

8th & 8th Health Centre
Domestic Violence/Abuse Screening Guidelines

Implementation Evaluation

August 15, 2002 to August 14, 2003

FINAL REPORT



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1.0 KEY FINDINGS AFTER ONE YEAR

Screening Results

- ▶ An average of 39% of all medical program visits were asked about domestic violence/abuse over the first year; 52% of visits were recorded as “not asked”; and 10% of visits were “not applicable” (3%) or “blank” (7%).
- ▶ Nurses asked patients about domestic violence 20,256 times from August 15, 2002 to August 14, 2003.
- ▶ Domestic violence/abuse was reported in the lives of 16% of those visits that were asked and 6% of all visits whether asked or not.
- ▶ Approximately 42.4% of all female visits were asked about domestic violence/abuse and 37.1% of all male visits. Domestic violence was disclosed in 8.2% of all female visits and 4.3% of all male visits.
- ▶ Screening rates were influenced by: shift (43.8% of day visits and 32.7% of night visits were asked); by the age of the patient (young adult visits (18 - 39 years) were most likely to be asked (42.8%), child visits (0-12 years) were the least likely to be asked (25.3%)); and by the urgency of the visit.
- ▶ Screening rates initially dropped after implementation from a high of 50.1% in the first month to a low of 28.9% at six months (Feb/Mar). The screening rate increased over the last six months of the evaluation reaching its highest rate of 52.0% in the last evaluation month (July/Aug).

Implementation Successes

- ▶ Staff at 8th & 8th have performed extremely well in terms of documenting, screening, and maintaining domestic violence screening. Screening rates are considerably higher and are maintained longer than those recorded in other emergent care settings.
- ▶ 8th & 8th staff should be commended for asking both sexes at similar rates. Asking both men and women is a unique feature of this initiative. We have found no other published studies where both sexes were routinely screened for domestic violence.
- ▶ The ED Guideline Development Committee and Implementation Discussion Group developed a strong implementation plan and provided information, resources, and training opportunities throughout the course of implementation. These activities served to remind staff of the importance of screening for domestic violence.

- Successes are also due in large part to the efforts of key staff leaders who recognized the learning process involved in implementation and ensured that guidelines were quickly adapted to meet the needs of daily nursing practice and the delivery of patient care.
- Understanding the purpose of asking about domestic violence, quickly recognizing problems, and adapting procedures to meet individual patient care needs not only validated staff concerns but also resulted in a stronger commitment to implementation.
- Staff felt that having Mental Health Services on-site gave them a feeling of control in knowing that there was help immediately available if patients chose to accept it.
- The attentiveness nurses, medical staff, and other staff show to their patients resulted in many clients responding positively to being asked and disclosing experiences of domestic violence in a setting that could address their current needs.
- Implementing screening protocols throughout the Calgary Health Region seemed to reinforce the importance of the initiative and the seriousness with which the Health Region was placing on screening for domestic violence.

Challenges

- Staff are overcoming barriers such as time and staff resources, language and cultural differences, particular patient populations, their own experiences of abuse and violence, and in dealing with a complex issue in their daily practice.
- Visits that staff felt were particularly difficult to screen include: patients who do not speak English; patients with different cultural backgrounds; children; and senior visits.
- Some nurses described difficulties with screening in terms of a process of learning how to ask about domestic violence in a fast-paced setting in a way that adequately conveys the importance of the issue in a caring and positive way.
- It was difficult for many staff to recognize the impact that simply asking the question had on addressing domestic violence.
- Regardless of some negative experiences, staff no longer think about the issue of domestic violence in the same way because of this initiative. The process of learning about the prevalence of domestic violence, the available resources, and the process of disclosing and addressing abuse and violence has not only influenced personal perceptions but positively impacted professional practice as well.

**Acknowledging the significant barriers to screening in emergent care settings,
8th & 8th staff should be commended for their efforts
and for success in this regional directive.**

2.0 INTENT OF DOMESTIC VIOLENCE SCREENING

Domestic violence is a common problem nationally. According to data from the 1999 General Social Survey on Victimization (GSS), approximately 1,239,000 people (8% of all women and 7% of all men) reported experiencing at least one incident of spousal violence from 1994-1999 (1). In Alberta, 158,000 people (11% women and 9% of men) reported spousal violence over the same period (2). Half of Canadian women (51%) have been victims of at least one act of physical or sexual violence since the age of 16 (3).

Less than 15% of abused women ever seek medical care. Of those women who do seek medical care, an estimated 75% will use emergency departments but often present with complaints not suggestive of abuse (4). Furthermore, only 2% to 8% of trauma patients are clinically recognized as abused even though research strategies and identification protocols identify abuse in 30% of the same population (5). While women use emergency departments as one of their primary health services and sources of help (6) they are unlikely to disclose abuse unless they are asked directly (7).

The prevalence of domestic violence, its recognized impact on health, and the health system's inability to identify victims has prompted professional organizations to implement guidelines and recommendations for identifying and addressing domestic violence (for example, Health and Welfare Canada 1989 (8) and the Canadian Nurses Association, 2002 (9) and 1992 (10)).

The *Calgary Health Region (CHR) Emergency Department and 8th & 8th Health Centre Domestic Violence Guideline Development Committee* (ED Guideline Development Committee) has been meeting since April 2000 to develop a comprehensive response to domestic violence in emergent care settings. Composed of physicians, nurses, social workers, and community representatives, this committee has worked together to identify and develop screening guidelines, documentation procedures, and funding and evaluation options specific to the needs of the Calgary Health Region.

On August 15, 2002, 8th & 8th Health Centre, Urgent Medical Care began a protocol where nurses would directly ask all patient visits about domestic violence and abuse in their lives using the following statement:

We know that violence and the threat of violence in the home is a problem for many people and can directly affect their health. Abuse can take many forms: physical, emotional, sexual, financial or neglect. We routinely ask all clients/patients about abuse or violence in their lives. Is this or has this been a problem for you, your family, or your child(ren) in any way?

While nurses were responsible for asking the domestic violence question, all 8th & 8th staff including physicians, security, home care, etc., had some role to play in this initiative and in

its continuation. We use the term “staff” throughout this report to emphasize the roles and responsibilities of all 8th & 8th staff.

The Committee selected the 8th & 8th Health Centre to pilot universal domestic violence screening as 8th & 8th offers 24-hour urgent medical care¹ as well as mental health, public health, continuing care services and community liaison in one location. Results were to be evaluated both to give 8th & 8th staff feedback on their performance and to identify potential issues that would impact implementation in the Emergency Departments in the Calgary Health Region.

The purpose of screening for domestic violence in emergent care settings is to:

- a. Raise awareness that family violence is a widespread problem affecting many families;
- b. Prevent further abuse through early identification and intervention;
- c. Assist individuals to identify abusive behaviour; and
- d. Intervene in domestic abuse by providing information on community resources and assisting in the development of personal safety plans.

Screening questions were designed to directly ask about abuse in order to identify both individuals who have been abused and individuals with abusive behaviour. Triage nurses were to ask all patients (regardless of sex, age, and language spoken) about domestic violence, and offer resource information, during every patient assessment. Events were to be recorded on the screening form for each visit (Appendix A). No disciplinary action would be taken against nurses who failed to screen but screening rates were monitored and reported back to the staff as a measure of performance.

If abuse was disclosed, the nurse was to validate and support the individual making the disclosure; provide information on available resources; and, develop a plan for referral and follow-up including referring clients to Mental Health where full assessments could be completed by trained staff.

Screening is viewed in the literature primarily as a secondary preventative intervention; however, by opening the door for later discussions and/or delivering the message that abuse is unacceptable to society (11), screening may also serve a role in primary prevention (12;13). It was emphasized throughout the process of implementation that raising the issue of domestic violence during patient visits was seen as an intervention in itself, regardless if domestic violence was disclosed.

¹ 8th & 8th Medical Centre provides urgent care services on a "walk-in" basis for problems that are not likely to require hospitalization. 24 hour x-ray and lab services are available

3.0 EVALUATION COMPONENT

Potential issues surrounding training and implementation for Emergency Departments in the Calgary Health Region were to be identified through a process evaluation of pilot data collected over the first year of implementation. This data would also be used to assist 8th & 8th assess their performance (by screening rates), identify problems and successes as they unfolded, and to include staff opinions in the process of implementation.

The Office of Medical Bioethics at the University of Calgary and the Adult Research Committee of the Calgary Health Region approved the study prior to data collection.

An evaluation of pilot data was not to determine if domestic violence screening protocols would continue or not but to identify ways of facilitating implementation in CHR Emergency Departments. Of particular interest to the ED Guideline Development Committee, the Implementation Discussion Group, and 8th & 8th staff was feedback to training, screening rates, disclosure rates, and staff opinions of the screening process. Due to the limited funding provided for this evaluation, outcomes such as the impact of screening and/or disclosure on patients could not be measured.

A number of methods were employed to gather data for this process evaluation:

- To measure screening rates, disclosures, and potential influencing factors, PHANTIM data was extracted and anonymized by Calgary Health Region Performance and Data Management and analysed using Stata 8;
- To gather information not recorded in PHANTIM, a review of screening forms in 100 randomly extracted patient charts was completed and extracted data was analysed using Stata 8;
- Feedback forms (n= 41) were collected from four training sessions held prior to implementation and analyzed with qualitative analysis software (QSR N5);
- Qualitative Data was collected through interviews with key 8th & 8th staff, through the anonymous “Comments” section in the “DV Resource Binder” (n= 4), from responses to a feedback questionnaire distributed by the Clinical Educator December 2002 (n= 6), written feedback to a poster presentation (n=3), and from discussions during the “Refresher Course” offered to 8th & 8th nurses as part of their Recertification (July 2003);
- The Research Coordinator attended 8th & 8th Implementation Discussion Group meetings and ED Guideline Development Committee meetings;
- Data was extracted from documents and meeting minutes; and
- A review of the current (1998 to present) literature on domestic violence screening in emergent care settings was completed.

Since data was to be used to inform both the ED Guideline Development Committee and the 8th & 8th staff, steps were taken to ensure that quantitative data would be made available in a timely manner and that feedback from nurses and physicians would be actively sought and incorporated into implementation and evaluation strategies on an ongoing basis. The ED Guideline Development Committee recognized from the outset that evaluation data needed to be collected for longer than six months to allow staff time to become aware of and comfortable with the screening and referral process.

Data collection for this evaluation began August 15, 2002 and ended early December 2003.

4.0 PROCESS OF IMPLEMENTATION

The *CHR Emergency Department and 8th & 8th Health Centre Domestic Violence Guideline Development Committee* (ED Guideline Development Committee) initiated a number of activities, materials, and support systems in order to facilitate implementation at 8th & 8th including: domestic violence guideline training sessions for all staff; screening guidelines; screening forms in patient charts; resource information on domestic violence; and information made available to clients. These activities were designed to provide the needed resources and supports were available to ensure the successful implementation and maintain of the screening protocols. We briefly discuss each of these and identify some of the issues surrounding their implementation.

4.1 The Implementation Discussion Group

Including members from the ED Guideline Development Committee, the Implementation Discussion Group was formed to identify ways of introducing routine screening for domestic violence in the 8th & 8th Health Centre. This group met regularly to discuss ways of implementing and maintaining routine domestic violence screening, keeping in mind both the unique services and clientele of 8th & 8th and the needs of the larger implementation in CHR Emergency Departments. This group was instrumental in ensuring that screening guidelines were realistic and adaptable.

4.2 Key Staff Leaders

There were a number of key staff who served as “leaders” in this initiative and were crucial to its success. As the main resource person for protocols, the Clinical Educator for Medical/Urgent Care², the Team Manager for Urgent Care, and Manager, Mental Health Services provided information and quick feedback, addressed the concerns of nursing staff, physicians, and patients, and consistently reinforced the goals and outcomes of the guidelines. For example, the Clinical Educator received numerous comments about the protocol in the first five days of implementation. An emergency meeting was held to address these concerns and Q & A (Question and Answer) documents were produced to clarify confusions and assist the screening process (Appendix B).

The Manager of Mental Health Services and the Medical Director also played important roles in ensuring that screening guidelines were integrated into 8th & 8th health services. These individuals continue to support staff in following the guidelines, identifying

² Two people held the Clinical Educator for Medical/Urgent Care position over the course of this evaluation. Both were equally knowledgeable individuals dedicated to implementing DV screening guidelines. Therefore, we define the position and not the individual.

emerging issues, and providing feedback to both staff, the Implementation Discussion Group and the ED Guideline Development Committee.

4.3 Training

Training was offered to 8th & 8th staff in late May 2002. Sessions included information on guideline development, definitions and terms, an overview of the nurses' role, procedures, and community resources. Funds were provided for replacement staff so that all nursing staff could attend a training session prior to the implementation date. Funds were also available for physicians to attend training sessions but they did not attend any of the sessions.

Feedback to Training Sessions

One-page questionnaires were distributed at the end of training sessions in order to gather feedback on the information presented. A total of 41 responses were gathered from four separate training sessions.

In the questionnaires, staff reported that they felt more comfortable asking about domestic violence because they learned about the procedures and expectations, the standard questions to ask, and because they will be asking everyone the same questions. There was also a sense that staff were more confident in asking about domestic violence because they now recognized the prevalence of domestic violence in their community and that there were many resources in the community to address the issue.

Staff expressed their concern for their clients' well being. In their responses, staff wanted to know more information about what they may be "getting their clients into" when they screen for domestic violence. Staff were genuinely interested in learning more about the agencies involved especially concerning aspects of the Justice system, Shelters and the Calgary Sexual Assault Response Team (CSART).

Overall, comments about the training session and specifically about the presenters were very positive but were mixed with some skepticism. As one respondent recognized:

I think the presentation was very well done. Diverse speakers, dynamic, experienced, lots of relevant case scenarios. I feel some resistance; it will just take time to become comfortable.

While comments to the training sessions were overwhelmingly positive, perceptions of the training changed after the guidelines were put into place. In feedback gathered post-implementation, some staff felt that they could have used more "how to" information and practice and examples to use in different situations. While training was successful in introducing key aspects of domestic violence, first hand experience and was necessary in beginning to make screening part of practice.

4.4 Domestic Violence Screening Guidelines

Written as a staff resource, the 8th & 8th Health Centre Domestic Violence Guidelines provide universal screening questions for early identification of violence issues and referral to resources both within the Health Centre/Emergency Department and in the community. The guidelines were developed for piloting in the 8th & 8th Health Centre and implemented in the Calgary Health Region Emergency Departments and are consistent with the guidelines established by the Canadian Nurses Association (10). The guidelines were not intended to replace existing practices and protocols for sexual assault and child abuse.

The Screening Guidelines provide an outline definitions of domestic violence, the purpose of universal screening, ways of asking about domestic violence, exceptions to screening, goals of intervention, steps in interventions, documentation and confidentiality procedures, interagency conflict resolution, and education resources³. Copies of the guidelines and other resources information were given to staff during training sessions. Copies were also located in the Domestic Violence Resources Binder (DV Binder) for easy reference.

4.5 Screening Forms

A separate screening form was added to all patient charts to become part of the patient record (Appendix A). Its purpose was two-fold: 1) to prompt and assist nurses in asking the questions as outlined in the guidelines, and 2) as a data collection source for evaluation purposes.

The original form included the standard statement and questions for all patients. Nurses were to use the form to record:

- If the patient was screened (yes, no, reason not asked)
- If language cards / line were used (yes, no)
- If abuse was disclosed (yes, no)
- If abuse disclosed, how long ago?
- If abuse disclosed, what happened?
- If abuse disclosed, is the patient safe now? (yes, no)
- If resource information was offered (yes, no)
- If Mental Health services were offered (yes, no)

Steps to be taken when abuse was disclosed were also outlined on the form. Data recorded on the forms was to be entered into PHANTIM for analysis.

Changes to the Screening Form

Within the first week of implementation, it became apparent that there were problems with the screening form. For example, when asked if abuse was a factor for their families in any

³ Refer to the 8th & 8th Health Centre Domestic Violence Guidelines document for more detailed descriptions.

way, nurses were told stories of the patients' distant relatives. When asked how long ago the abuse occurred and/or what happened, patients often gave lengthy descriptions of abuse that occurred many years ago but currently had no immediate safety concerns. The screening form as written was sometimes creating long patient visit times and forcing nurses to learn about problems that would be better addressed by Mental Health services.

As a result, the original screening form was revised within the first two weeks of implementation. The "family" aspect and the "what happened?" parts of the question were deleted and the form was rewritten to better identify immediate safety concerns.

Even with the changes, the screening form itself did not do what it was intended to do. For example, it was often placed underneath the main assessment form and instead of serving as a prompt for nurses, it was sometimes unseen and simply "forgotten about." Also, the forms did not serve as an effective data collection tool as many were not fully completed nor was all of the information from the forms entered into the database.

The paper version of the screening form was eliminated in May 2003 and the screening questions are currently included directly on the nursing assessment form (with other standard patient questions). Interestingly, both screening and documentation rates increased after this change but we cannot assess if this was due to changes to the screening form itself. Learning from this experience, the CHR Emergency Departments opted not to have a separate form and placed the domestic screening questions directly into the patient assessment.

4.6 Resource Information for Staff

Information on domestic violence and resources were provided to staff through a variety of means. In the training sessions, staff were given a package containing various information materials. These materials were also available in different areas of the Centre. Copies of the Calgary Resource Inventory were placed in every exam room. Language cards with the domestic violence screening question written in 12 different languages, as well as cards in large print and in easy language were available in the triage areas and in the back rooms. A "DV Binder" was easily accessible and located in the Clinical Educator's office and contained copies of the guidelines and decision tree, CSART information, information on child welfare, publications on the topic, and a section where anonymous comments and questions could be written.

4.7 Information for 8th & 8th Clients

8th & 8th Health Centre initiated a number of activities to raise awareness and prepare clients to be screened. Posters on domestic violence were posted in the waiting area and changed periodically to catch patients' attention. Information on domestic violence and resources

were made available to clients both in the waiting area and in private examination rooms. Throughout the process of implementation, the Implementation Discussion Group explored ways of communicating messages about domestic violence in different ways (such as changing the location and/or putting up new posters) that would catch the attention of 8th & 8th patients. These activities were intended to create an environment that informed clients that abuse is a significant issue and that staff was able to assist.

Wallet sized “24-hour Help for Everyone” resource cards, listing the available services, were to be offered in every patient visit. These cards were also available in 12 different languages and were to be found readily accessible in all examining rooms. Contact information and operating hours for 8th & 8th Mental Health services were stapled to the cards to emphasize that help were also available at the Centre itself. These cards were viewed as the primary method for informing patients about domestic violence services in Calgary.

4.8 Feedback Opportunities

Key components to implementation success were opportunities for staff to give their perspectives of the initiative and to have their concerns validated and addressed. The ED Guideline Development Committee, Implementation Discussion group, and especially, key staff leaders provided many opportunities for staff to express their views. For example, providing pages for anonymous feedback in the information binders; distributing comment sheets to be completed; staff being able to “drop-in” to discuss particular problems on an individual basis; asking staff their opinions at meeting and training sessions; and providing staff with evaluation results on a regular basis.

Recognizing that staff are often asked to implement many procedures but are rarely recognized for the effort involved in doing so, key staff leaders made it a point to commend staff for their efforts throughout the implementation process. At the end of the evaluation period, leaders worked with the evaluators to design a poster illustrating evaluation results and a commendation to 8th & 8th staff (Appendix C). This poster was displayed in the staff room and refreshments were provided to reward staff on the success of the initiative. The research coordinator was on-site for one morning to gather feedback to evaluation results.

4.9 Domestic Violence Refresher Course

An hour dedicated to “Protocol Refresher” was integrated into re-certification sessions for nurses May 26 and June 2, 2003. The one-hour refresher component included a review of the protocol procedures, and update on responses to domestic violence in the community, and an opportunity for feedback and discussion about protocol use and barriers to screening. The Research Coordinator attended both sessions, documenting the discussion and offering information about the evaluation when requested. It is interesting to note that screening rates increased over the three months following the refresher session.

4.10 Summary

The successes in implementation can be attributed in large part to the activities set out by the ED Guideline Development Committee and Implementation Discussion Group. Providing information, resources, and training opportunities throughout the course of implementation served to remind staff of the importance of screening for domestic violence during every patient visit. The success is also due to the efforts of key staff leaders who recognized the learning process involved in implementation and ensured that guidelines were adapted to meet the needs of 8th & 8th staff and patients.

5.0 SCREENING RESULTS

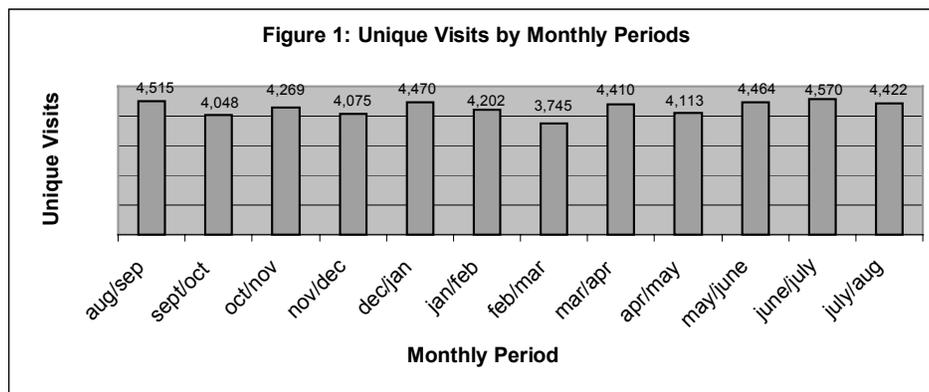
5.1 Methods

The patient data for this analysis consisted of chart data routinely collected at 8th & 8th Clinic and data from the domestic violence screening form. Personnel from the Calgary Health Region's Performance and Data Management staff retrieved specified non-identifiable data including: assigned unique id; date of visit; time of visit; date of birth; sex; domestic violence screening and CAEP codes. Limits were set so that only unique, face-to-face, medical program visits, with no V07.8 diagnosis codes or sub-codes were included in the data. All data for was analyzed using Stata 8 statistical package for Windows.

The analyses reported here are based on the number of unique visits, NOT the number of unique patients. That is, the same patient may be included multiple times. This is appropriate, as any given patient may be asked or not asked about domestic violence/abuse at each visit.

5.2 Descriptions of Patient Visits

Over the 12-month period, a total of 25,236 patients accounted for 37,834 unique visits to the medical program at 8th & 8th. The number of visits in any given monthly period ranged from 3,743+ in mid-February to mid-March 2003 to 4,500+ in mid-August to mid-September 2002 (Figure 1).



Based on information provided by 8th & 8th, there are three typical nursing shifts: days (7 a.m. - 3 p.m.), evenings (3 p.m. - 11 p.m.), and nights (11 p.m. - 7 a.m.). Over this 12-month period, the average percentage of visits recorded on days (46.4%) is slightly higher than evenings (42.1%). Patient visits recorded in the night shift accounted for only 11.4% of total visits. This trend stays relatively constant over time. The majority of visits (81.6%) were coded by CAEP codes as semi- or non-urgent.

Of all patient visits, 6.9% were children (0-12 years), 4.3% were adolescents (13-<18), 55.9% were young adults (18-<40), 28.1% were midlife (40-<65), and 4.8% were seniors (>+65). The mean age of patient visits in the population seen over the 12-month period was 34 years, with a range of 7 weeks old to 102.6 years old. Males had a slightly higher mean age (34.6 years) than females (33.3 years). Adults between the ages of 18 and 64 comprise 85% of the patient visits seen in the 12-month period.

5.3 Screening by Monthly Periods

In order to examine trends over time, yet limit the time periods to a reasonable number, we grouped the 12-month period into monthly periods as follows (Table 1):

Date	Period	Label in Analysis
Aug 15/02- Sept 15/02	1	aug/sept
Sep 16/02- Oct 15/02	2	sept/oct
Oct 16/02-Nov 15/02	3	oct/nov
Nov 16/02-Dec 15/02	4	nov/dec
Dec 16/02-Jan 15/03	5	dec/jan
Jan 16/03-Feb 15/03	6	jan/feb
Feb 16/03-Mar 15/03	7	feb/mar
Mar 16/03-Apr 15/03	8	mar/apr
Apr 16/03-May 15/03	9	apr/may
May 16/03-June 15/03	10	may/june
June 16/03-July 15/03	11	june/july
July 16/03-August 15/03	12	july/aug

Database entries included eight responses: “blank”; “not applicable”; “not asked”; “no”; “no domestic violence/abuse”; “yes”; “yes-checked on form”; “yes-domestic violence/abuse.” We defined these as follows (Table 2):

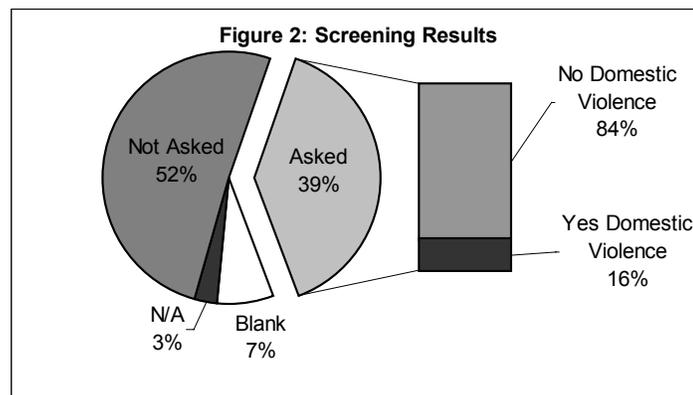
Blank	Screening form not completed.
Not applicable	Patient visit was not asked / assessed, reason was to be given but was not recorded by Information Systems.
Not asked	Patient visit was not asked, no reason recorded.
No No Domestic violence	Patient visit was asked but no disclosure of violence
Yes Yes-checked on form Yes-domestic violence	Patient visit was asked and violence was disclosed

Because of the initial confusion over how to enter the screening forms into the database (explaining no values past late August for “no,” “yes,” and “yes-checked form”). These were regrouped by definition into the categories of “blank,” “not applicable,” “not asked,” and “asked.”

“Blank” forms contained no data. “Not applicable” was entered when the patient visit cannot be screened for any of the reasons outlined in the screening guidelines (including patient leaving before being assessed by a nurse). “Not asked” and “asked,” indicate whether the patient visit was screened or not.

5.4 Screening Results

As illustrated in Figure 2, of all patient visits over the initial nine-month period, approximately 39% of patient visits were asked about domestic violence/abuse, 52% were not asked about domestic violence/abuse, 7% of the forms were blank, and 3% of all patient visits were not applicable. Domestic violence/abuse was reported as an issue in 6% of all visits to 8th & 8th whether asked or not asked. When asked, domestic violence was reported in 16% of patient visits.

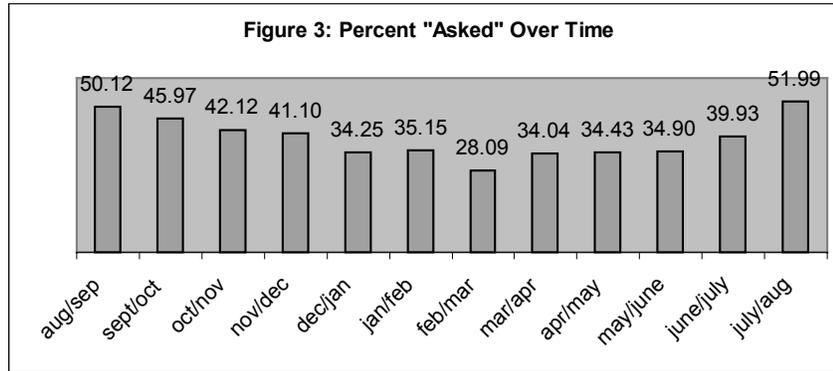


Of the 16% of patient visits (n=3,101) where domestic violence was disclosed, 61.1% (n=1,892) were female.

It is important to note that over 7% of all screening forms were blank. We cannot assess whether these patient visits were screened or not. We also do not have data on reasons why visits were not asked.

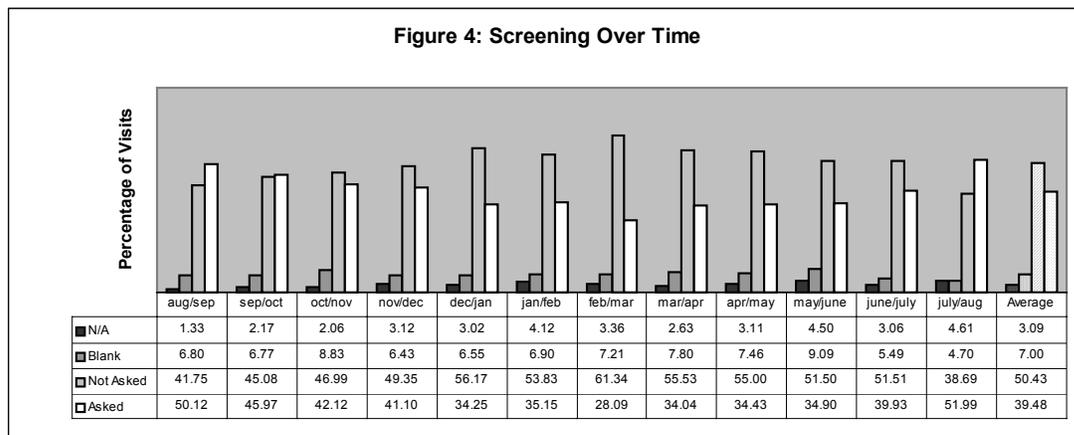
5.5 Screening Patterns Over Time

Screening rates fluctuated over the first year of implementation (Figure 3), from an implementation high of 50.12%, to a low 28.09% around midpoint, and to highest recorded rate of 51.99% in the last month of evaluation data. 8th & 8th achieved an average screening rate of 39.48% over the first year of this directive.



Staff at 8th & 8th should be highly commended for achieving this high screening rate and for not only maintaining the high rate but also increasing it towards the end of the evaluation period. Comparatively, protocols in similar settings report screening rates of 10% to 30% at implementation (7;14-17) and report steep declines in screening rates within the first year) (18).

As illustrated in Figure 4, staff have also improved their documentation practices over time, resulting in more accurate data for analysis. On average, 7.0% of forms were recorded as "blank" (93% completed) with documentation improving from the rate at implementation (94.2% complete, 6.8% blank), achieving the highest rate of 96.3% completed (4.7% blank) in the last month of analysis.



The documentation rate achieved by 8th & 8th is especially notable as other researchers identify lack of documentation as one of the primary limitations to evaluating screening protocols/ guidelines in health care settings. For example, in an evaluation of health service interventions in response to domestic violence against women (United Kingdom), Watts (2002) reports that only 4.3% of eligible forms were returned for analysis. In an Australian evaluation, Laing (2001) reports that only 29% of forms were completed.

In conversations, 8th & 8th staff reported that the increase in screening rates and documentation in the last three months of the evaluation may be the result of a number of initiatives including: emphasizing documentation practices during staff meetings; the “refresher” seminar during re-certification week; the implementation of screening guidelines in all CHR emergency departments (“*We are not alone in this*”); and, improved communication of results from the evaluators enabling key staff leaders to address identified issues.

5.6 Screening Patterns by Shift

When examining shift patterns of screening for domestic violence/abuse (Figure 5), we see that:

- On any given shift, about 10% of visits are recorded as either “blank” or “not applicable”;
- The highest percentage of asking (on any given shift) is days – 43.77% of day shift visits are asked about domestic violence; and
- Night shift tends to ask the least – 32.7% of night shift visits are asked about domestic violence.

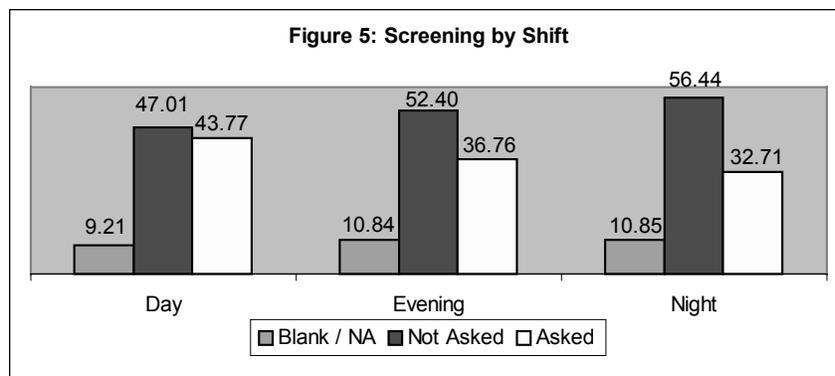
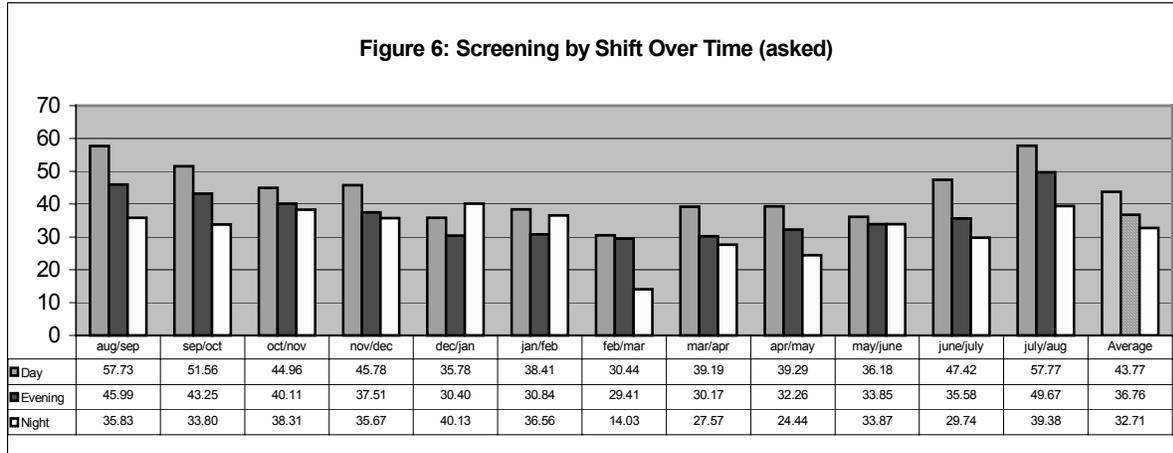
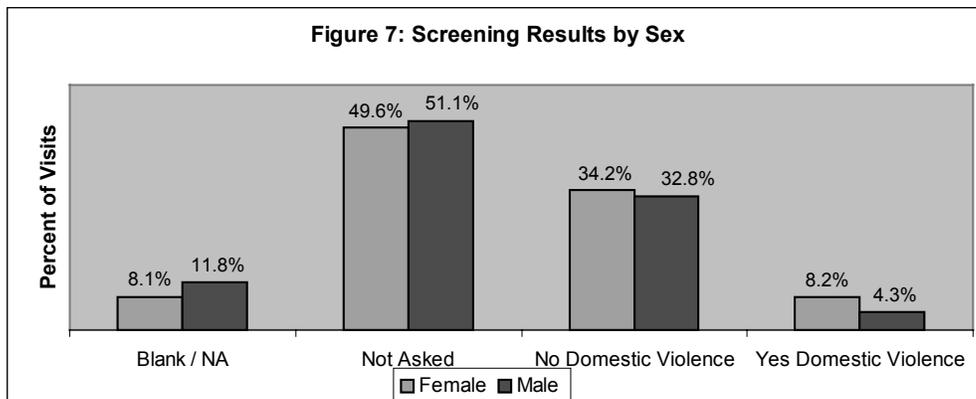


Figure 6 illustrates how screening pattern by shift changed over time. Overall, day shifts screened more visits (43.8% average) than evening shifts (36.8% average) and night shifts (32.7% average). The night shift has shown the most fluctuation in screening rates, which might be attributed to changing staff and staff to patient ratios. It should be noted that during December 16 to January 15, the night shift was screening at a higher rate (40%) than both day (36%) and evening (31%) shifts.



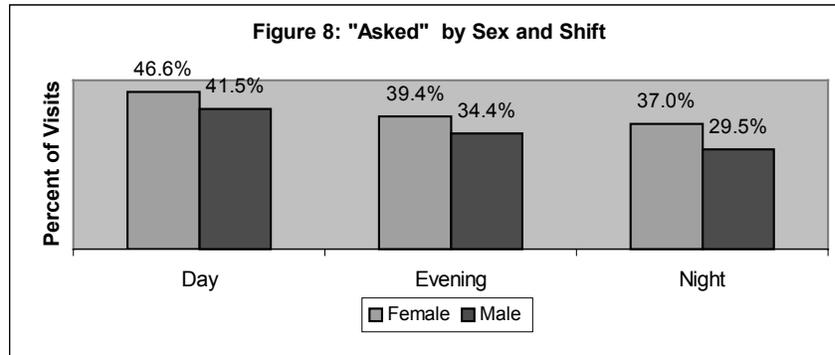
5.7 Screening and Sex of Patient

Of the 51,303 patient visits for whom sex is known⁴, approximately 42.4% of all female visits were asked about domestic violence/abuse and 37.1% of all male visits (Figure 7). Domestic violence was disclosed in 8.2% of all female visits and 4.3% of all male visits.



⁴ There were 32 entries where the sex of the patient was unknown. These patients were excluded from analysis of variables by sex.

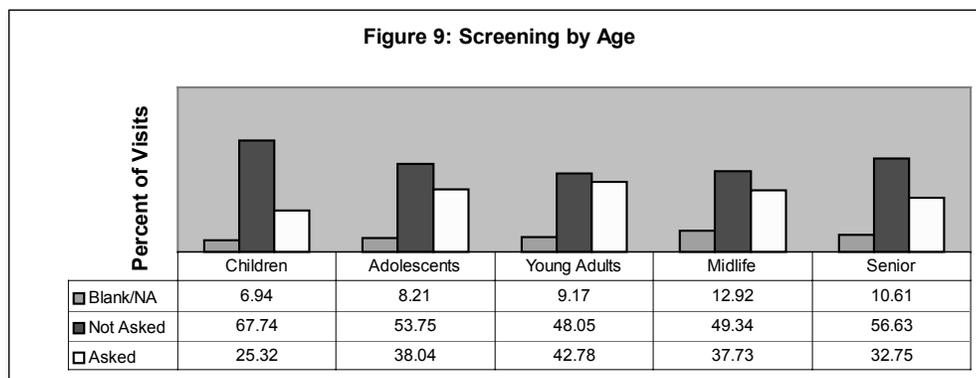
As Figure 8 illustrates, during the day and evening shifts, female visits are slightly more likely to be asked about domestic violence/abuse. On the night shift, the difference increases to 38% of female visits asked compared to 28% of male visits asked.



Asking both men and women is a unique feature of this initiative. We have found no other published studies where both sexes were routinely screened for domestic violence. Typically, the term “universal screening” implies that all *women* are to be screened for domestic violence. 8th & 8th staff should be commended for asking both sexes at similar rates.

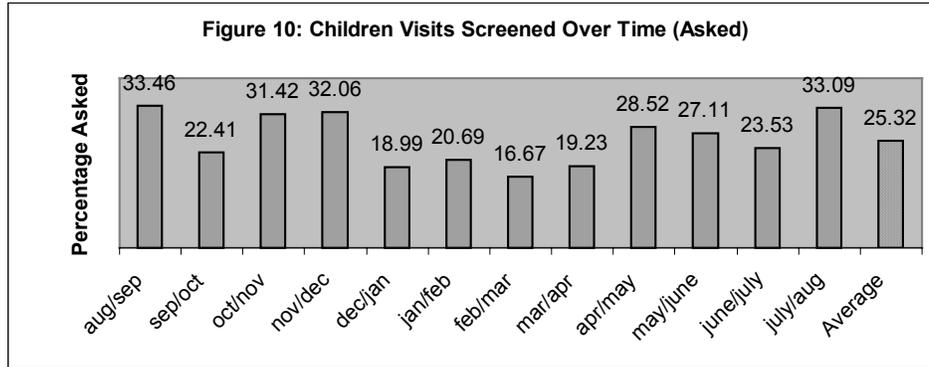
5.8 Screening and Patient Visit Age

Within the age groups (Figure 9), children visits (0-<13) were the least likely to be asked about domestic violence/abuse (25.32% asked). Senior visits, making up 4.9% of all visits, are only asked 32.8% of the time. Young adults (18-<40) were the most likely to be asked (42.8%). These trends hold for both sexes and over time.



Over the past year of implementation, staff have recognized that screening for domestic violence is most problematic during children visits and have had many discussions about screening this population.

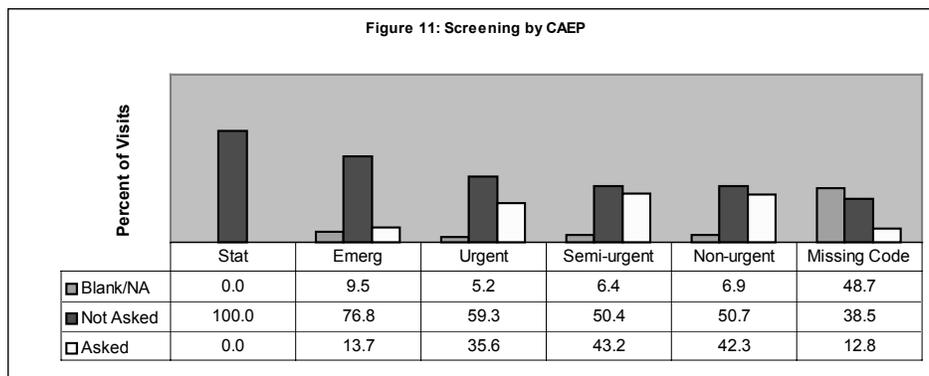
Screening of children visits dropped suddenly from 33% at implementation to 22% after the first month (Figure 10). The screening rate rose again between months three and four (31%, 32%) and remained under 21% until month nine. Children visit screening rates have increased to an average of 27.3% over months nine to twelve. Overall, screening for domestic violence during children’s visits remains a challenge.



5.9 Screening and Urgency of Patient Visit (CAEP)

We examined the relationship between CAEP codes⁵ and those who were asked the domestic violence/abuse questions. All patients classified as “stat” or requiring emergency care are not to be asked the domestic violence question until their status is downgraded to “non-urgent.” There were no visits classified “Stat” during the three-month period.

Almost nine percent of visits (n=4,436) were missing data for this variable. As shown in Figure 11, as urgency of the visit decreased, the more likely it was that the visit was asked the domestic violence questions. Of those assigned CAEP codes (n=11,046), 42% of semi-urgent and non-urgent visits were asked the domestic violence protocol questions. Over 13.7% of the “emergency” visits were asked about domestic violence despite the urgent nature of these visits.



⁵ CAEP codes, or assigned safe wait time intervals, are coded as: I - Stat (resuscitation); II - Emergency (< 15 minutes); III - Urgent (15 -30 minutes); IV - Semi-urgent (30-60 minutes); V - Non-urgent (1-2 hours).

5.10 Data Limitations

Interview and feedback data revealed that staff sometimes did not use the screening form for a number of reasons. Some felt that it was obvious from the patient chart why they did or did not screen (for example, level of urgency; patient history; domestic violence already identified). Others simply did not see the form in patient charts but may have actually asked about domestic violence. Blank forms may have also been recorded as “not asked” by information systems, an error as we cannot know if these patients were asked or not during these visits.

Many staff felt that the screening rate was actually higher than indicated through the screening forms. Actual screening rates may be higher than reported due to errors in data entry. We cannot know the number of “blank” or “not asked” entries that should have been recorded as “not applicable” nor can we know if “blank” visits were asked or not. There are situations when a patient should not be asked about domestic violence including needing urgent care (in which the patient should be asked once the medical situation is addressed), lack of privacy, or having a family member present (where the nurse is supposed to ask to speak with the patient alone). Other reasons for not asking included language and cultural barriers, hostile patients, patients with limited mental abilities, and patients known to the nurse.

5.11 Summary

The staff at 8th & 8th have performed extremely well in terms of documenting, screening, and maintaining domestic violence screening. 8th & 8th staff have achieved an overall screening rate of 39%, maintained a screening rate of approximately 37% over months 6 to 12, and reached a 52% screening rate in the last month of analysis. Furthermore, documentation rates increased over the last months of the evaluation period achieving an overall documentation rate of 93%. Similar studies have reported a response rate (completing the forms) as low as 4%. Similar to other evaluations, patient visits are more likely to be screened if they are young adult female, and present during the day with less acute symptoms (17). Data from 8th & 8th follows this trend. These rates are considerably higher and are maintained longer than those recorded in other emergent care settings (7;14-20).

6.0 CHART REVIEW

In order to examine patient questions found on the screening form but not entered into PHANTIM, we examined 100 randomly pulled charts of patients seen within the first nine months of implementation (August 2002 to May 2003).

Unfortunately, over 80 (56%) of the patient visits in the pulled charts had no screening information either because the form was blank (n=36, 25%) or missing from the file (n=44, 30%)⁶. It is impossible to assess if the patient was asked about domestic violence in these cases.

Despite the missing forms, the random chart review showed similar screening rates as recorded in PHANTIM. In total, 50 of the 144 patient visits in this sample were screened for domestic violence (34.7%). Among those patient visits asked, abuse was disclosed 13 times (26% of all visits asked, 9.0% of all patient visits). Four patient visits (2.78%) were not assessed by a nurse and therefore would not have been screened for domestic violence. There was a high representation of children in charts pulled (51.75% of patient visits in this sample were <18 years as compared to 11.2% of patient visits in PHANTIM) which may have an impact on results.

Only 10 visits (6.94%) clearly indicated that the patient visit was not asked about domestic violence. Reasons given for not asking centred on lack of privacy including: family member present during visit (n=4); child with parents (n=2); MD came in (n=1); friend present (n=1); and left without being seen (n=1, which should have been recorded as “not applicable”).

6.1 Language Cards

Of the 50 visits that were known as screened, 52% reported that language cards were not used and 48% of the entries were left blank. Therefore, the language cards were not indicated as used in any of the visits in this sample. Language was not listed as a reason for “not asking” on any of the forms examined.

6.2 Safety

Out of those who did disclose domestic violence (13 patient visits), 92.3% of those reported that they presently felt safe (n=12 of 13). One patient visit reported not always feeling safe and one patient visit reported not feeling safe at the moment but was seeking help.

⁶ Key staff noted that Data Management was mistakenly removing blank screening forms from patient charts, a problem that was addressed early in the initiative.

6.3 Resources Offered

Of the 13 people who disclosed domestic violence, 2 accepted and 4 declined other resource information (8 were blank).

6.4 Summary

The chart review was limited in its ability to give us more information on screening practices. There were a high number of children visits, already identified as difficult to screen, represented in the sample which may have influenced findings. Also, the low number of completed forms does not give us much information to work with. We can infer that 26% of the patients disclosed domestic violence but very few had immediate safety concerns. Language cards are either not being used or are not needed to screen patient visits nor do many disclosures accept resources. Also, while resource information is to be given to all patient visits, this action is rarely documented.

7.0 IMPLEMENTATION SUCCESSES

- Consistently higher than average screening, disclosure, and documentation rates;
- Domestic violence screening complements patient services already offered by 8th & 8th;
- Supportive team to address concerns as they arise;
- Procedures adapted to meet the needs of daily nursing practice;
- Positive client feedback;
- An understanding of the importance of screening even when it is difficult to do so.

7.1 Screening Results

Screening guidelines at 8th & 8th outlined asking all patient visits, regardless of the patient's sex or age, about the possibility of domestic violence in their lives. Given this definition of universal screening, there are very few available Canadian studies evaluating domestic violence protocols/guidelines in Health care settings and comparable literature on screening for domestic violence has been difficult to find. The term "universal screening" is typically defined in the literature as only women screened. We could find no studies that include both women and men in the definition universal screening (as in the case of 8th & 8th). Furthermore, most evaluations only assess screening rates for adult women (>18). Results for screening parents during children's visits are presented in terms of pediatric care settings and separate from evaluations of adult patient screening.

Screening may have been facilitated by the definition of "universal." Although this was not directly assessed in the evaluation, training feedback and interview data revealed that staff may have been more comfortable with screening because they knew that everyone would be asked rather than select groups and could reassure patients that they were not being "singled out". This allowed them to develop the habit of asking the question at every visit regardless of the client. Knowing that all of the Emergency Departments in Calgary would be mandated to implement the same screening procedures also helped staff recognize the importance of routine screening and gave them a sense that they "were not alone." This was also observed in an Australian evaluation of screening in different health settings where screening in emergency departments increased from 7.6% screened and 1.6% disclosures to 23% screened and 8.5% disclosures upon implementation of a larger multi-site initiative in the 2nd phase (16). Implementing screening protocols throughout the Calgary Health Region seemed to reinforce the importance of the initiative and the seriousness with which the Health Region was placing on screening for domestic violence.

7.2 Screening Rates

8th & 8th's average annual screening rate of 39% is considerably higher than rates documented in the literature on domestic violence screening in emergency settings. For example, Australian emergency departments with screening protocols in place recorded screening only 23% of eligible patients (16). An American evaluation of screening in the ED recorded a screening rate of 29.5% over the first year (17).

Screening rates initially dropped after implementation, from a high of 50.14% in the first month to a low of 28.9% at six months (Feb/Mar). Other protocol evaluations report screening rates of 10% to 30% at implementation (7;14;15;17) that steeply decline over the first year of implementation (18). In contrast to these trends, screening rates at 8th & 8th steadily increased over the last six months of evaluation data and reached the highest screening rate of 52% in the *last* month of the evaluation period (July 15 to August 14, 2003). As presented earlier, this increase may be attributed to a number of initiatives including refresher courses, key staff leaders emphasizing the importance, implementing guidelines in *all* CHR Emergency Departments, and staff increased comfort in raising and addressing the issue.

7.3 Disclosure Rates

Disclosure rates as a result of direct screening do not accurately measure the prevalence of domestic violence in a population, as many patients may not disclose when asked. We know that the nature of domestic violence often means that a victim may be asked about the presence of violence in their life many times before s/he seeks assistance - otherwise known as "the dance of disclosure"(21). Furthermore, this disclosure may occur at a later time and/or setting than where the issue was first raised (22-24).

At 8th & 8th, 16% of those patient visits asked responded that domestic violence or abuse was an issue in their lives at some point. We do not know how many of disclosures had immediate safety concerns but data collected from interviews with staff suggests that this number was very low. As well, very few patients accepted the offer of help from Mental Health Services for this issue. Staff also reported being very surprised at the number of male disclosures of previous abuse (usually childhood abuse) both in terms of prevalence and in terms of male patients being comfortable enough to disclose.

Comparably, Vancouver General reported disclosure rates of 6% with universal screening (adult women only)(22);(25). Other evaluations report identification rates of 2.6% without universal screening procedures in place (19). The higher disclosure rate at 8th & 8th than reported in the literature may suggest that staff were successful in creating an environment whereby patients felt comfortable to talk about abuse.

7.4 Documentation

As noted earlier, staff at 8th & 8th have improved their documentation practices over time resulting in more accurate data for analysis. On average, 7.0% of forms were recorded as “blank” (93% completed) with documentation improving from implementation (93.2%) to the highest documentation of 95.3% in the last month of analysis. This is especially notable as other researchers identify lack of documentation as one of the primary limitations to evaluating screening protocols or guidelines in health care settings. In an evaluation of health service interventions in response to domestic violence against women (UK), Watts (2002) reports that only 4.3% of eligible forms were returned for analysis (26). Another report from Australia reports that only 29% of forms were completed (16).

We should caution that blank forms may have also been recorded as “not asked” by information systems, an error as we cannot assume that these patients were asked or were not asked during these visits.

7.5 Supportive Team

One of the primary reasons why the implementation of domestic violence screening guidelines at 8th & 8th was successful was the supportive team environment in which they were implemented. Staff did not hesitate to share their opinions on how well or not the guidelines were working for them and their clients, and the Implementation Discussion Group addressed their concerns as best as they could.

The success of this initiative was also assisted by having knowledgeable and dedicated staff on-site to address problems as they arose. This is preferable than having an external contact person who may not have understood the unique ways in which 8th & 8th operates. Within the 8th & 8th team, the Clinical Educator Medical/Urgent Care, Team Manager for Urgent Care, and the Manager, Mental Health Services continue to play a major role in the implementation and maintenance of domestic violence screening by:

- being sources of on-site information;
- responding to unanticipated problems as they arise;
- providing quick feedback to staff on their performance; and
- recognizing staff needs and suggesting changes as needed.

As one staff member recognized, *“For real success in any initiative you need someone to follow through and to be there as a mentor on a weekly basis.”*

One of the most important observations from interviews and responses from the training sessions is how frequently staff demonstrate their concern for the well-being of their clients. Staff often phrase their comments about screening in terms of how it will impact their clients’ immediate and future care. For example, many staff wanted to know what shelters were like so that they could fully understand the process of disclosure. Towards the end of

the evaluation, staff began to phrase their increased support for domestic violence screening in terms of how it fit with other initiatives (such as asking if a patient had adequate housing and the means to pay for prescriptions) to provide total patient care.

7.6 Adaptable Protocol

Over the course of implementation, the screening guidelines at 8th & 8th changed slightly according to emerging needs and the unique features of 8th & 8th as a Community Health Centre. Within the first two weeks of implementation, it became apparent that the guidelines would not work as written. As a result of a strong team response to problems, changes were made to the way the question was worded and the ways in which procedures were documented (by removing the paper screening form).

Many nurses found the screening question as written long and impersonal. As Nurses grew more confident in their knowledge of domestic violence and more comfortable with asking, they developed their own style and adapted the way they ask and respond to meet their own professional style. These slight procedural changes ensured that the philosophy and the intent of the guidelines would remain and that screening would be incorporated into routine staff practice.

Understanding the purpose of asking about domestic violence, quickly recognizing problems, and adapting procedures to meet individual patient care needs not only validated staff concerns but also resulted in a stronger commitment to implementation.

7.7 8th & 8th as a Community Health Centre

The unique features of 8th & 8th Health Centre itself facilitated the successful implementation of domestic violence screening. 8th & 8th works closely with other downtown community groups and agencies to identify community needs and health concerns, raise awareness of social issues, promote community action, strengthen links with urban Aboriginal people, and strengthen links with downtown ethno-cultural communities.⁷

Staff reported that having Mental Health services available on-site helped them to screen. Having Mental Health “right there” reassured staff that services were available to deal with disclosures. Staff felt that this also benefited the patients as a smooth referral process gave them a feeling of control in knowing that there was help immediately available and that patients could choose whether or not to accept it. Staff was also reminded that even when a patient does not immediately accept Mental Health services that they have been empowered to make the choice by being given information on available resources (resource cards, Mental Health Services referral and/or information).

⁷ Information from “CHR - Healthy Communities” web-site, <http://www.calgaryhealthregion.ca/hecomm/8th/commdevt.htm> (last accessed October 31, 2003).

7.8 Positive Client Feedback

Many other studies have demonstrated that in a compassionate and supportive environment, and when done in an empathetic and non-judgemental manner, women welcome the opportunity to be asked and to discuss domestic violence during medical visits (21;27;28) In other studies, women were 60.5% in favour of routine screening, 18.4% were slightly uncomfortable, and 5.6% were uncomfortable (this proportion increases with previous experience of abuse) (26).

Based on data collected from staff interviews, the majority of patients responded positively to being asked about domestic violence. While many patients were surprised to be asked the question in visits, some have responded with, *“not anymore!”* and *“no, but I am glad that you asked.”*

There have been some negative patient responses to screening which are clearly discouraging for staff. For example, patients may feel they are being ‘singled out’ or feel as though they are being accused as a result of the question. Often these concerns were effectively addressed by emphasizing that everyone is being asked the same question.

Rather than being discouraged by negative reactions, many staff viewed these reactions as part of the process of changing attitudes. As more patient visits are asked, in more health care settings, it is hoped that there will be an increasing awareness that domestic violence is an important health issue. As a result of this initiative, staff, patients, and the community may become more aware of the presence and factors of domestic violence.

7.9 Summary of Successes

8th & 8th staff are consistently screening, intervening, and documenting their screening practices at higher rates than found in comparable evaluations. This success is due largely in part to the nature of 8th & 8th as a Community Health Centre and the presence of a supportive team of staff. Key staff leaders are readily available to address concerns as they arise. The screening procedures were quickly adapted to meet the needs of daily nursing practice and the delivery of patient care. Furthermore, the attentiveness nurses, medical staff, and other staff show to their patients resulted in many clients responding positively to being asked and disclosing experiences of domestic violence in a setting that could address their current needs. Additionally, staff, patients, and the community in general may have become more aware of the nature, prevalence, and impact of domestic violence and the available resources in their community.

8.0 CHALLENGES TO IMPLEMENTATION

- Infrastructure barriers that are difficult to change;
- The nature and expectations of urgent and emergent care settings;
- Particular patient populations;
- Consensus that asking about domestic violence is an intervention in itself; and
- Working with the complex issue of domestic violence, one not easily addressed in one question.

8.1 Infrastructure

Emergent care settings pose a number of challenges to routine domestic violence screening. Other evaluations have recognized how the nature of the ED setting itself poses barriers (5;7;29-31) Staff resources, time, and privacy were recognized as infrastructure barriers to screening not easily overcome.

Time

The number of available staff and high patient numbers limit the amount of time available to spend with each patient. Nursing and medical staff sometimes felt pressured to see patients very quickly and that asking the domestic violence question simply *“takes too much time”* especially when minimal patient assessments are done during busy periods. When domestic violence is disclosed to the nurse and resources offered, a patient has often waited so long to see the medical staff that they do not want to spend any more time waiting to access Mental Health services.

There is a strong recognition that disclosures of domestic violence, especially those with immediate safety concerns, take time to address even when they are few and far between. While there are available community resources and on-site referral mechanisms, the process of referring a patient with immediate safety concerns often takes many hours. During busy periods, nurses often feel as though they do not have the time to ask about domestic violence nor the time to address a disclosure, so they simply do not ask.

Privacy

To assure safety and anonymity, patients are to be asked the domestic violence question when alone and in private, as outlined in the domestic violence guidelines. Privacy is not always possible at 8th & 8th as curtains divide some of the examining areas. Some staff have devised alternative ways of overcoming this barrier by either whispering the question so that others cannot hear the response or having the patient indicate on the form what their responses are.

Privacy is also difficult to ensure when patients visit 8th & 8th with other family members and friends. Patients who do not speak English often have family members with them to

translate. Teenagers often feel are more comfortable having their friends with them during visits. While nurses often ask those accompanying patients to leave the room so that they can ask “just a few questions,” and that assessing patients alone is part of standard practice, asking others to leave the room is sometimes met with resistance from both patients and those accompanying them. In the end, if it is the patient’s wish, nurses do not force others to leave the room. They are then supposed to indicate “lack of privacy” as a reason for not asking in the patient chart.

8.2 Expectations of Urgent and Emergent Care Settings

As discussed in the previous section, staff are very aware of the importance of domestic violence. Some nurses expressed the difficulty in screening in terms of learning how to ask the domestic violence question in a fast-paced setting in a way that adequately conveys the importance of the issue in a caring and positive way.

Patients presenting to urgent care settings only expect to have their immediate medical concern addressed through minimal assessments and not to be asked about other issues in their life (such as questions about domestic violence). Nurses reported that asking the question during some visits seems to throw patients “off guard” as they think they are only at 8th & 8th to address a minor complaint such as a sore throat.

8.3 Particular Patient Populations

There are particular patient populations that staff identified as challenging to screen. Interestingly, different staff members had difficulties asking different populations about domestic violence. As one staff member remarked, *“Every population is at risk and presents its own perceived barriers to asking,”* and yet staff have reported that, *“There are some (clients) that I just won’t ask.”*

Visits that staff felt were particularly difficult to screen include: patients who do not speak English; patients with different cultural backgrounds; children; and senior visits.

Language and Culture

Language and cultural differences were recognized early on as a potential barrier to screening. The screening question is written in many different languages and the “24-hour Help for Everyone” resource cards are available in 12 languages. The “Language Line” (telephone translation service) is also available to assist staff for completing patient assessments. These resources were recognized from the outset as “not ideal”⁸ but that they do attempt to communicate that abuse is wrong and that there are resources available.

⁸ CRHA Emergency Department and 8th & 8th Health Care Centre Domestic Violence Guideline Development Committee, Meeting Minutes, March 25, 2001

While these translation resources are available to staff, they do not ensure that staff are comfortable in using them. Staff expressed that language barriers often make identifying basic medical needs difficult, let alone introducing the complex topic of domestic violence. Some languages have not yet been translated in the cards. Communicating with patients who do not speak English through translators takes time and involves others so that provider/patient confidentiality may be broken. During these visits, medical assessment and treatment takes priority over screening for domestic violence.

Staff also expressed concern over introducing a concept that may not be understood in some cultures. In attempting to raise the issue, staff encountered individuals who did not understand what they were trying to ask. Staff felt that domestic violence was an accepted part of some cultures and that addressing the issue was not easily accomplished in a single visit. Others felt that raising the issue of domestic violence might have been perceived as a potential threat to an already vulnerable population.

Children Visits

Recognising that domestic violence in the parent's life indirectly affects the child, parents are to be asked during children visits if domestic violence is a part of their family's life in any way. Parents were not asked if they abuse the child nor were children directly asked about abuse in their lives. Screening during children visits remained inconsistent from a high of 33.46% at implementation to a low of 16.67%, reaching an average of 25.32%.

Asking about domestic violence during children visits is consistently difficult for many staff primarily because of the fear of negative reactions from parents. Many staff felt that parents reacted in a highly defensive manner feeling that they were being accused of violence and that Child Welfare might be called. Staff struggled with ways of posing the question in a non-accusing manner, usually stating that this was a question posed to *everyone at every visit*.

The screening guidelines indicate that a child or adolescent should only be directly screened if their parents are for some reason not in the room with them. Even though an average of 38% of adolescent visits are recorded as screened (the second highest rate by age), staff have reported finding it difficult to ask parents of adolescents about abuse when, given their maturity, adolescents are often asked about their medical concerns directly. To shift the domestic violence question to the parent(s) is awkward in these situations.

Discomfort in asking about domestic violence during paediatric visits is not unique to 8th & 8th. While other studies indicate that mothers feel as though asking about domestic violence in these visits is important, and that mothers will disclose if asked (32;33) it is equally important to address the child's medical needs first, screen in an empathetic way, and that immediate assistance be available if needed (34). While the difficulties in asking about domestic violence during children visits were recognized from the beginning of implementation, staff were reassured that the process would get easier with practice.

Senior Visits

While not as difficult as children visits, some staff found senior visits difficult to screen because they did not know what kind of reaction they would receive. Some seniors did not understand what they were being asked; others reacted very negatively to being asked, while others simply replied, *"I wish you had asked me that years ago."* Approximately 33% of senior visits were asked about domestic violence. There are little comparative studies on screening seniors for domestic violence.

Other Patient Populations

Staff identified other types of patient visits in which it can be difficult to raise the issue of domestic violence:

- Patients with mental health problems are often difficult to communicate with and hostile throughout their visit and were often not asked about domestic violence.
- Staff felt that it was redundant to ask women who were known to already be in a domestic violence shelter and women who presented needing treatment for disclosed domestic violence.
- It was difficult to ask other staff members who used 8th & 8th medical services. Staff often asked their colleagues if they wanted to be asked the domestic violence question.
- Given its central location, guests from nearby hotels are often referred to 8th & 8th for medical concerns. Staff questioned the usefulness of asking out-of-towners about domestic violence if available resources were Calgary based.
- Some patients have many social and medical issues that need to be dealt with such as poverty, housing, and addictions. Staff often felt overwhelmed by the needs of these patients and felt that asking about domestic violence would only emphasize the obvious hardships of these patients, *"I can't rescue you so why am I asking?"*

Staff were encouraged to acknowledge which groups they found difficult to ask about domestic violence, to explore different ways of bringing the issue up, and to always record reasons for not asking in the patient chart.

8.4 Staff Experiences of Domestic Violence

Given the prevalence of domestic violence, it stands to reason that the same proportion of 8th & 8th staff is affected by domestic violence (35). Three staff members were reported to have sought assistance to address past and current abusive relationships as a result of this initiative. Some staff felt as though asking others about domestic violence raised too many issues from their lives. Key staff encouraged these individuals to continue screening by stating that they of all people understood the difficulties that victims of domestic violence face.

8.5 Reinforcement

Staff recognized the importance of addressing domestic violence during patient visits but also recognized that such a short question often resulted in some very emotional responses and influenced interactions with their patients

Staff were surprised by how many of their patients had been impacted by violence or abuse in their lives. Many patients responded with:

*No, but thanks for asking;
I didn't realize it was such an important issue; and/or
Not any more, thank you!*

Staff also reported that some patients replied with, “*Why did you have to bring that up?*” Some staff felt as though asking the question had hurt some patients who were dealing with or had overcome abuse in their lives and were hesitant to continue to ask. While it was good to hear about how people had overcome their abusive experiences, it was also difficult when staff “*can't fix it*” (cannot help a patient address current abuse).

If a patient disclosed, staff felt that handing them a resource card did not do enough to validate the patient. Also, staff felt uncomfortable offering resource cards to those patients who reported that violence was not an issue in their lives. They were, however, encouraged to state that, “*There may be a time in your life when it may affect you or someone you love. Keep this card for future reference.*”

The frustration of suspecting that abuse is an issue for a patient who does not choose to disclose, or the negative reactions of some patients to being asked can discourage many staff from continuing to ask at every visit. As one nurse remarked in the refresher course, “*After a few (negative reactions), I just don't have the energy to ask anymore.*” Staff effectively addressed negative reactions by reminding patients that they were not being singled out or specifically suspected - “*We ask everyone,*” by emphasizing that abuse and violence impacts health, and that there are resources available.

It was difficult for staff to recognize the impact that simply asking the question has on addressing domestic violence. Given the nature of domestic violence, victims may be asked many times before they will disclose that they are in an abusive relationship. Furthermore, victims may or may not disclose to those who asked them in the first place, disclosing instead to other friends, family, or agencies in the community (22-24).

While we could not assess the impacts or outcomes of screening in this evaluation, the literature suggests that screening and referral can be effective in addressing domestic violence. In an American Emergency Department, 258 of 528 disclosed cases of intimate partner violence received community-based services (54%), 127 cases reported that they were no longer at risk, and 230 reported a life free of violence 2.5 years after the disclosure (36).

8.6 Summary of Challenges

“The ED is paradoxically the best and the worst setting for intervention with victims of domestic violence” (30). Staff are overcoming barriers such as time and staff resources, language and cultural differences, particular patient populations, their own experiences of abuse and violence, and in dealing with a complex issue in their daily practice.

Regardless of some negative experiences, staff did not think about the issue of domestic violence in the same way. The process of learning about the prevalence of domestic violence, the available resources, and the process of disclosing and addressing abuse and violence has not only influenced personal perceptions but positively impacted professional practice as well.

Acknowledging the significant barriers to screening in emergent care settings, 8th & 8th staff should be commended for their efforts and for success in this regional directive.

9.0 NEXT STEPS

Learning from early pilot results, Emergency Departments in the Calgary Health Region implemented their own guidelines June 23, 2003. By asking a routine, direct, domestic violence screening question of all emergency patients on every visit to emergency and by responding to disclosures of abuse consistently with information on safety planning and resources, the Emergency Departments joined sixty-four other agencies in Calgary in the development of screening guidelines to prevent further domestic abuse. Recognizing how staff benefit from knowing implementation results, the Calgary Health Region Domestic Violence Guideline Implementation Committee and the Evaluation Group (including the evaluators) are currently planning a separate implementation evaluation specific to the Emergency Departments.

Next steps include maintaining and even improving screening rates at 8th & 8th. ICD-10 codes for domestic violence are beginning to be entered and are expected to result in more accurate data collection and analysis. Key staff recognize the need for ongoing monitoring and feedback on performance. Domestic violence, screening, and intervention training needs to be ongoing as new staff are employed and new issues arise. Moreover, staff express the desire to move forward as a Region to effectively address the problem of domestic violence in Calgary.

By asking about domestic violence during patient visits, 8th & 8th staff continues to:

- raise awareness that domestic violence is a widespread problem affecting many families;
- prevent further abuse through early identification and intervention;
- assist individuals to identify abusive behaviour;
- intervene in domestic abuse by providing information on community resources and assisting in the development of personal safety plans; and
- demonstrate commitment to providing total patient care.



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APPENDIX A 8th & 8th Screening Form⁹

Screening for Domestic Violence/Abuse																	
Date: _____ Time: _____																	
*Use same form for multiple screenings in the same 24 hr period (example IVT visits) . See bottom of sheet.																	
Refer to existing Sexual Assault/Child Abuse protocols (located in DV binder) when sexual abuse is disclosed or there are suspicions/disclosures of child abuse. Clinic Nurse will screen all clients for domestic violence. Screen using language cards or Language Line Service as required.																	
We know that violence and the threat of violence in the home is a problem for many people and can directly affect their health. Abuse can take many forms: physical, emotional, sexual, financial or neglect. We routinely ask all clients/patients about abuse or violence in their lives. Is this or has this been a problem for you, or your child(ren) in any way?																	
1. a) Client screened?	Yes _____	No _____ Not asked (reason) _____															
b) Language cards/line used?	Yes _____	No _____															
2. a) Abuse Disclosed?	No _____	Resource information offered: accepted ____ declined ____															
b) Abuse Disclosed?	Yes _____	<div style="border: 1px solid black; display: inline-block; padding: 2px;">Clinical Nurse then asks the following:</div>															
Do you feel safe right now?																	
When safety issues are identified. The nurse will: Provide resource information: Accepted _____ Declined _____ Offer Mental Health Consult: Accepted _____ Declined _____ If Mental Health not available, provide client with the following options: ♦ Wait for Mental Health ♦ Assist in contacting a shelter ♦ Provide information on contacting police *Please thoroughly document actions taken on continuing care record	When no safety issues are identified. The nurse will: Provide resource information: Accepted _____ Declined _____ Offer Mental Health at client consultation: Accepted _____ Declined _____																
<table border="1" style="width: 100%; border-collapse: collapse;"> <thead> <tr> <th style="width: 15%;">Time</th> <th style="width: 40%;">Abuse Disclosed</th> <th style="width: 45%;">Signature</th> </tr> </thead> <tbody> <tr> <td> </td> <td style="text-align: center;">Yes No</td> <td> </td> </tr> <tr> <td> </td> <td style="text-align: center;">Yes No</td> <td> </td> </tr> <tr> <td> </td> <td style="text-align: center;">Yes No</td> <td> </td> </tr> <tr> <td> </td> <td style="text-align: center;">Yes No</td> <td> </td> </tr> </tbody> </table>	Time	Abuse Disclosed	Signature		Yes No		Pt. Label										
Time	Abuse Disclosed	Signature															
	Yes No																
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⁹ Developed by the Calgary Health Region Emergency Department and 8th & 8th Health Centre Domestic Violence Guideline Committee.

APPENDIX B Q & A Memos¹⁰

MEMO

Date: August 20, 2002
To: 8th & 8th Health Centre Staff Persons
Re: Guidelines for Screening for Domestic Violence

Screening for domestic violence at 8th & 8th Health Centre began August 15, 2002. 8th & 8th Health Centre was chosen as the pilot site for the screening guidelines for all of the emergency departments. The pilot will not determine if a Regional Domestic Violence Screening Policy will be implemented, but rather if the present screening guidelines need to be modified.

After several days of screening nurses and physicians raised concerns about the screening process and an urgent meeting was held with staff representation to streamline/modify the screening process.

Present at the meeting were:

Dr. Sandra Stoffel, Marg Callbeck Connie Olsen, Micheline Nimmock, Belinda Osborne, Lise Lalonde, Dr. Billie Thurston (Faculty of Medicine, Community Health Sciences, Evaluator), Amanda Eisener (Research Assistant), and Gaye Warthe (Protocol Development Consultant)

The following issues were discussed at an August 20 meeting.

Q: What is the purpose of screening for domestic violence?

A: 8th & 8th Health Centre is one of 64 agencies that have developed domestic violence screening guidelines in Calgary. The purpose of screening is to raise awareness about domestic violence and increase safety for individuals and families affected by abuse.

Q: What is happening with the information collected?

A: Very little information is collected during screening. As discussed above, this is a new service that we now provide, and not a research study. The only data collected is the number screened, number not screened and the results of the screening. The benefits of screening in the health care system are already well documented therefore data is not being collected to prove the value. The screening form was developed to assist nurses not as a data collection tool.

Q: What is the role of the nurse when the client discloses abuse?

A: Nurses recognize that they are not therapists trained to provide domestic violence treatment. However, the response of the nurse to a disclosure is key to ensuring that clients feel validated and have access to information and specialized resources that will increase their safety. The goals of intervention once abuse has been disclosed is to:

¹⁰ Written by D.G. Warthe on behalf of the Implementation Discussion Group.

- Validate and support the individual making the disclosure;
- Provide information on community resources by giving clients a 24-Hour Help for Everyone card; and
- Develop a plan for referral and follow-up including referring clients to Mental Health.
- To assist with referrals to Mental Health, the Mental Health business hours will be printed on the 8th & 8th cards that are distributed to clients.

Q: Clients are often surprised when they are asked about abuse. Is there anything that the Centre can do to prepare clients while they are waiting?

A: Activities to raise awareness and prepare clients to be screened include creating an environment that informs clients that abuse is a significant issue and that staff persons are able to assist. 8th & 8th Health Centre can do this by having posters on domestic violence in the waiting area and by making information on domestic violence and resources available to clients both in the waiting area and in private examination rooms.

Q: How do we address the issue of family and friends that want to come into the room during the initial assessment?

A: It is not uncommon that family and friends would like to accompany the client to the examination room. To maximize the likelihood of clients disclosing that domestic violence is an issue and that they are concerned about their safety it is ideal if the client is alone to allow the nurse to screening for domestic violence. However, if it is not possible to have private conversation with the client, screening should be delayed. Clients will still have the opportunity to access information in the waiting area, the washrooms and in examination rooms.

Q: Does asking about domestic violence cause additional trauma for clients?

A: No. Clients have been living with their experiences of abuse, frequently for many years, before they disclose. Overall, clients report that they are glad they were asked, even if domestic violence is not an issue for them at the time they were asked. It is often our own discomfort with what we are told that is most difficult to deal with.

Q: I am not comfortable asking the screening question, is there anything that I can do to increase my comfort level?

A: Asking the question will become easier over time and with experience, like most other skills we learn. Hearing disclosures of abuse does not become easier nor is this the expectation considering the degree of emotional trauma and abuse that many of our clients have experienced. Our tendency when we hear about the experiences of our clients is to want to provide some intervention that will “fix” the problem and take away the pain. It is difficult for most of us to comprehend that asking the question and listening to the disclosure is an intervention even if the client chooses not to follow-up on a referral to Mental Health or other community resource.

Q: I have not worked in a pediatric setting and am uncomfortable asking parents about the abuse of their children. What can be done to address this?

A: As noted above, asking parents will become easier with practice. As well, the social work staff at the Alberta Children’s Hospital add witnessing violence to the types of violence identified in the question and ask if their child(ren) have been exposed to violence or abused directly. This can feel less direct and can help in asking the question.

Q: After clients disclose that domestic violence is a problem for them or someone in their family, we ask what happened. The result of such an open-ended question is that clients are providing lengthy descriptions of abuse that often happened a long time ago and that may not be of current concern. The disclosure of this information takes a great deal of time and can cause delays for other clients. Is there a way to streamline this process?

A: Yes. It was suggested that in the actual screening question “your family” be removed to prevent disclosures about what happened to extended family members. While this is important, it does not typically present an immediate safety concern for the client. The screening question will read as follows:

We know that violence and the threat of violence in the home is a problem for many people and can directly affect their health. Abuse can take many forms: physical, emotional, sexual, financial or neglect. We routinely ask all clients/patients about abuse or violence in their lives. Is this or has this been a problem for you or your child(ren) in any way?

As well, the follow-up questions will no longer include “how long ago was the last incident” or “what happened”. The only follow-up question will focus on immediate safety concerns. It will read as follows:

Do you feel safe right now?

The intervention will remain the same. Clients will be provided with resource information and referred to Mental Health for a consult, with client consent.

Many thanks to everyone who participated in the discussion on August 20 and who raised concerns that were brought to the meeting. Please continue to write comments and questions in the domestic violence binders and bring concerns/issues to your managers who will address them as soon as possible. (Success stories would also be accepted!) Current screening forms will be modified to reflect the changes noted above.

MEMO

Date: October 3, 2002

To: 8th & 8th Health Centre Staff Persons

Re: Guidelines for Screening for Domestic Violence

Screening for domestic violence at 8th & 8th Health Centre began August 15, 2002. 8th & 8th Health Centre was chosen as the pilot site for the screening guidelines for all of the emergency departments. The pilot will not determine if a Regional Domestic Violence Screening Policy will be implemented, but rather if the present screening guidelines need to be modified.

After several weeks of screening, the process seems to be working effectively and overall nurse representatives have stated that there have been no further serious concerns about the screening process. However, it is perhaps time again to clarify some of the important points, which should be communicated to the clients, and staff when the screening process is taking place.

Q: Should we continue to screen all clients during the night shift even though mental health personnel are not immediately on hand?

A: Yes, please screen all possible patients during the night shift. If immediate safety issues are identified, follow the guidelines offered on the screening tool. For example, assist the client in contacting a shelter to discuss their safety plan or offer client to wait at 8th & 8th Health Centre until morning (in the mental health consultation room) when mental health personnel arrive.

Q: How do we explain to clients why we are asking the question and what we are doing with the information obtained?

A: This is a new service that we now provide, and not a research study. The information obtained is kept confidential along with all other information that makes part of the client chart. The only data collected is the number screened, number not screened and the results of the screening. The purpose of screening is to raise awareness about domestic violence and increase safety for individuals and families affected by abuse.

Q: How exactly are we to screen the pediatric population?

A: When a parent is present with a child or infant, it is the parent that we are screening about domestic violence in their lives. We recognize the fact that if there are domestic violence issues in the parent's life, this indirectly affects the child. We are not asking the parent if he/she abuses the child, nor are we asking the child about abuse in their lives with the parents present in the room. A child/adolescent should only be screened only if for some reason they are being seen here without their parent/care-giver present in the room with them.

APPENDIX C Poster Presentation

Screening for Domestic Violence at 8th & 8th: Findings After One Year

W.E. Thurston, L.M. Tutty, A. C. Eisener

University of Calgary

The Emergency Department and 8th & 8th Health Centre Domestic Violence Guideline Development Committee has been meeting since April 2000 to develop a comprehensive response to domestic violence. 8th & 8th is considered a pilot site for implementing this regional directive and has provided valuable information for implementation in all Calgary Health Region Emergency Departments.

8th & 8th staff are commended for their success in domestic violence screening and intervention!

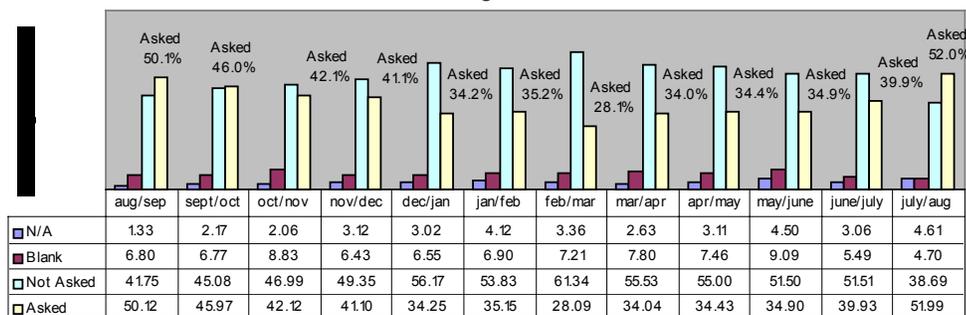
As a result of asking patients about domestic violence during every patient visit, you have:

- Raised awareness that family violence is a widespread problem affecting many families;
- Prevented further abuse through early identification and intervention;
- Assisted individuals to identify abusive behaviour;
- Intervened in domestic abuse by providing information on community resources and assisting in the development of personal safety plans; and
- Demonstrated your commitment to providing total patient care.

Highlights after one-year

Nurses have asked patients about domestic violence 20,256 times. On average, 39% of all medical program visits were asked about domestic violence/abuse; 52% of visits were recorded as "not asked"; and 10% of visits were "not applicable" (3%) or "blank" (7%).

Screening Over Time



- Domestic violence/abuse was reported in the lives of 16% of those visits that were asked (6% of all visits whether asked or not).
- 42.4% of all female visits and 37.1% of all male visits were asked
- 43.8% of day visits and 32.7% of night shifts were asked
- Young adults visits (between 18 - <40 years) were most likely to be asked (42.8%). Children visits (0-12 years) were the least likely to be asked (25.3%).

Successes

- Higher than average screening, disclosure, and documentation rates
- Supportive team to address issues
- Positive client feedback
- Increased community awareness

Challenges

- Infrastructure (rooms, time, workloads)
- Particular patient populations (culture, language, age, mental health, etc.)
- Not realizing how much asking is intervention
- "Simple question, complex answer"

Know that by asking about domestic violence you have impacted the lives of many of your clients simply by raising the issue.

Tell us what you think ...

Please return completed feedback sheets to the box below or contact Amanda Eisener at 220-2748, aeisener@ucalgary.ca.

All responses will be confidential.

NOTES

NOTES
