International Emergency Nursing 23 (2015) 65–70

Contents lists available at ScienceDirect

International Emergency Nursing

journal homepage: www.elsevier.com/locate/aaen

An exploration of the perceptions of emergency department nursing staff towards the role of a domestic abuse nurse specialist: a qualitative study

Julie McGarry DHSci, MMedSci, BA (Hons), RN (Associate Professor) *,
Stuart Nairn PhD, RN (Lecturer)

School of Health Sciences, Royal Derby Hospital, University of Nottingham, Uttoxeter Road, Derby DE22 3DT, UK

ARTICLE INFO

Article history:
Received 9 May 2014
Received in revised form 13 June 2014
Accepted 16 June 2014

Keywords:
Emergency department
Domestic violence and abuse
Nurse specialist role
Qualitative research

ABSTRACT

There is a clear body of evidence which indicates that a substantial number of people who have experienced domestic violence and abuse attend the emergency department (ED). However, many individuals do not receive effective identification or support. The present study sought to explore the perceptions of ED staff about the perceived value and utilisation of a new domestic abuse nurse specialist role that has been created in one ED in the UK.

A qualitative design was used and involved sixteen in-depth interviews with a range of practitioners. The findings highlight that staff highly valued the role of the nurse specialist as one which offered support both professionally and personally. However, the study has also drawn attention to the conundrum that surrounds identification and management of abuse and of enquiry more generally. The ED is ideally suited to identify at risk individuals but is not institutionally organised in a way that prioritises the social concerns of their patients and this nursing role is one way that this issue can be addressed. In light of recent UK and global policy directives further research is needed to explore the development and implementation of identification, management and support in the future.

1. Introduction

Domestic abuse, which also is often referred to in the literature as domestic violence, intimate partner and family violence, has been identified as an international health and social concern (Husso et al., 2012). Globally, domestic abuse has been described as reaching 'epidemic proportions' (van der Wath et al., 2013). While in the United Kingdom (UK) it has been estimated that approximately 30% of women and 17% of men between the ages 16 and 59 years have experienced domestic abuse (Smith et al., 2012). Domestic abuse takes many different forms and has been traditionally defined as including physical, psychological, sexual, financial and emotional abuses (Olive, 2007). However, The UK Home Office (2012) has recently revised the definition of domestic abuse as follows to reflect the increasing recognition of the often complex and multi-faceted nature of its presentation:

> *[Domestic violence and abuse is]. . .Any incident or pattern of incidents of controlling, coercive or threatening behaviour, violence or abuse between those aged 16 or over who are or have been intimate partners or family members regardless of gender or sexuality. This can encompass but is not limited to the following types of abuse: psychological, physical, sexual, financial, emotional [. . .]*
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> *Controlling behaviour is: a range of acts designed to make a person subordinate and/or dependent by isolating them from sources of support, exploiting their resources and capacities for personal gain, depriving them of the means needed for independence, resistance and escape and regulating their everyday behaviour.*
>
> *Coercive behaviour is: an act or a pattern of acts of assault, threats, humiliation and intimidation or other abuse that is used to harm, punish, or frighten their victim."**
>
> **This definition, which is not a legal definition, includes so called 'honour' based violence, female genital mutilation (FGM) and forced marriage, and is clear that victims are not confined to one gender or ethnic group* (Home Office, 2012).

Those who experience domestic abuse report significant immediate and longer-term health impacts which affect both physical and mental health status (Lacey et al., 2013; McGarry et al., 2011). However, despite recognition of the consequences that domestic abuse exerts on the health and wellbeing of those affected it is only relatively recently there has been a shift at a policy and service delivery level from the construction of domestic abuse as a largely social

* Corresponding author. Tel.: 01332 724905.
E-mail address: julie.mcgarry@nottingham.ac.uk (J. McGarry).

http://dx.doi.org/10.1016/j.ienj.2014.06.003
1755-599X/

problem to its 'reconstruction' and growing recognition as both a health and social care issue (Lavis et al., 2005). Within the UK for example, domestic abuse is now a key concern within both health and social care policy contexts at a national level. In February 2014 the National Institute for Health and Care Excellence (NICE) published detailed guidance entitled '*Domestic violence and abuse: how social care, health services and those they work with can identify, prevent and reduce domestic violence and abuse*' (NICE, 2014). From the guidance all agencies, including health will have a central role to play in the prevention and management of domestic abuse. However, while there has been a growing recognition of the importance of the effective management of domestic abuse within health care environments at a policy level, also it has been increasingly acknowledged that on the whole health care professionals on the ground are not adequately prepared in terms of responding to individuals who present in health care settings as a consequence of abuse (Bacchus et al., 2003; Taylor et al., 2013).

2. Background

Individuals who have experienced domestic abuse may present to a number of health care agencies including maternal health services (Stenson et al., 2005), primary care (Feder et al., 2011), and mental health care providers (Dienemann et al., 2000). There also is a clear body of evidence which indicates that a substantial number of people attend emergency departments (ED) either as a direct result of their injuries or an associated condition for example substance misuse or self harm (Boyle et al., 2006). Due to the relative anonymity of the ED, survivors may also choose to access the ED rather than other care services. However, Corbally (2001) identified that while ED is a 'vital source of assistance' to those who have experienced domestic abuse, many patients who attend as a result of domestic abuse 'pass through the healthcare system unnoticed' (p. 27).

These sentiments have been echoed by a number of commentators and attempts to address this perceived deficit have included research studies within ED environments which have focused on the development of screening tools as a possible mechanism for effective identification of domestic abuse (Houry et al. 2008; Trautman et al., 2007). It also has been identified however that in addition to the implementation of a particular process there needs to be a clear and supportive infrastructure. Trautman et al. (2007) have cited logistical problems, the absence of a social worker support for example, as a limitation to effective screening, while Dowd et al. (2002) stated that domestic abuse screening initiatives in ED 'need to take into account the attitudes and beliefs of those doing the screening' (Dowd et al., 2002, p. 795).

Clearly, staff attitudes and beliefs towards domestic abuse play a major part in the identification and management of domestic abuse overall. Yam (2000) reported that women who attended an ED as a result of domestic abuse felt that staff had a 'rushed and hurried approach' (p. 469) towards them which further reinforced their reluctance to disclose the circumstances surrounding their admission. While Dowd et al. (2002) highlighted that ED staff have questioned the appropriateness of using ED resources to screen for domestic abuse. Within this context it has also been suggested that the organisational culture of the ED, where 'work flow', 'rapid interventions' and an emphasis on the technological aspects of care (Andersson et al., 2012) may mediate against disclosure of abuse (Yonaka et al., 2007). A number of other factors have also been raised as potentially hindering staff in ED from approaching the question of domestic abuse with patients, for example fear of offending patients (Gamble, 2001), frustration at an inability to address the problem or help survivors immediately (Robinson, 2010; Yonaka et al., 2007) and a lack of training to address particular needs (Chuang and Liebschutz, 2002).

Health care professionals are often on the 'front line' in terms of first contact with women who have experienced abuse. In ED environments, as previously identified there is a growing body of evidence that would suggest that health care professionals do not feel well equipped to meet the needs of this client group. While the barriers to effective management have been articulated and repeatedly highlighted in the literature, potential strategies to address these deficits remain largely absent. Moreover, while debate has centred on the increasing role of health care professionals in the identification and management of domestic abuse (Taket et al., 2003) there are currently very few designated services and considerable ambiguity regarding good practice guidelines or support for those responsible for care delivery (Olive, 2007).

In an attempt to address this gap in service and care delivery one large regional ED in the UK developed and appointed a specialist nursing post with the specific remit of supporting staff in the identification and management of domestic abuse. The specialist nurse's role involves development and provision of staff training, supporting clinical staff with assessment and referral of survivors of abuse and liaison with a number of other agencies and specialist services. The post itself represents an innovative initiative and is novel in the UK and as such has the potential to inform significant future developments in this area. To date however, while anecdotal evidence at a local level had suggested that staff working in the ED valued the role of a domestic abuse nurse specialist, there had been no formal evaluation undertaken. This study aimed to address this gap.

3. The study

3.1. Aim

The overarching aim of this study was to explore the perceptions of emergency department nursing staff about the utilisation of the role of a domestic abuse nurse specialist.

4. Methods

4.1. Design

In order to explore the perspectives of clinical staff with regard to the role of the domestic abuse nurse specialist, a qualitative approach was utilised within the study.

4.2. Sample and setting

The project was undertaken in one large regional ED in the UK. A range of clinical staff were invited to take part in the study. Purposive sampling was used and in total sixteen clinical staff agreed to take part in the study. Participants included eleven staff grade nurses, four specialist or advanced nurse practitioners and one ED assistant. The length of time working in the ED ranged from 4 months to 27 years. One participant was male.

4.3. Data collection

Data collection was undertaken over a 6 month period between September 2011 and February 2012 and utilised semi-structured interviews. A pre-piloted aide-memoir was developed to guide the interviews and included questions relating to background and clinical experience of participants and more in-depth exploration of professional experiences surrounding identification or disclosure of domestic abuse and the role of the domestic abuse nurse specialist. With the participants' permission the interviews were audio-recoded and transcribed. Data collection and analysis were