

CLINICAL PRACTICE

Hands on!!! Infusing intimate partner violence simulation in nursing education

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ABSTRACT

Intimate partner violence (IPV) has a 1 in 4 prevalence for women globally. Nursing programs are positioned to prepare students to address IPV screening and brief counselling policy recommendations within curricula. The purpose of this project was to refine the undergraduate nursing curriculum to better facilitate student comfort with and knowledge of IPV screening and intervention using simulation. **Methods:** We used a 4-item pre/posttest tool to evaluate nursing students' comfort level with IPV screening and safety planning before and after an IPV simulation with a standardized patient as part of the formative assessment of the simulation. **Results:** Close to 80% of students (N = 133) reported feeling more comfortable with discussing IPV, screening for IPV, talking to people about IPV, and safety planning after completing the IPV simulation. **Conclusion:** Infusing IPV screening and intervention simulation into curricula gives students a hands-on opportunity to practice critical trauma-informed skills before encountering a patient exposed to violence. This exposure enhances student comfort with and increases knowledge of screening and intervening with families exposed to IPV and as a result may help to decrease known barriers to IPV screening and intervening post licensure.

Key Words: Domestic violence, Intimate partner violence, Nursing students, Nursing education, screening intervention, Simulation

1. INTRODUCTION

Intimate Partner Violence (IPV) is a global public health epidemic affecting 30% of women worldwide.^[1] In the United States (U.S.), 1 in 4 women and 1 in 10 men are exposed to some form of IPV.^[2] IPV is the physical, psychological, and/or sexual violence by an intimate partner that causes many negative mental, sexual/reproductive and maternal health sequelae in and contributes to increased incidence of chronic diseases.^[1] The U.S. Preventative Services Task

Force (USPTF) endorses screening and brief counselling for IPV as one of the preventive health services that should be offered to all women under the Affordable Care Act.^[3] This recommendation allows IPV screening and counselling to be covered by third-party payers in the U.S. with no out-of-pocket charges such as co-payments or deductibles.^[4] Many professional associations including the National Academy of Medicine, American College of Obstetrics and Gynecology, American Nurses Association, and Emergency Nurses

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Association also recommend IPV screening in conjunction with support for women exposed to IPV.^[5] Yet rates for IPV screening and support by health care professionals (HCPs) remain around the 22% range relatively low.^[6,7] It is unclear if the USPTF recommendations alone can increase screening rates. Barriers to screening and intervention persist among HCPs and include recognizing signs of abuse, being unfamiliar with resources and referral guidelines and not knowing what to do if a patient discloses IPV. Miller, McCaw, Humphreys, and Mitchell also noted difficulty nurturing ongoing therapeutic relationships in our fragmented health system, lack of opportunities to teach or practice survivor-advocacy; and weak connections between agencies on a local level as additional challenges to IPV screening and intervention.^[8]

2. BACKGROUND

Nurses are highly trusted HCPs who establish therapeutic relationships with patients across numerous settings and are well-positioned to screen and implement interventions. Often nurses are a critical point of contact for women accessing the healthcare system especially during pregnancy; a time in which the incidence of IPV is increased. The Domestic Violence Enhanced Perinatal Home Visit (DOVE) is an IPV empowerment intervention study of 239 women in the US experiencing perinatal IPV. It found a larger mean decrease of 40.82 in IPV scores overtime from baseline to 24 months postpartum when IPV screening and interventions were incorporated into prenatal home visits versus a 35.87 decline in the group that did not receive the intervention.^[9] The DOVE protocol was delivered by nurses who received training (i.e. role-playing video, IPV materials, IPV education, and IPV case studies) and ongoing support in delivering IPV screening and interventions. Findings from an evaluation of DOVE identified the robust training and support as key to its success, which provided an easy-to-use, flexible approach that can be applied across other settings and populations.^[10] Such education and support are essential to overcoming the identified barriers to providing confident and effective care to those exposed to IPV.^[11]

Nursing students also need IPV practical education. Beccaria, Dawson, Gorman, Harris and Hossain examined whether IPV education and preparation increased the ability of undergraduate nursing students in Australian universities to identify and manage IPV.^[12] Before their intervention, participants rated their abilities to address IPV issues in their future practice as low; they felt unprepared to address this topic in the healthcare setting. They also emphasized the need for more IPV education.^[12] In the Tambag and Turan study, nurs-

ing students were unable to recognize symptoms of IPV.^[13] Nursing students identified IPV as an important topic within their curriculum in a study by Rocha, Landerdahl, Cortes, Viera and Padoin, but did not think they received enough content and were unsure about the nurse's role in caring for individuals exposed to IPV.^[14] Bermele, Andresen, and Urbanski demonstrated a significant knowledge increase using modules and role-playing to educate nurses on IPV screening and interventions.^[15] One study of 222 health profession programs in Ontario, Canada reported 57% of the schools provide IPV education, but only 26% of those programs and 14% of nursing programs reported utilizing IPV standardized patient scenarios.^[16]

These studies underscore the benefits of an engaging approach to IPV education that can increase nurses' ability to effectively care for their IPV exposed patients. Ample research on the benefits of medical-surgical skill-based learning exists yet research on IPV assessment and intervention simulations for nursing students is limited. Evidence of trauma and violence-informed educational models used within nursing curriculum and the extent to which IPV is taught in U.S. nursing programs could not be found. These gaps created the opportunity to first explore and then integrate an IPV simulation component into undergraduate nursing education.

Nursing students will inevitably encounter individuals exposed to IPV during clinical experiences before and after graduation. The prevalence of IPV combined with policy recommendations to assess, respond and care for families experiencing IPV creates a compelling argument that nursing programs should address skills related to IPV within curricula.

Providing experiential learning via simulation can help develop clinical reasoning and prepare students for IPV screening and intervention. Simulation provides a safe space for students to practice skills that are outside of their comfort zone.^[17] Mistakes can be tolerated and encouraged as a learning tool because simulation permits an immediate critique, with opportunities to repeat practice as needed. Simulation allows students to reorganize their thinking and develop confidence in new skills.^[17] According to the International Nursing Association for Clinical Simulation and Learning (INACSL), use of simulation provides a great learning opportunity if it is structured effectively in accordance with recommended standards of best practice.^[18] The INACSL sets out 11 criteria outlined in Table 1, which are deemed necessary for simulations to achieve best practice levels.^[18] Although these guidelines exist, there is little documented evidence of best practice in IPV education, and nothing related to IPV simulations for nursing students.

Table 1. The INACSL 11 criteria necessary for simulations to achieve best practice levels (INACSL, p S6-S12, 2016)

Item	INACSL Best practice criteria for simulation
1	Conducting a needs assessment
2	Constructing measurable objectives
3	Format structured on purpose, theory and modality for the simulation-based experience
4	A scenario or case that provides context for the simulation experience
5	Use of various types of fidelity to create the perception of realism
6	Maintains a facilitated approach
7	Begins with pre-briefing
8	Follows simulation with a debriefing
9	Includes participant valuation of the experience
10	Provides preparation materials and resources to promote the participants' ability to meet and achieve objectives
11	Pilot-test simulation-based experiences before full implementation

The goal of our evaluation was not human subject research. It was a required element of the undergraduate curriculum that was revised to better facilitate student preparation, comfort with and knowledge of IPV best practices screening and intervention. Therefore, the IPV preparation and training simulation curriculum (IPV PTSC Model) was designed for implementation within a population health curriculum as a normal educational practice.

3. METHODS

The IPV PTSC model was refined based upon an early pilot with 9 nursing student volunteers. Briefly, this earlier pilot involved the use of a standardized patient who played the role of a person experiencing IPV and these nursing students, who were given some basic information about IPV, then used screening tools to screen and intervene with the patient. Feedback from those students were that the pilot was very helpful in increasing their comfort and knowledge of IPV and that it would be useful to integrate more broadly in a robust way for their fellow classmates. The course professor at a nursing school in the US further developed and evolved pilot basics to create the IPV PTSC model which was delivered to 133 students in its first year. The core components of the IVP PTSC model include: in-class didactic components and IPV simulation with standardized patients under the supervision of, clinical instructors (CIs) with structured pre and post-simulation briefings.

The in-class component of the model consists of two 65-minute sessions dedicated to education about IPV. These required sessions always occur before the scheduled simulation. In the first session students are introduced or in some cases are re-introduced (depending upon the courses they have already taken) to IPV. They receive a didactic presentation about IPV, its health effects, the cycle of violence,

and the healthy relationship wheel and are introduced to the DOVE protocol materials including a portion of the 3-part training video developed by the DOVE team.^[9] The DOVE protocol materials are disseminated to students in their simulation materials packet which is reviewed and explained during this class. The printed DOVE protocol materials consisted of: two IPV screening tools-the Abuse and Assessment Screen (AAS) and the Women's Experience with Battering Scale (WEB); the DOVE brochure that discussed the cycle of IPV, safety planning and contained the danger assessment; and a section at the back where local resources for referral could be listed.^[19,20] The remainder of their packet contained a detailed overview of the simulation; introducing a DOVE IPV communication sheet; the IPV simulation preparation checklist; the IPV case study; and a personal stress injury prevention worksheet. Given time constrains students often are only able to view part of the video that demonstrates a nurse introducing and conducting a dialogue with a 'patient' using DOVE. However, the students are allotted in-class time to work in pairs with their classmates to practice initiating a dialogue about IPV using the materials and what they saw role-played in the video. Student pairs are supported by the course professor who guides and facilitates their learning. In the second session, students are expected to bring their DOVE materials back to class and complete a personal assessment worksheet that allows them to plan how to mitigate any trauma they might encounter prior to participating in the simulation. They also receive a trauma-informed care lecture guided by US Substance Abuse and Mental Health Services Administration Guidelines and engage in discussion about the DOVE protocol and local community resources for those exposed to IPV. Upon arrival for their simulation, which was scheduled at a later date, students' must submit a signed checklist to their clinical instructors identifying completion of the required preparation items (readings, review

of all DOVE materials and 3 parts of the video, personal worksheet, and knowledge of community referral resources).

The simulation objectives are to: 1) increase student knowledge and awareness of IPV, its health effects and how to use an evidence-based trauma and violence-informed approach to address IPV; 2) apply the DOVE protocol to screen and intervene with people who may be at risk or are currently experiencing IPV; 3) effectively engage students in communicating with people who are abused or not abused and practice skills in navigating difficult conversations about this topic; and 4) to enhance student knowledge of appropriate IPV identification, follow-up, referrals and of DOVE screening and interventions. The student learning objectives are a) to practice screening and intervening for IPV using the DOVE protocol; b) to become more knowledgeable about screening and intervening for IPV; and c) to practice use of therapeutic and compassionate communication in difficult conversations.

Students are assigned to the simulation by clinical group immediately after completing the in-class portion. Each clinical group of 8 is further sub-divided into two smaller groups of 4 and attend with their clinical instructors (CI). The CIs receive all IPV preparation materials on IPV and can attend the two IPV in-class lectures. The CIs are mentored by in-house faculty with IPV expertise for their first set of simulations, which allows them to conduct subsequent simulations independently. A protocol of the simulation procedure was created for CIs by the course professor to assure fidelity across groups and between instructors. The protocol provides procedures for facilitating the simulation and key post-simulation debriefing questions. After an initial semester of face-to-face mentoring by an IPV expert, the CIs are supported by having a designated IPV expert on stand-by and access to the course professor (also an IPV expert). At the beginning and end of each semester the course professor reviews and discusses the simulation in-depth with the CIs.

The simulations occur in the nursing schools' clinical simulation center. Students (in groups of 4) arrive to the simulation conference room with their simulation materials packet. Using the procedural protocol, CIs give an overview of the simulation, its objectives, and review the case study scenario. Before the simulation begins, students are asked to rate their comfort level with screening and intervening for IPV using a 4-question Likert-style survey. This questionnaire was developed, pretested and revised during the pilot study of nine students who offered feedback regarding the readability of the questions, and the adequacy of the answer options. Then the group of 4 students is split into pairs, and each student pair takes turns interacting with the SP while the other pair and CI observe from the adjacent room using

video technology. While interacting with the SP, the student pairs discuss the issue of IPV, use the DOVE screening tools, and conduct the brief intervention using the DOVE brochure. After 15 minutes the student pairs switch and repeated this process. At the end of the simulation all students regroup with their clinical instructor for critical reflection, debriefing, and reassessment of their comfort level.

4. RESULTS

Prior to the simulation slightly more than half of the students (N = 133) taking the Likert-style survey either 'strongly disagreed' or 'disagreed' that they felt comfortable screening a woman who they suspect is experiencing IPV and 11% of the students either 'strongly agreed' or 'agreed' with feeling comfortable screening. After the simulation (N = 130), only 2% 'strongly disagreed' or 'disagreed' that they felt comfortable screening, reflecting a reduction of 54% in levels of discomfort. After the simulation, 83% of participants (N = 110) either 'strongly agreed' or 'agreed' with feeling comfortable screening.

When asked if they felt comfortable discussing a safety plan with a woman who they suspect is experiencing IPV, 15% of students (N = 21) 'strongly agreed' or 'agreed' with this statement before the simulation whereas 77% (N = 120) felt more comfortable afterwards. Prior to the simulation 28% of students (N = 37) 'strongly agreed' or 'agreed' to feeling comfortable discussing IPV, rising to 87% (N = 116) afterwards. Prior to the simulation slightly less than a quarter of the students felt comfortable talking to someone experiencing IPV which increased to 82% after the simulation. These results point to an overall increase of 77% in students who either strongly agreed or agreed with each statement and an overall decrease of 94% in those who disagreed or strongly disagreed after completing the simulation. Overall, students reported their comfort level increased across all four areas: screening, safety planning, discussing IPV in general, and talking to people experiencing IPV as a result of the simulation.

5. DISCUSSION

These findings demonstrate that students clearly felt more confident addressing and discussing IPV after the simulation. What is not clear is how much of this comfort was influenced by the various components of preparation prior to simulation and how much can be attributed to interacting with a SP during the simulation itself. This is a limitation of this study that will be addressed in future research. Still, we know that if educating students about IPV in the classroom would be enough to create feelings of comfort with screening and intervening, the reported pre-simulation feelings of

comfort would have been higher. Our results suggest that without an opportunity to practice these skills, students and providers likely will not feel comfortable and prepared to respond when they encounter a patient exposed to IPV. Given the prevalence of IPV, screening and responding to trauma and violence are essential expectations of basic nursing practice otherwise we leave our students and their patients at risk. IPV-related issues will be ignored or inadequately addressed if we do not provide students with hands-on opportunities to develop these skills and improve their comfort with these topics during their educational programs.

In addition to adding a pre-test before the didactic portion of this curriculum is implemented, future studies will collect formative and summative knowledge and performance data. The lack of this information is a limitation of this study; however, data collected demonstrates that we increased these future clinician's comfort level with screening. Indeed, this curriculum addresses the two most noted reasons for not screening people exposed to IPV; lack of training and provider discomfort both of which were addressed in this study.^[21,22] Other studies suggest that providing opportunities to interact with an IPV-exposed individual enhances nurses' confidence in their ability to screen and intervene.^[10,11,15] Our results suggest that role-playing SPs can provide this type of experience for students. The simulation experience improved student's level of comfort with providing assessment, discussing IPV, and safety planning, which are the core essentials of IPV response. This suggests that the addition of simulation with a SP to classroom-based content is essential to overcome the above-noted barriers to addressing IPV in clinical practice. Even after receiving more than two hours of didactic information and in-class activities related to IPV, a large percentage of students reported still not being comfortable with utilizing this material with patients. This makes the post-simulation improvements in comfort noteworthy. Our results demonstrating improved student comfort with this difficult and sensitive subject after practice with a SP is an encouraging indicator suggesting that the opportunity to practice these assessments and discussions during simulation is critical to the development of IPV-related competencies and using trauma and violence-informed approaches to care.

Nurses must negotiate difficult and socially complex situations in their practice. Infusing this IPV simulation early helps develop transferable skills for use with high-risk populations in high-risk situations. It is a critical skill for learning to use trauma and violence informed approaches, motivational interviewing in difficult conversations, and assessing contextual influencers of health. This complex form of history-taking prepares nurses to properly respond to someone exposed to IPV. How healthcare providers respond to

these individuals is just as important as failing to respond and if not handled properly can be re-traumatizing and detrimental.

We suggest that the embedding of three core fidelity mechanisms into our IPV PTSC curriculum contributed to its strength and strongly encourage their inclusion in any adaptation of this approach. First, we believe the use of expert IPV nurse-researchers as mentors increased the willingness, confidence and competence of CIs to supervise this simulation. Secondly, extensive in-class preparation of students by a knowledgeable content expert provides a crucial foundation before attempting assessments and difficult conversations in the simulation environment. Finally, in the event that a student is inadvertently triggered or experiences a flashback during the classroom or simulation components of the model, it is important to have a safety protocol in place. In the pilot program, the team did not have a safety protocol in place, and this was a limitation that was addressed before up-scaling the model. Another limitation of this project was that baseline information was not obtained from the students prior to the classroom portion of the model. This data would have allowed us to evaluate how much students' comfort was improved by the didactic portion of the model.

Although we did meet many of the INACSL guidelines, careful attention to the criteria up front would have provided an excellent framework to guide a formal program evaluation. As with any simulation, the model continues to be refined with each cohort. Ongoing revision, modification and testing of this model as a best practices approach for nursing students uses the INACSL criteria.

Given the prevalence of IPV and its consequences, it is inevitable that all healthcare providers will encounter families dealing with IPV whether or not they are adequately prepared to assess for and address it. Gaps in the literature clearly show the need for research examining evidence-based approaches to IPV screening and intervention among nursing students and other healthcare providers.

Nursing education presents many opportunities to incorporate IPV screening and intervention competencies into the curriculum. For example, this material is relevant to community health, health assessment, maternal child health, mental health and therapeutic communication. We strongly believe that the fundamental approach of the IPV PTSC should be incorporated into nursing and other healthcare provider curricula. Beyond coursework, this model can be used in continuing education or workshops for nurses and other healthcare providers. Utilizing innovative platforms and exploring ways to leverage educational spaces that facilitate safe and transformative learning experiences is important for current and

future workforce development and preparedness.

6. CONCLUSION

Health care is a rapidly changing environment that present difficult and challenging situations. Globally, there is a commitment to primary health care approaches that facilitate healthcare system reform toward universal accessibility by 2030. Thus, how we prepare our nursing students requires a more global and novel approach, too. This includes envisioning and developing a practice orientation focused on primary rather than tertiary health care and providing future nurses with a wider repertoire of communication skills. The IPV PTSC model meets current and future educational needs of nurses while building comfort and knowledge in IPV screening and interventions. It also is an option for improving and enhancing the quality of traditional IPV education lecture-only approaches, by creating a lasting experiential style learning experience.

Furthermore, IPV is trauma with lasting effects. Nurses have to be taught how to identify and navigate trauma-exposed

patients using trauma-informed approaches to providing care. They need to be comfortable with such skills and know how to appropriately intervene with someone experiencing violence before they encounter the individual, not in the midst of the encounter. Lack of preparation in IPV screening and intervention can be harmful and revictimizing if not implemented using best practice approaches and with the proper baseline knowledge. The IPV PTSC model is a promising approach that offers a solution to address known barriers to screening and intervening for IPV; that being provider comfort and lack of training pre and post licensure. With very limited work in this area, the IPV PTSC model makes an important contribution in supporting the development of a more adaptable nursing workforce by giving nursing students the opportunity to practice and receive expert guidance for future use across health care settings and other contexts in health care.

CONFLICTS OF INTEREST DISCLOSURE

The authors declare that there is no conflict of interest.

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