



Educating Nurses to Screen and Intervene for Intimate Partner Violence During Pregnancy

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More than one third of women in the United States have experienced physical violence, sexual assault, or stalking by an intimate partner in their lifetimes (Black et al., 2011). Intimate partner violence (IPV) is defined as physical

or sexual violence, stalking, and psychological aggression, including coercive tactics, by a current or former intimate partner (Breiding, Basile, Smith, Black, & Mahendra, 2015). Prevalence rates of IPV for pregnant women

Abstract Intimate partner violence (IPV) is a problem affecting women and families across the nation, and it has been associated with adverse pregnancy and birth outcomes. Here we describe how our team implemented an evidence-based protocol for the screening of pregnant women for IPV and case management for those experiencing violence. This protocol was implemented on an antepartum triage unit where nurses were educated on IPV, methods for screening pregnant women, and a brief intervention. Education included an online module and a live session with role-playing exercises. Test scores indicated a significant increase in nurses' knowledge after completion of the module, and the overall educational program was rated as excellent by program participants. As part of the project, the Abuse Assessment Screen and the Danger Assessment-5—two instruments with predictive validity—were incorporated into the electronic health record. <https://doi.org/10.1016/j.nwh.2017.12.006>

Keywords Abuse Assessment Screen | Danger Assessment | intimate partner violence | IPV | pregnancy



vary widely. The Pregnancy Risk Assessment Monitoring System (PRAMS) surveys postpartum women regarding numerous health indicators, including IPV. Findings from the most recent survey indicated that 2.6% of women had experienced IPV during the 12 months before

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becoming pregnant, and 2.2% were abused during the pregnancy (Centers for Disease Control and Prevention, 2017). A meta-analysis of studies that researched the association of IPV with birth outcomes found that the risk for preterm labor or the birth of a newborn with low birth weight or one who was small for gestational age increased significantly in women who had experienced violence (Shah, Shah, & Knowledge Synthesis Group on Determinants of Preterm/LBW Births, 2010). Data from the National Violent Death Reporting System indicated that 54.3% of suicides in pregnant women were preceded by intimate partner conflict, and 45.3% of homicides of pregnant women were associated with IPV (Palladino, Singh, Campbell, Flynn, & Gold, 2011).

The U.S. Preventive Services Task Force (USPSTF) recommends that clinicians screen women of childbearing age for IPV at each visit and provide women who have positive screening results with interventions or referrals to services (Moyer & USPSTF, 2013). According to the Association of Women's Health, Obstetric and Neonatal Nurses (2015), "Women should be universally screened for IPV in private, safe settings where health care is provided" (p. 405). The Joint Commission (2017) standard on assessing abuse and neglect requires a hospital to have written criteria for identifying patients who may be experiencing abuse or neglect and to assist with referral of victims to community agencies for services. The standard also requires that the hospital's staff be educated on the recognition of abuse or neglect and their role in follow-up care. A meta-analysis of studies that researched barriers to screening

identified a provider's discomfort with discussing IPV, a lack of knowledge, and time constraints to be the greatest barriers to screening (Sprague et al., 2012). A recent survey of primary care clinicians, including nurses and nurse practitioners, in California found that only 14% always screened women for IPV and that 34% rarely or never performed screenings. Results suggested that providers lacked confidence in their abilities to screen for IPV or assist women experiencing violence (Tavrow, Bloom, & Withers, 2016).

Evidence-Based Intervention

Abuse During Pregnancy: A Protocol for Prevention and Intervention, published by the March of Dimes, is a continuing education program for nurses formatted for independent or facilitated group study. The protocol involves the screening of pregnant women for abuse using the Abuse Assessment Screen (AAS). For women who are experiencing IPV, the Danger Assessment (DA) is administered to determine their risk of homicide. After completion of the assessment tools, a nurse meets with the woman to help develop a safety plan and to offer referrals to community agencies (McFarlane, Parker, & Moran, 2007).

Abuse Assessment Screen

The AAS was developed by the Nursing Research Consortium on Violence and Abuse for use with pregnant women receiving outpatient or inpatient care. The tool is administered by the provider during a face-to-face encounter in a private and confidential setting. The instrument asks women to respond *yes* or *no* to three questions about abuse, including sexual abuse, occurring within the last year and since becoming pregnant. An affirmative response to any of the items is regarded as a positive screening result for abuse. For each item, the woman is questioned about the number of abusive incidents and is asked who committed the abuse. The instrument, available for use at no cost, can be printed in English, Spanish, and Chinese (Soeken, McFarlane, Parker, & Lominack, 1998). A systematic review of studies in which the predictive validity of the AAS was identified noted a sensitivity of 93% to 94% and a specificity ranging from 55% to 99% (Rabin, Jennings, Campbell, & Bair-Merritt, 2009).

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Danger Assessment

The DA, a self-administered survey available in numerous languages, includes 20 items associated with intimate partner homicide. The Danger Assessment–5 (DA5), a brief version of the DA, includes five survey items identified as the best predictors of serious harm. Sensitivity of the DA5 for respondents answering *yes* to three of the five items was 83%, and the specificity was 56% (Snider, Webster, O’Sullivan, & Campbell, 2009). The DA5 includes recommended actions based on the number of affirmative responses. The DA and DA5 can be downloaded at no cost from the DA Web site (Johns Hopkins School of Nursing, n.d.). Time constraints were previously noted as one of the greatest barriers to screening. An advantage of the self-administered DA and DA5 instruments is that either can be completed in privacy by the woman.

Empowerment Intervention

After reviewing the DA, the nurse meets with the woman for approximately 20 minutes to provide her with information on abuse during pregnancy and to determine her safety options. The session includes information on the cycle of violence, orders of protection, the filing of criminal charges, and local resources the woman may contact for assistance (e.g., shelter, counseling/legal services, toll-free hotline). She is provided with an English or Spanish version of a two-page handout customized from

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the *Helping Women Determine Safety Options* handout included with the protocol (McFarlane et al., 2007, pp. 44–47). The intervention is based on Dutton’s (1992) empowerment model, developed as a framework for increasing an abused woman’s safety and enhancing her skills in decision making. An assumption of the model is that the complex issues involved in any situation are best understood by the woman, and the provider serves as a facilitator in the decision-making process. The goal of the intervention is to increase the woman’s sense of control and independence.

A randomized clinical trial was conducted of women who used public health and Special Supplemental Nutrition Program for Women, Infants, and Children (WIC) clinics in an urban area. Women in one group with positive screening results on the AAS received a wallet-sized card from a local women’s center. The card listed a safety plan and information on community resources, content covered in the protocol’s safety handout. In addition to the card, women in the second group with



screening results positive for abuse received case management from nurses trained on use of the empowerment intervention. Women in both groups reported increased safety behaviors and decreased incidents of violence at 12 and 24 months after the intervention. There was no significant difference in the overall effectiveness of the two interventions, leading researchers to conclude that screening and referral constituted an effective intervention (McFarlane, Groff, O'Brien, & Watson, 2006). The study was cited in the review of research evidence to support the USPSTF recommendation for the screening of women of childbearing age for IPV (Moyer & USPSTF, 2013).

A second randomized clinical trial had similar results. It compared outcomes of an empowerment intervention, delivered by social workers to women receiving standard care, in which women received a wallet-sized referral card with information on local agencies. The study was conducted with prenatal patients in Lima, Peru, and safety behaviors were measured before the intervention and at 6 weeks postpartum. No statistically significant differences were noted between the two groups (Cripe et al., 2010).

The Project

The purpose of this quality improvement project was to implement *Abuse During Pregnancy*, a protocol for the screening and case management of IPV, on an antepartum triage unit at a 292-bed hospital serving the racially diverse population of a Midwestern U.S. city. An inter-professional team hired for the labor and delivery unit staffs the triage unit, including 36 registered nurses, medical residents, and a social worker who is available on weekdays.

Women entering the hospital's emergency department with prenatal symptoms (e.g., prolonged vomiting, vaginal bleeding, contractions, spontaneous rupture of membranes, preeclampsia) at 20 or more weeks gestation are referred directly to the antepartum triage unit located adjacent to the hospital's labor and delivery unit. The unit is composed of three private rooms with an average daily census of 7.6 patients. The length of stay typically ranges from 2 to 6 hours, with 86% of the women being discharged and 14% admitted to the labor and delivery unit.

Program Planning

The nurse manager and social worker for the antepartum triage unit expressed a need for nurses to improve their assessment skills for IPV and to communicate effectively with women experiencing violence. A need for nurses to become more comfortable with the screening process and provision of supportive interventions was discussed with the project director, a nurse educator for the hospital, particularly because a social worker is not available 24 hours per day. Training on "how to ask the question" and the "modeling of effective interventions" was requested.

The protocol's educational component includes cognitive objectives aimed at increasing a nurse's knowledge of abuse during pregnancy and how to recognize it. Expected practice outcomes focus on a nurse's ability to screen for IPV and to implement the empowerment intervention (McFarlane et al., 2007, pp. 14–15). Upon completion of training on the protocol, nurses would be expected to screen all women on the antepartum triage unit for IPV. Those experiencing IPV would be assessed for their risk of serious harm. The nurse would review the protocol's handout on IPV and safety options with the woman and refer her to community resources when indicated. The unit's social worker would be available to meet with the woman if the nurse made a referral (see Figure 1). The social worker for the triage unit collaborated with the project director on customization of the protocol's safety handout in English and Spanish. The handout was titled *Steps to Be Safe*, signifying the incremental steps required to end abuse and be safe.

All registered nurses on the labor and delivery unit participated in the project. The nurse manager helped the project director identify two nurse champions for the project, including one from each of the 12-hour shifts. They each received a copy of *Abuse During Pregnancy* and were asked to complete the book, formatted as an independent study, before the project's go-live date (McFarlane et al., 2007). Information on the project was disseminated at a monthly staff meeting when nurses from both 12-hour shifts were present.

A module on the protocol was delivered as a 45-minute narrated slide presentation that included videotaped vignettes. Slides available from the March of Dimes Web site for

continuing nursing education served as the foundation for the presentation (March of Dimes Foundation, n.d.). They were customized, and additional slides were added, to prepare nurses for implementation of the protocol on the triage unit. Narration to accompany the slides was recorded by the project director. Additionally, a script was written for a vignette that was videotaped and embedded into the presentation. The scenario involved a pregnant woman whose abusive partner was present when the nurse entered the room to perform the antepartum assessment. The presentation was formatted for the hospital's online educational system.

The module was reviewed for content and clarity by nurse experts in maternal-child care and by the organization's director of nursing education.

The videotaped vignette was recognized as an effective strategy for demonstrating content covered throughout the module. The presentation was preceded and followed by 15-item multiple choice pre- and posttests that included questions from the protocol's Independent Study Test (McFarlane et al., 2007, pp. 63–64). Before the program's launch, the two project champions completed the module. Their responses to the module were positive, and they commented that the test questions were fair and straightforward. Scores improved from the pretest to posttest for both champions and far exceeded 80%, the hospital's minimum standard for successful completion of educational modules.

In addition to development of the educational program, the project director worked with the nurse informaticist

and nurse champions to format the AAS and DA5 for the electronic health record (EHR). An affirmative response to any item on the AAS would direct the nurse to the DA5. After completion of the DA5, a checkbox would be used to indicate whether or not the *Steps to Be Safe* handout was reviewed with the woman. Space for a narrative note was added. The nurse would also be able to refer the woman to the social worker through the EHR.

Program Implementation

All nurses working on the labor and delivery unit successfully completed the online module. An in-service education program that included role playing was delivered to nurses in small groups after their completion of the online module. Nurses received 2.0 continuing education units for completing the online module and the in-service education program. A copy of *Abuse During Pregnancy* was purchased as a reference for the unit, and a raffle was held at a staff meeting during which two copies of the book were awarded to nurses on the unit (McFarlane et al., 2007).

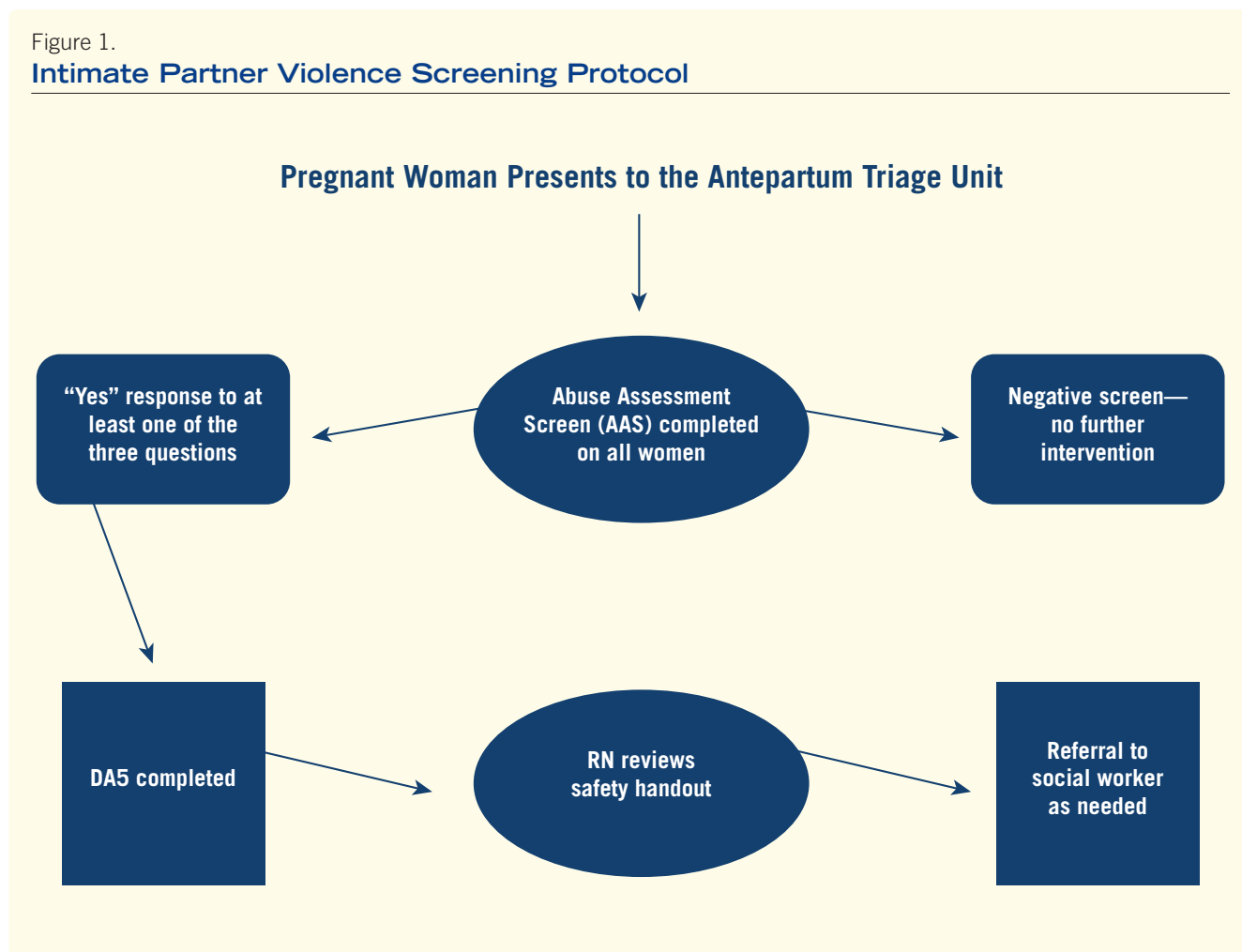
Two to six nurses attended each of the 40-minute sessions held in a spacious conference room on the unit. Copies of the AAS and DA5 were distributed, and nurses were provided with a brief script for beginning an IPV screening (see Box 1). The *Steps to Be Safe* handout, developed for women experiencing IPV, was distributed. Several scenarios included with the March of Dimes slides served as the basis for role-playing exercises, including the assessment of a pregnant woman for abuse and formation of a safety plan (March of Dimes Foundation, n.d.). A pocket-sized card that outlined the protocol's step-by-step process was developed and distributed to all participants. Phone numbers for referral agencies were displayed on the reverse side of the card. During these live sessions, nurses shared personal and

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Figure 1.
Intimate Partner Violence Screening Protocol



professional stories related to IPV. Several had been victims of IPV. One nurse recalled staying in shelters as a child. Other participants described steps they had taken to locate resources for women experiencing IPV, including Internet searches. One nurse had contacted her husband, a police officer, for information.

Program Evaluation

Nursing Education

All of the nurses participating in the project ($N = 35$) completed the module's pre- and posttests. Results were analyzed using SPSS version 22, for a paired t test to determine if knowledge of IPV and the protocol increased after completion of the module. Because the two nurse champions completed the

independent study version of the program before the online module, their scores were excluded from the analysis. The mean score for participants on the posttest ($M = 94\%$) was significantly greater than the pretest mean score of 75% ($p < .001$).

A 10-item, 5-point Likert scale program evaluation was developed based on the protocol's Module Evaluation (McFarlane et al., 2007, pp. 67–68). Items evaluated the online module and in-service education program, and space was provided for comments. The evaluation was completed at the conclusion of the live session. Mean scores for each item ranged from 4.8 to 4.9, with a score of 5 indicating a rating of *excellent*. In their comments, participants noted that they found the module's videotaped scenario particularly

effective, and the in-service program's role-playing exercises helped them envision how they would begin an assessment for IPV.

Adherence to Protocol

The project director observed nurses during weekly visits to the unit on both shifts and communicated with them verbally and by e-mail. Throughout the implementation period, nurses consistently commented that the protocol was clear and easy to follow. Rates for positive screenings on the AAS were monitored for 12 months. Monthly positive screening rates for the 3,888 women screened that year ranged from less than 1% to 2.1%, with an overall rate of 1% ($n = 39$) for the year. The DA5 was administered to all women with positive screening results on the AAS.

Box 1.

Opening Statement for Abuse Assessment Screen

“We ask all of our patients about their relationships since they can have such a large impact on your health. Because so many women experience violence in their lives, I am going to ask you three questions that relate to abuse.”

Overall, 31% of the women ($n = 12$) responded *yes* to at least one of the five items on the DA5, and 85% ($n = 33$) of the women with positive AAS screening results received the *Steps to Be Safe* handout; however, the EHR did not capture reasons for not reviewing the handout with women. A total of 64% of the women experiencing abuse ($n = 25$) were referred to the social worker.

Implications for Nursing Practice

Knowledge of IPV and the *Abuse During Pregnancy* protocol increased significantly, and the educational program was well received by staff nurses. However, the rate for positive screening results using the AAS was low compared with the previously cited results of the CDC (2017) PRAMS survey. The primary issue identified by nurses that could have affected sensitivity of the AAS for this population was the presence of visitors in the room while the assessment was conducted. The vignette in the online module and the role-playing exercises included this scenario. Content from both stressed that visitors were to leave the room before the assessment was conducted even if the visitor insisted on staying. It was evident from the nurses' comments that they found it difficult to ask visitors to leave the room to complete the antepartum assessment in a private and confidential setting with the woman. Nurses also noted that women sometimes requested that visitors remain in the room when asked to leave.

A survey of inpatient nurses that identified barriers to screening for

IPV noted the challenges that exist when family members are in the room (DeBoer, Kothari, Kothari, Koestner, & Rohs, 2013). Citing the Emergency Nurses Association's position statement on the presence of family members during invasive procedures and resuscitation, the study's authors speculated that the support of professional organizations for family presence may contribute to the lack of privacy nurses experience when discussing sensitive issues with patients. DeBoer et al. (2013) suggested that visitors be restricted during the admission process and initial assessment. Although the hospital in which this project was conducted has a policy specifying the number of visitors allowed on the labor and delivery unit, the policy includes no parameters for excluding visitors. As a result of this project, a policy revision is in process that will enable a nurse to have time alone with a woman while the antepartum assessment, including screening for IPV, is completed.

The decision to refer a woman to the social worker was left to each nurse's own discretion, and nurses were not provided with parameters for making a referral. Almost two thirds of the women with positive screening results for abuse were referred to the social worker. Although the EHR included space for a narrative note, specific reasons for a referral were not documented. It is evident from these results that nurses appreciated the availability of a social worker. The social worker for the unit has extensive experience caring for women experiencing IPV. Because almost one third

of the women who had positive screening results for abuse were at risk for serious harm based on results of the DA5, it is understandable that a nurse would refer those women for a visit with the social worker.

Conclusion

IPV affects women and families across the nation, and it has been associated with adverse pregnancy and birth outcomes. Despite recommendations for the screening of all women of child-bearing age for IPV, health care providers identify barriers to screening. *Abuse During Pregnancy*, an evidence-based protocol for the screening and case management of IPV, was implemented on an antepartum triage unit as a quality improvement project. Nurses were educated on the problem of IPV, methods for screening pregnant women for IPV, and a brief intervention. An online module and a live session with role-playing exercises were developed. Test scores indicated a significant increase in knowledge after completion of the module, and the overall educational program was rated as excellent by program participants. The AAS and DA5, instruments with predictive validity, were incorporated into the EHR. Although screening rates for the first year were below what would be expected, policy revisions were initiated to promote the screening of women in a private setting. **NWH**




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