionals, including medical residents, medical students, nurse practitioner students, registered nurses, and physician assistant students screened all patients for domestic violence (Krimm & Heinzer, 2002). This assessment screening was completed during the history and physical which is normally performed by either the primary nurse or the presenting resident or doctor.

Screening Tool

In a pilot study by Day etal., social workers used a four-question yes or no survey to assess patients (2015). A "yes" on any of the four questions in the survey would trigger further assessment with a 28-question instrument. Some screening tools had to be adapted to a lower reading level to cater to the patients that the level one trauma center served. As such, most screening tools were yes or no questions. At a level one trauma Emergency Department in Arizona, the screening tool was adjusted to a 6th-grade level for more comprehension (Karnitschnig & Bowker, 2020a).

One level one trauma center used a digital screening form that the patient would fill out in a semi-private booth (Houry et al., 2008). Although this type of screening would allow for faster screening and more privacy which would hopefully lead to more accurate data collection, the use of the technology was a barrier for some patients. Another level one trauma center used touchscreen computers, offering both English and Spanish language options. The survey at this facility also provided three separate opportunities for the patient to stop answering questions and end their screening. The subjects were given a consent form and asked to read it but there was no requirement to sign a consent form. There forth in both the electronic form and written form opportunities to withdraw were offered assuring that the patient wanted to continue. This same facility further offered a paper form of their questionnaire, again instructing the patient that they could stop at any time. There were 214 subjects in this setting, 106 who used the computer and 108 who received the screening on paper. This allowed for the study to compare the results of using electronic and paper methods of screening (Ernst et al., 2012). When the patients were asked if the method, they were using was preferred over the other method offered, majority said their method was easier showing no significant bias either way.

As a commonality, all interventions consisted of a questionnaire to screen for potential domestic violence. One study was as short as three questions, while others ranged to 28. A common tool used in more than one study was the W.A.S.T. which stands for Women Abuse Screening Tool. This tool is seven questions long and includes a Likert scale for answers (Perciaccante et al., 2010). Most facilities had a preexisting set of questions that were asked of every patient consisting of mostly yes or no questions in which one yes would trigger a positive score.

A significant barrier to domestic violence screening in the emergency room setting is that nurses find it difficult to ask questions regarding domestic violence (Karnitschnig & Bowker, 2020). One intervention by Karnitschnig & Bowker included education for nurses and provided sample scripted statements for the nurses to use when approaching patients. In addition to difficulties with initial screening, many nurses didn't know how to handle the situation when the screening was positive (Karnitschnig & Bowker, 2020). Lipsky et al. stated that time and resources are limitations in both screening patients and getting them the help, they need if their screening was positive. The race and ethnicity of each patient should be a carefully considered factor when screening for domestic violence due to the demographic makeup surrounding most level one trauma centers. In this study, the black race has a higher association with domestic violence victimization. Lipsky et al. also suggest that many of the people seen in the emergency room setting, especially those being screened for domestic violence, should also be screened for perpetration (2004).

Summary

Upon completion of a literature review, it is evident that the studies identified strengths and weaknesses in current procedures used to screen for domestic violence. A commonality

among the articles is the optimal location for patient screening is the emergency room, by a trained or educated medical professional. Each individual hospital had a different method of screening patients ranging from paper screening forms, digital screening on a tablet or computer, and even hospital staff asking the questions verbally. A barrier identified in several articles was the nurse's comfort level in approaching patients with these questions and what actions should be taken following a positive screening. With training including role play, scripts, and in-person training, healthcare providers were able to learn how to ask these questions and how to make referrals for the patients that screen positive.

Purpose and Specific Aims

The purpose of this DNP project was to improve screening rates for domestic violence at the selected institution by reinforcing the current screening and documentation protocols to floor nurses to ensure that every patient admitted to the floor has been screened. If screening is found to be incomplete, then the floor nurse should screen at that time and document findings as well as implement appropriate referrals as needed. The aim of this project was to meet the institution's goal of a 100% screening rate on every patient admitted to the hospital.

Conceptual Framework/Model

Plan-Do-Study-Act Cycle

This model helps implement a change on a smaller scale which will be appropriate for this intervention starting on just two in-patient units. This four-step cycle was coined by Walter Shewhart and Edward Deming as a quality improvement framework (*Improving Health and Health Care Worldwide,* 2022).

Plan

Domestic violence was identified as a prevalent issue within all healthcare systems including the level one trauma center in which this intervention took place. After a thorough literature review, the research and evidence point to a need for improvement in the screening process for patients admitted to the hospital.

Do

To promote an increase in screening, patient education was provided to the floor nurses and included both form location and form completion methods. Some of the barriers identified by the staff and stakeholders have shifted the targeted intervention group to the nurses in the inpatient units. The teaching intervention included Cerner screenshots to help the nurses visualize how to open the E-from when they are completing the patient's admission.

Study and Act

To assess for improvement in screening patients for domestic violence a retrospective chart review compared pre and post intervention data. The charts were audited for completion of the preexisting domestic violence screening form located within the electronic charting system. Educating nurses on how to access the e-form is the first, yet most important step in connecting domestic violence victims to the resources they need to end their cycle of violence.

Adult Education Model

Based on the situational leadership model, Gerald O. Grow coined an adult learning education model named the Staged Self-Directed Learning Model (Grow, 1991). After his many years in teaching, he realized that adults had very different ways of learning and that they were most successful when their education and knowledge were self-directed. Grow's model provided specific roles for both the student and teacher in each of the stages. The relevancy of this model to the nursing practice is placing importance on the adult and individual learner, specifically the

concept of meeting the learner where they are. The stages ascent as so; stage one is dependent, two is interested, three is involved and finally four is the desired self-directed. The staged self-directed learning model provides examples of educational tools and methods that are appropriate for each stage. Grow emphasizes the most important part of his theory is the teacher's ability and involvement.

Methods

Procedure

This project consisted of three different phases with specific goals and timelines. The first phase consisted of a retrospective chart audit, phase two included education and reinforcement and the third phase included post intervention chart audits.

Phase I- Retrospective Chart Audit

Phase I consisted of a retrospective chart audit that began in early 2023 and took place over a specific six-week time frame. A total of 252 charts were selected using a systematic chart selection process starting at the first bed on the unit, selecting six new patient charts a day. The chart audits were done in the hospital's electronic health record system, which was accessed with permission after approval of both the University of Louisville IRB as well as the hospital system review board.

Audit information included gender, age, race, and the completion status of the domestic violence screening form. The patient's gender and age were found in the patient's chart on the main screen on the banner across the top. The form completion status was found under the "form browser" selection located on the main page of the patient's chart.

The demographic information included in the audit will provide data to analyze for trends or possible bias in certain demographics or populations possibly impacting the screening process.

This information was provided to the agency along with recommendations in the spirit of continuous quality improvement. There can be a tendency for nurses to prioritize patients that they consider high risk for domestic violence while not screening others like the elderly, English as second language patients, patients who identify as LGBT, or men.

Phase II- Staff Education

The DNP Project Lead educated the nurses on each unit by providing a two-to-three-minute review of two separate visual aids and then allowed for a teach back demonstration. Education for the floor nurses took place over a span of two weeks. At the time of the education intervention, the two units shared a manager but had different workflows. On 8South, there was a shift huddle at both 7am and 7pm. The DNP Lead educated and showed the visual aids at the shift huddle twice a day for the two-week intervention period. Then the DNP Lead spoke to the nurses individually while they were at the nurses' station and had a computer in front of them to make sure that they understood where to find the screening and how to document appropriately. At the time of intervention, 8East did not have shift huddles so one-to-one teaching occurred after shift change when the nurses had started their day. A staffing list for 8East and 8South was printed and used as a sign-in sheet which served as a sign off that each nurse received the education.

The DNP Project Lead created two separate visual aids using screenshots from the charting system at the University of Louisville and facts about domestic violence. The first visual aid provided pertinent and local domestic violence facts along with reminders on how to document the screening form. The second visual aid was created using real screenshots describing the steps for accurate documentation of the domestic violence screening. Once a

patient chart was opened, the form can be accessed through “Ad Hoc” under nursing interventions.

The following movements were captured through screen shots.

- Hovering mouse over “Ad Hoc”
- Selecting “nursing interventions”
- Selecting “domestic violence screening”
- When form is complete- green check mark in top left corner

The DNP Project Lead printed 50 copies of each visual aid and laminated 10 of those. On 8East the laminated copies of the tool were placed on; the break room door (on the inside), the bathroom located in the medication room, the medication room on the Omnicell door, in between the two computers on one side of the nurse’s station and between the two computers on the other side of the nurse’s station. On 8South the laminated copies of the two tools were placed on: the break room door, the staff bathroom, the door of the omni cell, the cabinet in the medication room, and at two of the separate computer charting areas. The other copies were placed in both staffing binders located at the unit secretary's desk at the nurse’s station.

With permission from the unit manager, a pdf file of both tools was uploaded to communication forums for both units. The communication database is used to update the staff on important deadlines and information. There was an initial introduction post to provide background and goals for the project. Following the initial post, the DNP Project Lead made weekly posts with questions that nurses had asked and other useful pointers. The tools were also emailed out to the entire staff of each unit to make sure they are familiar with the resource and have seen it in an array of mediums.

Phase III-Post Intervention Chart Audits

Patient charts were audited post-intervention for a six-week timeframe. The post-intervention time frame mirrored the timeline of the pre-intervention retrospective chart audit. The same information was collected as follows: gender, age, race, date on which the patient was admitted to the hospital, and the completion status of the domestic violence screening form. Once the six-week audit was completed the retrospective chart audit data was compared to the post-intervention chart audit data.

Measures

- Gender
    - Male
    - Female
    - Other
    - This is a nominal measurement.
- Age
    - The age of the patient at the time of their visit - continuous
- Form Completion
    - Yes
    - No
    - This is a nominal measurement.
- Race
    - Black or African American
    - Hispanic/Latino
    - Caucasian

- Other
- This is a nominal measurement.

Sample

The DNP project lead audited charts in both a retrospective chart review and a post-intervention chart review in which the number of charts assessed after the intervention was matched in the pre-intervention collection. Six patients were systematically selected from each day for a six-week period totaling 252 charts. The charts were randomized by a continuous rotation starting at the first room on the unit, auditing six beds in a row and moving to the next six the next day. The same method was used post-intervention assessing 6 charts a day for six weeks arriving at a total of 252 charts.

Data Analysis and Results

The patient demographic data obtained through retrospective chart review was analyzed using descriptive statistics including mean, median, and percentage. The percentage rate of form completion was calculated by dividing the number of patients with completed forms divided by the total number of patients reviewed. The patient cases were sorted into specific age ranges according to the following criteria: 1-19, 20-29, 30-39, 40-49, 50-59, 60-69, 70-79, 80-89, and 90-99. The pre-intervention data included patients ranging from 15 at the youngest and 99 at the oldest while the post-intervention data ages ranged from 14 to 96. The most common age range between both sets of patient data was 50-59, both pre and post data each had 53 patients in this category. The form completion status was sorted based on the “yes” or “no”. The pre-intervention data included 252 patients with 172 (68%) of those patients having completed forms and 80 (32%) patients without. The post-intervention data included 252 patients with 160 (63%) completed domestic violence screening forms and 92 (37%) patients with incomplete forms.

There was a 5% decrease in form completion comparatively from the pre-intervention data to the post-intervention data.

Discussion

A detailed literature review was completed to analyze and review evidence-based interventions for domestic violence screening in the inpatient setting. While most studies pertaining to domestic violence were about the screening form itself, this evidenced-based project focused on the form completion before discharge. The setting for this study, The University of Louisville Hospital, had a preexisting domestic violence screening tool that normally is administered by triage in the emergency room. The purpose of this evidence-based project was to ensure all patients were screened for domestic violence before discharge yet statistically, there was little change between the pre and post-intervention data. The domestic violence screening completion rate before the evidence-based intervention was 68% and dropped to 63% after the education was provided. This 5% decrease in domestic violence screening form completion could be explained by preexisting barriers including; when the form is administered during the patient's stay, access to a private space for screening, and time constraints.

A study in the literature review stated that nurses normally completed the domestic violence screening form during the history and physical which happens during the patient's hospital admission (Krimm & Heinzer, 2002). A comment made by nurses during the two-week educational period was a desire for the domestic violence screening form to be integrated into the admission workflow. Unfortunately, the timeline of this evidence-based project intervention did not allow for the addition of the domestic violence screening form into the admission workflow, but it should be considered for future implementation.

Another barrier identified by the floor nurses was time constraints which is another reason why the form would be more easily accessed if included in the admission workflow. Houry et al. found patients at a level one trauma center who have privacy, are more willing to answer the questions on the domestic violence screening form which presented an issue in this setting. The current practice at The University of Louisville Hospital is to screen patients in triage; however, if it is not completed in the ER then floor nurses are required to complete the screening. The rooms on 8East and 8South are all semiprivate which limits patient privacy decreasing their willingness to answer questions honestly.

Site-specific barriers that limited the success of this evidence-based project were staffing shortages and inconsistent management. At the time of the project implementation, there was an interim traveling unit manager on both units and a traveling director over the mixed acuity units. From the time of project approval through the post-data collection there were three different managers on 8East within a year time frame. The staffing shortage started towards the end of the coronavirus pandemic and has worsened over time with an increase in the availability of travel nurse positions. There was limited core staff on both units with most of the daily staff being float pool nurses. The nurse-to-patient ratio at the time of this study was a minimum of 6 to 1 and a maximum of 8 to 1, this limits the amount of time the nurse can spend with each patient.

Ethical Considerations/Permissions

This DNP project was submitted to the U of L Institutional Review Board as a non-human subject quality improvement project. After the determination of non-human subject status, the project was reviewed by the site specific to this project, the University of Louisville Hospital. Finally, after all the required approvals, the DNP was granted access to both retrospective charts and charts post-intervention. Data was compiled on an Excel spreadsheet,

on a password protected computer. No protected health information was recorded for the completion of this project. The data collected were entered into the Statistical Package for the Social Sciences (SPSS) system for analysis. HIPAA standards were maintained throughout the data collection process.

Conclusion

The rise of domestic violence on both a national and local level emphasizes the importance of reaching 100% domestic violence screening form completion. The purpose of this evidence-based project was to reinforce the need for completion of the preexisting domestic violence screening form to the floor nurses before the patient is discharged from the hospital. Statistically, the pre and post-intervention data showed that over 60% of audited patients were screened for domestic violence leaving room for improvement and indicating a need for continued education. The DNP project lead communicated to S.A.F.E. Services management the suggestion made by floor nurses to integrate the domestic violence screening form into the admission flow sheet. For future quality improvement initiatives more emphasis should be placed on assuring all patients are screened for domestic violence before discharge and if positive, given the necessary resources. The present analysis showed that even with the education provided to the floor nurses, significant barriers limited the ability to screen patients before discharge. Education and research should continue to support survivors of domestic violence and to aid in the nurse's critical front-line role screening patients in an inpatient setting.

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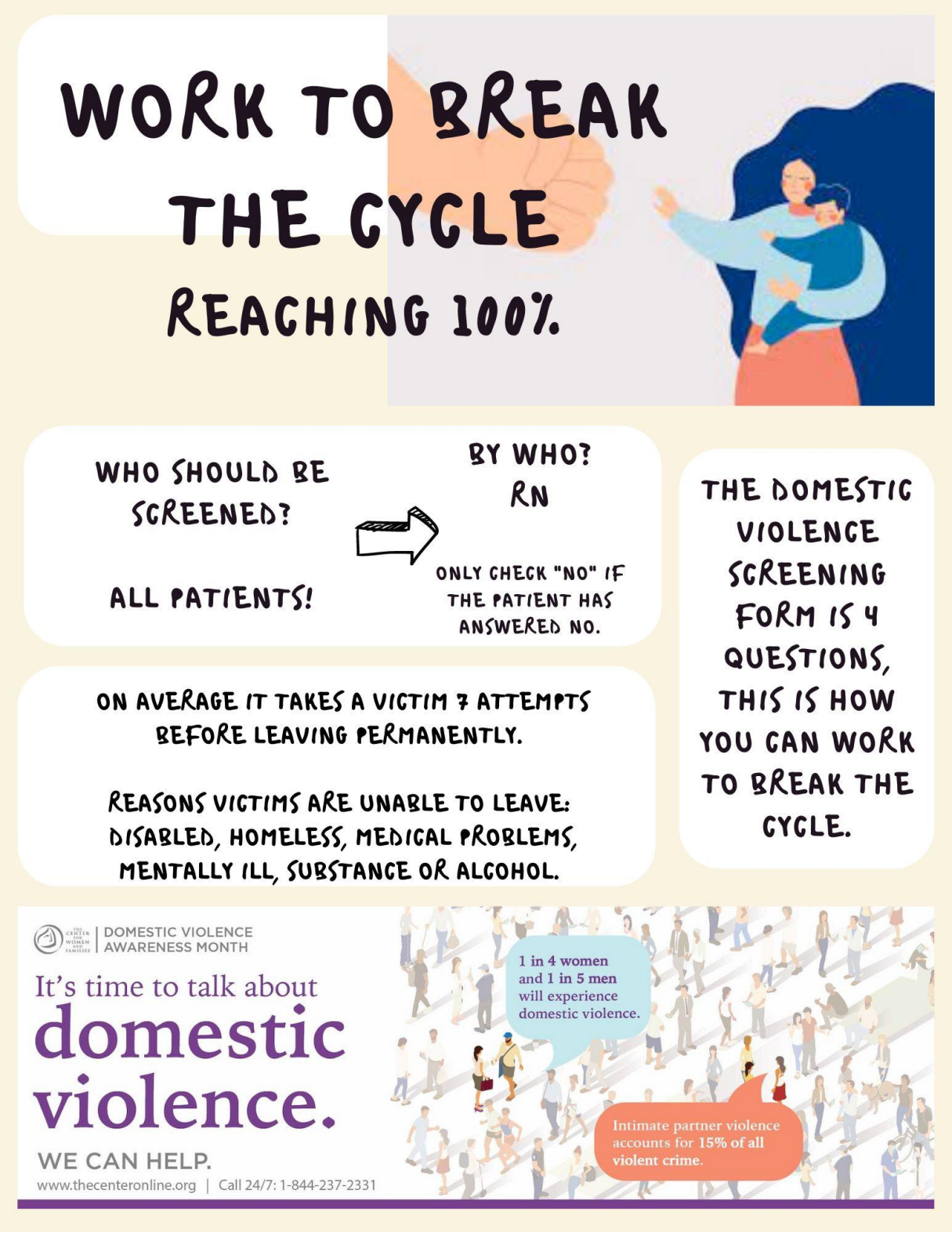
Appendix A

Visual Aid "Work to Break the Cycle"



Appendix B

Visual Aid "How to Screen Patients for Domestic Violence"