

Novice Nurse Intimate Partner Violence Education Through the
Use of a Standardized Patient Experience: A Quality Improvement Project

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Running Head: NOVICE NURSE IPV EDUCATION

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By

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Dedication

This DNP project is dedicated to my husband and children who supported me in all things great and small, celebrated my achievements, and encouraged me when I most needed it.

Acknowledgments

It is with sincere appreciation that I thank my committee members for their time, support and guidance. My deepest thanks go to Dr. Michele Bracken, the chairperson of my committee, who offered encouragement and support, from when this project was just a mere thought through when it came to be something tangible. She was an admirable role model, trusted mentor, and an enjoyable companion! My gratitude also goes to my colleague Kathy Cvach, who shared her unending support, her wealth of knowledge, and her organization skills to implement this project seamlessly. I am also grateful for the enthusiasm of Dr. Voncelia Brown, who supported this project from the beginning and provided much appreciated input.

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Finally, I would like to thank my family, friends and fellow DNP students at Salisbury University who shared their expertise and offered support in many forms.

Perseverance is not a long race; it is many short races one after the other - Walter Elliott

The Spiritual Life: Doctrine and Practice of Christian Perfection, 1918.

Abstract

Problem Statement: Patients experiencing Intimate Partner Violence (IPV) is a serious issue that nearly every nurse will encounter. A lack of training for nurses in IPV screening techniques may lead to ineffective assessment and failure to identify these patients.

Purpose: A quality improvement project to determine the impact of a simulated IPV standardized patient/educational experience on nurse self-reported confidence levels, perceptions and attitudes regarding IPV screening, knowledge of appropriate interventions for those experiencing IPV, and IPV detection.

Methods: A pretest-posttest design was used. Participants were voluntary newly graduated nurses enrolled in a four-hospital novice nurse program. The nurses participated in a live standardized patient (SP) scenario with a male and female couple with the stated purpose to collect a health history on the pregnant female SP. The objective was to recognize that the female SP was a potential victim of IPV. Each nurse debriefed with the SPs and a project team member and all nurses received evidence-based education regarding best practices. Percentages were used for data analysis to evaluate if there were changes in perceptions, attitudes, and knowledge regarding IPV related practices, and open-ended comments were reviewed to enhance quantitative data.

Results: An SP experience resulted in an increase in knowledge, response preparedness and confidence. Cost and logistics will determine sustainability of the program.

Significance: Knowledge and confidence supports effective assessment and identification of patients experiencing IPV which may lead to appropriate interventions and referrals.

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Project Overview

Intimate Partner Violence (IPV) is a serious problem in the United States (US). It is estimated that one out of every four women and one out of every seven men will experience it in some form during their lifetime (Smith, et al., 2017; Wood, 2016). Although nearly every nurse will encounter a patient experiencing IPV, most practicing nurses believe their education did not prepare them for screening or providing interventions for patients experiencing IPV (Connor, Nouer, Speck, Mackey, & Tipton, 2013; Nutt, 2016; Wood, 2016). The novice nurse program at University of Maryland Shore Regional Health (UMSRH), a rural healthcare system on Maryland's Eastern Shore, utilizes classroom and clinical components to transition new nurses into independently practicing nurses. The use of evidence-based practice (EBP) based education and training early in the careers of novice nurses is a possible solution to integrate improved IPV screening knowledge as well as increase confidence and positive perceptions and attitudes regarding IPV screening and interventions into the healthcare system.

Problem Statement

A lack of training for nurses in screening techniques for IPV may lead to ineffective patient assessment and subsequent failure to identify patients who are experiencing IPV. A systematic review judiciously suggests that IPV education with healthcare practitioners is associated with some improvements in some knowledge, attitudes, skills and behaviors (Sawyer, Coles, Williams, & Williams, 2016). The U.S. Preventive Services Task Force (USPSTF) (2016) makes recommendations that childbearing age women are screened for IPV and that women who screen positive are

referred for intervention. The Centers for Medicare & Medicaid Services (2013) includes preventative IPV screening and counseling as one of its free services under the Affordable Care Act. However, universal screening for IPV remains low, with only 2% to 50% of medical professionals reporting that they routinely screen female patients, although selective screening rates may range between 45%-85% (Alvarez, Fedock, Grace, & Campbell, 2016). Only when effective assessments are performed and patients experiencing IPV are identified can appropriate interventions and referrals begin to decrease the harmful effects of IPV.

Purpose

The objective of this project was to determine the impact of implementation of an IPV standardized patient/educational experience on nurse self-reported confidence levels as well as perceptions and attitudes regarding screening for IPV, knowledge of appropriate interventions for those experiencing IPV, and detection of IPV.

PICOT Question

In novice nurses at a rural healthcare system, does the implementation of IPV screening education through use of a standardized patient experience impact nurse self confidence levels as well as perceptions and attitudes regarding IPV screening, detection, interventions, and referrals?

Succinct Synthesis/Analysis of Supporting/Related Literature

A literature search of several databases was conducted to explore the effects of IPV education and training and use of standardized patients (SPs) and patient simulation. The following databases were used: Cochrane Library, Cumulative Index to Nursing and Allied Health Literature (CINAHL), MEDLINE (via EBSCO), ABI/INFORM Global,

Academic Search Complete, WorldCat.org and Google Scholar. Additional studies were found when referenced as a primary source in obtained resources. After multiple revisions, key words included: standardized patient/intimate partner violence/nursing or patient simulation/intimate partner violence/nursing, standardized patient/domestic violence/nursing, patient simulation/domestic violence/nursing, standardized patient/nursing or patient simulation/nursing and intimate partner violence/nursing or domestic violence/nursing.

Inclusion criteria included English language, peer-reviewed and/or scholarly journals, IPV and SP studies involving healthcare related areas of study, nurses, students, and patients, and studies published between 2008 and 2017. Exclusion criteria included studies that used standardized patients as a clinical assessment tool and studies that used mannequins as opposed to live actors. Appendix A illustrates how the Preferred Reporting Items for Systematic Reviews and Meta-Analyses (PRISMA) outlined the literature search process (Liberati et al., 2009). Construction of the Table of Evidence (Appendix B) determined the quality of evidence.

Summary of Evidence

A lack of nurse training in IPV screening techniques and lack of knowledge regarding appropriate interventions may lead to ineffective patient assessment and subsequent failure to identify and successfully assist patients who are experiencing IPV. To decrease the harmful effects of IPV, patients experiencing IPV must be identified and provided with effective interventions and referrals. Use of a standardized patient SP experience has been used as a training method for IPV interventions as well as other medical training.

Significance of the Issue

According to The National Intimate Partner and Sexual Violence Survey it is estimated that nearly 6% of women and 5% of men in the United States have experienced rape, physical violence, and/or stalking victimization by an intimate partner in the past year (Smith, et al., 2017) It is suggested that the annual prevalence of patients in the hospital setting experiencing IPV is close to 16% (DeBoer, Kothari, Kothari, Koestner, & Rohs, 2013). At University of Maryland Shore Regional Health (UMSRH), a survey of direct care nurses found that 60.9% reported they had not identified patients experiencing any type of family violence, including IPV, in the last year (Durham-Pressley, Speroni, Kingan, MacDougall, & Williams, 2018). A similar survey of clinical nurses in the inpatient setting revealed a total of 82.6% of nurses reported caring for 2 or less patients, and 45% reported not caring for any patients, who experienced IPV in the past year (DeBoer, et al., 2013).

IPV has been shown to cause a range of difficulties, from minor health problems to death (Whiting, Liu, Koyutürk, & Karakurt, 2017). The effects of IPV include anxiety, depression, mental health and substance abuse disorders, suicidal ideation, sexually transmitted infections, gynecological issues, gastrointestinal problems, chronic pain, and neurological symptoms (Whiting et al., 2017).

Nurse Barriers to IPV Screening

When it comes to screening for IPV, numerous barriers exist, increasing the need for education and training to remove these barriers (Sprague et al., 2012). Nurses indicate that screening is important, yet they are not identifying patients experiencing IPV, and these nurses perceive a lack of knowledge and confidence regarding IPV and IPV

screening (DeBoer, et al., 2013; Durham-Pressley, et al., 2018). A meta-analysis of 22 studies regarding IPV detection in health care finds both resource and personal barriers to screening; the most frequent resource barriers are time constraint, lack of knowledge, education or training regarding screening, and inadequate follow-up resources (Sprague et al., 2012).

Effectiveness of IPV Screening Education in Nursing Education

Graduate nursing students with IPV training perceived higher preparation and knowledge than those with no previous training and felt better prepared for screening and intervention of patients experiencing IPV (Connor, et al, 2013). Following a SP experience, nursing students stated they felt more confident in assessing for IPV and providing resources (Johnson & Montgomery, 2017). A comprehensive educational program for IPV generated a significant increase in not only perceived knowledge and preparation, but also actual knowledge, with simulation furnishing more powerful results than lecture alone (Wood, 2016). Schlegel, Woermann, Shaha, Rethans, & van der Vleuten (2011) found that the use of SPs in a structured clinical examination is superior to role play and resulted in increases in self-efficacy, and positive ratings in communication training of nursing students was also reported. Caring for an IPV standardized patient can enhance comfort level, with nursing students highlighting the effectiveness of the life like situation; these students and the SPs also reported increased caring and empathy (Thornton & Persuad, 2017). Through the use of standardized patients, actual patient outcomes can be improved with effective screening and intervention (Nutt, 2016).

Effectiveness of IPV Screening Education through Use of Standardized Patients in Healthcare

Support for SPs as an effective IPV training method for social workers was demonstrated by Forgey et al., who, cited increased knowledge of critical IPV assessment content in an empirical setting, and increased proficiency in interviewing skills (Forgey, Badger, Gilbert, & Hansen, 2013). More than 70% of third year pharmacy students, second year physical therapy students, and fourth year nursing students agreed or strongly agreed that they gained insight and a different perspective from working as a team during an IPV SP experience (MacDonnell, George, Nimmagadda, Brown, & Gremel, 2016).

Effectiveness of Education through Use of Standardized Patients in Healthcare

Enhanced communication skills, increased confidence, and improved comfort levels are recurring themes with use of an SP experience (Elley, et al., 2013; Herge et al., 2013; Schlegel, et al., 2012; Shin, Park, and Kim, 2014). Shin et al. (2014) found that post intervention improvements were greater with SPs than traditional learning methods. SP use with medical students helped to develop communication skills, improved confidence and allowed them to better detect depression (Elley, et al., 2013). Bosse (2012) found that when SPs were compared to peer role play (RP), RP seemed to foster more empathy and increased understanding of the patient's perspective and was also less elaborate and more cost effective. However, with dietary students, both SP and RP experiences were comparable for this group, except the SP experience had higher score for gathering of information (Schwartz, Rothpletz-Puglia, Denmark, & Byham-Gray, 2015). For occupational therapy students, there was a high degree of satisfaction with the

SP experience, finding that feedback from SPs enhanced skill performance, self-efficacy, and confidence level, with 100% of students reporting that SPs were useful or very useful (Herge, et al., 2013). However, there is no currently available evidence of how SP training can provide economic benefit and little evidence on the effect on patient outcomes (Kaplonyi et al., 2017).

Effectiveness of SP and IPV Training Transfer to the Clinical Setting

While screening increases the identification of women experiencing IPV in healthcare settings, rates of detection are low compared to the prevalence of IPV, and there is a lack of evidence to support screening in healthcare settings (O'Doherty, et al., 2015). However, contributing to the low rate of detection is the commonly identified barrier of lack of training (DeBoer, et al., 2013). Although results for use of SPs can be inconclusive, when it comes to clinical competency for nurses, it has been determined that up to 50% simulation can be effectively substituted for traditional clinical experience (Hayden, Smiley, Alexander, Kardong- Edgren, & Jefferies, 2014). Williams & Song (2017) also support that the use of SPs improves clinical competence and the acquisition of skills for healthcare practice. Simulated learning is supportive in its contribution to knowledge, skills, safety, but there is a gap in evidence in how it transfers to the clinical setting (Norman, 2012). It has been shown that IPV screening instruction increases confidence and detection, but policies, procedures, and accountability are necessary for maintenance of screening practices (Todahl & Walters, 2011).

Variations in Populations

When it comes to nursing students and IPV training, studies support the use of SPs, which promotes comfort, knowledge, and confidence. There is success suggested

with pharmacy, social work, and physical therapy students. In areas of training outside the area of IPV, there is also evidence of success with SP experiences as well. The literature finds gaps in translating the transfer of the skills gained through the SP experience to the clinical setting.

Variations in Methods Quality

The literature review included peer reviewed sources ranging from non-experimental surveys to randomized controlled trials. Overall, there is general awareness of importance of IPV screening but there continues to be wide variation in how the screening is performed (Williams, Halstead, Salani, & Koermer, 2016). Future implications regarding IPV training for health care practitioners suggest more rigorous methods and validated instruments for its support, as well as a wider target of health care professionals (Sawyer, et al., 2016).

Summary

Nurses recognize the importance of IPV and its impact on population health, yet IPV detection and intervention practices are not optimal. Nurses indicate a lack of knowledge and confidence regarding IPV and IPV screening and intervention practices. Nursing students and those in healthcare related fields express increased knowledge, comfort and confidence with IPV training through the use of SPs and use of SPs is supported in the literature as well.

Conceptual/Theoretical Framework & QI/EBP Model Theoretical Framework

A theoretical framework is an important component for supporting the interpretation of data collected. Adopting a new or improved behavior in an organization is based on more than simply providing evidence to support the change. Rogers (2003)

developed the diffusion of innovations theory, a five-step theoretical approach to the decision-making process. The diffusion of innovations approach can prove to be helpful when implementing an evidenced based organizational change (Melnyk & Fineout-Overholt, 2015). Rogers (2003) explains innovation as an idea, practice or object that is considered to be new, and through diffusion this innovation is communicated through the social system over time. Knowledge is the first exposure to the practice, and then in the second stage of persuasion the individual becomes interested regarding the advantages of the practice (LaMorte, 2016). LaMorte (2016) continues that in the third stage, decision, the individual discerns whether to use the practice, then in stage four, implementation, the individual starts using the practice, and finally through confirmation the individual decides to continue using this practice. Adopting the practice means that the individual does something differently than what they had done previously (Rogers, 2003).

Individuals will move through the bell-shaped curve process at different rates, depending upon whether they are innovators, early adopters, early majority or late majority, or laggards (Melnyk & Fineout-Overholt, 2015, pp. 322-323). Targeting receptive individuals is an essential area of focus until the innovation becomes standard practice (Melnyk & Fineout-Overholt, 2015, pp. 322). Adoption is also influenced by the perception that the innovation is better than what it replaces, if it is compatible with the adopters, how complex the innovation is, as well as the extent that it can be tested and tangible results are observed (LaMorte, 2016). Using the diffusion of innovations theory, this IPV standardized patient and educational experience with novice nurses was implemented. Use of Rogers' key attributes of trialability, advantage, compatibility, observability, and simplicity helped to define the aspects of this project (Geibert, 2006).

This project took place with a cohort of 17 novice nurses at UMSRH. One of the key components of the diffusion of innovations theory is trialability, which aims to initially undertake the intervention on a small scale (Geibert, 2006). The pretest-posttest design with a qualitative component addressed Rogers's attribute of advantage by inquiring if the practice is important and if it will make things better (Geibert, 2006). The attribute of compatibility asks if the practice will work in the system's environment and culture (Geibert, 2006). The implementation of this experience in the nurse's work environment and practical solutions for the hospital's setting facilitated this attribute. Nurses can help identify and intervene with patients experiencing IPV if they are aware of and understand its forms, causes, prevalence, effects and manifestations, and are also aware of their own attitudes (Ali, McGarry, & Dhingra, 2016). The SP experience, debriefing process, and educational process assisted in this awareness and understanding. Ali et al. (2016) also recommends that nurses should also be aware of the organizations' policies and available services, and these were included in the educational session. The education also addressed Roger's attributes of observability and simplicity (Geibert, 2006). This was accomplished by providing education regarding of the signs and symptoms of IPV, evidence-based IPV screening practices, and awareness regarding the availability of appropriate resources.

Evidence-Based Practice Model

The Academic Center for Evidence-Based Practice (ACE) Star Model of Knowledge Transformation is a framework for understanding the relationships between stages of knowledge transformation and the usefulness of several forms of knowledge in the decision-making process (Melnyk & Fineout-Overholt, 2015). The five main stages

of knowledge transformation are (1) discovery research, (2) evidence summary, (3) translation into guidelines, (4) practice integration and (5) process, outcome evaluation (Stevens, 2012). The goal of this model is knowledge transformation, which aims to convert research findings in a manner that will positively impact patient outcomes, and patient safety through evidence-based care (Stevens, 2012).

Star point 1: Discovery research. During the first stage of knowledge transformation, new research is generated, the findings of which serve as the basis for EBP guideline development (Melnyk & Fineout-Overholt, 2015; Stevens, 2012) These findings can be descriptive, correlational, or causal in nature and can range from randomized control trials to qualitative findings (Stevens, 2012). The use of primary research is essential in developing the most effective standardized patient experience related to IPV and educating nurses.

Star point 2: Evidence summary. Prior to implementing EBP, a comprehensive review of the most current evidence is performed. The comprehensive review allows large amounts of information to be manageable and supports generalizability across participants, settings, and study designs while increasing power in the relationship of cause and effect (Stevens, 2012). It can also drive decisions regarding nursing care, economic decisions, and formation of policies and procedures (Stevens, 2012). For this project, a literature review was completed utilizing IPV and SP studies involving healthcare related areas of study including nurses, students, and patients.

Star point 3: Translation to guidelines. During the third step of the model the evidence is transformed into actual practice through two stages, translation of evidence into practice recommendations, followed by integration into practice (Stevens, 2012).

The objective of this step is to provide useful and applicable evidence that is timely, cost effective and allows for appropriate care (Stevens, 2012). This evidence guides the implementation of the SP intervention and educational experience.

Star point 4: Practice integration. This step involves formal and informal change of both individual and organizational practices (Stevens, 2012). Through this integration, the evidence is put into action (Melnyk & Fineout-Overholt, 2015). During the described practice integration the IPV standardized patient/educational experience was implemented with the novice nurses.

Star point 5: Process, outcome evaluation. Evaluation measures the impact of the EBP based intervention on health care quality, as well as the effects on patient outcomes, provider and patient satisfaction, and ultimately health status (Melnyk & Fineout-Overholt, 2015; Stevens, 2012). Through descriptive statistics and qualitative comments, analysis of results determined the effectiveness of the experience and support that knowledge transformation has occurred.

Project Design

This QI project design incorporated a practice intervention as well as an educational intervention, which has the potential to lead to a process improvement. This experience utilized trained actors to present a realistic IPV situation in a safe environment, followed by individual nurse debriefing and evidence-based education regarding best IPV practices. It used both quantitative and qualitative responses to obtain the data to determine the effectiveness of the project.

Project Population

Participants in this project were novice nurses who were enrolled in the novice nurse program at UMSRH. Novice nurses are newly graduated nurses who enrolled in a program to facilitate transition into practice as a registered nurse following completion of nursing school. Novice nurses receive full benefits and pay while receiving classroom instruction as well as simulation and clinical orientation in a safe and supervised environment (Kram & Wilson, 2016). The one-year post-hire retention rate for these nurses is 95% (Kram & Wilson, 2016). The sample size was 17 novice nurses (100%). Participation in this SP experience was completely voluntary; participants were informed that they could conclude their participation in the experience at any time. The pilot project was expected to last approximately one year or less, and the active portion of the project ended on August 29, 2018 when post experience surveys were collected.

Setting

UMSRH is a regional, nonprofit, medical delivery care network that serves the Mid-Shore region, which includes Caroline, Dorchester, Kent, Queen Anne's, and Talbot counties. Novice nurses from four hospitals participated: University of Maryland Shore Medical Center at Chestertown, University of Maryland Shore Regional Health at Dorchester, University of Maryland Shore Regional Health at Easton and the University of Maryland Shore Emergency Center at Queenstown. This experience took place specifically at University of Maryland Shore Regional Health at Easton. The standardized patient experience was completed in a simulated hospital room, individual debriefing took place in one of two private offices, and education occurred in a classroom setting. A Strengths, Weaknesses, Opportunities, and Threats (SWOT) analysis (Appendix C)

reveals that a need had been shown for improvement in IPV screening knowledge and processes in this hospital system, and there was potential to improve utilization of existing resources. The SWOT analysis supported the existence of a vague understanding of the prevalence of domestic violence and a lack of awareness that domestic violence is a major health care concern in the mid-shore community. The project was deemed exempt by the University of Maryland IRB (Appendix D) and the Salisbury University IRB (Appendix E) before implementation. A letter of collaboration was obtained by the Chief Nursing Officer of UMSRH (Appendix F). A timeline was set for the project from start to completion (Appendix G).

Intervention

The novice nurses participated in a standardized patient experience during their classroom hours. They were provided a patient scenario, which they had 15 minutes to review before interacting with the standardized patients. They waited in an open lounge area and were escorted to the hospital room simulation center at UMSRH. In this scenario, the nurse was asked to assist by completing a health history on a patient. The objective of this experience was to recognize that the female SP was a potential victim of IPV and that the nurse would take the opportunity to address this appropriately with the patient. After each nurse had participated in the simulation, they had the opportunity to debrief with the SPs and a member of the project team. After all nurses completed the SP experience, they met the following morning and received an evidence-based educational session regarding best practices for interacting with IPV patients.

The nurses received the following information:

You are being pulled by the nursing supervisor to the Labor and Delivery floor to provide assistance as they are currently experiencing an overwhelming influx of patients. You will assist with a patient who is waiting to begin induction of labor. Unfortunately, the electronic medical record (EMR) has also unexpectedly gone offline so you will be provided with a paper copy of the patient's record. You are being asked to help by assessing pain/comfort, and then review the patient's health history. You will not be completing a physical exam. You will have 15 minutes to complete your own assessment, and after all nurses have completed their assessments we will reconvene and discuss the experience. You are asked to not share your experience with your peers until the group meets as a whole.

In this scenario, the SP was a visibly pregnant female with a history of one previous birth who was estimated to be a week past her due date. She had information in her record including missed visits, recent falls, and being kicked by a horse. This female SP had a bruise on her cheek and finger shaped bruising on her arm. She was accompanied by a second SP acting as her controlling male spouse. The intended result was not completion of the assessment, but rather provision of a hands-on realistic experience for assimilating the information that was provided during the educational component.

The classroom educational component (Appendix H) included:

- Defining IPV;
- IPV trends in United States and locally;
- Risk factors for violence against a spouse or significant other;
- Why victims stay with the abusive partners;

- Why victims of IPV are not identified in the healthcare system;
- Ways to create a safety plan;
- How to do a risk assessment and initiate an intervention or treatment plan;
- The hospital system's policies and procedures.

The educational program also provided best practices for screening for IPV and effective interventions including signs and symptoms of IPV and the availability of appropriate resources to seamlessly integrate effective IPV screening into nursing practice. All participants were asked to complete three anonymous pen and paper surveys: the pretest survey (Appendix I) and posttest survey (Appendix J) to elicit responses regarding how this experience has impacted their perception and attitudes regarding IPV knowledge, screening and interventions, and one additional survey (Appendix K) was administered to evaluate the effectiveness of the standardized patient experience.

Tools

The standardized patient experience was assessed for effectiveness using the SET-M (Appendix K), a Likert scale tool with one comment box. The Set-M is a modified version of the Simulation Effectiveness Tool (SET) with internal consistency to evaluate Prebriefing ($\alpha = .833$), Learning ($\alpha = .852$), Confidence ($\alpha = .913$), and Debriefing ($\alpha = .908$). The overall internal consistency reliability was good ($\alpha = .936$) (Leighton, Ravert, Mudra, & Macintosh, 2015).

Results regarding nurse attitudes and perceptions were assessed via two nearly identical attitude and perceptions surveys. The differences define one as a pretest (Appendix I) and one as a post test (Appendix J). These surveys, based on a survey previously used at UMSRH with employed nurses, was intended to solicit quantitative

and qualitative responses using the nurses self-reported perceptions and attitudes. The nurse researchers in the study from which the survey was obtained developed and validated the study survey which yielded a satisfactory item-level and scale content validity index of 1.0 (Durham-Pressley, et al., 2018).

Data Collection, Handling and Confidentiality

Data were collected anonymously from the SET-M and the attitudes and perceptions surveys. Data were organized into table shells based on participant responses. Confidentiality was ensured as data were made available only to the project team members and was stored in a locked area and on a password-protected computer. Data were reported in aggregate and no demographics were collected to protect anonymity. Descriptive statistics for all data collected were presented in summary. No recordings were made. Data will be locked and stored for three years from the date of completion of this project.

Risks/Benefits

The risks and discomforts presented in the standardized patient experience were anticipated to be less than would be encountered in a real-life patient experience as it took place in a safe environment and the nurses were informed before beginning that they may exit any portion of the pilot at any time. Due to the sensitive nature of the topic, a behavioral health nurse was on site during the SP experience and education session if any nurse participant would require additional support. The risks or discomforts during the educational session via a practical PowerPoint presentation and fact driven handouts were no greater than would be encountered in a normal classroom setting. There was a possible loss of confidentiality due to the small number of participants. To mitigate risks, data

were reported in aggregate. It was anticipated that the participants obtained experience with patient care and had the opportunity to gain additional knowledge in the classroom setting. Participation allowed for the opportunity to assess the effectiveness of the standardized patient experience and education.

Regulatory Considerations

This project was conducted in accordance with the ethical principles that have their origin in the Declaration of Helsinki and that are consistent with good clinical practices and the applicable laws and regulations. No project-related procedures were performed prior to approval as a Quality Improvement Project by the University of Maryland IRB and Salisbury University IRB.

Project Implementation

The project was implemented as illustrated in the project timeline (Appendix G). The impact of the experience was assessed through the use of quantitative measures and qualitative measures were also used to verify the nurse perceptions of the experience.

Barriers and Facilitators

One potential barrier was that one of the two novice nurse instructors was not completely supportive regarding the novice nurse participation in this project, as she expressed discomfort with the novice nurses participating in a blind experience. This did not have any impact on novice nurse participation. Another barrier for this project was technical in nature. A web camera had been purchased for this intervention to observe unrecorded nurse interaction for debriefing purposes, but the hospital Wi-Fi was not able to support this camera without being hardwired. An alternative streaming web cam without recordings was used for observation only, but the sound quality was poor. At the

time when the proposal was written, the schedule was unknown for the novice nurses and the time span of five days between the pretest survey and posttest survey was likely too close together to provide useful data. These novice nurses had also not experienced any time working as independent nurses in the hospital system; results relating to their perceptions regarding IPV may have been impacted by only experiencing classroom training. However, this time frame was the only time that all nurses were available in the same setting to allow for participation in this project.

There were multiple facilitators for this project. The process of rotating the nurses from the classroom to the waiting area to the simulated patient room went smoothly, with enhancement by ideal locations of these three areas and a sufficient number of team members to guide the participants. The nurse instructors for the novice nurses were unaware of the nature of the project, ensuring that the participants were not clued in ahead of time. The debriefing process proved efficient in utilizing the rotation of three experienced nurses, including this investigator, who were also team members for this QI project.

Summative Evaluation of Implementation Process

The objective of this project was to determine the impact of implementation of an IPV standardized patient/educational experience on nurse self-reported confidence levels, perceptions and attitudes regarding screening for IPV, knowledge of appropriate interventions for those experiencing IPV, and detection of IPV. This project used trained actors that were paid through funding from the Memorial Hospital Foundation. This pilot project was reviewed by the University of Maryland IRB and Salisbury University IRB and deemed to be exempt by both boards.

Participants were newly graduated registered nurses in the novice nurse program at UMSRH, a rural healthcare system. A pretest-posttest survey design of attitudes and perceptions relating to IPV with a qualitative component and additional post experience evaluation of the standardized patient experience was used. The pretest survey was given to the nurses at the beginning of their program and all 17 (100%) returned the surveys within four days on their first day of classroom orientation. The intervention, completed four days following the pretest survey, consisted of a standardized patient experience with trained actors to expose the novice nurse to a realistic IPV situation in a safe environment. This was followed by an individual debriefing immediately after the experience. To meet the project design specifications allowing the experienced nurse evaluators to view the novice nurse interaction with the SPs and provide individualized feedback, the debriefing was completed in rotation.

The morning following the SP experience, an evidence-based educational session described best practices when encountering an individual experiencing IPV. All 17 (100%) of the participants had completed the pretest survey prior to the experience. All 17 (100%) of the participants completed the SET-M evaluation tool following the education session. One anonymous participant of the 17 novice nurses declined to complete the posttest survey.

The sample size was anticipated to be 100% of the novice nurses with an expectation of 15-20 nurses. The number of novice nurses in the cohort was 17 and all participated in this standardized patient experience. Participation was completely voluntary; participants were informed they may conclude their participation in the experience at any time. There was one nurse that was unsure if she wanted to participate

in the actual experience with the SPs, but she decided to do so and commented afterwards that she was glad that she did participate.

The project timeline (Appendix G) outlined the individual steps to complete the project. During the debriefing, multiple participants commented that the actors were realistic, with all participants agreeing that the debriefing process contributed to learning. During the education session, nurses were provided packets that included a copy of the PowerPoint for future reference, hospital policies and procedures, sample abuse screening tools, copy of a lethality assessment, a form to create a safety plan, and several flyers for the local council on family violence.

Analysis and Discussion of Findings

This QI project was followed by the Shore Regional Health Research Council. The results of the pilot have been shared with the Shore Regional Health Nurse Executive Committee with recommendations and data to support the continuation of this project in future novice nurse programs. The Professional Nursing Practice Department has followed the project and has been provided with the findings to support permanent inclusion in the novice nurse program. As IPV can occur with any patient encountered by nurses, this project could prove beneficial in any healthcare setting. An added future consideration is the implementation of this QI project as an official research project to continue to contribute to knowledge to this important topic.

The target population has been reached by this QI project. The participants were actively involved in the SP experience and debriefing but less engaged in the educational process. This supports that a simulated experience motivates a participant's autonomy

and centeredness and allows them to feel connected to the experience, perhaps more so than in a classroom setting (Walters, Potetz, & Fedesco, 2017).

Participants commented on the effectiveness of a simulation to provide a safe space to practice skills with feedback from actors, which enhanced understanding of how to respond to situations in which IPV may exist. One participant commented, “It helped me understand how to better handle situations in which IPV is present.” These nurses also commented on the effectiveness of having a simulated interaction to give them knowledge surrounding how to react to IPV in a real-life situation. A suggested area for improvement was to provide education regarding IPV before the SP experience. This is illustrated by one nurse comment, “I felt we shouldn't have done it this early and to get more information in the beginning.” Another nurse comment countered this statement by stating, “Provided excellent learning and real-life experience for a situation where many of us had no prior interactions as such. Wish we had more simulations like yesterday's situation in nursing school.” This comment echoes research that indicates that IPV related education is a valuable piece to be included early on in a nurse’s career, supporting the inclusion of a program such as this for nursing students as well as novice nurses (Connor, et al. 2013).

This QI project was intended to evaluate output of the effectiveness of a SP experience and IPV education for nurses. This involved planning and managing this project for 17 novice nurses, and the ability to measure the effectiveness through the use of pretest-posttest surveys and an evaluation tool. These planned outcomes, objectives, and goals were achieved, and data indicates that this project has been beneficial to novice nurses.

Educational needs are identified as a key component of lack of IPV screening (Crombie, Hooker, & Reisenhofer, 2017). The literature revealed that nurses reported little to no IPV training during their nursing education (Connor, et al., 2013; Wood, 2016). Prior to this QI Project, none of these newly graduated nurses reported receiving IPV education in the past year (Table 1).

Table 1

Intimate Partner Violence (IPV) Pre-test Polar Questions 1-4, 22, 25 Responses, n=17

	Yes	No
1. Feel that <i>two questions</i> , when asked during the evaluation/admission process, allow adequate identification of a patient positive for IPV	71% (12)	29% (5)
2. Would modify the questions asked to better detect patients experiencing IPV	82% (14)	18% (3)
3. Would include additional questions in the admission database to allow adequate identification of a patient positive for IPV	41% (7)	59% (10)
4. Would include additional assessments/screenings in the admission database to allow adequate identification of a patient positive for IPV	59% (10)	41% (7)
22. Completed/received additional IPV education in the past year	0	100% (17)
25. Has recommendations for nurses to better detect patients experiencing IPV	65% (11)	35% (6)

After the intervention, only 50% (8) stated that the current process was effective (Table 2). Before the SP experience, 18% (3) indicated they would modify the questions, but afterwards, 31% (5) would modify the questions, with an additional 25% (4) of nurse participants suggesting to not modify but add additional methods of assessment (Table 1; Table 2). These results support that the SP experience allowed novice nurses to acquire knowledge of additional methods of screening for IPV. One nurse expressed, “I feel that

nurses need more training in IPV so we know what to ask the patient and how to handle the partner if they are present during the assessment/interview.”

Before the intervention, 71% (12) felt that the current questions used to assess for IPV allowed them to identify a patient positive for IPV (Table 1). A similar level of agreement with the adequacy of the same questions, 69.5%, was seen in staff nurses in a survey at the same facility in relationship to family violence, yet greater than 60% of nurses in this study had not identified any patients experiencing family violence in the previous year. (Durham-Pressley et al, 2018).

Table 2

Intimate Partner Violence (IPV) Post-test Polar Questions 1-4, 22, 25 Responses, n=16

	Yes	No	Did Not Respond
1. Feel that <i>two questions</i> , when asked during the evaluation/admission process, allow adequate identification of a patient positive for IPV	50% (8)	50% (8)	0
2. Would modify the questions asked to better detect patients experiencing IPV	63% (10)	31% (5)	6% (1)
3. Would include additional questions in the admission database to allow adequate identification of a patient positive for IPV	38% (6)	50% (8)	12% (2)
4. Would include additional assessments/screenings in the admission database to allow adequate identification of a patient positive for IPV	50% (8)	38% (6)	12% (2)
22. Completed/received additional IPV education in the past year	0	100% (16)	0
25. Has recommendations for nurses to better detect patients experiencing IPV	50% (8)	50% (8)	0

Results of the SET-M tool indicated that 59% (10) of the respondents strongly agreed they were better prepared to respond and 41% (7) felt somewhat prepared to

respond after the SP experience, with the same number of nurses agreeing that they had the opportunity to practice their clinical skills (Table 3).

Table 3

Simulation Effectiveness Tool - Modified (SET-M) Scenario Responses, n=17

	Strongly Agree	Somewhat Agree	Do Not Agree
I am better prepared to respond to changes in my patient's condition.	59% (10)	41% (7)	0
*I developed a better understanding of the pathophysiology.	44% (7)	44% (7)	12% (2)
I am more confident of my nursing assessment skills.	53% (9)	41% (7)	6% (1)
I felt empowered to make clinical decisions.	12% (2)	76% (13)	12% (2)
**I developed a better understanding of medications. (Leave blank if no medications in scenario.)	1	0	1
I had the opportunity to practice my clinical decision-making skills.	59% (10)	41% (7)	0
I am more confident in my ability to prioritize care and interventions.	47% (8)	47% (8)	6% (1)
I am more confident in communicating with my patient.	70% (12)	24% (4)	35% (6)
I am more confident in my ability to teach patients about their illness and interventions.	12% (2)	76% (13)	12% (2)
*I am more confident in my ability to report information to the health care team.	44% (7)	37% (6)	19% (3)
I am more confident in providing interventions that foster patient safety.	59% (10)	35% (6)	6% (1)
I am more confident in using evidence-based practice to provide nursing care.	23% (4)	71% (12)	6% (1)

*One participant did not answer this question.

** Most participants did not answer this question.

When it came to confidence in prioritizing care and interventions, 94% (16) strongly agreed to somewhat agreed to confidence in this area (Table 3). Seventy percent (12) strongly agreed to confidence in communication with the patient (Table 3).

Table 3 shows that the majority of nurses, 76%, somewhat agreed with feeling empowered to make clinical decisions and confident in the ability to teach patients about their illness and intervention, supporting a need for additional education in these areas. All nurse participants but one agreed they were strongly or somewhat confident in fostering patient safety. One participant summed up the experience by stating, “It was a good learning opportunity. It's better to have some experience whether it's simulated or not than to go out and have a patient and not know what to do. As a new RN it helped me learn what to do and how to act. The actors were great and it was very realistic.”

Table 4

Simulation Effectiveness Tool - Modified (SET-M) Debriefing Responses, n=17

	Strongly Agree	Somewhat Agree	Do Not Agree
Debriefing contributed to my learning.	100% (17)	0	0
Debriefing allowed me to verbalize my feelings before focusing on the scenario.	94% (16)	6% (1)	0
Debriefing was valuable in helping me improve my clinical judgment.	88% (15)	12% (2)	0
Debriefing provided opportunities to self-reflect on my performance during simulation.	94% (16)	6% (1)	0
*Debriefing was a constructive evaluation of the simulation.	94% (15)	6% (1)	0

*One participant did not answer this question.

Debriefing was a crucial component for the QI project, as seen in Table 4 with 100% strongly agreeing that debriefing contributed to their learning. Eighty-eight percent strongly agreed that debriefing helped to improve their clinical judgement, and 12% somewhat agreed. One nurse stated, “Simulation created a safe space to practice skills with feedback from actors.” Verbalization of feelings and self-reflection was evident with 94% of respondents strongly agreeing to both attributes.

Participants did not report they were confident going into the scenario; 76% (13), somewhat agreed to an increase in confidence with prebriefing, but nearly half 47% (8) agreed that prebriefing was beneficial to their learning (Table 5). The design of the project with the presentation of an unknown situation likely leads to the lack of confidence yet a report of usefulness to the learning process. One participant commented, “Wasn't expecting the scenario to be about violence until the assessment portion and making patient introductions. Was an eye-opening experience.”

Table 5

Simulation Effectiveness Tool - Modified (SET-M) Prebriefing Responses, n=17

	Strongly Agree	Somewhat Agree	Do Not Agree
Prebriefing increased my confidence.	12% (2)	76% (13)	12% (2)
Prebriefing was beneficial to my learning.	47% (8)	47% (8)	6% (1)

An attainable goal from this type of intervention and education is that every nurse asks every time about IPV and has the knowledge to ask effectively and to be able to provide appropriate resources. Even after the project was completed, one nurse illustrated the further need for knowledge, resources, and IPV prioritization by hospital systems. She commented, “since I am unaware of the current policies and was not able to get clarity on what occurs with the data collected outside of the nurse responsibility to link the patient with proper resources, it is difficult to make further recommendations.” Through improvement of hospital policies, procedures, screening processes and provision of IPV education opportunities it is still possible to intervene and improve the health of patients and provide interventions to manage this difficult and complex issue.

From an administrative, organizational, and/or personnel perspective the implementation of this project required significant and perhaps serendipitous coordination, ranging from use of the hospital facility, availability and organization of novice nurses, funding to support the project, and committee members to assist in implementing the project. The project team participated out of personal interest with substantial time commitment in addition to their normal responsibilities. Implementation of this type of program as an integral part of the novice nurse program requires dedication and planning. For project sustainability, allotment of time for developing and participating in a simulation experience in addition to current responsibilities is a necessity. As the novice nurse program is under reorganization, this could either positively or negatively impact the inclusion of the SP experience in future cohorts. Cost for updated equipment and payment for all participants is also a challenging factor.

In relationship to dissemination of information, there have been multiple barriers related to events at UMSRH that have led to cancelled committee and council meetings. The implementation of a new electronic medical record (EMR) has led to changes in the screening process for IPV, with the current EMR providing less prompting for IPV screening. This suggests that there may be an even greater need for nurse IPV training. One nurse sums up fuel for motivation to continue this program with any type of nurses, “Was glad to be able to do the simulation. Never had any situational exposure before and was glad I could react appropriately in the situation - please reuse this scenario.”

Nurses are in a unique position to assess and identify occurrences of IPV as they function in multiple settings throughout healthcare and the community. One nurse illustrated this opportunity that nurses possess by stating “Talk to the patient privately,

get answers from the patient, advocate for the patient, gain their trust.” Subsequent follow up in the form of physical and emotional assessments, safety planning, and suitable referrals can have the opportunity to occur if nurses possess knowledge related to IPV screening and interventions. An experience such as this early on in a nurse’s career can foster improvement in attitudes, skills, and knowledge that could potentially continue through the nurse’s career (Connor et al, 2013; Sawyer et al., 2016).

Dissemination Plan

Results of this project have been shared with the UMSRH Research Council and the UMSRH Nurse Executive Committee. Conversion of this DNP project to a manuscript will be considered for publication in a peer-reviewed journal, as well as poster and podium presentations at regional and national conferences and professional meetings.

Summary

This quality improvement project examined the effects of a standardized patient experience and educational intervention on attitudes, skills, and knowledge held by nursing students. Generalizability of the findings is limited due to the small sample size and rural population, but the findings support positive change in nurse self confidence levels as well as perceptions and attitudes regarding the difficult circumstances surrounding IPV screening, detection, interventions, and referrals. It is anticipated that the procedures for this QI project can be used for both continued implementation of this intervention as well as for further research to evaluate this type of standardized patient experience.

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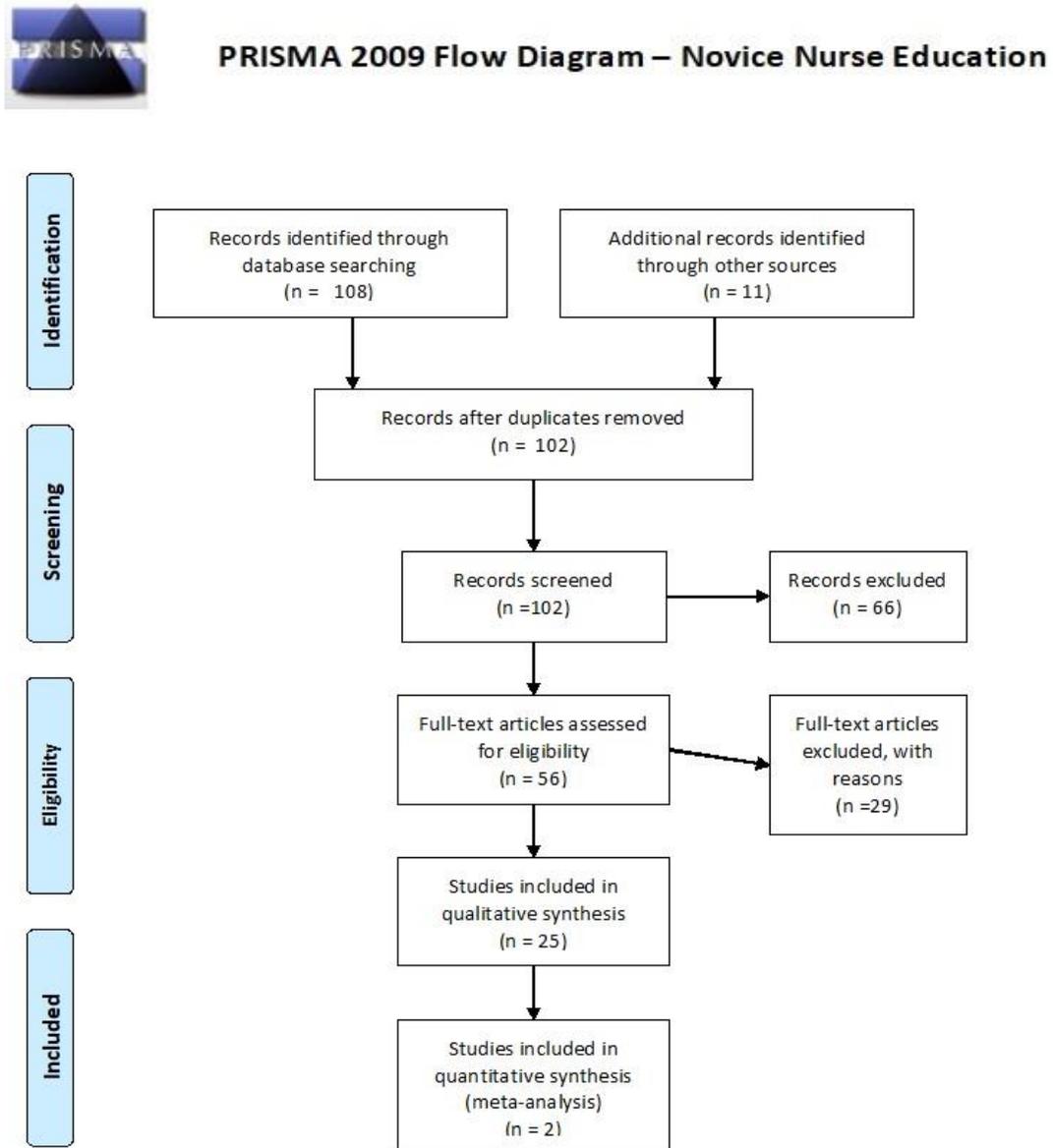
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Appendices

Appendix A: Prisma Diagram



From Moher, D., Shamseer, L., Clarke, M., Ghersi, D., Liberati, A., Petticrew, M., ... & Stewart, L. A. (2015). Preferred reporting items for systematic review and meta-analysis protocols (PRISMA-P) 2015 statement. *Systematic reviews*, 4(1), 1

Appendix B: Table of Evidence

Citation	Conceptual Framework	Design & Method	Sample & Setting	Major Variables Studied	Measurement of Major Variables	Data Analysis	Study Findings	Strength & Quality of Evidence
Bosse, Schultz, Nickel, Lutz, Möltner, Jünger, J., ... & Nikendei (2012) The effect of using standardized patients or peer role play on ratings of undergraduate communication training: a randomized controlled trial <i>Patient Education and Counseling</i>	To compare role play, which is convenient, and standardized patients, which are more expensive	Randomized Controlled Trial	103 fifth year medical students of the University of Heidelberg Role Play (34) standardized patients (35) Control (34)	Self-efficacy, objective communication	Pretest-posttest questionnaires, The Calgary-Cambridge-Observation-Guide Checklist	Analysis of variance, Multivariate analysis or variance chi-square tests, post-hoc tests, Cohen's d.	Both increase self-efficacy. Peer role play seems to foster more empathy and increased understanding of the patient's perspective, was less elaborate and costs less	II-B
Connor, Nouer, Speck, Mackey, & Tipton (2013) Nursing students and Intimate Partner Violence education: improving and integrating knowledge into health care curricula <i>Journal of Professional Nursing</i>	To measure Intimate Partner Violence curriculum content experience knowledge, attitudes, beliefs, and prevalence in programs	Non-experimental survey	52 Doctorate of Nursing Practice and Doctor of Philosophy nursing students	Intimate partner violence education exposure; Perceived Preparedness, Perceived Knowledge, and Actual Knowledge; and intimate partner violence prevalence for these students	Adaptation of the Physician Readiness to Manage Intimate Partner Violence Survey	Mann-Whitney U tests Exploratory multivariable and logistic regression analyses	Nursing students with Intimate Partner Violence training had higher perceived preparation and knowledge, 40% of students reported experiencing Intimate Partner Violence	III-B
DeBoer, Kothari, Kothari, Koestner, & Rohs (2013) What are barriers to nurses screening for Intimate Partner Violence? <i>Journal of Trauma Nursing</i>	To identify nurse attitudes and perceived barriers to screening	Descriptive study, web-based survey	156 nurses at a level I trauma center	Nurses' attitudes and perceived barriers to screening.	cross-sectional survey study of hospital-based nurses from a 450-bed level I trauma center. Survey Monkey	Descriptive data	Nurses feel screening is important, yet are not identifying patients experiencing Intimate Partner Violence	III-B
Durham-Pressley, Speroni, Kingan, MacDougall, & Williams (2018) Nurse perceptions of the family violence screening process and education program in a rural healthcare system <i>Nursing2018</i>	To identify rural nurse attitudes and perceived barriers to screening	Descriptive study, web-based survey	128 nurses in a rural hospital system	Nurse attitudes and perceived barriers to screening	Adapted nurse designed survey	Descriptive data	Nurses feel screening is important, yet are not identifying patients experiencing Intimate Partner Violence	III-B
Elley, Clinick, Wong, Arroll, Kennelly, Doerr, ... & Kerse (2012) Effectiveness of simulated clinical teaching	To assess the effectiveness of standardized patient clinics compared to	Random Controlled Trial, students in standardized patient group (24 consults),	128 urban general practice medical students in New Zealand 63 randomized, 65 control	Self-rated knowledge of services, confidence, attitudes and communication skills, experience	Pre-existing questionnaires "that had been used in previous years"	Means and standard deviations Univariate analysis of variance.	Standardized Patients help develop communication skills, improve confidence, but	I-B

in general practice: randomized controlled trial <i>Journal of Primary Health Care</i>	standard clinics	students in community group (variable number of real patients)		and confidence in managing conditions and skills			confidence improves more with real patients	
Forgey, Badger, Gilbert & Hansen (2013) Using standardized clients to train social workers in Intimate Partner Violence assessment <i>Journal of Social Work Education</i>	To evaluate the effectiveness of an evidenced based Intimate Partner Violence training program for social workers	Knowledge pre and posttest, videotaped pre and post assessment interviews	8 social workers	Value of using SCs to train and evaluate social workers in IPV assessment.	Written knowledge pretest and posttest and videotaped pretest and posttest assessment interviews	Atlas.ti, a qualitative research data analysis software system. Paired t tests	Standardized clients are an effective training method.	III-B
Hayden, Smiley, Alexander, Kardong-Edgren, & Jefferies (2014) The NCSBN national simulation study: A longitudinal, randomized, controlled study replacing clinical hours with simulation in pre-licensure nursing education <i>Journal of Nursing Regulation.</i>	To determine if simulation is sufficient and how it compares to classroom experience, provide evidence on nursing knowledge, clinical competency, and the transferability of learning from the simulation laboratory to the clinical setting	Comparison on study using a randomized, controlled, longitudinal, multisite design	666 nursing students	students' knowledge, competency, and critical thinking as well as their perceptions of how well their learning needs were met.	Creighton Competency Evaluation Instrument (CCEI), the New Graduate Nurse Performance Survey (NGNPS), and the Global Assessment of Clinical Competency and Readiness for Practice.	Basic descriptive statistics Parametric and nonparametric tests Multivariate analysis of variance (MANOVA)	Up to 50% simulation can be effectively substituted for traditional clinical experience	I-A
Herge, Lorch, DeAngelis, Vause-Earland, Mollo, & Zapletal (2013) The standardized patient encounter: A dynamic educational approach to enhance students' clinical healthcare skills <i>Journal of Allied Health</i>	To evaluate if Standardized Patient experience is a viable teaching method	25 min Standardized Patient experience, feedback from Standardized Patients, complete surveys, group debriefing, graded report by faculty	69 occupational therapy students at Thomas Jefferson University	Self-rated perception of experience, skills, standardized patient feedback, informal discussion	Survey of unknown origin. Guided debriefing, no Cronbach alphas	Descriptive Statistics, percentages	High degree of satisfaction, feedback from Standardized Patients enhanced skill performance, self-efficacy, and confidence level, 100% of students reported Standardized Patient was useful/very useful	III-C
Johnson & Montgomery (2017) Improving nursing students' comfort dealing with Intimate Partner Violence <i>Teaching and Learning in Nursing</i>	To discuss simulated experience with nursing students when given opportunity to assess for Intimate Partner Violence	Post experience and debriefing and discussion, survey	Unknown number nursing students	Confidence and skill development related to intimate partner violence patients	Survey, details unknown	No specific statistics identified	Students stated they felt more confident in assessing for Intimate Partner Violence and providing resources	III-B
Kaplonyi, Bowles, Nestel, Kiegaldie, Maloney, Haines, & Williams (2017) Understanding the impact of simulated patients on health care	To analyze existing research, to determine if Standardized Patient training improves learner-patient communication and how	Systematic Review	60 studies	Analyze the existing research to find if standardized patient use improves learner-patient communication, how communication	Medline, ProQuest (Health & Medical Complete, Nursing and Allied Health Source) and CINAHL (EBSCOhost) Education Resources	Systematic Review	There is limited evidence of how Standardized Patient training translates to patient outcomes no indication of economic	I-A

learners' communication skills: a systematic review. <i>Medical education</i>	it is measured			n skill improvement is measured, and who measures these improvements	Information Centre (ERIC)		benefit of Standardized Patient training	
MacDonnell, George, Nimmagadda, Brown, & Gremel (2016) A team-based practicum bringing together students across educational institutions and health professions. <i>American journal of pharmaceutical education</i>	To assess perceptions of teamwork and to evaluate if students could identify domestic violence through a standardized patient interview	Post exercise survey	4th year nursing students (N=120) 2nd medical students (N=121) 3rd year doctor of pharmacy students (N=120) 2nd year graduate students in social work (N=48) 2nd doctor of physical therapy students (N=34)	Students' perceptions regarding the association between collaborative practice and patient outcomes	Modified Student Perceptions of Physician-Pharmacist Interprofessional Clinical Education Revised tool	Descriptive statistics, percentages	Further training on team resource recognition and utilization would be beneficial, lack of recognition of how team members can help identify domestic violence and provide resources	III-B
Norman (2012) Systematic review of the literature on simulation in nursing education <i>ABNF Journal</i>	To examine literature on simulation outcomes in nursing education from the years 2000-2010.	3 themes; internal outcomes, external outcomes, and clinical evaluation	17 studies	Knowledge and skills, safety, communication, clinical judgment, satisfaction, confidence, and clinical evaluation	CINAHL Plus, Medline, Health Source: Nursing/Academic Education, Google Scholar, and Digital Dissertations and Theses through ProQuest	Systematic Review	Simulation is helpful in contributing to knowledge, skills, safety, confidence when learning, gap in transfer to clinical setting	I-A
Nutt (2016) Improving Intimate Partner Violence screening through the use of standardized patients <i>Journal of Obstetric, Gynecologic & Neonatal Nursing</i>	To enhance Intimate Partner Violence screening practices of nurses	Paired t test to compare initial and repeat SP experiences.	Sample size not specified	Not applicable	Not applicable	Not applicable	Patient outcomes can be improved with effective screening and intervention	V-B
O'Doherty, Hegarty, Ramsay, Davidson, Feder, & Taft (2015) Screening women for Intimate Partner Violence in healthcare settings <i>The Cochrane Library</i> .	To assess effectiveness of healthcare screening for Intimate Partner Violence and identification, referral, re-exposure to violence, and health outcomes for women, and determine if screening causes harm.	Meta-analysis	13 trials that recruited 14,959 women	Effectiveness of healthcare screening in relation to intimate partner violence	CENTRAL, Ovid MEDLINE, Embase, CINAHL, six other databases, two trial registers, reference list search of included articles and organization websites	Meta-analysis standardized estimation of the odds ratio (OR). Mean difference or standardized mean difference 95% confidence interval	Screening increases the identification of women experiencing Intimate Partner Violence in healthcare settings. Rates were low compared prevalence and evidence is insufficient to justify screening in healthcare setting	I-A
Sawyer, Coles, Williams, & Williams (2016) A systematic review of Intimate Partner Violence educational interventions delivered to allied health	To examine current evidence for Intimate Partner Violence education to inform the next generation	Systematic search of multiple databases up to the end of May 2015	2757 articles found, from which 18 were selected for inclusion	Examine the current evidence for intimate partner violence education so that it may inform the next generation of	Studies were evaluated based on methodological quality, education context and outcome measurement.	Systematic search	Rigorous methodology and validated instruments for future study evidence-based outcomes, wider target of health care professionals,	I-B

care practitioners <i>Medical Education</i>				educational interventions			suggested content, delivery, and study methodology	
Schlegel, Woermann, Shaha, Rethans, & van der Vleuten (2011) Effects of communication training on real practice performance: a role-play module versus a standardized patient module <i>Journal of Nursing Education</i>	To determine if a communication skills module with Standardized Patients would have superior effects when compared to peer role play	Randomized posttest and follow up test	26 First year nursing students in Switzerland	Self-efficacy, patients' perspective on the quality of communication, supervisors' perspective on the quality of communication	European Donor Hospital Education Programme Self-Efficacy Questionnaire, Art of Medicine Survey scale, Work Samples and Situation-Related Questions to Measure Workplace-Related Competences scale	Non-parametric Kolmogorov-Smirnov test, t test, mean, analysis of variance, Cohen's d	Using Standardized Patients is superior to role play, increases in self-efficacy, and positive ratings in communication training	II-B
Schwartz, Rothpletz-Puglia, Denmark, & Byham-Gray (2015) Comparison of standardized patients and real patients as an experiential teaching strategy in a nutrition counseling course for dietetic students <i>Patient education and counseling</i> ,	To explore feasibility of using Standardized Patients in comparison to role play for training	Retrospective analysis, random assignment to standardized patient or role playing	75 dietetic students Standardized Patient (42) Role Play (33)	Communication on skills, gathering information, behavior change	Communication on skills- Calgary Cambridge Observation Guide Skills promoting toll Behavior change-Behavior Change Counseling Index tool.	Descriptive statistics, mean, median, individualized sample t- tests Mann-Whitney U test, post hoc test, two-way analysis of covariant	Both Standardized Patient and Role Play are comparable for this group, except Standardized Patient had higher score for gathering information	II-B
Shin, Park, & Kim. (2015) Effectiveness of patient simulation in nursing education: meta-analysis <i>Nurse Education Today</i>	To identify the best available evidence about effects of patient simulation in nursing education	Meta-analysis	20 articles, (excluded no control, non-empirical, literature reviews, poor effect size, qualitative)	Effects of patient simulation	Kirkpatrick's four levels of evaluation, Comprehensive Meta-Analysis version 2, Homogeneity test, funnel plot, forest plot	Meta-analysis	Significant post intervention improvements with simulation	I-A
Smith, Chen, Basile, Gilbert, Merrick, Patel, ...& Jain (2017) The National Intimate Partner and Sexual Violence Survey (NISVS): 2010-2012 State Report. Atlanta, GA: National	National prevalence of Intimate Partner Violence, Sexual Violence, and stalking among women and men in the United States	Ongoing national random-digit dial telephone survey	Varied	Describe Sexual violence, stalking, and intimate partner violence statistics	Ongoing, national random-digital (RDD) telephone survey on sexual violence (SV), stalking, and intimate partner violence (IPV) victimization	aggregated 2010-2012 data because this combined dataset provides the greatest number of reliable estimates at the national and state levels.	Over 1 in 3 women (37.3%) experienced lifetime contact sexual violence, physical violence, and/or stalking victimization by an intimate partner	II-B
Sprague, Madden, Simunovic, Godin, Pham, Bhandari, & Goslings (2012) Barriers to screening for Intimate Partner Violence <i>Women and Health</i>	To identify and understand barriers to Intimate Partner Violence screening	Systematic Review	24 studies	Personal barriers, resource barriers, perceptions and attitudes, fears, and patient-related barriers	MEDLINE, PsychLIT, and Sociological Abstracts databases from 1966 to January 1999	Presentation of tables	Numerous barriers exist and increased education and training is needed to remove barriers	II-A

Thornton & Persuad (2017) Enhancing understanding of Intimate Partner Violence among undergraduate nursing students <i>Journal of Nursing Education</i>	To enhance nursing student understanding of individual experiencing Intimate Partner Violence	Analysis of written reflections and post experience debriefings	Number not specified	Usefulness of standardized patients to teach about intimate partner violence	Discussions	Written reflections and open-ended comments, debriefing	Caring for an Intimate Partner Violence standardized patient can enhance comfort level	III-B
Todahl & Walters (2011) Universal screening for Intimate Partner Violence: A systematic review <i>Journal of Marital and Family Therapy</i>	To summarize literature related to Intimate Partner Violence screening rates and practices, and associated factors	Systematic Review	Qualitative (14) Quantitative descriptive/survey (41) Quantitative intervention (31)	Intimate partner violence screening rates/practices, role of training and institutional support on screening, disclosure rates, client beliefs and preferences, safety considerations and competencies	Eligibility based on defined criteria	Methodology described by Petticrew (2006) and Stevens and Milne (1998),	Intimate Partner Violence universal screening instruction generally increases providers confidence & detection, although not maintained unless there are policies, procedures, and practitioner accountability	II-B
Whiting, Liu, Koyutürk, & Karakurt (2017) Network map of adverse health effects among victims of Intimate Partner Violence <i>Pacific Symposium on Biocomputing 2017</i>	To determine strength of relationships of health issues with Intimate Partner Violence	Retrospective electronic record review	5870 records of Intimate Partner Violence identified patients compared to 14,315,140 not identified as Intimate Partner Violence	Health effects of intimate partner violence	Mining of national aggregated de-identified electronic health record data	Bonferroni correction, manual coding	Strong connection to cardiovascular, gastrointestinal, gynecological, and neurological conditions	III-A
Williams & Song (2016) Are simulated patients effective in facilitating development of clinical competence for healthcare students? A scoping review <i>Advances in Simulation</i>	To evaluate the effectiveness of Standardized Patients in improving clinical competence	Scoping review of Medline, EMBASE, CINAHL and Scopus.	33 articles	Development of clinical competence	First five stages of six-stage methodological framework	Narrative review approach	24/33 articles showed Standardized Patients are effective in promoting clinical competence	II-A
Williams, Halstead, Salani, & Koerner. (2016) Intimate Partner Violence screening and response: Policies and procedures across health care facilities <i>Women's health issues</i>	To examine policies and procedures for identifying and responding to Intimate Partner Violence among different types of health care settings	Epidemiologic, cross-sectional, observational study design	Telephone questionnaires of 288 health care facilities in Miami-Dade County, Florida.	Facility characteristics, policy or procedures in place for screening/identifying intimate partner violence including frequency of screening, questions asked, referral/response procedures, training, fidelity	Telephone questionnaire, design not identified	Descriptive statistics Bivariate statistical analyses (chi-square, analysis of variance)	There is general awareness of importance of Intimate Partner Violence screening but wide variation in practices	II-A

				monitoring, written policies				
Wood (2016) Simulation as a training tool for Intimate Partner Violence screenings <i>Clinical Simulation in Nursing</i>	To examine effect of Intimate Partner Violence training w/ simulation experience on nursing students' perceptions & knowledge of Intimate Partner Violence	Quasi- experimen- tal one group pretest posttest, data at 3 points	Convenience sample - 99 undergraduate students in Mental Health Nursing course at Midwestern University, 92% completion rate	Intimate partner violence background, perceived preparation, perceived knowledge, actual knowledge, attitude	Preservation Metadata Implementatio n Strategies tool, Cronbach alpha 0.65- 0.70	Descriptive and Inferential, Analysis of variance, Tukey's pairwise comparison test	Lack of knowledge leaves students feeling un- educated, significant increase in perceived knowledge & preparation, as well as actual knowledge	II-A

Appendix C: SWOT Analysis

SWOT ANALYSIS OF UMSRH

<p style="text-align: center;">STRENGTHS</p> <ul style="list-style-type: none"> • Potential source of funding to support pilot program • Availability of novice nurse participants • UMSRH hospital system supportive of project • Need has been shown for improvement in IPV screening knowledge and processes • UMSRH is committed to providing quality care for the community • Potential to reach multiple departments across the UMSRH system • This program would be the first SP intervention in the UMSRH system 	<p style="text-align: center;">WEAKNESSES</p> <ul style="list-style-type: none"> • Potential small sample size of novice nurses • IPV training is not a priority for many health care providers and institution • Lack of clear guidelines at the institutional level • Lack of knowledge regarding domestic violence resources in the mid-shore area • Need for buy-in for continuation of educational program and subsequent funding • Vague understanding of the prevalence of domestic violence in the mid-shore area as well as denial and stigma related to the issue
<p style="text-align: center;">OPPORTUNITIES</p> <ul style="list-style-type: none"> • Unique approach to IPV awareness and education • Potential to improve utilization of existing resources • Potential to increase collaboration between UMSRH and community health organizations • Potential to improve patient health by improving assessment, detection and intervention for patients experiencing IPV 	<p style="text-align: center;">THREATS</p> <ul style="list-style-type: none"> • Confusion about the role, function, scope, that healthcare providers and the community have in relationship to domestic violence prevention and intervention • Lack of provider and community belief that domestic violence is a major health care concern in the mid-shore community

Appendix D: UMB IRB Not Human Research Determination



University of Maryland, Baltimore
 Institutional Review Board
 Phone: (410) 706-5037
 Fax: (410) 706-4189
 Email: hrpo@umaryland.edu

NOT HUMAN RESEARCH DETERMINATION

Date: May 29, 2018

To: Christine Durham-Pressley
 RE: HP-00081084
 Name: Novice Nurse Intimate Partner Violence Education Through the Use of a Standardized Patient Experience

This letter is to acknowledge that the UMB IRB reviewed the information provided and has determined that the submission does not require IRB review. This determination has been made with the understanding that the proposed project does not involve a systematic investigation designed to develop or contribute to generalizable knowledge OR a human participant (see definitions below).

This determination applies only to the activities described in the IRB submission and does not apply should any changes be made. If changes are made and there are questions about whether these activities are human subject research in which the organization is engaged, please submit a new request to the IRB for a determination.

Definitions –**Human Research:** Any activity that either:

- Is "Research" as defined by DHHS and involves "Human Subjects" as defined by DHHS ("DHHS Human Research"); or
- Is "Research" as defined by FDA and involves "Human Subjects" as defined by FDA ("FDA Human Research").

Research as Defined by DHHS: A systematic investigation, including research development, testing and evaluation, designed to develop or contribute to generalizable knowledge.

Research as Defined by FDA: Any experiment that involves a test article and one or more human subjects, and that meets any one of the following:

- Must meet the requirements for prior submission to the Food and Drug Administration under section 505(i) of the Federal Food, Drug, and Cosmetic Act meaning any use of a drug other than the use of an approved drug in the course of medical practice;
- Must meet the requirements for prior submission to the Food and Drug Administration under section 520(g) of the Federal Food, Drug, and Cosmetic Act meaning any activity that evaluates the safety or effectiveness of a device; OR
- Any activity the results of which are intended to be later submitted to, or held for inspection by, the Food and Drug Administration as part of an application for a research or marketing permit.

Human Subject as Defined by DHHS: A living individual about whom an investigator (whether professional or student) conducting research obtains (1) data through Intervention or Interaction with the individual, or (2) information that is both Private Information and Identifiable Information. For the purpose of this definition:

- Intervention means physical procedures by which data are gathered (for example, venipuncture) and manipulations of the subject or the subject's environment that are performed for research purposes.
- Interaction means communication or interpersonal contact between investigator and subject.
- Private Information means information about behavior that occurs in a context in which an individual can reasonably expect that no observation or recording is taking place, and information which has been provided for specific purposes by an individual and which the individual can reasonably expect will not be made public (for example, a medical record).
- Identifiable Information means information that is individually identifiable (i.e., the identity of the subject is or may readily be ascertained by the investigator or associated with the information).

Human Subject as Defined by FDA: An individual who is or becomes a subject in research, either as a recipient of the test article or as a control. A subject may be either a healthy human or a patient. A human subject includes an individual on whose specimen (identified or unidentified) a medical device is used.

Please keep a copy of this letter for future reference. If you have any questions, please do not hesitate to contact the Human Research Protections Office (HRPO) at (410) 706-5037 or HRPO@umaryland.edu.

Appendix E: SU IRB Not Human Research Determination

Salisbury
A Maryland University of National Distinction

Salisbury University
Institutional Review Board
Committee on Human Research
Phone: (410) 548-3549
Fax: (410) 677-0652
Email: humanresearch@salisbury.edu

IRB Research Protocol Approval Notification

Date: 7/12/18

To: M. Bracken
RE: Protocol #60
Type of Submission: Exempt
Type of IRB Review: Exempt
Protocol is scheduled to begin 8/18 and 5/19

Approval for this project is valid from 7/12/18 to 5/31/19

CONGRATULATIONS.

This letter serves to notify Dr. Michele Bracken that the Salisbury University (SU) Institutional Review Board (IRB) approved the above referenced protocol entitled, Novice Nurse Intimate Partner Violence Education through the Use of a Standardized Patient Experience: A Quality Improvement Project on July 12, 2018.

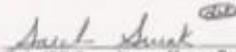
Pursuant to Federal regulations 21 CFR 56.109, the IRB has determined that this protocol qualifies for Exempt review.

Federal regulation 45 CFR 46.103 (b)(4)(iii) requires Primary Investigators (PI), except when a subject is in immediate danger, to assure any change to an approved protocol is not initiated prior to IRB review and approval. Additionally, the PI must also inform the IRB of unanticipated problems involving risks to participants.

These same federal regulations require continuing review of research be conducted by the IRB at intervals appropriate to the degree of risk. Your research is scheduled to begin 8/18 and 5/19. When necessary, the PI will receive a continuing review reminder notice prior to the date protocol approval ends; however, it is the PI's responsibility to submit continuing review reports in a timely manner (at least 3 weeks prior to scheduled end date on the protocol approval).

The SU IRB is organized and operated according to guidelines of the United States Office for Human Research Protections and the United States Code of Federal Regulations and under Federal Wide Assurance No. FWA00020237.

If you have any questions about this review or questions, concerns, and/or suggestions regarding this process, please do not hesitate to contact the Office of Graduate Studies and Research at 410-548-3549 or humanresearch@salisbury.edu.


Chair, IRB Committee on Human Research

Appendix F: Letter of Collaboration/Permission



UNIVERSITY of MARYLAND
SHORE REGIONAL HEALTH

TO: Christine Durham-Pressley, BSN, RN
Doctor of Nursing Practice Degree Program Student

FROM: Ruth Ann Jones, EdD, MSN, RN, NEA-BC
Sr Vice President Patient Care Services and Chief Nursing Officer

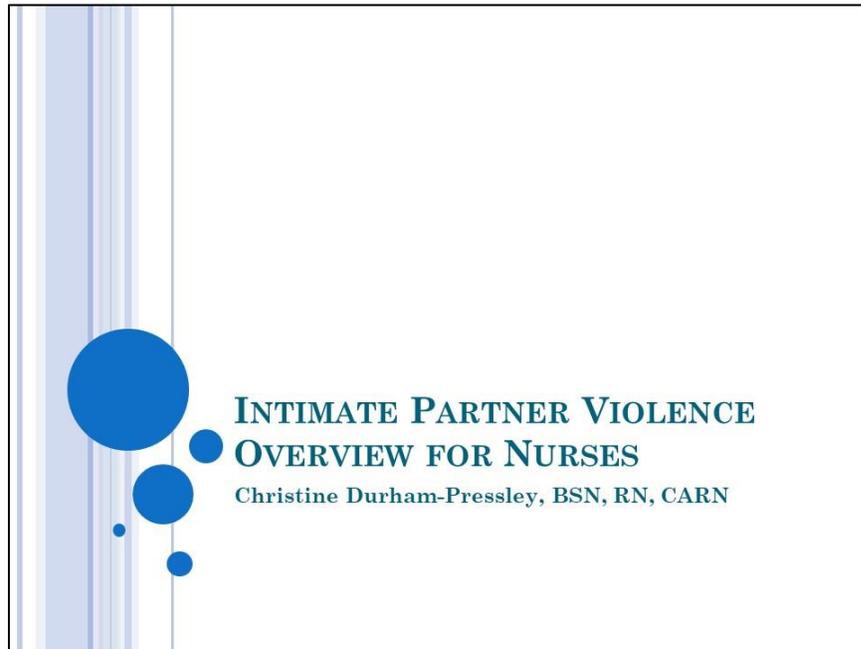
SUBJECT: Collaboration and Support for DNP Pilot Project

DATE: April 17, 2018

I have read your proposal for the pilot project "Novice Nurse Intimate Partner Violence Education Through the Use of a Standardized Patient Experience". Thank you for the opportunity to review. I am in full support of the project and look forward to collaborating with you throughout your educational journey.

I wish you well and good luck with your project. If you should have any questions please do not hesitate to call me at 410-822-1000 or email me at rajones@umm.edu.

Appendix H: Educational PowerPoint

**OBJECTIVES**

- Define Intimate Partner Violence (IPV).
- Recognize IPV trends in the United States.
- Recognize IPV trends locally.
- Identify risk factors and warning signs for violence against a spouse or significant other.
- Discuss why victims stay with the abusive partners.
- Explain why victims of domestic violence are not identified in the healthcare system.
- Discuss ways to create a safety plan.
- Review SRH policies and procedures.
- Review best practices for screening and intervention.

DEFINE IPV – CDC DEFINITION

- Intimate Partner Violence can take many forms.
 - Examples:
- An intimate partner is a person with whom one has a close personal relationship that can be characterized by the following:
 - Emotional connection
 - Regular contact
 - Ongoing physical contact and/or sexual behavior
 - Identity as a couple
 - Familiarity and knowledge about each other's lives

(Breiding, et al. 2015)



4 TYPES OF IPV

- Physical Violence
- Sexual Violence
 - Rape or penetration of victim
 - Victim was made to penetrate someone
 - Non-physically pressured unwanted penetration
 - Unwanted sexual contact
 - Non-contact unwanted sexual experiences
- Stalking
- Psychological Aggression

(Breiding, et al. 2015)



IPV TRENDS IN THE UNITED STATES

- 2015 National Intimate Partner and Sexual Violence Survey (NISVS) – WOMEN
 - In the U.S., over 1 in 3 (36.4% or 43.6 million) women experienced contact sexual violence, physical violence, and/or stalking by an intimate partner during their lifetime.
 - About 1 in 4 women (24.4% or 29.2 million) in the U.S. experienced contact sexual violence, physical violence, and/or stalking by an intimate partner during their lifetime and reported some form of IPV-related impact
- 

IPV TRENDS IN THE UNITED STATES

- 2015 National Intimate Partner and Sexual Violence Survey (NISVS) – WOMEN
 - An estimated 1 in 18 (5.4% or 6.5 million) women in the U.S. experienced contact sexual violence, physical violence, and/or stalking by an intimate partner during the 12 months preceding the survey.
 - Over one-third of women (36.4% or 43.5 million) experienced psychological aggression by an intimate partner during their lifetime.
- 

IPV TRENDS IN THE UNITED STATES

- 2015 National Intimate Partner and Sexual Violence Survey (NISVS) – MEN
 - In the U.S., about 1 in 3 (33.3% or 37.2 million) men experienced contact sexual violence, physical violence, and/or stalking by an intimate partner during their lifetime.
 - Nearly 1 in 10 (10.6% or 11.8 million) men in the U.S. experienced contact sexual violence, physical violence, and/or stalking by an intimate partner during their lifetime and reported some form of IPV-related impact.
- 

IPV TRENDS IN THE UNITED STATES

- 2015 National Intimate Partner and Sexual Violence Survey (NISVS) – MEN
 - About 1 in 20 (5.1% or 5.7 million) men in the U.S. experienced contact sexual violence, physical violence, and/or stalking by an intimate partner during the 12 months preceding the survey.
 - Over one-third of men (34.3% or 38.4 million) experienced psychological aggression by an intimate partner during their lifetime.
- 

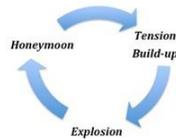
IPV TRENDS LOCALLY

- o Domestic violence also affects the mid-shore area of Maryland. Between July 1, 2015 and June 30, 2016, Mid-Shore Council on Family Violence (MSCFV) served 368 victims of family violence as well as their 461 children (Ovwigo, 2016)
- o MSCFV serves the mid-shore area of Caroline, Dorchester, Kent, Queen Anne’s, and Talbot counties.



CYCLE OF VIOLENCE

TENSION BUILDING	BATTERING INCIDENT	CALM RESPITE “Honeymoon”
Tension	Batterer's intent is to teach a lesson	Batterer is kind and charming
Batterer is irritable, frustrated, unable to cope	Batterer loses control	Batterer afraid that the victim will leave
Victim attempts to appease the batterer	Only the batterer can end this phase	Victim believes the suffering is over
Victim often assumes responsibility	Victim needs a safe place to stay	Cycle continues
Victim denies inevitability	Once over, victim will deny the incident, injuries, terror	
Batterer fears the victim will leave		



WARNING SIGNS FOR VIOLENCE

- Extreme jealousy
- Blames others for their faults problems
- Unpredictable behavior
- Verbally abusive
- Unable to control their anger
- Asks for a second chance, they'll change
- Their family resolves problems with violence
- Plays on your guilt
- Their way is the only way
- Behavior worsens with alcohol or drugs
- Cruelty to animals

(Farrell, 2011; Theobald et al., 2012)

Batterers come from all social classes, races, cultures, religions, backgrounds, and countries (WHO, 2016).



RISK FACTORS FOR VIOLENCE

- Family history of violence
- Alcohol and drug use
- Emotional dependency, insecure and low self-esteem
- Lack of impulse control
- Antisocial, aggressive, and borderline personality disorders
- Poverty
- Marital discord or conflict

(Farrell, 2011; Theobald et al., 2012; WHO, 2016)



WHY VICTIMS STAY

Lack of resources

- Dependent children, not employed, doesn't own any property, no cash, fear of being charged with desertion

Institutional responses

- Save the marriage at all costs, dispute instead of a crime, poor prosecution, lenient sentencing, little to prevent an abuser from returning and repeating the assault, even with a restraining order, not enough shelters

Traditional ideology

- Divorce is not an option, a single parent family is unacceptable, isolation of a victim, rationalization of their abuser's behavior, abuser is "good"

(Farrell, 2011; Theobald et al., 2012; WHO, 2016)



WHY HEALTHCARE DOESN'T IDENTIFY VICTIMS

- Lack of time
- Lack of training
- Lack of resources
- Language barriers
- Cultural barriers
- Discomfort with the topic
- Behavior of the victim
- Fear of offending the patient or partner
- Need for privacy
- Perceived lack of power to change the problem



SIGNS AND ASKING QUESTIONS

- Physical Signs
 - Not so obvious Signs

 - Broad Question: “How are things at home?”
 - Observational Question: “When I see injuries like this, I wonder if someone could have hurt you?”
 - Direct Questions: “Are you concerned about your safety or the safety of your children?”
- 

INITIATING INTERVENTION OR TREATMENT

- First have to identify individuals who may be experiencing domestic violence
- Encourage him or her to talk about it
- Listen non-judgmentally
- Validate their fears and concerns
- Document their complaints, symptoms, and injuries
- Assess the danger they are currently in
- Provide appropriate referral and support

(Saddock, 2015)



NURSING EFFECTIVE IPV INTERVENTIONS

- **Listening:** Being listened to can be an empowering experience for an individual who has been abused.
- **Communicating belief:** “That must have been very frightening for you.”
- **Validating the decision to disclose:** “It must have been difficult for you to talk about this” or “I’m glad you were able to tell me about this today.”
- **Emphasizing the unacceptability of violence:** “You do not deserve to be treated this way.”

Power, C. (2011)



CREATING A SAFETY PLAN

- Plans in case of dangerous situations or changes in the relationship, such as breaking up
- Identify safe friends and safe places
- Identify the essential items to take should decide to leave home, or have to leave home
- Include information about local domestic violence resources and legal rights
- Build on what a survivor is already doing to survive

The Center for Relationship Abuse and Awareness. (2018)



BEST PRACTICES FOR IPV SCREENING

The 6 tools that showed the most sensitivity and specificity were:

- HITS (Hurt, Insult, Threaten, Scream)
- OVAT (Ongoing Violence Assessment Tool)
- STaT (Slapped, Things and Threaten)
- HARK (Humiliation, Afraid, Rape, Kick)
- CTQ-SF (Modified Childhood Trauma Questionnaire–Short Form)
- WAST (Woman Abuse Screen Tool)

U.S. Preventive Services Task Force, 2013



MORE INFORMATION

- Intimate Partner Violence and Sexual Violence Victimization Assessment Instruments for Use in Healthcare Settings

<https://www.cdc.gov/violenceprevention/pdf/ipv/ipvandsvscreening.pdf>



DANGER ASSESSMENT

- Helps to determine the level of danger an abused woman has of being killed by her intimate partner.
 - developed by Jacquelyn Campbell (1986)
 - Two parts to the tool: a calendar and a 20-item scoring instrument.
 - Training Module

www.dangerassessment.org



LETHALITY ASSESSMENT PROGRAM

- Based on the research of Jackie Campbell
- Designed for law enforcement first responders and asks victims eleven questions
- Certain responses trigger the “protocol referral” which is an immediate connection with a local advocacy program.



MARYLAND RESOURCES

- National Domestic Violence Hotline:
 - 1-800-799-SAFE (1-800-799-7233)

- Maryland Network Against Domestic Violence
 - <http://www.mnadv.org>
 - 1-800-MD-HELPS

- Mid-Shore Council on Family Violence
 - <http://mscfv.org/>
 - 1-800-927-HOPE (4673)



HOSPITAL POLICIES AND PROCEDURES



CEU FAST – 3 CEUs

- o **Domestic Violence, Sexual Violence, Intimate Partner Violence**

- Melissa DeCapua (DNP, PMHNP-BC)

<https://ceufast.com/course/domestic-violence>



QUESTIONS/COMMENTS



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Appendix I: Attitudes and Perceptions Pre-Test

**NOVICE NURSE INTIMATE PARTNER VIOLENCE
PERCEPTIONS AND ATTITUDES**

You are being asked to participate in the following survey during your novice nurse program at University of Maryland Shore Regional Health (UMSRH). This survey is part of a doctor of nursing practice (DNP) project for a student at Salisbury University who is also a current nurse employed at UMSRH. Your responses are based on your own perceptions; there is no right or wrong answer. Please do your best to answer each question, only leave the questions blank if you are sure that they do not apply to you. Your answers in this survey are confidential.

DEFINITION OF INTIMATE PARTNER VIOLENCE:

<https://www.cdc.gov/violenceprevention/intimatepartnerviolence/definitions.html>

Intimate partner violence (IPV) is a serious, preventable public health problem that affects millions of Americans. The term “intimate partner violence” describes physical violence, sexual violence, stalking and psychological aggression (including coercive acts) by a current or former intimate partner.

An intimate partner is a person with whom one has a close personal relationship that can be characterized by the following:

- *Emotional connectedness*
- *Regular contact*
- *Ongoing physical contact and/or sexual behavior*
- *Identity as a couple*
- *Familiarity and knowledge about each other’s lives*

The relationship need not involve all of these dimensions. Examples of intimate partners include current or former spouses, boyfriends or girlfriends, dating partners, or sexual partners. IPV can occur between heterosexual or same-sex couples and does not require sexual intimacy.

IPV can vary in frequency and severity. It occurs on a continuum, ranging from one episode that might or might not have lasting impact to chronic and severe episodes over a period of years.

1. Currently there are two yes or no questions used at UMSRH by nurses during the admission process that could be used to identify patients’ positive for IPV:

- Has been or is afraid of being physically hurt by someone
- Has been forced to have sexual activities

Do you feel these *two questions*, when asked during the evaluation/admission process, allow you to adequately identify a patient positive for IPV?

- Yes**
- No**

2. How would you modify the questions asked to better detect patients experiencing IPV?

- I would not modify the questions.
- I would modify the questions as follows:

3. What additional questions would you include in the admission database to allow you to adequately identify a patient positive for IPV?

- I would not include additional questions in the admission database.
- I would include the following questions:

4. What additional assessments/screenings would you include in the admission database to allow you to adequately identify a patient positive for IPV?

- I would not include additional questions in the admission database.
- I would include the following assessment(s)/screening(s):

Please indicate your level of agreement with the following statements:

Questions	Strongly Disagree	Disagree	Neutral	Agree	Strongly Agree
5. I have insufficient knowledge about IPV					
6. I am able to recognize the signs & symptoms of IPV					
7. I know how to ask if a patient is experiencing IPV					
8. I am uncomfortable about asking patients questions about IPV					
9. It is difficult to identify patients positive for IPV					
10. I have concerns I would lose the patient's trust if I asked questions about IPV					
11. I have enough time to screen patients for IPV					
12. I have enough time to document on patients positive for IPV					
13. It is none of my business if the patient is a positive for IPV					
14. Identification of IPV is the responsibility of the physician not the nurse					
15. IPV is a medical issue					
16. Patients only need to be screened for IPV when they present or are admitted with an injury					
17. There are more important problems to deal with than IPV					
18. I don't know what to say if a patient says they are experiencing IPV					
19. I have a confidential environment to screen patients for IPV					
20. I know my responsibilities when I identify patient positive for IPV					
21. I feel comfortable referring patients positive for IPV					

22. In the past year I have completed/received additional IPV education.

Yes

No

(If yes, please explain the type of additional education):

23. When did you last review the hospital policy entitled “Suspected Abuse and Neglect?” (select one)

Within the last 12 months

Never

Unsure

24. When did you last review the hospital policy entitled “Management of Patients Under Threat of Domestic Violence” (select one):

Within the last 12 months

Never

Unsure

25. What else would you recommend for nurses to do to better detect patients experiencing IPV?

I do not have recommendations.

I recommend the following:

26. Please provide any IPV comments here:

Appendix J: Attitudes and Perceptions Post-Test

NOVICE NURSE INTIMATE PARTNER VIOLENCE
PERCEPTIONS AND ATTITUDES

You are being asked to participate in the following survey during your novice nurse program at University of Maryland Shore Regional Health (UMSRH). This survey is part of a doctor of nursing practice (DNP) project for a student at Salisbury University who is also a current nurse employed at UMSRH. Your responses are based on your own perceptions; there is no right or wrong answer. Please do your best to answer each question, only leave the questions blank if you are sure that they do not apply to you. Your answers in this survey are confidential.

DEFINITION OF INTIMATE PARTNER VIOLENCE:

<https://www.cdc.gov/violenceprevention/intimatepartnerviolence/definitions.html>

Intimate partner violence (IPV) is a serious, preventable public health problem that affects millions of Americans. The term “intimate partner violence” describes physical violence, sexual violence, stalking and psychological aggression (including coercive acts) by a current or former intimate partner.

An intimate partner is a person with whom one has a close personal relationship that can be characterized by the following:

- *Emotional connectedness*
- *Regular contact*
- *Ongoing physical contact and/or sexual behavior*
- *Identity as a couple*
- *Familiarity and knowledge about each other’s lives*

The relationship need not involve all of these dimensions. Examples of intimate partners include current or former spouses, boyfriends or girlfriends, dating partners, or sexual partners. IPV can occur between heterosexual or same-sex couples and does not require sexual intimacy.

IPV can vary in frequency and severity. It occurs on a continuum, ranging from one episode that might or might not have lasting impact to chronic and severe episodes over a period of years.

1. Currently there are two yes or no questions used at UMSRH by nurses during the admission process that could be used to identify patients’ positive for IPV:

- Has been or is afraid of being physically hurt by someone
- Has been forced to have sexual activities

Do you feel these *two questions*, when asked during the evaluation/admission process, allow you to adequately identify a patient positive for IPV?

- Yes
 No

2. How would you modify the questions asked to better detect patients experiencing IPV?

- I would not modify the questions.
- I would modify the questions as follows:

3. What additional questions would you include in the admission database to allow you to adequately identify a patient positive for IPV?

- I would not include additional questions in the admission database.
- I would include the following questions:

4. What additional assessments/screenings would you include in the admission database to allow you to adequately identify a patient positive for IPV?

- I would not include additional questions in the admission database.
- I would include the following assessment(s)/screening(s):

Please indicate your level of agreement with the following statements:

Questions	Strongly Disagree	Disagree	Neutral	Agree	Strongly Agree
5. I have insufficient knowledge about IPV					
6. I am able to recognize the signs & symptoms of IPV					
7. I know how to ask if a patient is experiencing IPV					
8. I am uncomfortable about asking patients questions about IPV					
9. It is difficult to identify patients positive for IPV					
10. I have concerns I would lose the patient's trust if I asked questions about IPV					
11. I have enough time to screen patients for IPV					
12. I have enough time to document on patients positive for IPV					
13. It is none of my business if the patient is a positive for IPV					
14. Identification of IPV is the responsibility of the physician not the nurse					
15. IPV is a medical issue					
16. Patients only need to be screened for IPV when they present or are admitted with an injury					
17. There are more important problems to deal with than IPV					
18. I don't know what to say if a patient says they are experiencing IPV					
19. I have a confidential environment to screen patients for IPV					
20. I know my responsibilities when I identify patient positive for IPV					
21. I feel comfortable referring patients positive for IPV					

22. Prior to this session: In the past year I have completed/received additional IPV education.

Yes

No

(If yes, please explain the type of additional education):

23. Prior to this session: When did you last review the hospital policy entitled “Suspected Abuse and Neglect?” (select one)

Within the last 12 months

Never

Unsure

24. Prior to this session: When did you last review the hospital policy entitled “Management of Patients Under Threat of Domestic Violence” (select one):

Within the last 12 months

Never

Unsure

25. What else would you recommend for nurses to do to better detect patients experiencing IPV?

I do not have recommendations.

I recommend the following:

26. Please provide any IPV comments here:

Appendix K: SET-M Tool

Simulation Effectiveness Tool --- Modified (SET---M)

After completing a simulated clinical experience, please respond to the following statements by circling your response.

PREBRIEFING:	Strongly Agree	Somewhat Agree	Do Not Agree
Prebriefing increased my confidence	3	2	1
Prebriefing was beneficial to my learning.	3	2	1
SCENARIO:			
I am better prepared to respond to changes in my patient's condition.	3	2	1
I developed a better understanding of the pathophysiology.	3	2	1
I am more confident of my assessment skills.	3	2	1
I felt empowered to make clinical decisions.	3	2	1
I developed a better understanding of medications. (Leave blank if no medications in scenario)	3	2	1
I had the opportunity to practice my clinical decision making skills.	3	2	1
I am more confident in my ability to prioritize care and interventions	3	2	1
I am more confident in communicating with my patient.	3	2	1
I am more confident in my ability to teach patients about their illness and interventions.	3	2	1
I am more confident in my ability to report information to health care team.	3	2	1
I am more confident in providing interventions that foster patient safety.	3	2	1
I am more confident in using evidence--based practice to provide care.	3	2	1
DEBRIEFING:			
Debriefing contributed to my learning.	3	2	1
Debriefing allowed me to verbalize my feelings before focusing on the scenario	3	2	1
Debriefing was valuable in helping me improve my clinical judgment.	3	2	1
Debriefing provided opportunities to self--reflect on my performance during simulation.	3	2	1
Debriefing was a constructive evaluation of the simulation.	3	2	1
What else would you like to say about today's simulated clinical experience?			

Leighton, K., Ravert, P., Mudra, V., & Macintosh, C. (2015). Update the Simulation Effectiveness Tool: Item modifications and reevaluation of psychometric properties. *Nursing Education Perspectives*, 36(5), 317--323. Doi: 10.5480/15--1671.

Contact: Kim Leighton: kleighton@devry.edu; 402--617--1401

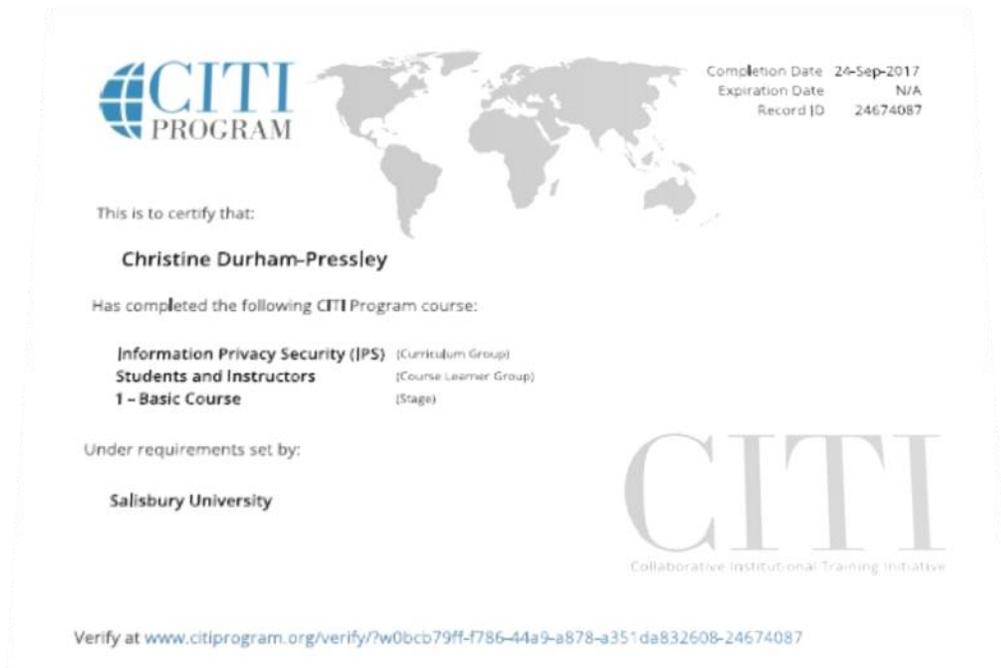
Appendix L: Human Subject Certificate Michele Bracken



Appendix M: NIH Human Subject Certificate Christine Durham-Pressley



Appendix N: CITI Human Subject Certificate Christine Durham-Pressley 1



Appendix O: CITI Human Subject Certificate Christine Durham-Pressley 2



Completion Date 26-Sep-2017
Expiration Date 23-Sep-2020
Record ID 24674057

This is to certify that:

Christine Durham-Pressley

Has completed the following CITI Program course:

Social & Behavioral Research - Basic/Refresher (Curriculum Group)
Social & Behavioral Research - Basic/Refresher (Course Learner Group)
1 – Basic Course (Stage)

Under requirements set by:

Salisbury University



Verify at www.citiprogram.org/verify/?wddda25ea-a763-49c4-97a9-a3237af22490-24674057

Appendix P: Human Subject Certificate Christine Durham-Pressley 3



This is to certify that:

Christine Durham-Pressley

Has completed the following CITI Program course:

Social and Behavioral Responsible Conduct of Research (Curriculum Group)
Social and Behavioral Responsible Conduct of Research (Course Learner Group)
1 - RCR (Stage)

Under requirements set by:

Salisbury University



Verify at www.citiprogram.org/verify/?w6ae98bb9-33cd-4b9a-8dec-d3e5d268f8c8-24674058

Appendix Q: Human Subject Certificate Christine Durham-Pressley 4



This is to certify that:

Christine Durham-Pressley

Has completed the following CITI Program course:

Students conducting no more than minimal risk research (Curriculum Group)
Students - Class projects (Course Learner Group)
1 - Basic Course (Stage)

Under requirements set by:

Salisbury University



Verify at www.citiprogram.org/verify/?w2922c9c8-3464-4297-a8d0-ea01068ea530-24674086

Appendix R: Attitudes and Perceptions Pre and Post Test Comments

How would you modify the questions asked to better detect patients experiencing IPV?

Pre-test

- 1) Have you ever been or are you currently felt your life was in danger by someone you know or a stranger? Have you been either harmed or threatened physically, mentally [sic], emotionally, or sexually by a loved one or a stranger?
- 2) Have you ever been fearful of someone you have had an intimate relationship with?
- 3) Has been or is afraid of being physically hurt or emotionally attacked by another individual.
- 4) (Answered would not modify but added following comment) Ask additional questions to better identify in relation to what the answers are to previous questions.

Post-test

- 1) “Do you feel safe at home” or something more broad to gain a relationship first.
- 2) Have you ever been verbally or physically, intimately intimidated around your partner or ex-partner.
- 3) Ask the patient about any certain situations they felt they were in danger/felt unsafe.
- 4) Do you feel sad, any recent injuries, are you depressed, have you ever been verbally abused.
- 5) Ask more specifics
- 6) (Answered would not modify but commented) I wouldn't modify questions necessarily, just add more questions to the assessment to allow better detection.
- 7) (Answered would not modify but commented) Make them more specific.
- 8) (Answered would not modify but commented) I would pay attention to cues.
- 9) (Answered would not modify but commented) I would also like to see pt asked a question about change in routine or lifestyle to appease another person – have you made an adjustment to your normal routine or lifestyle to avoid conflict with your partner or individual you have close and continuing contact.
- 10) (Did not check box but commented) Do you feel safe at home?

What additional questions would you include in the admission database to allow you to adequately identify a patient positive for IPV?

Pre-test

- 1) Are you intimately [sic] involved? Does your partner have a history of violent or negligent behavior? Do you currently feel safe at home?
- 2) Are you currently afraid of being physically hurt by someone? Do you fear for your life?
- 3) Maybe a more vague question, like "Do you feel safe at all times at home?"
- 4) Are you afraid of your current partner.
- 5) Recent hospital visits, injuries, falls.
- 6) Do you feel safe in your environment?
- 7) Ever been afraid? If answer is yes, question how recent? Emotional status?
- 8) Do you feel safe at home or in current living situation?
- 9) Has been or are being emotionally hurt?
- 10) Have you ever or currently now changed or eliminated select daily activities to avoid conflict with another individual you interact with.

Post-test:

- 1) Do you feel safe in your home? Do you feel belittled or degraded by your partner? Do you ever feel emotionally abused?
- 2) Listed above. How pt is acting if possible abuser in room how is she or she acting.
- 3) Do you feel comfortable talking with me? Do you feel safe right now? Are you concerned w/ your safety? DO you know what a safety plan is? Do you have one? Have you felt forced to complete activities/chores/etc in fear of retribution from partner?
- 4) Do you ever feel threatened by someone you know? If yes is it someone you live with? Has your significant other/family member made you feel harmed/threatened?
- 5) Ask about verbal abuse – not just physical
- 6) Do you feel safe at home?
- 7) Do you feel safe?
- 8) I would also like to see a question on change or routine or lifestyle. Have you made an adjustment to your normal routine or lifestyle to avoid conflict with a significant other or individual you have close and continuing contact.

What additional assessments/screenings would you include in the admission database to allow you to adequately identify a patient positive for IPV?

Pre-test:

- 1) A hx or partner, financial [sic] hx, psych assessment, thorough skin assessment, STI/preg screening
- 2) Physical Assessment, ask questions about any suspicious injuries.
- 3) I would assess both the child and parents, or adult, family elderly [sic] behaviors during these questions and how they react when the parent is asked to step out of the room.
- 4) Emotional status questions. Is patient stable/reliable enough to answer questions effectively/accurately.
- 5) Making sure family/friends are not present when asking questions.
- 6) Would re assess again if needed once trust or privacy has been established.
- 7) Not sure what is in the database beside the 2 questions provided. I would screen pt's for concerns of financial complication (ability to support one's self without the assistance of others).

Post-test

- 1) Make connection w/ pt and open communication to hope if something was going on the patient would say something.
- 2) Listed above. Any bruising [sic] (different time periods), past med hx.
- 3) Family history, partner history, flags for ER/hospital visits/missed appointments.
- 4) STI/pregnancy exam, psych eval, financial [sic] assessment, medical/health hx screening
- 5) Ask about verbal abuse/how things are at home.
- 6) Do you have the financial means to support yourself without the assist of another individual or organization?
- 7) (Did not check box but offered comment) Physical assessment.

What else would you recommend for nurses to do to better detect patients experiencing IPV?

Pretest:

- 1) Slow down and observe patient, interactions, and body language. We want to immediately fix the physical problem, but need to take time to confidently identify others.
- 2) Making sure they assess pts when visitors are present to see if they detect any changes in pts behavior.
- 3) Look at body language when they answer and listen to their tone. Ask them when they do not have family/friends in the room.
- 4) Continued education on signs of IPV and the nurses role in dealing with IPV. Clear resources in area to give to patients experiencing IPV.
- 5) Always ask! Make time even if you don't see any signs.
- 6) Not only assess a child, adult or elderly but also the caretaker, family, or parents and their behaviors.

Posttest:

- 1) Follow up with screening questions when the patient is alone.
- 2) Ask prior to every admission. Monitor the family's reactions – we know you are busy. Reassure pt that the pt being abused is not alone and not stupid.
- 3) Taking the time to effectively converse and observe the nonverbal communication of patients and their partners/families/children. Protect privacy at all times and know resources available and strategies to use.
- 4) Assess the big picture (emotion, eyes, tone of voices, how pt is acting). Assess pt and the abuser if he/she is there.
- 5) To remember to look at the whole patient holistically and explore anything that may seem abnormal.
- 6) Making better connection and taking the time to build trust w/ their patients so they are able to feel comfortable and able to open up and talk about it.
- 7) Talk to the patient privately, get answers from the patient, advocate for the patient, gain their trust.
- 8) Take the time while asking the questions to really listen to your patient as opposed to asking the questions with your back turned staring [sic] at a computer screen. Many tend to downplay the questions as we ask everyone and I'm asking the question but I'm not really asking because I care.

Additional IPV comments:

Pretest

1. Since I am unaware of the current policies and was not able to get clarity on what occurs with the data collected outside of the nurse responsibility to link the patient with proper resources it is difficult to make further recommendations.
2. Not everyone will admit to abuse therefore we must assess the situation as a whole.

Post Test

1. I feel that nurses need more training in IPV so we know what to ask the patient and how to handle the partner if they are present during the assessment/interview.
2. I think that we should've had teaching on IPV before the situation. I also think they should have given more information before.

Appendix S: SET-M Open Ended Comments

1. It helped me understand how to better handle situations in which IPV is present.
2. Live role players greatly enhance the sim. This kind of opportunity allows a provider to ask tough questions or make uncomfortable comments to a patient in a safe environment that does not affect actual patient care. It can be very frightening as a provider to question someone about abuse, suicide, and harmful situations. This type of scenario may give a new provider the confidence to speak to a patient and provide them help.
3. Wasn't expecting the scenario to be about violence until the assessment portion and making patient introductions. Was an eye opening experience.
4. I felt it was a great learning experience. I definitely took something away from this experience.
5. Provided excellent learning and real life experience for a situation where many of us had no prior interactions as such. Wish we had more simulations like yesterday's situation in nursing school.
6. It was a good learning opportunity. It's better to have some experience whether it's simulated or not than to go out and have a patient and not know what to do. As a new RN it helped me learn what to do and how to act. The actors were great and it was very realistic.
7. Was glad to be able to do the simulation. Never had any situational exposure before and was glad I could react appropriately in the situation - please reuse this scenario.
8. Simulation created a safe space to practice skills with feedback from actors.
9. I would say possibly have extra people to act as your hospital's resources in that situation to make it more realistic.
10. I felt we shouldn't have done it this early and to get more information in the beginning.