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Details Matter: A Quality Improvement Study on Screening for Intimate Partner Violence at a Labor and Delivery Hospital

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BACKGROUND

Intimate partner violence (IPV) is a pattern of behavior used to establish power and control over an individual through fear and intimidation. IPV includes physical, sexual, emotional, and financial abuse, and it is estimated that 1 in 3 women will experience IPV in their lifetime.[1,2] IPV has both immediate and long-term physical and mental health effects. Immediate health effects include physical injuries, sexually transmitted diseases, unintended pregnancies, psychological distress, and even death.[3] Long-term health impacts include panic attacks, depression, anxiety, post-traumatic stress disorder, substance abuse, gastrointestinal disorders, chronic pain, headaches, difficulty sleeping, activity limitations, asthma, and diabetes.[3-5] In addition, children exposed to IPV are at increased risk for abuse and neglect, mood and anxiety disorders, post-traumatic stress disorder, substance abuse, and school-related problems.[6]

Survivors of IPV access healthcare more often than the general public, creating an opportunity for healthcare providers to identify survivors of IPV.[7] The American Academy of Pediatrics, American Congress of Obstetrics and Gynecology, and U.S. Preventive Services Task Force recommend that healthcare professionals screen women for IPV.[8-10] Despite the widespread recommendations that healthcare providers screen for IPV, only 2% to 50% of healthcare providers report routinely screening for IPV.[11]

Screening in public health refers to “the use of a test, examination, or other procedure rapidly applied in an asymptomatic population to identify individuals with early disease.”[12] There are validated screening tools for IPV, but there is no consensus regarding the most acceptable screening setting or modality.[13] Some of the major healthcare organizations have made recommendations on screening practices. The American College of Obstetricians and Gynecologists recommends that health care providers: 1) screen for IPV in a private and safe setting; 2) prior to screening, offer a framing statement to show that screening is done universally and that the screening will be confidential; 3) incorporate IPV screening into the routine medical history so all patients are screened

regardless if abuse is suspected; 4) develop partnerships with agencies that offer IPV services; 5) regularly offer IPV training to staff; 6) have printed resource sheets available; and 7) use language that makes the patient comfortable and is nonjudgmental.[10]

While screening for IPV is a necessary step to identify survivors, screening will lead to a positive disclosure only if the survivor is ready to share. Barriers to women choosing to disclose abuse are many and include both screening practices and the survivor's readiness to take action.[14] Some experts recommend taking a trauma-informed approach to normalize conversations with patients about violence, create a safe place for disclosure, and respond to disclosures of violence with empathy.[15] A meta-analysis of 25 qualitative research studies by Feder et al identified constructs that support disclosure, which include: being asked by a healthcare provider; healthcare providers showing compassion, sensitivity, and nonjudgment; and not feeling pressure to disclose. Constructs that prevent disclosure include: lack of privacy; fear of lack of confidentiality; perception that the healthcare provider was rushed; perception of the healthcare provider as judgmental, pitying, blaming, or trivializing; fear of the abuser; fear the disclosure would lead to future violence; shame; fear of consequences for children; and fear of not being believed.[16,17]

To understand the local context of IPV screening, Correa et al. conducted a series of three focus groups with 17 survivors of IPV in Houston, Texas.[18] The survivors were recruited from three agencies that provide services to IPV survivors. The focus groups assessed help-seeking behaviors of survivors of IPV to identify strategies on how to improve screening for IPV. Half of the participants informally reported that they had been screened for IPV by a healthcare professional, but they were all screened in front of their abusive partner, so they were unable to disclose the abuse. As a result, the survivors emphasized the importance of isolating the patient before screening for IPV. The survivors also shared that many of them were in abusive relationships for years before they recognized the relationship as abusive. The survivors recommended that healthcare providers ask specific direct questions that include questions on emotional abuse. The validated instruments for screening for IPV include specific and direct questions, but the participants reported only being asked generic questions such as, "Do you feel safe at home?" or "Are you in an abusive relationship?" The participants also advised health professionals to show compassion and to tell patients what will happen if they disclose abuse prior to the screening because survivors of IPV are fearful of information getting back to the abuser and of their children being

taken away by child protective services. The survivors also shared graphic stories of abuse during pregnancy, reported that their abuse was worse during pregnancy, and identified an obstetrician/gynecologist's office as the place they would be most comfortable being screened and disclosing IPV.[18]

The purpose of this quality improvement study was to apply the lessons learned from our previous focus groups to: 1) modify a protocol for screening for IPV that is reflective of local survivors' experiences and recommendations; 2) implement the protocol; and 3) evaluate if the modified protocol led to a change in screening or disclosure rates. This study utilized a quality improvement process that uses an iterative process to improve the delivery of healthcare outcomes.[19]

IMPLEMENTATION PROCESS

Current Screening Process

The survivors of IPV in Correa et al's focus group indicated that they would be most comfortable being screened for abuse by and disclosing abuse to OB/GYNs and their staff. As a result we identified a large labor and delivery hospital to partner with to modify and improve the screening process for IPV. We met with nurse leaders and reviewed the screening data from the electronic health record, which revealed that 88% of patients were being screened for IPV and 0.43% were disclosing abuse. Patients and their partners and/or family members would arrive at the hospital and check in at the security desk. In this study, the patients are pregnant women. The security officer would check in both the patient and her partner/family members and provide them with wristbands. As part of the hospital's security protocol, only employees and guests with the wristbands are allowed in the assessment center at the hospital. The security officers would give the expectant mother the intake forms and direct her to the waiting room to complete the forms. The forms included 3 questions on IPV. Next, the charge nurse would call the patient back to the assessment center, and the patient and her partner/family members would go back to the unit.

A review of the current screening process revealed that patients were completing the IPV screening questionnaire in the waiting room and in the presence of their partner and family members, so we decided to

update the IPV screening policy to ensure that patients were being screened alone and in a manner that would make survivors of IPV more comfortable to disclose abuse.

Listening Sessions

Initially we conducted 2 listening sessions with 12 nurses. In these listening sessions, we provided information on IPV and pregnancy, and we asked for their input on the best way to conduct the IPV screening and the best way to isolate the patient before screening. The nurses discussed at length the feasibility of asking the partner to leave the room so they could conduct the IPV screening. While some nurses were supportive of this strategy, the majority said they did not want to ask the partners to leave the room. One of the nurses during the listening sessions suggested that we change the check-in process so only the patient would initially come back to the assessment center. The majority of the nurses were in favor of this arrangement. The nurses also discussed if the screening should be done verbally or on paper. There was no consensus as some nurses said they wanted to screen verbally so they had the opportunity to show compassion and build rapport with the patients, while other nurses wanted to use a paper screening tool.

Development of Modified Screening Protocol

After the 2 listening sessions, we developed a draft protocol and met with leadership from nursing and security to share the proposed protocol for changing the check-in and IPV screening procedures. The nursing and security managers were in favor of the changes and provided us with the necessary approvals to update the protocol.

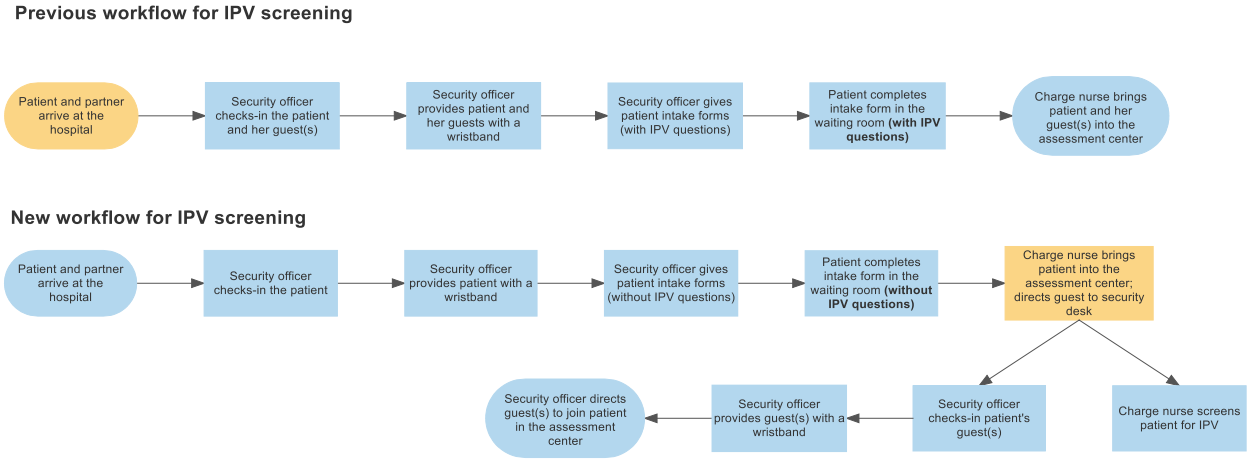
The Modified Screening Protocol

We developed a new protocol for IPV screening to create an environment in which patients would be comfortable disclosing abuse. In the new protocol, the patient and her partner arrive at the security desk to check in. The security officer only checks in the patient. After the check-in process is complete, the security officer gives the patient the intake forms and directs the patient and her partner and/or family to the waiting room. The patient completes the intake form, which no longer includes questions on IPV. Next, the charge nurse calls the patient back to the assessment center and directs the patient's partner to go to the security desk to check

in. While the patient's partner is checking in and the patient is alone with the charge nurse in the assessment center, the charge nurse screens the patient for IPV. The charge nurse has the option of using a paper screen or screening verbally. If the screen is negative, the partner is granted access to the assessment center after they check in. If the screen is positive, the charge nurse counsels the patient about the positive screen and recommends a consult with social work. In these scenarios, the patient decides if and when the partner is granted access to the assessment unit (Figure 1).

To support the change in protocol, we developed step-by-step instructions on how the security guards would check in patients. We also developed sample scripts for the security guards on what to say during the new check-in process. The security managers trained the security guards on the new check-in process and provided the security guards with the new instructions and sample scripts. We updated the intake forms that patients complete in the waiting room and removed the questions on IPV. We created a new IPV screening form to be completed in the assessment center by the charge nurse. We developed new step-by-step instructions for the nurses on bringing the patients back from the waiting room and screening for IPV as well as sample scripts. The sample scripts were developed to help the nurses quickly build rapport with the patients and to explain what would happen if the patient disclosed abuse before the screening occurred. We developed a 30-minute training program on IPV, the new protocol, and what to do if there is a positive screen. We offered the training 6 different times for the nurses to accommodate day, night, weekday, and weekend schedules. Through email and through the nurse and security managers, we communicated our start date to begin the new screening protocol for IPV (Figure 1).

Figure 1. IPV screening workflows



Outcomes from the Modified Screening Protocol

The baseline screening rate for IPV was 88% with a positive disclosure rate of 0.43%. After the change in protocol, the screening rate remained consistent at 88% and the positive disclosure rate increased to 2.5%.

DISCUSSION

By focusing on how IPV screening was being conducted, we were able to achieve a small increase in disclosure rates of IPV in a labor and delivery hospital.

Engaging with Hospital Staff and Leadership

A key to our success in this initiative was our level of engagement with the nursing staff, security guards, and leadership as each group played a critical role. The nursing staff helped develop the protocol and identified how to overcome our biggest challenge of isolating the patient. We also met with security officers, and anecdotally the security guards seemed pleased to be included in an initiative to improve the care and safety of our patients. Leadership also played a key role in communicating to the nursing staff and security officers and in reinforcing the new procedure.

Flexibility

One of the lessons learned during the implementation of this protocol was the need to be flexible to account for individual strengths and preferences while simultaneously standardizing care offered to all patients. For example, during the interviews and focus groups, some of the nurses had very strong opinions on whether the screening should occur verbally or on paper. Some nurses argued that the screening needed to occur verbally as they wouldn't be able to show compassion and develop a rapport with the patient if the screening was on paper. Other nurses strongly voiced that they wanted the screen to be completed on paper, which may be an indication of discomfort with the questions and topic. With our new protocol, we allowed nurses to screen verbally or on paper based on their personal preference. The literature is not clear on which method is better, so we allowed the nurses to screen in a manner that they were most comfortable with.[20]

Communication

The implementation of the new protocol highlighted the importance of communication. On our first day of implementation, there was quite a bit of confusion as some of the security guards and nurses were following the new protocol and others were following the old protocol. We had offered 6 training sessions to all of the nurses to accommodate day, night, weekend, and weekday schedules, and the nurses were informed of the new protocol through their managers and through our emails. The security guards were notified of the new protocol through their staff meetings and through emails with their managers. On the second day, we sent additional emails, we posted signs at the security desk and in the assessment center to remind staff of the new protocol, and we were also onsite to help answer questions and to remind staff of the new protocol. While we thought we had effectively communicated with the staff about the new protocol, it was evident on the first day that we needed more visual cues to serve as reminders of the new protocol.

Limitations

This initiative was part of a quality improvement study. Therefore it was designed to improve the quality of care at this specific hospital and it is unknown if other hospitals would achieve similar results.

In addition, the screening protocol took place in the assessment center for the hospital. During this study we learned that patients with scheduled cesarean sections do not go through the assessment center and as a result are not screened for IPV. While it is expected that hospitals would not be able to screen 100% of patients due to medical emergencies, there is an opportunity to update the protocol to ensure that women with scheduled cesarean sections are also screened for IPV.

CONCLUSION

We updated a labor and delivery hospital's protocol for IPV screening utilizing a quality improvement process, which led to an increase in positive disclosure from 0.43% to 2.5%. While a 6-fold increase is encouraging, a 2.5% disclosure rate is still substantially lower than the estimated prevalence of IPV.[21] While hospitals are encouraged to continue to screen for IPV, efforts to screen for IPV should also incorporate OB/GYN practices. At these practices, staff and providers are able to build rapport with patients and screen multiple times throughout the course of the pregnancy.

This increase in IPV positive disclosure rates was achieved by identifying that best practices such as screening alone and showing compassion were not being done and by updating the screening protocol to align with best practices. This highlights the need of addressing *how* screening is conducted and not just *if* screening is conducted. This finding is timely and relevant as more healthcare organizations incorporate screening for IPV and other social determinants of health into their practices.[22] Healthcare organizations must ensure that screening processes are designed in a manner in which patients are comfortable giving honest responses and that practices are prepared to respond in a helpful and sensitive manner.

REFERENCES

1. US Dept of Justice. Domestic violence. https://www.justice.gov/ovw/domestic-violence. Accessed September 3, 2020.

2. Basile KC, Hertz MF, Back SE. *Intimate Partner Violence and Sexual Violence Victimization Assessment Instruments for Use in Healthcare Settings:Version 1.* Atlanta, GA: National Center for Injury Prevention and Control, Centers for Disease Control and Prevention; 2007.
3. Nelson HD, Bougatsos C, Blazina I. Screening women for intimate partner violence: a systematic review to update the U.S. Preventive Services Task Force recommendation *Ann Intern Med.* 2012;156(11):796-808.
4. Breiding MJ, Chen J, Black MC. *Intimate Partner Violence in the United States--2010*. Atlanta, GA: National Center for Injury Prevention and Control, Centers for Disease Control and Prevention; 2014.
5. Centers for Disease Control and Prevention. Understanding intimate partner violence. Published 2014. Accessed October 2, 2020. http://www.ctcadv.org/files/7914/5322/2538/CDC_IPV_Fact_Sheet.pdf. 2014.
6. Wathen CN, MacMillan HL. Children's exposure to intimate partner violence: impacts and interventions. *Paediatr Child Health.* 2013;18(8):419-422.
7. Campbell JC. Health consequences of intimate partner violence. *Lancet.* 2002;359:1331-1336.
8. US Preventive Services Task Force. Intimate partner violence, elder abuse, and abuse of vulnerable adults: screening (final recommendation statement). https://www.uspreventiveservicestaskforce.org/uspstf/recommendation/intimate-partner-violence-and-abuse-of-elderly-and-vulnerable-adults-screening. Published October 23, 2018. Accessed September 3, 2020.
9. Thackeray JD, Hibbard R, Dowd MD; American Academy of Pediatrics Committee on Child Abuse and Neglect; Committee on Injury, Violence, and Poison Prevention. Intimate partner violence: the role of the pediatrician. *Pediatrics.* 2010;125(5):1094-1100.
10. American College of Obstetricians and Gynecologists Committee on Health Care for Underserved Women. ACOG committee opinion No. 518: intimate partner violence. *Obstet Gynecol.* 2012;119(2, pt 1):412-417.
11. Alvarez C, Fedock G, Grace KT, Campbell J. Provider screening and counseling for intimate partner violence: a systmatic review of

practices and influencing factors. *Trauma Violence Abuse.* 2017;18(5):479-495.
12. Miller E, McCaw B, Humphreys BL, Mitchell C. Integrating intimate partner violence assessment and intervention into healthcare in the United States: a systems approach. *J Womens Health.* 2015;24(1):92-99.
13. Nelson HD, Bougatsos C, Blazina I. Screening women for intimate partner violence and elderly and vulnerable adults for abuse: systematic review to update the 2004 U.S. Preventive Services Task Force recommendation. 2013.
14. Chang JC, Dado D, Hawker L, et al. Understanding turning points in intimate partner violence: factors and circumstances leading women victims towards change. *J Womens Health.* 2010;19(2):251-259.
15. Chamberlain L, Levenson R. *Addressing Intimate Partner Violence Reproductive and Sexual Coercion: A Guide for Obstetric, Gynecologic, Reproductive Health Care Settings.* 3rd ed. Futures Without Violence; 2012.
16. Feder GS, Hutson M, Ramsay J, Taket AR. Women exposed to intimate partner violence: expectations and experiences when they encounter health care professionals: a meta-analysis of qualitative studies. *Arch Intern Med.* 2006;166(1):22-37.
17. Rose D, Trevillion K, Woodall A, Morgan C, Feder G, Howard L. Barriers and facilitators of disclosures of domestic violence by mental health service users: qualitative study. *Br J Psychiatry.* 2011;198(3):189-194.
18. Correa NP, Cain CM, Bertenthal M, Lopez KK. Women's experiences of being screened for intimate partner violence in the health care setting. *Nursing for Women's Health.* 2020;24(3):185-196.
19. Agency for Healthcare Research and Quality. Section 4: Ways to approach the quality improvement process. https://www.ahrq.gov/cahps/quality-improvement/improvement-guide/4-approach-qi-process/index.html. Published November 2015. Last reviewed January 2020. Accessed September 3, 2020.
20. Paterno MT, Draughon JE. Screening for intimate partner violence. *J Midwifery Womens Health.* 2016;61(3):370-375.
21. Smith SG, Zhang X, Basile KC, et al. *The National Intimate Partner and Sexual Violence Survey: 2015 Data Brief--Updated Release.* Atlanta, GA: National Center for Injury Prevention and Control, Centers for Disease Control and Prevention; 2015.

22. Andermann A. Screening for social determinants of health in clinical care: moving from the margins to the mainstream. *Public Health Rev.* 2018;39(19).