Improving Nursing Students’ Comfort Dealing With Intimate Partner Violence

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Many nurses will encounter victims of intimate partner violence during their career. The purpose of this article is to discuss the use of a simulated experience using standardized patients to provide prelicensure nursing students with an opportunity to assess for intimate partner violence. Through this simulated experience, students identify victims of intimate partner violence and implement appropriate interventions in a safe learning environment.

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Introduction

Intimate partner violence (IPV) is a significant public health problem affecting millions of men and women in the United States each year. Twenty people per minute are victims of physical violence by an intimate partner in the United States (Breiding et al., 2014). Nurses are often the first health care professionals to assess victims of abuse and, therefore, are in a position to screen for IPV and ensure patient safety (DeBoer et al., 2013). Women with a history of IPV report that they wish a previous health care provider would have asked them about IPV. Survivors of IPV have identified that validation of the abuse by a health care provider made a significant difference in changing their situation (Weinsheimer, Schermer, Malcoe, Balduf, & Bloomfield, 2005).

One of the most common identified barriers to nurses not screening for IPV is the lack of training. As a result, nurses may not recognize signs of IPV or feel confident in handling the situation (DeBoer et al., 2013). In addition, nurses may not fully understand the social, health, and economic impact of IPV or have preconceived ideas of who is subjected to IPV and therefore not adequately screen for IPV (Beccaria et al., 2013). In order to ensure prelicensure nursing students gain experience in assessing for IPV and implementing appropriate intervention strategies, nursing faculty developed a novel IPV-simulated experience using standardized patients.

Benefits of Simulated Experiences

The use of simulation or simulated clinical experiences using standardized patients has become standard practice in most nursing programs to ensure that students gain exposure to complex clinical situations in a supportive learning environment, and accrediting bodies continue to foster support of innovative approaches to simulation (Hayden, Smiley, & Gross, 2014). Simulation allows students to use technical and interpersonal skills in situations that replicate real-world nursing experiences in a cost-effective, efficient, and high-quality manner (Aldridge, 2016; Jeffries, 2005). During clinical simulations, faculty should allow students to make independent decisions and witness firsthand the positive or negative results of those decisions. The role of the faculty is to facilitate learning through provision of a safe environment, prebriefing, observation, debriefing, and evaluation (Gaberson, Oermann, & Shellenbarger, 2015). Learning is enhanced by adding the therapeutic encounter between the student and the patient and adds the opportunity to practice therapeutic interactions (Rose, Courey, Ball, Bowler, & Thompson, 2012).

Simulation and debriefing typically occurs with small groups of learners and the instructors. However, many simulation centers are equipped with recording and live viewing technology, and this allows students to observe their peers during simulation. This capability enables students to learn from the valuable errors and teaching points generated by a team within a scenario (Okuda, Godwin, Jacobson, Wang, & Weingart, 2014). Although this may increase anxiety for the students in the scenario, studies indicate that learners may have improved knowledge retention in stressful situations (Demaria et al., 2010; Fraser et al., 2012; Khacharem, Zoudji, Kalyuga, & Ripoll, 2013). Utilizing this method of teaching also provides a time of...
reflection and open discussion after the scenario that benefits all of the students, both the observers and the ones engaged in the simulated experience.

**I IPV Scenario**

The IPV was part of a simulated learning experience. Students were not informed of specifics of the simulation or that live patients were part of the scenario. The scenario was held at the end of the semester and was intended to be a culminated learning experience. The only information given about the scenario was that it would require them to utilize content from women’s health, pediatric nursing, and public health nursing. There was a live feed setup of the simulation experience, and the students not involved in the actual simulation watched in a classroom. Students in the scenario knew that classmates were watching and that a debriefing would be held after the simulated experience. All students were given the same information about the scenario; therefore, the students in the classroom did not know any more than the students in the simulation.

Standardized patients were used for this scenario. An adult female played the role of the abused wife, a small child played the role of the abused child, and an adult male played the role of the abusive husband. Makeup was used to create bruises on the mother and child. Faculty and the children of faculty stepped into these roles and were provided information pertaining to the objectives of the scenario, how to respond to students’ questions, and how the scenario was expected to run. Additional faculty were in an observation room behind a two-way glass and stepped into the roles of a social worker, child life specialist, and security officer as needed.

The scenario that was developed involved a woman presenting to the emergency department with her husband and young child. The woman was experiencing preterm contractions after a fall, and she had noticeable bruises. Also present with the patient were her husband and young daughter. The daughter also had noticeable bruises, and her arm was in a sling. Students were expected to assess the mother and implement appropriate interventions for the preterm contractions. However, the expectation was that they would also notice the bruises on her, along with the injuries to the child, and question her about the fall. During the assessment of the woman, the husband was controlling and hostile, and the woman exhibited fear and nervousness in his presence. The actor playing the husband was instructed to interrupt questioning of his wife, insist they treat her quickly so he could take her home, and become belligerent during questioning.

In this experience, students were expected to thoroughly assess the patient and implement appropriate interventions; demonstrate an understanding of the physical and emotional signs of abuse; communicate effectively with the patient, family member, and other health and safety professionals; ensure the safety of the patient; and provide appropriate resources for the patient. The goal of this experience was that students would recognize the woman as a victim of IPV, remove the husband from the room (by calling the “security officer” if needed), ensure that the child’s injuries were assessed and emotional support was provided (by calling the “child life worker” if needed), and provide the woman with community resources to ensure that she would be safe (by calling the “social worker” if needed). The scenario ended once the students successfully removed the husband from the room and were able to talk to the woman about IPV and provide her with appropriate resources.

After the simulation ended, the community health faculty debriefed the students who participated in the scenario and those students observing in the classroom and allowed them to reflect on their thoughts about providing care for a victim of domestic violence, dealing with potentially violent family member, and ensuring that appropriate resources are provided. The students participating in the scenario and the students observing were asked to discuss what the group did well and what might have been done differently. After the group debriefing, students were given a survey that evaluated their learning experience. Some of the questions asked were if the simulation offered a sufficient amount of time for learning and a variety of ways in which to learn the material, if it increased confidence level and ability to provide nursing care, if the simulation assisted in learning about IPV, and if the student would feel comfortable caring for a patient that had experienced IPV after this simulation. Additional questions were asked about the simulation and if it helped to meet clinical expectations and assisted in understanding classroom theory, allowed modeling of the professional role in a realistic manner, and if the debriefing helped with the understanding of the clinical decision-making. Feedback from students indicated that they valued the opportunity to experience dealing with IPV in a safe learning environment. Students also stated that they would be more confident in assessing for domestic violence and providing resources to patients who are victims of IPV.

**Conclusion**

Theoretical content related to IPV can be delivered in the classroom to increase nursing students’ awareness of the problem and to provide information as to how appropriately screen for it in the clinical setting. However, students will not feel confident that they can actually implement what they have learned until they interact with live patients. Because the number of clinical hours is limited by clinical site availability, students often will not have the opportunity to screen for IPV and provide appropriate resource material during their clinical rotations. Developing an experiential learning experience using simulated patients is an excellent opportunity to provide students with hands-on learning in a safe environment. With the growing number of students and limited clinical hours, it is also often difficult to rotate all students through a simulated experience during a semester. Allowing classmates to watch the scenario and involving them in debriefing ensures that all students benefit from the IPV-simulated experience.

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