11-2009

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Journal for Nurses in Staff Development (JNSD), Vol. 25, No. 6 (November-December 2009): 287-291. DOI.

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Abstract

Screening for intimate partner violence is an important injury prevention strategy. Nurses who develop staff education, to promote screening, need to select a method that is sensitive to learners. Online learning, although convenient, is not well suited to sensitive topics such as screening for intimate partner violence. The purpose of this article is to describe a curriculum for intimate partner violence screening based on self-efficacy theory, which includes a hospital-produced video, a role play, and a discussion.

The efficiency of online technology makes it an attractive method for education. Online learning is convenient and allows learners individual freedom. However, with online learning, communication is generally only through words on a computer screen, so feedback from the learner is delayed (National Nursing Staff Development Organization, 2006). This one-way process for the delivery of education limits the important component of interaction between the instructor and the learner. For educational content that triggers emotional reactions or teaches communication-based content, an immediate opportunity for discussion is clearly important. Therefore, as educators, it is important to recognize that online education may not always provide the best format to teach and learn. Educators need to advocate for staff nurses by selecting the medium of education that prepares them to meet the expectations of the initiative while still being sensitive to their learning needs. Although traditional classroom learning allows for interaction, it can be both time prohibitive and logistically difficult. A learning method that is time sensitive and allows for interaction is ideal for certain types of content. In this article, the authors describe the background and process used to develop an online program to teach staff about screening for intimate partner violence (IPV) in a pediatric setting.

BACKGROUND

Intimate partner violence screening, also known as domestic violence screening, is an example of a communication-based skill and an emotionally charged topic. *IPV* is defined as physical, sexual, or psychological harm by a current or former partner or spouse (Tjaden & Thoennes, 2000). IPV harms victims, their children, and communities (Centers for Disease Control, 2006; Knapp, Dowd, Kennedy, Stallbaumer-Rouyer, & Henderson, 2006; Park, Wolfe, Gokhalw, Winickoff, & Rigotti, 2005). It is a Joint Commission standard to screen patients for IPV during healthcare encounters. Those in a key position to identify and intervene with victims include physicians (Knapp et al., 2006; Park et al., 2005), nurses (Ellis, 1999; Schoening, Greenwood, McNichols, Heermann, & Agrawal, 2004; Stinson & Robinson, 2006), and social workers.

A national study found that 29% of women and 22% of men had experienced physical, sexual, or psychological IPV during their lifetime (Coker et al., 2002). Nurses have a higher incidence of abuse than women in the general population (Hinderliter, Doughty, Delaney, Pitula, & Campbell, 2006). Although it is not mandated that a child witnessing IPV be reported to Child Protective Services in Wisconsin, literature shows that witnessing IPV harms children (Kerker et al., 2000). Children who live in homes where there is IPV are more likely to be abused (Martin, 2002). Child abuse is a mandated reportable event to the Child Protective Services in Wisconsin. These requirements were considered in the development of the program's content and delivery method.

Leaders and other healthcare providers were part of a multidisciplinary team at a large Midwestern children's hospital that formed to create a curriculum to support staff members in their role as screeners for IPV. Online learning was suggested as the delivery method as recent online education rollouts had been well received. Staff and leaders noted the benefit of cost effectiveness. Online modules are an efficient method to deliver information as they are done independently. As such, they can fit into a regular work day without having to leave patients in the care of others. However, educators were steadfast in keeping in mind the emotionally charged nature of the topic and the necessity for interaction with the nurses as they learned and considered a theoretical framework to guide the development of the program.

THEORETICAL FRAMEWORKS

The theoretical framework chosen was Bandura's (1977) self-efficacy theory. *Self-efficacy* is defined as a person's belief in his or her ability to perform a specific task (Bandura, 1977). The theory includes mastery experience, vicarious experience, verbal persuasion, and physiological states as critical components that must be addressed to promote a feeling of self-efficacy. These contribute to a person's confidence in the ability to perform a specific task such as screening for IPV.

The educators also considered principles of effective instructional programs. These include (a) providing relevant information, (b) demonstrating knowledge, (c) practicing the skill, and (d) providing feedback after practice (Salas & Cannon-Bowers, 2000).

LITERATURE REVIEW

The literature provided important information about barriers for screening and potential strategies to incorporate for this communication-based education. The question was, "What is the most effective education design to teach nurses how to screen for IPV?"

The literature revealed that physicians with a high self-efficacy were more likely to screen for IPV (Park et al., 2005). The same study concluded that the content of the training that the physicians received was more important than the amount of training received. However, it appears that relatively few physicians screen for IPV (McCloskey et al., 2005). Most nurses receive education about screening for violence in their basic education programs, and hospitals have policies concerning universal screening for IPV. However, again, there is a gap between knowledge and attitudes of nurses and their actual screening behavior (Hinderliter et al., 2003).

Lack of confidence is evidenced in hospital's work environments. Nurses who do not speak up may be afraid of confrontation and intimidation or believe that doing so will have no impact (Fontaine & Gerardi, 2005). Therefore, it is essential to do more than educate with facts about IPV to encourage nurses to screen for IPV. The screening must take into account the attitudes, feelings, and beliefs of those doing the screening and those being screened (Dowd, Kennedy, Knapp, & Stallbaumer-Rouyer, 2002).

Barriers to IPV screening identified in the literature included not having enough time (Ellis,1999; Knapp et al., 2006), a lack of confidence (Fontaine & Gerardi, 2005; Lazenblatt, Thompson-Cree, & McMurray, 2006), not knowing how to ask (Ellis, 1999; Knapp et al., 2006), lack of privacy to screen (Ellis, 1999), fear of offending or scaring parent or caregiver (Knapp et al., 2006), not knowing what to do with the

information once it is obtained (Knapp et al., 2006), and the belief that IPV does not fall within the purview of pediatrics (Knapp et al., 2006). When a parent of a child reveals to the nurse that the parent is a victim of IPV, the nurse is instructed to let the parent know that the nurse is glad that the parent was able to share this information. The nurse should also confirm that the parent is not at fault. The process of the screening itself is interventional as it allows the parent to feel a sense of worth once he or she confides in the nurse (Chamberlain & Perham-Hester, 2002).

Simulation is an effective learning strategy that helps build the confidence necessary for nurses to put into effect the information that they learn in education programs. Nursing students showed a significant increase in their self-efficacy before and after simulation activities related to health teaching. They perceived themselves as more confident (Goldenberg, Andrusyszyn, & Iwasiw, 2005). Course participants in an IPV curriculum offered to emergency department staff showed consistent, positive changes in attitudes and self-efficacy (Knapp et al., 2006). The program involved a 2-hour time commitment which included definitions and concepts regarding IPV in the pediatric healthcare setting; attitudes, beliefs, and behaviors identified as barriers to screening and intervention; and the protocol for screening.

PURPOSE

The goal of the curriculum was to provide relevant information with an opportunity for practice and feedback. The educators thought that this would increase nurses' confidence in their ability to screen for IPV and further thought that the improved confidence could translate into more nurses screening parents for IPV.

EVIDENCE-BASED EDUCATION DESIGN

Content Development

A unit-based education curriculum for the staff included a hospital-produced video which contained only essential information for nurses to gain confidence in screening for IPV and know how to follow through if screening detected IPV. A nurse educator prepared a script, based on the current IPV literature and the Wisconsin regulations, for screening for and reporting IPV and child abuse. Screening should not be performed when spouses are present or if children older than the age of 2 years old are present. In addition to the scripted information, the video included actual film footage of IPV victim testimonials. Two women shared their experience with IPV and expressed the need for screening and recognition of victims in healthcare settings. The program ends with an opportunity to practice screening via a scripted role play with a partner.

The content was pilot tested as a PowerPoint presentation during the central orientation of new staff nurses. This test group provided valuable feedback during the development phase. Staff members shared publicly or privately their experience with the topic. It was clear that there was an emotional response to the presentation. Some nurses were concerned about situations where the victim wanted to maintain confidentiality and did not wish more immediate help. The educators realized that this scenario needed to be included in the role play. Evaluation of the process and content over a 3-month period solidified the essential components of the program.

Developing the Video

The essential content was placed on a teleprompter that was read during filming of the 20-minute-long video entitled "IPV Screening Education Video." Knowledge presented in the video included (a) what is IPV, (b) what IVP looks like, (c) how children are affected, (d) why it is important to know about IPV as a nurse, (e) how one screens for IPV, (f) how one can help a victim of IPV, (g) what to do if someone refuses a social work consult, (h) whether or not it is mandatory to report IPV, and (i) what resources are available to share with individuals. Information was provided as part of the video on how to contact the hospital's employee assistance program should the viewer be a victim of IPV.

The video also included the testimonials of victims and a simulation of a nurse screening for IPV. In addition, simulations of a nurse and the parent of a hospitalized infant are presented. The simulations demonstrate the IPV screening process. A decision tree which guides the learner through the screening and intervention process is presented. A standard screening question ("Because violence is an issue for so many families and can be harmful to children, we ask everyone about their exposure to violence. Do you have concerns about your safety, your child's safety or your family's safety?") was demonstrated in the video and included on the admission assessment form for nurses to read to parents when screening.

The videotaping and editing process took about 3 months to complete. Original footage was approximately 1 hour's worth of material. Editing the content was a time-consuming, challenging experience but was essential to the development of a curriculum that captured only the essential content.

Implementation Process

A VHS copy of the video as well as a DVD and all supporting education materials were placed in a tool kit. The educational materials included community resources, scripted role play activity, Just-in-Time teaching sheet outlining essential information on screening for IPV, and a personal safety plan. The personal safety plan is a resource sheet created in-house that outlines things to consider and to take when one plans to leave an abusive home. The tool kit was distributed to the department educators in preparation for unit-specific training sessions.

The hospital policy and procedure were updated to reflect the change in practice. A train-the-trainer approach was used with educators and managers of inpatient and ambulatory settings. The education was first presented at a leadership meeting with an opportunity for questions. The tool kits were distributed at the end of the meeting. All clinical staff members were included in the education. Staff nurses gathered in groups of two or more to view the 20-minute video about IPV.

After watching the video, the nurses are given a scripted role play to complete with a partner. The simulation took approximately 5 minutes. Second, the nurses read through a one-page Just-in-Time information sheet about safety resources which included a National Domestic Hotline telephone number. Small community resource cards were posted in the bathrooms throughout the hospital and clinics. Leaders provided specifics on where the resources were stored on the units and how to access them.

Key to the whole process was the opportunity for the nurses to comment and seek feedback on what they see and read. Finally, they were instructed to log in on the online education system after they completed all of the components to get credit on their electronic education records. This method was used in lieu of cumbersome sign-in sheets. No follow-up test was offered, which surprised the staff. The entire education session was 30 minutes.

Feedback

Throughout the education process, the educators gathered staff members' feedback. Staff identified that IPV was an important issue and that the education program provided essential information they needed to feel confident in their ability to screen. During the early rollout of the program, several staff members took the time to share their stories. One staff nurse stated that her experience of screening for IPV played out "just like the video role play.".

Several clinic nurses shared their experiences about screening parents of children for IPV. The staff seemed to recognize that raising awareness of the problem was a goal of the education program. Many staff members shared their appreciation for this kind of education. Staff educators reported that the staff members were able to complete the program efficiently and for the most part independently.

An important aspect of the program was information about how staff members could access support for themselves if they were victims of IPV. In the video, a human resources representative shared information about seeking help through the employee assistance program. A final message from nursing leadership encouraged staff to seek help early and to use the resources available in the institution. The message was clear that IPV affects not only patients and families but also the hospital's workforce. This message of recognition and support was well received by the staff.

CONCLUSIONS

As educators, our role is to look at the evidence base prior to selecting the education content and the teaching strategy. Taking the time up front to hone in on key evidence-based information and cultivate the essential content and messages is critical. Usability testing in a variety of forums helps the development of the material and the program. Asking staff what is both important and nonessential information is a very valuable process during the development phase of any project.

Keeping work flow in mind when designing a clinical program or implementing a program is also important. Linking a form or a process to another essential process will help the implementation. Making an information sheet for parents that they receive automatically, rather than a stand-alone form, also helps with the implementation of the project. Looking ahead for potential barriers to screening, such as the presence of other children, and minimizing the barriers were key aspects of the program. IPV screening is an emotional process for both parents and staff. Because it is not appropriate to discuss IPV in front of children older than 2 years old, we had to accommodate for the presence of children. Alternate strategies to ensure that the screening would take place once the children were not present included placing an order in the computer to screen when the children were not present. Parents tend to focus on the needs of their children who are sick and stressed. Privacy is not an easy situation to create during a child's encounter in the healthcare setting.

The act of screening for IPV can be life changing for anyone who is a victim of IPV. It can open doors and plant seeds for families and children who are suffering from domestic violence. If the screener is successful, advocacy can be contagious, and peers may follow the lead and screen others for IPV. Education that motivates staff and instills a sense of confidence that they can make a difference in the lives of the children and families they serve is the goal of any program in a family-centered environment.

Successful translation of evidence into practice occurs by providing the most relevant content in the most appropriate manner and system that supports it. The expectation should be that the education strategy will differ based on the topic and the audience. Using the evidence as the base for decision making also allows the educator to justify the choice of the education strategy, when it appears less attractive to other options such as online education.

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