

## *A Critical Pathway for Intimate Partner Violence Across the Continuum of Care*

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**Objective:** The authors developed an interdisciplinary critical pathway for intimate partner violence (IPV) assessment and intervention for use across health care settings. Intimate partner violence may be emotional, physical, and/or sexual and involves coercion and control by one partner over the other.

**Design:** A pathway developed with input from focus groups of battered women was subjected to a modified Delphi technique to improve the pathway's scientific accuracy and feasibility.

**Setting:** The study was conducted in one urban, one suburban, and one rural hospital with IPV advocacy programs in the mid-Atlantic region of the United States.

**Patients/Participants:** Four researchers and 13 clinicians participated in the validation, with at least one physician, one nurse, and one social worker or IPV counselor from each hospital.

**Main Outcome Measures:** Each element of the pathway was analyzed for the degree of consensus on scientific accuracy and feasibility.

**Results:** Consensus on the scientific accuracy and feasibility of the pathway was achieved after three rounds of the Delphi process.

**Conclusions:** This is the first known critical pathway for IPV. It addresses physical and mental health and safety and has content validity affirmed by an interdisciplinary panel of experts. Further process and outcome evaluation is warranted and invited. *JOGNN*, 32, 594–603; 2003. DOI: 10.1177/0884217503256943

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Intimate partner violence (IPV) is a major, chronic health problem for women, resulting in ongoing physical and psychological health consequences (Humphreys, Parker, & Campbell, 2001). Higher risk groups include young women, poor women, women with a history of childhood sexual abuse, and African American women (Campbell et al., 2002; Coker, Smith, Bethea, King, & McKeown, 2000; Eby, Campbell, Sullivan, & Davidson, 1995; Letourneau, Holmes, & Chasedunn-Roark, 1999; Plitchta & Abraham, 1996). Recent population-based surveys indicated that between 1.5 and 4.4 million women are physically or sexually assaulted by an intimate partner each year (Plichta, 1997; Tjaden & Thoennes, 1998). The chronicity of IPV has been frequently noted in health-care-system and population-based studies (Mahoney, 1999; Miller & Veltkamp, 1996).

Health care professionals, and the systems they work within, vary in the degree in which they identify and intervene for IPV. So far, health care systems have focused primarily on activities to make IPV an organizational priority, such as educational programs to increase awareness of IPV as a health problem and policies for initial screening and interventions (Flitcraft, 1995). One study found that a positive reply to a screen for IPV is a strong predictor of future violence and therefore identifies those at risk for progressive morbidity (Koziol-McLain, Coates, & Lowenstein, 2001). A barrier to IPV screening by health care professionals is their lack of knowledge about interventions when a survivor discloses abuse (McGrath et al., 1997; Rodriguez, Bauer, McLoughlin, & Grumbach, 1999).

The Institute of Medicine (IOM) report on education in intimate partner violence in the health pro-

fessions indicated that this topic historically has not been covered in their education and training (2001). Although a majority of schools now address IPV, the quality and effectiveness of this education are unknown (IOM, 2001). Despite the new attention toward IPV, 10% of medical residents reported in a 2001 study that they did not feel prepared to counsel patients about IPV (Blumenthal, Gokhale, Campbell, & Weissman, 2001). This illustrates how cognitive training in issues regarding IPV does not provide the necessary skills to intervene competently.

This article reports on the development and validation of a critical pathway for IPV interventions that begins at disclosure by the patient and continues to the follow-up visit and multiple visits. The pathway is not site-specific but does imply communication among providers across a continuum of care (see Figure 1). It does not include screening and identification guidelines. Roles for the physician or nurse and social worker or IPV counselor are delineated.

Intimate partner violence against women affects as many as one in three women and has serious mental and physical health consequences.

## Treatment Guidelines

In the 1980s, continuous quality improvement and clinical decision-making tools called *guidelines* were introduced. Guideline development efforts accelerated in the late 1980s. Two descriptive terms were used to describe patient management policies. The IOM adopted the term *clinical practice guidelines* to refer to statements systematically developed to assist practitioners in providing patient care for specific clinical circumstances (Field & Lohr, 1992). The American Medical Association used the term *practice parameters* and added the functions of foundation for quality assurance, utilization review, faculty accreditation, and other review activities (Kelly & Toepp, 1992).

By 1993, approximately 1,500 guidelines had been developed, addressing many aspects of health care diagnosis and treatment by both government agencies and health professional organizations (Toepp & Kuznets, 1993). The Agency for Healthcare Research and Quality (AHRQ) (formerly the Agency for Health Care Policy and Research) supported the development of clinical guidelines (Agency for Health Care Policy and Research, 1993) and provides a web-based clearinghouse for clinical guidelines ([www.guideline.gov](http://www.guideline.gov)). Establishing clinical

guidelines using rigorous scientific methods requires labor-intensive review of the literature and consensus of expert opinion where scientific evidence is lacking. The involvement of practitioners to critique and build consensus yields the added value of credibility with other practitioners and potential enhanced adherence (Sheridan, 1998).

## Treatment Guidelines for IPV

Women experiencing IPV are at increased risk of a variety of physical and emotional problems. Abused women are more likely to suffer from a range of physical complaints, including chronic pain; gastrointestinal complaints; neurological complaints; arthritis; gynecological problems such as vaginal bleeding and pelvic pain; infertility; and increased risk for STDs, including HIV (Campbell et al., 2002; Campbell, Rose, Kub, & Nedd, 1998; Campbell & Soeken, 1999; Cohen et al., 2000; Coker et al., 2000; Letourneau et al., 1999; Plichta & Abraham, 1996; Smith, 1997). Mental health problems such as depression, anxiety, posttraumatic stress disorder, and drug and alcohol use are also more common among women who live with IPV (Cohen et al., 2000; Wingood, DiClemente, & Raj, 2000). A focused history and physical are needed with women disclosing IPV. They may not be aware of the relationship of their health problems to IPV and not report them when they disclose IPV.

Several guidelines for the screening and management of IPV have been published. The U.S. Preventive Services Task Force (1996) used a rigorous scientific review process to develop guidelines for multiple health problems. Their guidelines for family violence recommend the routine screening of all women for abuse and an increased index of suspicion for abuse in the case of suspicious injuries and all injuries in pregnant women and elderly patients. Any individual suspected of being abused should be given treatment and referrals to appropriate services, and the case carefully documented in the medical record. The American College of Obstetricians and Gynecologists (ACOG) (1995) also has recommended routine IPV screening of all women and the interventions of treatment that include safety planning and documentation and referral at routine gynecologic, family planning, and preconception visits and at least four times during pregnancy and the postpartum. Additionally, ACOG (1995) addresses the special needs of at-risk populations, such as children who witness abuse, adolescents, pregnant women, and elderly women. This is similar to the protocol of the March of Dimes, which recommends that all pregnant patients be interviewed about IPV and standard interventions given (McFarlane, Parker, & Cross, 2001). The American Medical Association (2000) recommends routine inquiry about IPV of all patients and standard interventions. The American Academy of Pediatrics (1998) recommends screening patients' mothers routinely for IPV.

No nursing organizations have published guidelines on IPV, but the American Nurses Association (1991), the Emergency Nurses Association (1998), the American College of Nurse-Midwives (1997, 2000), and the Association of Women's Health, Obstetric and Neonatal Nurses (1999, 2001) have position statements about violence against women, education of nurses, education of the public, mandatory reporting, and female circumcision. All support IPV education, universal screening, and nurses acting as advocates for survivors. The Abuse Assessment Screen, developed and tested by nursing scholars, is available in several different languages, is used widely in a number of settings, and can be easily obtained on the website of the Nursing Network on Violence Against Women International (NNVAWI.org) (Soeken, Parker, McFarlane, & Lominak, 1998).

Advocacy organizations have created and published guidelines on IPV screening and interventions in the health care setting. Such guidelines are available in textbooks as well. The Family Violence Prevention Fund (1999), a national nonprofit organization, has produced guidelines on routine IPV screening. The fund, in its resource guide, suggests appropriate questions for IPV screening and has several recommendations for assessment, including immediate safety needs, history of present complaint, physical examination with preservation of evidence, expanded primary care IPV assessment, safety and lethality, suicide and homicide, and mental health. Interventions include validating that IPV is a health problem that needs attention, providing information on IPV, safety planning, documenting, providing legal information such as offering to call the police and reporting child abuse, and referring for continuing IPV services (Warsaw & Ganley, 1998). A nursing textbook on women's health contains a chapter on violence against women (Rynerson, 2000). The author urges nurses to assess all women for IPV using direct questions. A framework for intervention, including safety planning, documentation, and education, is offered. No specific guide for integration of care processes is provided.

## Critical Pathways

As health care organizations moved from quality assurance to continuous quality improvement, they looked for new methods to identify and use evidence-based care processes to improve desired patient outcomes. Simultaneously, third-party payers and business coalitions became interested in guideline-based quality measurements for evaluating provider employees or evaluating the care received by beneficiaries (Renholm, Leino-Kilpi, & Suominen, 2002). This led health care systems to incorporate guidelines into policies and procedures, quality assurance, and quality improvement efforts. The two most common tools used to integrate guidelines into prac-

tice were critical pathways and algorithm decision trees. The difference between the two is that critical pathways include all care processes and decision trees focus on medical diagnosis and treatment.

**W**omen disclosing IPV need to have a focused history and physical as they may not be aware of the relationship of their health problems to IPV.

Critical pathways limit variation by reducing the range of treatment decisions made by health care providers. They are a visual summary of care processes, their timing, and the roles of each provider that can be attached to a chart and used as a reference to the sequence of interventions along a *path* or the division of labor among multiple disciplines. Critical pathways display the types, frequency, and sequencing of health care interventions, which lead to desired health outcomes for most patients.

Many organizations found that the critical pathway development process, using a team of multidisciplinary members working together, was in itself a great benefit. Physicians, nurses, and allied health care professionals found that even when the definition of *optimal care* was unclear, a reduction of wide variations in practice allowed the health care team to further analyze care regimens in relation to outcomes (Spath, 1994). This led to elimination of system breakdowns, better control over liability risk, reduction in length of stay, and decreased patient charges (Kelly & Toepp, 1992; Renholm et al., 2002).

Once developed, pathways will not reach their potential for system improvement unless an infrastructure of design steps, action mechanisms to change processes to include pathways, variance reporting mechanisms, and schedules for periodic review and update are included. Once in use, critical pathways contribute to continuous refinement of the processes of care by highlighting system bottlenecks and breakdowns. Periodic updates incorporate new medical knowledge and define changes in sequences of care or roles among staff.

Many critical pathways focus on an inpatient episode of care, which has been problematic for emergency departments, where the episode of care is often the immediate visit. Some critical pathways have addressed the continuum of care for one health condition or problem over time; for example, the management of pregnancy and early postnatal care across providers or a chronic illness such as diabetes or treatment and rehabilitation after a stroke (Bailey, Litaker, & Mion, 1998). Outcomes have

**INTIMATE PARTNER VIOLENCE (IPV) CLINICAL PATHWAY: TREATMENT AFTER DISCLOSURE**

**SEE SCREENING GUIDELINES ON BACK**

**PHYSICIANS, NURSES, SOCIAL WORKERS IMMEDIATE RESPONSE AT DISCLOSURE:**

1. Believe patient and tell patient the behavior reported is abuse.
2. Assure patient violence is the fault of perpetrator and not the victim.
3. Assure patient that there are options and offer referral to IPV Program Social Worker or other appropriate resource.
4. Give patient hotline number. National (1-800-799-SAFE) and Local HOTLINE telephone number.

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<b>ACTIVITY</b>	<b>INITIAL VISIT</b> (Physicians & Nurses do Physical and Mental Health Assessment and Treatment (A&T), SW or IPV Advocate/Nurse does Social A&T)	<b>FOLLOW UP VISIT</b> (Primary Care or referred Provider treatment team do Physical and Mental Health A&T, SW or IPV Advocate/Nurse does Social A & T)	<b>MULTIPLE VISITS</b> (Primary Care or referred Provider treatment team do Physical and Mental Health A&T, SW or IPV Advocate/Nurse does Social A&T)
<b>Physical Assessment and Treatment</b>	<b>PRESENTING COMPLAINT</b> 1. Assess Trauma 2. Document with body map/ photos and description. 3. Refer or treat as appropriate 4. Report to police if gunshot or knife wound or according to state law.	<b>PRESENTING COMPLAINT</b> 1. Treat and assess for old injuries – Review old x-rays and records if available. 3. Assess for new trauma – If YES document with body map and/or photos and report as state law requires. 4. Assess current IPV status. Suggest referral for IPV counseling and/or support group.	<b>PRESENTING COMPLAINT</b> 1. Treat 2. Assess for new trauma – If YES document and report as state law requires. 3. Discuss long term health consequences and follow up.
<b>Physical Assessment and Treatment</b>	<b>SEXUAL TRAUMA</b> 1. Ask about forced or undesired sex. 2. IF NO: document only. IF YES and not IPV RAPE: examine for injuries, treat, refer, document. Discuss contraceptive options prevent pregnancy & STDs. IF YES and IPV RAPE (within last 72 hours do pelvic exam, evidence collection): examine for injuries, treat, refer, document. OFFER pregnancy test and STD/HIV test.	<b>SEXUAL TRAUMA</b> 1. Remain alert to possibility, even if denied. Ask again. 2. IF YES, See initial visit. Take history of child abuse and/or rape. 3. If STD/HIV test done, inform patient of status for further referral or treatment. 4. Assess current IPV status. Suggest referral for IPV counseling and/or support group.	<b>SEXUAL TRAUMA</b> 1. Be alert to possibility, even if denied. Ask again. Discuss health impact of forced sex and high rate among IPV patients. 3. IF YES, See initial visit
<b>Physical Assessment and Treatment</b>	<b>PAIN</b> 1. Assess site, type, severity and duration. 2. IF NO: document only. IF YES: assess pain in relation to violence history and its possible influence on sign/symptoms/illnesses, especially: Neurological , GI/Abdominal, Gyn, Chronic stress, Other Document, refer and/or treat	<b>PAIN</b> 1. Assess effect of treatment and adjust treatment plan as indicated. 2. Review with patient possible relationship of residual pain to IPV history & alternate etiologies of pain. 3. Assess current IPV status. Suggest referral for IPV counseling and/or support group	<b>PAIN</b> 1. Continue treatment as appropriate.
<b>Psychiatric/ Mental Health Assessment and Treatment</b>	<b>SUBSTANCE ABUSE</b> 1. Screen for current substance abuse problems of patient and abuser. 2. IF NO: document IF YES: inform of treatment options and refer if interested at this time. Document. 3. Reinforce that this is a separate health problem from IPV although it may be exacerbated by or exacerbate IPV.	<b>SUBSTANCE ABUSE</b> 1. IF NO at initial visit. Remain alert for possibility, even if denied, screen again. Continue as in initial visit. 2. IF YES, and initially refused referral, inquire about interest in treatment now. IF YES and initially referred, inquire about progress & provide appropriate follow up. 3. Assess current IPV status. Suggest referral for IPV counseling and/or support group	<b>SUBSTANCE ABUSE</b> 1. Ask if IPV continues. IF YES, review options and sources for referral. 2. Continue as follow up visit.

(continued)

**FIGURE 1**  
Critical pathway for IPV.

included reduction in medical errors, liability and costs of care, and an increase in satisfaction and desired health outcomes for patients (Blegen, Reiter, Goode, & Murphy, 1995; Pearson, Goulart-Fisher, & Lee, 1995).

**Critical Pathway for IPV**

Process guidelines and desired outcomes for the associated serious mental and physical health consequences of IPV have been established. Yet, review of the nursing, medicine, and psychology literature revealed only one critical pathway for IPV, by Miller, Veltkamp, and Kraus (1997), which primarily focused on psychiatric assessment and intervention. Key activities under this pathway include assessment for physical and psychiatric issues, identification of reporting and legal obligations, treatment (particularly counseling), consultations with other specialists as needed, and education of the victim and family. No critical pathway was found to provide guid-

ance in the full range of physical health, mental health, and social assessment and treatment.

**Design**

The first draft of the IPV critical pathway was developed by the principal investigator (PI) for intervention at disclosure, follow-up, and multiple future visits. The draft incorporated the literature review and recommendations by women survivors in focus groups that were part of a larger study. In five focus groups held at the participating hospitals, survivors discussed their preferences for what nurses, physicians, or counselors should do when women disclose IPV (Dienemann, Glass, & Rheume, 2002 ). The pathway was organized in categories of physical assessment and treatment, psychiatric/mental health assessment and treatment, and social assessment and treatment. Subcategories under physical assessment and treatment were presenting complaint, sexual trauma, and pain. Subcategories under psychiatric/mental health assessment and

<b>Psychiatric/ Mental Health Assessment and Treatment</b>	<b>DEPRESSION</b> 1. Assess symptoms of depression, severity and duration and relationship to IPV history. 2. Assess client's need for medication. If appropriate, prescribe psychotropic medication and/or refer for psychiatric services or counseling. 3. Using danger assessment guidelines, assess for: Suicide/Homicide potential or attempts. IF YES, refer for psychiatric consult. Document. Review legal protections available for homicide prevention.	<b>DEPRESSION</b> 1. Discuss medication and counseling regimen, compliance, treatment effects & suicide/ homicide potential or attempts. 2. IF depression treatment elsewhere: Communicate with provider as indicated. IF treating depression: Adapt as indicated. 3. Assess current IPV status. Suggest referral for IPV counseling and/or support group.	<b>DEPRESSION</b> 1. Continue as in follow- up visit. 2. Inquire if attending IPV counseling and/or support group or about interest in referral.
<b>Psychiatric/ Mental Health Assessment and Treatment</b>	<b>PTSD/ANXIETY</b> 1. Assess sleep, startle, anxiety, re-experiencing of trauma (flashback), numbing. 2. IF YES, Refer for psychiatric consult.	<b>PTSD/ANXIETY</b> 1. Discuss medication, complementary therapy and/or counseling regimen, compliance and effects of treatment. Assess trauma history relative to symptoms. 2. IF PTSD treatment elsewhere: Communicate with provider as indicated. IF treating PTSD: Adapt as indicated. 3. Assess current IPV status. Suggest referral for IPV counseling and/or support group.	<b>PTSD/ANXIETY</b> 1. Continue as in follow- up visit. 2. Inquire if attending IPV counseling and/or support group or about interest in referral.
<b>Social Assessment and Treatment</b>	<b>IPV SERVICES</b> 1. IPV counselor meets with patient (see back). 2. Assess trauma history.	<b>IPV SERVICES</b> 1. Ask if interested seeing IPV counselor today.	<b>IPV SERVICES</b> 1. Ask if interested in seeing IPV counselor today.
<b>Social Assessment and Treatment</b>	<b>ADDITIONAL DEMOGRAPHICS</b> 1. <u>Marital status with Abuser:</u> Married, Sep., Div., Widow, Single 2. <u>Living with Abuser:</u> Yes, No, Sometimes 3. <u>Harassment and/or Stalking</u> by abuser? 4. <u>Children:</u> Number and ages? Custody? 5. <u>Health Insurance:</u> None, Abuser's policy, Personal policy.	<b>ADDITIONAL DEMOGRAPHICS</b> 1. Ask if changes	<b>ADDITIONAL DEMOGRAPHICS</b> 1. Ask if changes.
<b>Social Assessment and Treatment</b>	<b>INFORMATION ON CHILDREN</b> 1. <u>During woman's treatment/hospitalization:</u> Children living with patient? Where are they now? How can their safety and care be assured? How support mother's custody? 2. <u>Child Trauma:</u> Ask if children demonstrating signs of trauma from observing violence (ie: sleep problems, nightmares, aggressiveness or withdrawal, school problems). Refer if indicated.	<b>INFORMATION ON CHILDREN</b> 1. Ask about children, signs of trauma, and resources using.	<b>INFORMATION ON CHILDREN</b> 1. Ask about children, signs of trauma, and resources using.
<b>Social Assessment and Treatment</b>	<b>DANGER</b> 1. Use Danger Assessment guidelines (see back) to assess IPV severity and extent of danger. Express concern for safety. 2. Explain police services. ASK IF VICTIM DESIRES for provider to call police. 3. Explain court ex parte/ protection orders and victims services and legal assistance options. Give resource sheet. 4. Explain mandatory legal reporting of child abuse. Inquire if children have been abused and refer if indicated.	<b>DANGER</b> 1. Review changes in situation, express concern for victim's safety. 2. If referred to police or courts or protective services, inquire about outcome.	<b>DANGER</b> 1. Continue as in follow- up visit
<b>Social Assessment And Treatment</b>	<b>SAFETY PLANNING</b> 1. Use guidelines (see back) to assess safety behaviors and plans for future.	<b>SAFETY PLANNING</b> 1. Assess actions, effects and adjust plan as needed.	<b>SAFETY PLANNING</b> 1. Assess actions, effects and adaptation of plans. 2. Establish long term goals

(continued)

FIGURE 1 (continued)

treatment were substance abuse, depression, and post-traumatic stress disorder/anxiety. Under social assessment and treatment were IPV services, additional demographics, information on children, danger, and safety planning. The three time periods in the pathway were initial disclosure, follow-up appointment, and multiple future visits.

The IPV critical pathway was validated using a modified Delphi technique as part of a larger study. The Delphi technique was originated at RAND Corporation for technological forecasting and was named after the famous oracle at Delphi. The intent of the Delphi technique is to independently collect the judgments of a group of experts regarding decisions in response to specific questions and priorities for action or forecasts of future events and to obtain consensus through feedback in successive rounds (Crisp, Pelletier, Duffield, Adams, & Nagy, 1997). Its strengths include costing less than a face-to-face meeting, reducing personal influence by anonymity among participants, and developing multiple iterations based on feedback from the panel of experts. Criticisms include possible lack of rigorous criteria for choice of experts, lack of

accountability for anonymous answers, the possibility of hurried responses that lack reflection, and concerns as to whether consensus is truly achieved (Burns & Grove, 2002). In the health sciences, the Delphi technique has been used to determine nursing research priorities, health care priorities, and competencies of practitioners (Whitman, 1990).

The primary questions to be answered from this Delphi procedure were (a) To the best of your knowledge, was the proposed pathway scientifically accurate? (b) To the best of your knowledge, was the proposed pathway feasible in a health care system? and (c) What changes to increase accuracy and feasibility would you recommend? The pathway experts included researchers on IPV and clinicians from three hospitals with established programs of universal screening for IPV. The three hospitals (one urban, one suburban, and one rural) had previously worked together in a state project to establish and evaluate IPV screening. The program coordinator identified as experts a minimum of one physician, one nurse, and one social worker or IPV counselor at each site, and they

ABUSE ASSESSMENT SCREEN	DANGER ASSESSMENT	ASK ABOUT SAFETY BEHAVIORS:
<p>Universal screening is recommended for all women during ED visits, Hospital admission, Prenatal visits, Routine PE and GYN screening, and Well Child visits of her children to pediatrician.</p> <p><b>INTRODUCTION AND QUESTIONS:</b> Some agencies have nurses and/or physicians verbally ask and others include in written health questionnaire given all patients and others do both.</p> <p>Domestic violence is a problem for many women and men.</p> <p>1. <b>Within the last year.</b> Have you been hit, slapped, kicked or otherwise physically hurt by someone? IF YES, by whom? _____</p> <p>2. <b>If a prenatal visit: Since you've been pregnant:</b> Have you been slapped, kicked or otherwise physically hurt by someone? IF YES, by whom? _____</p> <p>3. <b>Within the last year.</b> Has anyone forced you to do sexual activities you did not want to do or force you to have sex when you did not want to? IF YES, by whom? _____</p> <p>4. Are you afraid of anyone at home or an ex-partner? _____ YES _____ NO</p> <p><b>SIGNS AND SYMPTOMS:</b> IF observed by health provider to have hovering partner, defensive injuries, delayed seeking of care for injuries, story not matching injuries, vague complaints without accompanying pathology, or other signs.</p> <p><u>Arrange for privacy and Directly ask ...</u> These injuries look like those from people being hurt by others. Who hurt you? OR Who did this to you? OR What is troubling you? OR These injuries look like ones done by another person. Did your partner do this?</p>	<p>Jacquelyn Campbell, PhD RN © 1986, 1995, 2003</p> <p>Several risk factors have been associated with homicides (murders) of both batterers and battered women in research conducted after the murders have taken place. We cannot predict what will happen in your case. But we would like you to be aware of the danger of <u>homicide in the situations of severe battering and for you to see how many of the risk factors apply to your situation.</u></p> <p>Using the calendar, please mark the approximate dates during the past year when you were beaten by your husband or partner. Write on that date - how bad the incident was according to the following scale.</p> <p>1 = Slapping, pushing; no injuries and/or lasting pain. 2 = Punching, kicking, bruises, cuts and/or continuing pain. 3 = "Beating up"; severe deep bruises, burns, broken bones 4= Threat to use weapon; head injury, internal injury, permanent injury 5= Use of weapon; wounds from weapon. (If any of the descriptions for the higher number apply, use the higher number)</p> <p><b>Mark YES or NO</b> for each of the following. ("He" refers to your husband, partner, ex-husband, ex-</p>	<p><u>Initial Visit:</u> Try to do the following: <u>Follow Up and Multiple Visits:</u> Since the last time we talked, did you...</p> <ul style="list-style-type: none"> <li>• Hide money</li> <li>• Hide extra set of house and car keys</li> <li>• Establish a code word for danger with family and friends</li> <li>• Ask a neighbor to call police if violence begins</li> <li>• Remove weapons</li> <li>• Hide a bag with extra clothing</li> <li>• Have available: <ul style="list-style-type: none"> <li>--Social Security Numbers (yours, his and children)</li> <li>--Rent and utility receipts</li> <li>--Birth certificates (yours and children)</li> <li>--Drivers License (yours and children)</li> <li>--Bank account numbers</li> <li>--Insurance policies and numbers</li> <li>--Marriage license</li> <li>--Valuable jewelry</li> <li>--Important Phone numbers</li> <li>--Copy of protection order</li> </ul> </li> </ul> <p><b>SPEAK WITH CHILDREN</b> Have a safe place? Know who is safe to tell you feel unsafe? Can call 911? How to make a collect call? Warn to stay out of adult conflicts and job is to be safe, not to protect parents.</p> <p><b>IF PATIENT IS PLANNING TO LEAVE:</b> --Remind this is a dangerous time and needs awareness and planning. --Review where planning to go, shelter option, need to be with others to curtail violence. --Review rights to possessions and what to take with her</p>

(continued)

FIGURE 1 (continued)

agreed to participate. The researchers were all nurses who had participated in externally funded research on IPV. Participants received a monetary honorarium. A total of 4 researchers and 13 clinicians, including 1 hospital chaplain, participated as experts.

For Round 1 of the completed pathway, a cover letter with instructions and stamped return envelope was mailed to each expert. They were asked to check agreement or need for change and to make specific suggestions for each step. The pathway had columns for checking agreement or need for change regarding scientific accuracy or feasibility for use at each step in the pathway. Respondents wrote in the margins or at the bottom of each page their suggestions for change or concerns. Respondents used the terms IPV and domestic violence interchangeably. General comments referred to the importance of follow-up; the need for education and skill-building about domestic violence for physicians, nurses, and social workers; and the need for the pathway to define

roles for nurses, physicians, and social workers. Specific changes suggested were providing the woman with control over some aspects of treatment, formulating a differential diagnosis regarding possible causes of pain to include injuries from domestic violence, emphasizing that substance abuse is a different problem from IPV, and remaining supportive of women who disclose IPV more than once and do not leave their partner. The research team met, reviewed the items that had less than 88% agreement, and created a summary to return to the participants. In items with disagreement, suggested changes were made immediately if the experts' comments reflected consensus. Changes were also made where there was scientific evidence of need for change.

For Round 2, revisions were highlighted in bold type and summaries of the expert comments were provided. The same instructions were given. Replies were reviewed using the same standards as in Round 1 and revisions made. Examples of changes included notations that rape

<p><b>DV SERVICES</b></p> <p>--Conduct a social assessment  --Actively listen to her story of the violence  --Verify that behavior she is describing is abuse  --Assure her that the abuser is at fault for hurting her, she is not.  --Offer her information on DV services and community resources</p> <p><b>IF she focuses on "saving the relationship"</b> intervention should focus on concern for her safety, that what she is experiencing is abusive and that she is not at fault. Offer hotline numbers and state an interest in her returning later.</p> <p><b>IF she focuses on "saving herself"</b>  Intervention should focus on danger assessment, safety planning and options. Discuss a wide range of resources. Assure her she is welcome to return, even if she does not leave.</p> <p><b>IF she focuses on "preserving the change"</b>  Intervention should focus on her personal needs for growth and her development of a support network to preserve the change. Danger assessment, safety planning and learning to use resources is still needed. Assure her she is welcome to return for support and information.</p> <p><b>Follow Up Visits</b>  Use guide such as Domestic Violence Survivor Assessment to holistically discuss factors which influence her behavior and issues such as:</p> <p>--What do you see as causing incidents of abuse?  --What do you do to control or avoid the abuse?  --What are your feelings of love toward the abuser?  --Does he isolate you from family, friends, neighbors?  --How do you view this relationship? Do you think you have options?  --Do your family and friends know of the abuse and how do they respond?  --What supports and resources have you used? Plan to use?  --What feelings do you have about your life right now (sadness, anger, numbness, frustration, trapped, grief, fear, fury, anxiety)?  --Do you see yourself as "how you have always been" or diminished?  --Do you see yourself as self sufficient and ready to be on your own?  --How is your mental health? How stressed do you feel? How sad do you feel? Have you ever thought of killing yourself or your abuser?  --What health problems do you have? Are you able to go to a doctor or other health professional for problems/injuries associated with the violence or does your partner prevent you?</p> <p>Adapted from AAS developed by Nursing Research Consortium on Violence and Abuse .May be reproduced without permission.  Domestic Violence Survivor Assessment © Jacqueline Dienemann and Jacquelyn Campbell 1999. Reprinted with permission.</p>	<p>partner, or whoever is currently physically hurting you)</p> <p>___ 1. Has the physical violence increased in severity or frequency over the past year?  ___ 2. Has he ever used a weapon against you or threatened you with a weapon ?  ___ 3. Does he ever try to choke you?  ___ 4. Does he own a gun?  ___ 5. Has he ever forced you to have sex when you did not wish to do so?  ___ 6. Does he use drugs? By drugs I mean "uppers" or amphetamines, speed, angel dust, cocaine, "crack", heroin, ecstasy, street drugs or mixtures.  ___ 7. Does he threaten to kill you and/or do you believe he is capable of killing you?  ___ 8. Is he drunk every day or almost every day (in terms of quantity of alcohol)  ___ 9. Does he control most or all of your daily activities? For instance: does he tell you who you can be friends with, when you can see your family, how much money you can use, or when you can take the car? (If he tries and you do not let him, check here ___)  ___10. Have you ever been beaten by him while you were pregnant? (If you have never been pregnant by him, check here ___)  ___11. Is he violently and constantly jealous of you? (For instance, does he say "If I can't have you, no one can."  ___12. Have you ever threatened or tried to commit suicide?  ___13. Has he ever threatened or tried to commit suicide?  ___14. Does he threaten to harm your children?  ___15. Do you have a child that is not his?  ___16. Is he unemployed?  ___17. Have you left him during the past year? (If you have never lived with him, check here ___)  ___18. Do you currently have another (different) intimate partner?  ___19. Does he follow or spy on you, leave threatening notes, destroy your property, or call you when you don't want him to?</p> <p>_____ Total YES answers.</p> <p><b><u>Thank you. Please talk to your nurse, advocate or counselor about what the Danger Assessment means in terms of your situation.</u></b></p> <p>Source: website: www.son.jhmi.edu/research/CNR/homicide/DA-2.htm  May be used in practice or research if share data with Jcampbel@son.jhmi.edu.  Reprinted with permission.</p>	<p><b><u>IF PATIENT NOT PLANNING TO LEAVE AT THIS TIME:</u></b></p> <p>--Review Danger Assessment and emphasize importance of safety  --Strategies to minimize injuries? Stay away from weapons and near exits during conflict.  --What friends and family know about problem and will help you? Arranged to go there if need to? Speak with EAP at work.  --Have a code to alert supporters of danger to you?  --If there is a gun in the house, is ammunition kept in a separate place?</p> <p><b><u>IF PERPETRATOR HAS BEEN REMOVED FROM HOME:</u></b></p> <p>--Discuss possible harassment and stalking and plans for coping. Speak with EAP at your place of work.  --Discuss changing locks, securing windows, outdoor lighting sensitive to movement.  --Do children know how to make collect calls on telephone if kidnapped?  --Make arrangements with schools and daycare for pick up by designated person.  --Tell neighbors, friends and family abuser is no longer living there; call 911 if seen there.  --Discuss protection orders, what to do if violated, and to inform others of order.</p> <p>Source: McFarlane J, Parker, B &amp; Cross, B. (2001) Abuse during pregnancy: A protocol for Prevention and Intervention 2nd Ed. March of Dimes, nursing module: March of Dimes Fulfillment Center PO Box 1657 Wilkes-Barre PA 18773 Website: www.modimes.org</p>
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FIGURE 1 (continued)

evidence collection did not occur at all sites and the patient may be sent elsewhere for this, that there is a need to acknowledge substance abuse as a different problem from IPV although it may be related, and to include follow-up of children's status and referrals on follow-up visits. The numbers of areas of disagreement in Round 2 were substantially reduced from those in Round 1.

Round 3 used the same format and instructions. Only two changes were indicated and made after Round 3, which were explanatory comments for phrases that were too brief; no additional rounds were needed. Participants were then sent copies of the completed pathway and their honoraria.

**T**his IPV critical pathway can be only as effective as the system of care in which it is embedded.

The final pathway was formatted as a continuous double page, with columns for activity, initial visit, follow-up visit, and multiple visits (see Figure 1). The reverse side included the Abuse Assessment Screen, signs and symptoms indicating risk, suggested domestic violence services in health systems, the Danger Assessment (Campbell, 1986, 1995; Campbell et al., in press), and a safety planning guide with references. Copies of the pathway were then distributed to members of the Nurses Network on Violence Against Women International at their annual conference and the Expert Panel on Violence of the American Academy of Nursing, with requests for review and comment. One comment led to the following changes: "Assess trauma history" was added to "when providing the full assessment for posttraumatic stress disorder at a follow-up visit to a specialist or primary care provider and at the initial assessment by the IPV counselor" and "obtain history of child abuse" was added to "at the follow-up visit when a woman has disclosed sexual trauma."

## Discussion

This IPV critical pathway can be only as effective as the system of care in which it is embedded. It will function best in an integrated health care delivery system where critical pathways and continuous quality improvement systems are in place and respected. An infrastructure that includes universal screening and an IPV response program with resources for immediate and follow-up IPV counseling by a dedicated social worker or IPV nurse or advocate will increase its effectiveness. When adopted in any facility, it must be assessed and adapted for feasibility within the

resources of the agency, current standards of practice, and knowledge and skills of the health care professionals who will implement it. For most agencies, this will entail extensive review of policies and procedures, revisions, and training of personnel. The first step may be to implement only the first column, for intervention at initial disclosure.

A strength of this pathway is that it provides a blueprint for interdisciplinary cooperation and optimal patient care. Although intended to be coordinated by a nurse, the pathway includes care by primary care physicians, specialty physicians, clinical social workers, and psychologists.

This pathway was not implemented or rigorously tested with an experimental design. Thus, its reliability to improve patient outcomes is not known. Future research is needed to measure both processes of implementation and patient outcomes. Barriers to implementation need to be identified, using qualitative techniques and quantitative process measures such as clinician participation rate in screening before and after the pathway and the clinician compliance rate with the specific areas for assessment and treatment in the pathway and across the three types of visits. Research on patient outcomes is also needed. Measures might include prevalence of IPV identified in emergency departments, inpatient admissions, and specialty and primary care visits; survivor satisfaction with assessments and interventions; survivor psychological outcomes such as change in depression or posttraumatic stress disorder; survivor physical outcomes such as number of symptoms identified and treated; pregnancy outcomes; and cost outcomes. A diverse national sample of health systems with established universal IPV screening and response programs would be needed for this research.

Critical pathways have previously been shown to improve patient outcomes for treatment of specific surgical procedures. Improved outcomes include patient satisfaction, patient education, continuity of care, continuity of information, quality of care, and costs of care (Renholm et al., 2002). Intimate partner violence, unlike surgery, is a condition where context outside the treatment facility has a substantial effect on patient outcomes. Yet there is sufficient scientific evidence on the efficacy of IPV identification and intervention by health care providers for government agencies and professional associations to have developed guidelines. This pathway brings together that evidence, using a tool with a demonstrated capability to improve patient outcomes. This IPV critical pathway is a new resource to effectively intervene and assist survivors in their quest for a violence-free, safer life.

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