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

Authors

(Corresponding author) Dr Julie MCGARRY DHSci, MMedSci, BA (HONS), RN (adult and mental health)

Associate Professor: University of Nottingham, School of Health Sciences, Royal Derby Hospital, Uttoxeter Road, Derby UK DE22 3DT. Tel: 01332 724905 email: Julie.mcgarry@nottingham.ac.uk

Dr Stuart NAIRN PhD, RN (adult), Lecturer: University of Nottingham, School of Health Sciences, Royal Derby Hospital, Uttoxeter Road, Derby. UK DE22 3DT. Tel: 01332 724946 email: Stuart.nairn@nottingham.ac.uk

Abstract

Domestic abuse has been identified as an international health and social concern. There is a clear body of evidence which indicates that a substantial number of people attend the emergency department (ED) either as a result of their injuries or associated conditions. However, it has also been identified that while ED has the potential to support survivors of domestic abuse, 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 utilization of a new domestic abuse nurse specialist role that had been created in one ED in the UK. A qualitative design was used and involved sixteen in-depth interviews with a range of practitioners. Data were collected between September 2011 and February 2012 and analysis of the data was informed by the Analytical Hierarchy Model. It was clear that all of the staff in the study highly valued the role and one which offered support both professionally and personally when nurse were often dealing with very difficult situations. 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. There is however, still work to be done in developing an infrastructure that supports identification, management and in building stronger relationships at an inter-agency level. The role of the nurse specialist continues to evolve locally, and in light of recent policy directives further research is

needed to explore the development and implementation of identification, management and support in the future.

Key words: emergency department, domestic abuse, nurse specialist role

What is known about the topic

- Evidence would suggest that a substantial number of patients who have experienced domestic abuse access emergency department services
- Patients who have experienced abuse face a number of barriers to effective management and support
- Practitioners are currently not well equipped to identify or management domestic abuse

What this paper adds

- The presentation of a innovative specialist nurse role approach to the management of domestic abuse in the ED
- ED practitioners perceptions of the role of the domestic abuse nurse specialist
- An examination of the value and utilization of the specialist nurse approach to the management of domestic abuse in the ED

INTRODUCTION

Domestic abuse, which is also 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.* 2011). Globally, domestic abuse has been described as reaching 'epidemic proportions' (van der Wath *et al.* 2013). While in the UK it has been estimated that approximately 30% of women and 17% of men between the ages sixteen and fifty-nine 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 abuse (Olive, 2007). However, The UK Home Office 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 […]*

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 problem to its 'reconstruction' and growing recognition as both a health and a 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 and in February 2014 the 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 it is clear that 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, it has also 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 (Taylor *et al.* 2013, Bacchus *et al.* 2003).

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 is also 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) has also 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' (p27).

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 (Trautman *et al.* 2007, Houry *et al.* 2008). It has also been identified however that in addition to the implementation of a particular process there also 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) state 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, p795).

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' (p469) towards them which further reinforced their reluctance to disclose the circumstances surrounding their admission. While Dowd *et al* (2002) highlighted that ED staff 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, 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 & 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. It is also clear from the literature that while the barriers to effective management have been clearly articulated and repeatedly highlighted, 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.* 2004) 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 department in the UK has recently developed and appointed a specialist nursing post with the specific remit of supporting staff in the identification and management of domestic abuse. 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.

THE STUDY

AIM

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

METHODS

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.

Sample and setting

The project was undertaken in one large regional ED department 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 four months to twenty seven years and all but one of the participants was female.

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 was contemporaneous and involved an iterative approach whereby emerging themes were explored in subsequent interviews.

Data analysis

Data analysis was informed by the Analytic Hierarchy Model (Ritchie & Lewis 2003) which is described as having essentially three stages; data management, descriptive accounts and developing explanatory accounts. Although the framework is described as a hierarchy there is also explicit recognition of the iterative nature of the analytical process which reflects the contemporaneous nature of data collection and analysis. Each interview was fully transcribed, read and re-read to elicit the meanings and nuances of the texts. Themes were developed in keeping with the focus of the research. The themes were generated both from the questions produced to explore the domestic abuse nurse specialist role and inductively from the empirical data gathered through open ended interviews. These themes were reviewed and discussed by the authors who agreed that the themes generated were representative of the data

and interview extracts have been used to clarify the themes throughout the paper.

Ethical considerations

Full ethical approval and R&D approval for the study was granted. Potential participants were recruited through a presentation of the research by the lead researcher during a series of departmental meetings. Information regarding the study was distributed during the meetings and participants were able to contact the lead researcher if they were interested in taking part in the study. An information sheet was given to each participant to read prior to taking part in the study and written consent was gained. All data were stored as directed by local research governance using a code number. All data was anonymous and stored securely. Participants were not identified in the subsequent writing up of the findings. The authors have previous experience of undertaking research in this field and were alert throughout the study to the potential implications for participants of exploring a sensitive topic area. As such, the appropriate support mechanisms were in place should the need have arisen.

FINDINGS

As previously described sixteen members of the ED clinical staff took part in the study. Analysis of the data identified 3 main themes and these are discussed in turn. Each theme is supported by verbatim quotes from study participants:

- Time constraints: taking things on face value
- Education and training: a very visible service
- Professional and personal support: somewhere to go

Theme 1

Time constraints: taking things on face value

In the present study it was clear that all of the participants we interviewed had encountered patients who attended ED as a result of domestic abuse as a part of their everyday role. However, it was also clear that they felt that time was a major barrier to engaging with women in terms of disclosure. 'Time' in this sense was a double-edged sword with participants acknowledging the need for time to discuss sensitive topics, while simultaneously describing time constraints in terms of not being able to build the rapport required for patients to disclose abuse. Participants also described how responding to disclose of abuse was time consuming and as one nurse described, like 'opening Pandora's box' where once a disclosure had been made there would then be inadequate time to respond. The following participant also described how time pressures might lead staff to accept explanations of causes of injuries on 'face value' and as such prevent them from probing deeper. It was also clear that this was a major source of concern:

You don't feel that you're giving as high a care as you would like to. But we do look after people, we do help them […] we don't always have the

time like you would on the wards to sit and talk to them […] sometimes a lot of it is taking things on face value and having to take their word for things, and not being able to perhaps to get into depth on anything (Participant 2, staff nurse).

Those in the study also spoke of the 'four hour [treatment time] targets' that were currently in place in UK ED departments as a major barrier in terms of engagement with patients who may have attended as a result of domestic abuse. This placed added pressure on staff to transfer patients out of ED:

It is a difficult one for our targets. The four hour target does put a strain on that because it might be that someone discloses at 3 hours and 45 minutes, and the pressure is very much on moving them […] there is some leeway, if that makes sense, because its in the patients best interest. And you would very rarely get someone [manager] who didn't understand that but yes it does add added pressure (Participant 4, staff nurse).

Participants also felt that disclosure of abuse was not something that could be undertaken in a hurried atmosphere. For example, a number of participants referred to the domestic abuse nurse specialist in terms of having the time to 'sit down and talk to people' or having the time 'to chat to the patient':

To phone [specialist nurse], because obviously it's a very personal thing and if they're only down here for a few hours and we're very busy, we don't get the personal time to sit and talk to them and make sure that it's followed through, so when [specialist nurse]'s on duty it's very good, you'll ring her and she'll come straight down and she'll have a chat with the patient, then she can follow it through (Participant 12, staff nurse).

It was clear that the advent of the domestic abuse nurse specialist role was regarded as a highly valued resource in terms of having the time to spend with patients and having time to probe in the sense of issues relating to domestic abuse that might otherwise be 'lost' in the rushed environment of the ED:

In addition to the time constraints that those in the study felt were imposed by the organisational culture of ED, there was also a sense of frustration at the amount of time that needed to be taken when attempting to liaise with services or refer women who had disclosed abuse to other agencies:

…to do a social service referral[for domestic abuse], you dread it because of the length of time it takes, the telephone calls that it then takes, the messages left on answering machines, waiting for someone to call you back, blah, blah, blah (Participant 3, advanced nurse practitioner)

However, while participants spoke of the hurried atmosphere of the ED and the issues of referral, it was also clear as the following participants

highlighted that staff both valued the domestic abuse nurse specialist input in terms of removing the responsibility of the referral process but also in terms of informing them about what had happened to a patient as a result of the referral:

And you don't really know what's happened once you've made a referral, you never really get that feedback, whereas with [specialist nurse] she'll tell you afterwards (Participant 13, staff nurse)

Theme 2

Education and training: a very visible service

A central part of the domestic abuse nurse specialists role involved developing and 'rolling out' a programme of education and training to all ED staff on an annual basis and also providing staff updates as required. As such, participants in the study spoke of an increased awareness of domestic abuse generally within the ED:

Yes, we do have quite good training, yeah. And [specialist nurse] is really good with when she does her lectures and things (Participant 1, advanced nurse practitioner).

I mean [specialist nurse] comes and does the talk for you when you first start and she explains to you about domestic violence, there's a brilliant video, and obviously she lets you know that the most important, or the most likely time that the person is to get themselves in a lot of trouble is when they're leaving their partner (Participant 12, staff nurse).

However, it was also evident that participants viewed a significant part of their raised awareness in terms of identifying and referring patients where there might be domestic abuse to the domestic abuse nurse specialist, rather than taking on the role of identification and management themselves. The general consensus among those in the study centred on their perceptions that the domestic abuse nurse specialist had the requisite 'experience' and possibly found it 'easier' or was more comfortable exploring domestic abuse with patients:

I think what [specialist nurse] has done well is she's done a very visible service and she's done, I think, an intense education to the staff of actually what her role is (Participant 3, advanced nurse practitioner)

I think she's a lot more experienced in that sort of field, and she's got her own experiences as well, she finds it easy to... well I don't know if she does find it easy but she knows really what to ask (Participant 13, staff nurse)

One participant however was more forthright in her response, both about the role and the rationale for referring to the domestic abuse nurse specialist:

The best thing about [specialist nurse]'s service is that it's very simple then to offload that patient, I know that sounds quite clinical, but when you've got four hours and probably if you break that down you don't have

four hours for that patient, you probably have between 40 minutes to 60 minutes touch time with that patient (Participant 13, staff nurse)

However, while discussions of 'offloading', though not expressed so explicitly, were not uncommon there was also a sense that it wasn't simply time constraints that staff found inhibiting but also their perceptions of their own limited knowledge in the field of domestic abuse or areas of sensitivity. One participant for example described that in the absence of the domestic abuse nurse specialist she would be sought out by colleagues as the person to 'deal' with 'these patients':

…because when people used to come in they'd [colleagues] say oh if [nurse specialist] is here she'll deal with it. So I think if I was here they would say to me, will you go and see that patient because you're good at dealing with that anyway. So I used to end up with all the overdoses (Participant 14, advanced nurse practitioner)

Theme 3

Professional and personal support: somewhere to go

Throughout the study, while the domestic abuse nurse specialist role was valued by staff in terms of perceptions of saving time and raising awareness, it was also clear that this role was highly valued in terns of providing a range of supportive mechanisms on an individual level. Respondents in the study felt that the supportive elements of the nurse specialist role enabled them to 'develop' their professional confidence in

the management to patients who attended ED as a result of domestic abuse:

You then develop onto your next case that comes in and in the processes we know a lot better because we've got that support in the department (Participant 4, staff nurse).

In the present study it was also clear that while it was common place for staff to work in quite stressful situations and difficult circumstances, cases of domestic abuse did impact on them significantly both professionally and personally. From a professional perspective a number of participants in the study expressed concerns that they felt 'helpless' when patients attended ED and it was apparent that participants felt on occasions there was little that they could do to support patients who presented to the ED. However, they also felt that since the domestic abuse nurse specialist had been in post that they were able to 'do a little bit more':

…I feel we can do a little bit more by leaving [the referral], by letting [specialist nurse] know (Participant 1, advanced nurse practitioner).

During the study it was clear that the domestic abuse nurse specialist also provided support to staff on a personal level. For example, one nurse practitioner spoke of a particularly harrowing abuse case that she had witnessed in ED and which had exerted a significant impact on her personally. After the event she had sought support from the domestic abuse nurse specialist. While another member of staff reported that the

domestic abuse nurse specialist had been available to 'talk through' the difficult situations that she encountered in relation to domestic abuse and which resonated with her personal experiences:

She's [specialist nurse] been supportive to me on a couple of times that I've needed it, and I'm sure it is for the rest of us as well (Participant 10, staff nurse)

Finally, throughout the study participants spoke about the relationship that they held with the domestic abuse nurse specialist who had previously worked within the department and who therefore was not perceived to be an 'outsider'. Staff felt that the domestic abuse nurse specialist was approachable on a number of levels. From this perspective there was a sense that staff felt that the domestic abuse nurse specialist supported them in the uncertainly and discomfort surrounding asking patients about domestic abuse where this was suspected or where patients' disclosed abuse:

Yes, I think because she was originally part of the team that's helped dramatically, so it's more of an approachable, it's not just some person within the trust, if that makes sense, because she's known throughout the department and it's an easy relationship and she's there as kind of a support network […] but I think because she's part of the team then it's more of an informal kind of... you can ring her if you're not sure of something (Participant 4, staff nurse).

DISCUSSION

The present study was undertaken in the specific context of the ED. There are therefore certain limitations in terms of transferability to other health care environments. However, to our knowledge this role is novel in approach and as such provides a starting point for further developments in this field.

Over the last decade or so there have been increased calls for improvement in the responses from health care professionals in relation to domestic abuse (Co-ordinated Action Against Domestic Abuse (CAADA), 2012, Dodge, et al. 2002). The background to this study has been founded on the recognition of the centrality of ED as a point of access for survivors of abuse alongside an acknowledgment of the enduring barriers to identification and effective management of domestic abuse within the ED (van der wath, et al. 2013). The present study has explored the innovative role of the domestic abuse nurse specialist that was in place in one UK ED from the particular perspective of those working in this environment. This study has also offered an insight into the nature and scope of the domestic abuse nurse specialist role in terms of addressing the barriers to effective recognition and support that have been identified within the literature to date.

In the first instance it was clear that all of the staff in the present study highly valued the role of the domestic abuse nurse specialist as one which offered support both professionally and personally when nurses were dealing with very difficult and emotive situations. It was also clear that

the ‘insider’ status of the domestic abuse nurse specialist was important for those in the study in terms of understanding the nature of the ED environment and the ways in which workload pressures could militate against effective enquiry or management of disclosure.

At the inception of the domestic abuse nurse specialist role it was envisaged that through the provision of support and training staff would be increasingly empowered to effectively manage disclosure, including making the necessary referrals and liaison with other agencies. However, there was little evidence from the present study that staff on the whole were taking on this role, preferring instead to refer back to the domestic abuse nurse specialist wherever possible. The data in the present study generated three broad themes, time, education and professional support. These themes have drawn attention to the conundrum that surrounds identification and management of abuse more widely within the ED setting where there are number of mechanisms that undermine and create barriers to effective care for survivors of domestic abuse in the ED.

One of these factors, and a theme that runs throughout the literature in this field is the perception of ‘helplessness’ that staff in ED feel when they are faced with survivors of domestic abuse . In the present study the origin of this sense of ‘helplessness’ appeared to be multifaceted, involving issues of professional confidence, perceived knowledge and organisational (time) constraints. The broader literature suggests that part of the problem within ED is that staff have concerns about raising the issue of suspected abuse with patients, and part of this appears to be

connected to a concern about what to do if they do raise it. There appears to be an anxiety about their knowledge base in relation to providing immediate psychological support, and knowing what types of services are available for them to refer the patient (Olive 2007, Leppäkoski and Paavilainen, 2013).

In this context having a domestic abuse specialist nurse as a contact point was seen as advantageous for emergency staff. While it does not overcome the known problem of staff taking on the role of identifying at risk patients themselves (Olive 2007) it does provide a route into follow up care and arguably make it more likely that nurses will ask patients about domestic abuse. Furthermore, Yam (2000) also suggests that while regular staff training and updates are important in terms of raising awareness, the organisation and working culture of ED means that the additional provision of an onsite support worker can augment such educational interventions.

In the present study it was evident that staff felt a sense of relief that they could refer patients to the domestic abuse nurse specialist, a process they referred to as 'offloading'. The time consuming intervention of identifying and managing disclosure of domestic abuse was also felt to produce too many obstacles to good care. Therefore the role of the domestic abuse nurse specialist was seen as a means to refer on to a competent specialist.

There is evidence that many users of emergency care presenting with a history of domestic abuse are not always treated sympathetically and that health care professionals sometimes appear to lack compassion. This can generate feelings of shame and obstruct survivor's willingness to fully express their concerns (Yam 2000, Olive 2007, Reisenhofer and Seibold, 2013). The evidence from our research suggests however that nurses are both concerned and empathetic towards this group of patients. Our study also echoes the wider literature in the sense that the ethos and organisational role of the ED with an emphasis on the technical is not necessarily conducive to delivering care of this kind (Nyström, Dahlberg and Carlsson 2003, Gordon *et al.* 2010, Andersson, et al. 2012). It is equally clear however that the ED will continue to provide a primary point of access for many survivors of abuse. This observation, taken alongside the growing emphasis on the role of health care in the identification and management of abuse highlights the need for effective responses to be developed to meet this need. The role of the nurse specialist continues to evolve locally, and in light of recent policy directives further research is needed to explore the development and implementation of identification, management and support in the future.

CONCLUSION

This study has highlighted the perceived value and utilization of the domestic abuse nurse specialist role within one ED in the UK. However, there is still work to be done in developing an infrastructure that supports effective identification and management of domestic abuse. The role of the nurse specialist in the present study was valued as a resource that

helped nurses to manage their time; however it is the nature of this approach that needs further exploration and research. As previously highlighted a number of authors have argued for specialist training for nurses and other front line staff working in ED. This study suggests that the use of a specialist nurse to refer survivors of domestic abuse and provide educational support for staff can be beneficial to the practice and culture of emergency work.

The context of emergency care is often focused on the acute biomedical event and the complex issues that arise from domestic abuse do not conform to the ideal ED patient. We would argue that the role of the specialist nurse is justified on this basis and that further work could go further in identifying the impact on patients and how they evaluated the service. 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.

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