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Cultural Identity of Labor and Delivery Nurses In the Assessment of Pregnant Patients For Interpersonal Violence

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The project and manuscript have been successfully completed and meet the standards of the School of Nursing at San Jose State University. The project demonstrates the application of professional knowledge, clinical expertise, and scholarly thinking. An abstract of the project and two copies of the manuscript are attached.

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Cultural Identity of Labor and Delivery Nurses

In the Assessment of Pregnant Patients

For Interpersonal Violence

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Abstract

Objective: Identification of barriers to assessment of interpersonal violence (IPV) in pregnant women.

Design: An exploratory descriptive study

Setting: The labor and delivery department of a public county hospital

Participants: 34 nurses, representing 8 cultures and 13 native languages, completed the survey, and 34 laboring patient's medical records were reviewed.

Main Outcome Measures: Any specific barriers, identified by nurses, to assessing for IPV in laboring patients

Results: Medical record review revealed 50% assessment rate in labor triage patients. Survey results revealed that cultural identity (85 %) was not a significant barrier. Approximately 65% of nurses agreed that in their culture it was acceptable to ask patients about IPV. Over 88% of nurses stated their culture strongly supported asking about IPV. Over 50% of nurses identified language as the single most prevalent barrier in both US and non-US born nurses.

Conclusion: Labor nurse's cultural identity, in itself, was not a barrier to the assessment for IPV. A nurse's inability to speak the same language as the patient emerged as the single most significant barrier in the assessment for IPV in this study.

Keywords: interpersonal violence-IPV, cultural identity, abuse in pregnancy, assessment barriers

Callouts (3)

1. Inability to communicate in the patient's language emerged as the most significant barrier for labor nurses, whether US or non-US born. (should appear in barriers to assessment)

2. To increase screening of pregnant women for IPV, we must understand the influence of language as a primary barrier. (should appear in discussion)

3. Conflict of languages presents a quality of care challenge as nurses are imported to fill staff shortages and increased immigration of non-English speaking patients continues. (should appear in implications for practice)

1   Interpersonal violence (IPV) directed at women is epidemic world wide.

2   In the United States, we commonly hear the term, *Domestic Violence* (DV), in

3   describing the destructive effects on women and their children. Yet, the definition

4   of DV limits the abuser to an intimate partner. Often the abuser is not the father or

5   the current partner, but may be any other person(s) in the mother's life. This study

6   on interpersonal violence, did not limit data to a specific circumstance of abuse,

7   therefore included those situations defined within "Domestic Violence".

8   Women who are pregnant have an increased risk of becoming victims of

9   violence. AWHONN has supported routine education for nurses in the

10   identification and treatment for IPV (Schoening, Greenwood, McNichols,

11   Heermann, and Agrawal, 2004). It is known that abuse of women and children is

12   as clearly linked to alcohol abuse as are major motor vehicle accidents. The rate

13   of abuse rises 15 times higher in household where husbands are often drunk than

14   homes where the husband does not drink (Health and Healthcare 2010, 2003).

15   It is estimated that between 9% and 25% of pregnant women are abused

16   (Giardino, 1999; Cox 2003). Using the most modest estimate of only 4-5%,

17   interpersonal violence in the prenatal period remains more common than diabetes

18   and preeclampsia, which are routinely screened for during pregnancy (Parsons,

19   Goodwin & Petersen, 2000). Outcomes of pregnancies affected by IPV include

20   complications of first and second trimester bleeding, miscarriage, preterm labor,

21   low birth weight infants, substance abuse, sexually transmitted diseases, and

22   urinary tract infections (McGrath, Hogan & Peipert, 1998; Cox, 2003).

23   Upon admission to a labor and delivery service, assessing pregnant

24   patients for risk factors is clearly defined and standardized. This assessment

25   consistently includes screening for possible IPV.

26   Barriers to assessment for IPV include lack of formal training, lack of

27   privacy, feeling of helplessness to change the situation, and the personal belief

28   system of the specific nurse. Ellis (1999) reported lack of privacy and time

29   constraints as primary barriers in 40 RN's in a large trauma center. Additional

30   studies have reported a rate of IPV in the personal experience of nurses to be as

31   high as 58% (Ellis, 1999; Cox, 2003; Denham, 2003).

32   Conceptual Framework

33   *Theory Description*

34   The Theory of Planned Behavior (TPB) provided the framework for this

35   study (Ajzen & Fishbein, 1980). The central factor in TPB is the *intention* to

36   perform an identified behavior. In truth, the theory does not address the actual

37   control a person has, but the perceived behavior control. Though a person may be

38   willing to perform a certain behavior, realistic barriers may exist in their

39   perception of the ability to do so.

40   Application of the TPB to assessment for interpersonal violence would

41   have individual nurses show intent to screen when they approached it confidently,

42   felt that others, important to them, thought they should do so, and believed the act

43   of intervention was under their control.

44   In the actual interaction of asking any woman about her safety and well-

45   being, there could have been a perceived ease or difficulty of performing the

46   action. Research on what impacted the ease or the difficulty would aid in the

47   future goal of increasing compliance with laws and policy

48   When looking at health care, behavioral intention was the willingness on

49   the part of the nurse to perform a specific behavior; how much they were willing

50   to try to do it. This intention to perform the behavior or the action was rooted in

51   the attitude, subjective norms, and perceived behavioral control (Ajzen, 1988).

52   Therefore, it followed that if a willing intention could be provoked, then action of

53   the desired behavior would follow. The intervention that would affect one nurse's

54   behavior would not necessarily trigger action in another.

55   In this study, the desired behavior was the act of the nurse asking

56   questions of the pregnant patient regarding past or current interpersonal violence.

57   Without the core concepts resulting in the intention to perform the assessment,

58   there would be little hope of success. Yet even with the intention, the individual

59   nurse needed to make the concerted effort to perform the act.

60

61

62

63   Literature Review

64   *Barriers to Assessment*

65   Despite the knowledge of the need for assessment of the pregnant woman

66   for violence, assessments are missed. The multiple barriers have been identified in

67   the literature, yet ability to speak of the language of the patient has not been

68   identified to date as a significant factor (Ellis, 1999; Thompson, Rivara,

69   Thompson, Barlow, Sugg, and Maiuro, 2000). In a major review of 24 studies

70   that examined health care provider barriers, lack of time and lack of training were

71   the most often cited barriers (Parsons, Goodwin & Petersen, 2000).

72   *Partner and Non-partner Abuse*

73   Khosla, Dua, Devi and Sud published a study in the Indian Journal of

74   Medical Sciences in 2005 focused on the prevalence of domestic violence aimed

75   at pregnant North Indian women. The notion of non-partner abuse is revealed by

76   the statistics of abuse by other members of the husband's family in 52% of the

77   cases studied. Abuse by the husband and his mother constituted the majority of

78   the cases, with many women having multiple abusers (Khosla, 2005).

79   Certainly nurses practicing in the US and who identify with the North

80   Indian culture may find it difficult to comply with regulations of assessment for

81   violence. Yet, conversely, the nurse may actually be a stronger advocate for the

82   patient due to this cultural experience.

83

84   *Training and Success*

85   Parsons, Goodwin and Petersen reported in 2000 that staff attendance at

86   didactic training programs alone did not change screening behavior for the long

87   term. In fact, training programs that combined instruction with institutional

88   supports, such as a violence resource nurse, had greater success (Parsons,

89   Goodwin, and Petersen, 2000). Certainly a referral to a nurse who speaks the

90   same primary language as the client was essential.

91   *Clinical Decision Making*

92   Bakalis and Watson (2005) studied the clinical decisions nurses made in

93   specific health care settings. No decision-making theories were applied. The aim

94   of the study was to determine if decision-making varied based on the specialty of

95   the nurse practice area. In conclusion, the authors posed an interest in knowing if

96   nurses showed particular aptitudes for the different levels/or types of decision-

97   making. Additionally, did the personality, education, or experience in nursing

98   have any influence? Culture of origin of the nurse was not discussed or referenced

99   in this study of 60 registered nurses (Bakalis & Watson, 2005).

100   Method

101   *Research Design*

102   An exploratory, descriptive study was used to measure the self assigned

103   cultural identity of labor and deliver nurses and the perceived barriers to assessing

104   for interpersonal violence in their patients. Training had been provided and

105   mandatory requirements for screening all women admitted to the triage area of

106   labor and delivery is well known. This descriptive study provided no treatment or

107   manipulation.

108   A literature search did not reveal a tool for assessment of the performance

109   of the mandatory screening with regard for the cultural identity of the nurse. An

110   instrument was developed specifically for this study by the Principal Investigator.

111   Demographics gathered the cultural factors of the participants, as well as the

112   perceived barriers to assessment for IPV.

113   The Smith Multicultural Questionnaire (SMQ) attempted to elicit

114   information about how cultural identity might influence the intent to assess for

115   IPV. The questionnaire was designed to inquire into three areas of influence.

116   First, how did the nurse's attitude, beliefs, and perceived outcomes influence the

117   intent to assess for IPV? Secondly, in what way did the influence of subjective

118   norms, or the social pressure to ask or not ask questions, influence clinical

119   decision-making about IPV? Thirdly, how did the perceived behavior control, or

120   the perception of the ease or difficulty of asking questions about IPV, influence

121   intent to assess?

122   The instrument was reviewed by two doctoral nursing faculty members at

123   San Jose State University, San Jose, CA; and three doctoral candidates from

124   University of California, San Francisco, CA for analysis of structure, validity, and

125   themes. Changes were made upon recommendations of the faculty. A pilot study

126   was completed using labor and delivery nurses at a Community Hospital located

127   northern California.

128   *Participants*

129   The participants represented a self-selected sub sample from a

130   convenience sample comprised of 75 labor and delivery nurses. All participants

131   were registered nurses, participation was voluntary, and no incentives were

132   provided. Thirty four nurses completed the SMQ, which represented 45% of the

133   pool. Age of nurses ranged from 21 to 60 years of age (mean range 41-45 $\pm$ 1.8)

134   (see Figure 1). The majority of the nurses had completed their baccalaureate

135   degree; had between eleven to fifteen years of registered nursing experience; and

136   were predominantly U. S. born (see Figures 2, 3, and 4).

137   *Setting and Sample*

138   The study was conducted in a busy labor and delivery department of a

139   524-bed public hospital owned and operated by a county in Northern California.

140   The total number of labor and delivery patient triage assessments in 2005 was

141   11,203. Of this number, 5887 were admitted for care and 5560 delivered their

142   pregnancy or a rate of approximately 463 births per month. The patients were

143   given prenatal care at 23 separate clinic sites who deliver at the study hospital.

144   Patients were primarily of Hispanic descent (74 %) and most were

145   monolingual Spanish Speaking. The next largest group was Caucasian women at

146   13%. The remaining patients were Black (African or African American) 5%,

147   Asian 2%, Filipino 1%, Arab 1%, Vietnamese 1%, Indochinese .23%, Pacific

148   Islander .16% American Indian .05%, and other or unknown 4%.

149   The 75 nurses in labor and delivery represented twelve cultural identity

150   groups. The eight cultural identity groups represented by the 34 voluntary

151   participants (45 %) included: Caucasian, Chinese, East Indian, Egyptian, Filipino,

152   Korean, Latina-Hispanic, and Nigerian (see Figure 4).

153   *Measures*

154   Nurse cultural identity was determined within the SMQ by direct question

155   "What culture do you identify with?" Twelve options and "other" were possible

156   responses. Place of birth did not necessarily indicate the nurses' individual sense

157   of her culture. Although several participants stated they were born in Canada, two

158   claimed "Caucasian" as their culture and not Canadian.

159   Barriers from the literature were introduced and reflected in the study

160   survey. Options that would represent family and culture as a barrier were added.

161   Cultural barriers included language spoken and family and/or cultural approval of

162   asking personal questions about relationships. The participants chose the one most

163   important barrier; and then any others that applied.

164   *Research Procedure*

165   Approval from two review boards (IRB) for the protection of human

166   subjects was obtained. Over a 4 week period of time, each nurse who agreed to

167   participate completed a consent form and a Smith Multicultural Questionnaire.

168   The survey did not contain any identifying information to ensure the anonymity of

169   the participants.

170   A 24 hour/one day data collection of the triage intake forms from patient

171   medical record was conducted from the same study institution. The goal was to

172   detect the percentage of forms that included, or did not include, the required

173   assessment for IPV with the quality care standard set at 100%.

174   The SMQ tool was introduced to the labor and delivery registered nursing

175   staff. Any qualified nurse participated by completing a consent and a survey. No

176   compensation was given for voluntary participation and the data remained

177   anonymous. All surveys were shredded following data collection by an

178   independent statistician.

179   Results

180   *Medical Record Review*

181   Thirty six admissions to labor and delivery triage took place within the

182   target 24 hours. Two were seen twice, giving the total number of patients at 34.

183   Of the 34, (n=18) or 50% were asked about current or past interpersonal violence:

184   all responses were "no", as evidenced by notation in the medical record.

185   Gestational age of the pregnancy on admission was from 15 weeks (motor vehicle

186   accident) to 41+2 weeks. Additional, only 50% of the 34 patients had

187   documentation of screening for IPV during prenatal care.

188   Upon evaluation of the medical records of the 34 patients, positive

189   findings for IPV were documented in 33% (n=6) of the patients who were actually

190   screened (n=18) in the prenatal period. The languages spoken by the patients with

191   IPV history were: English, Spanish, limited English, Spanish only, and Korean

192   only. The nurse participants spoke a total of 13 languages (see Table 1).

193   *Barriers to Assessment*

194   The initial assumption that a nurse's cultural identity would somehow be a

195   barrier was disproved. Interestingly, 85% of the participants stated that they

196   disagree that their culture would not approve of the nurse asking questions about

197   IPV with a significant level of p=.013. Only 9% (n=3) agreed that their culture

198   would not support their asking the IPV questions with one participant US born

199   and two were non-US born.

200   Additionally, 65% of the nurses agreed that in their culture it was

201   acceptable to ask questions about IPV. As for family approval of the nurses

202   asking the questions, 88% felt supported to do so.

203   Barriers to assessment were evaluated from the perspective of US

204   born and non-US born nurses. Both groups reported that inability to speak the

205   patient's language was the primary barrier for both US and non-US born nurses.

206   Inability to speak the patient's language was reported as the primary barrier by

207   50% of nurses with current or past abuse and 58% of the nurses without personal

208   experience of IPV.

209   Clearly, when the language of the nurses varied from that of the patients;

210   barriers to care existed. A total of 80% of nurses reported language as a primary

211   or secondary barrier. Results of the current study departed from prior research in

212   that the issue of language was neither studied nor identified as a barrier to IPV

213   assessment.

214   Discussion

215   The labor and delivery nurses self reported that only 73% screen routinely

216   for IPV in their patients, yet the actual documented assessment was only 50% in

217   the medical record review. These findings are consistent with the literature as

218   Ellis (1999) reported 45% of the nurses stated they routine screen all their patients

219   and only 9% of the charts reflected it was done. Alarmingly, with only half of the

220   patients being assessed in the prenatal period, the labor triage visit might have

221   been the only opportunity for intervention in several of the patients.

222   A nurse's inability to speak the same language as the patient emerged as

223   the most significant barrier in the assessment for IPV (see Table 2). Despite the

224   unique cultural environment at the study institution, we have begun to see this

225   trend of language barrier nationwide due to our importation of RN workforce and

226   increased immigration of non-English speaking patients,

227   Limitations

228   Limitations of the study include the small convenience sample size. The

229   unique cultural diversity of the nurses at the institution studied may not be similar

230   to other labor and delivery departments in institutions of similar size. Yet, this

231   complex diversity of cultural identity may represent the future of nursing in the

232   United States.

233   Implications for Practice

234   Despite the multicultural diversity in the nursing staff studied, it did not

235   match the client diversity in culture or language. The answer may not be in

236   language education, but perhaps in the development of non-verbal tools similar to

237   the Wong-Baker Pain Scale we use routinely for pain assessment. Provision of a

238   screening tool for nurses, nurse practitioners and physicians would allow initial

239   screening. Follow up with a translator in the event of positive findings would be

240   indicated

241   Research is lacking in the area of identification and study of the impact of

242   culture and language in the practice of nursing. Xu reports that the typical

243   internationally educated nurses are recruited from the Philippines, Canada, India

244   or the United Kingdom, yet language was not mentioned in the article on the

245   economics of dealing with the nursing shortage (Xu, 2005).

246   Hospitals, whose patients speak different languages, are responsible to

247   their patients by providing resources in the form of translators and translating

248   systems. These resources are not standardized and are less than sufficient to meet

249   patient needs. This study adds to the body of knowledge further showing how

250   important it to have nurses available who can speak different languages,

251   especially the primary languages spoken by the local patient community. This

252   study further supports the premise of how inadequate and, yet vital, language

253   translation resources are for the safety and optimal care of patients.

References

Ajzen, I. (1988). *Attitudes, personality, and behavior*. Chicago, IL: Dorsey

Press.

Ajzen, I., & Fishbein, M. (1980). *Understanding attitudes and predicting social

behavior*. Englewood Cliffs, NJ: Prentice-Hall.

Bakalis, N., & Watson, R. (2005). Nurses' decision-making and clinical

practice. (art and science research). *Nursing Standard, 19*, 33-40.

Cox, E. (2003). Synergy in practice: Caring for victims of intimate partner

violence. *Critical Care Nursing Quarterly, 26*, 323-330.

Denham, S. (2003). Describing abuse of pregnant women and their

healthcare workers in rural appalachia. *The American Journal of

Maternal/Child Nursing, 28*, 264-269.

Doll, J. & Ajzen, I. (1992). Accessibility and stability of predictors in the theory

of planned behavior. *Journal of Personality and Social Psychology, 63*,

754-765.

Giardino, E. R. (1999). Uncovering abuse in the pregnant woman. *Nursing

Spectrum, 9*, 11-14.

The Institute for the Future. (2003). *Health and health care 2010; the

forecast, the challenge*. Princeton: Jossey-Bass.

Khosla, A., Dua, D., Devi, L., & Sud, S. (2005). Domestic violence in

pregnancy in north Indian women. *Indian Journal of Medical*

Sciences, 59, n/a. Retrieved October 13, 2005 from Medknow

Publications, Electronic Collection: A133850715.

McGrath, M.E., Hogan, J.W., & Peipert, J.F. (1998). Prevalence survey of

abuse and screening of abuse in urgent care patients. *Obstetrics &*

Gynecology, 91, 511-514.

Parsons, L., Goodwin, M.M., & Petersen, R. (2000). Violence against women

and reproductive health: toward defining a role for reproductive health

care services. *Maternal and Child Health Journal, 4*, 135-140.

Schoening, A., Greenwood, J, McNichols, J. Heermann, J. & Agrawal, S. (2004).

Effect of an intimate partner violence education program on the attitudes

of nurses. *Journal of Obstetrical, Gynecologic, and Neonatal Nursing, 33*,

572-579.

Thompson, R. S., Rivara, F.P., Thompson, D. C., Barlow, W. E., Sugg, N. K.

Maiuro, R. D., et al. (2000). Identification and management of domestic

violence: A randomized trial. *American Journal of Preventive Medicine*,

19, 253-263.

Xu, Y., Kwak, C. (2005). Characteristics of internationally educated nurses

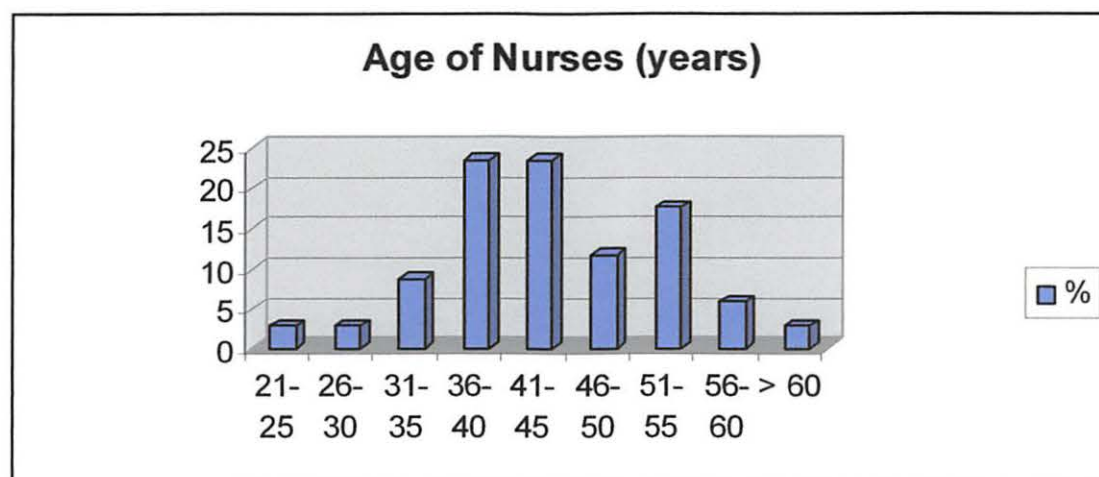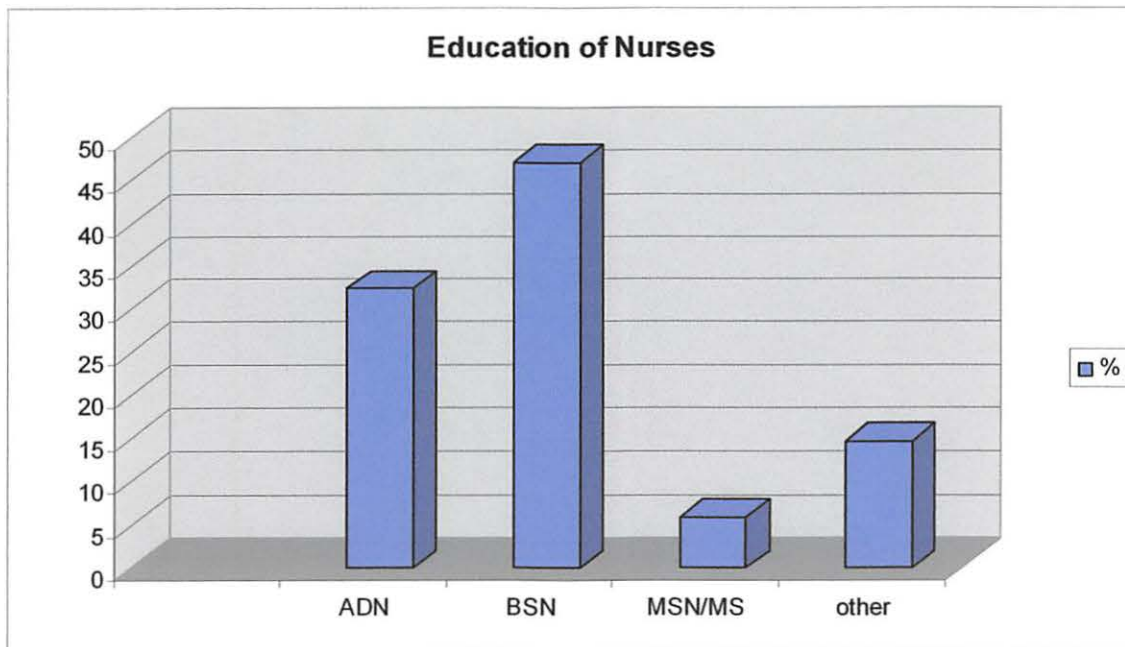in the United States. *Nursing Economics, 23*, 233-238.

Figure 1. Characteristics of Nurse Participants: Age (n=34)

Education of Nurses

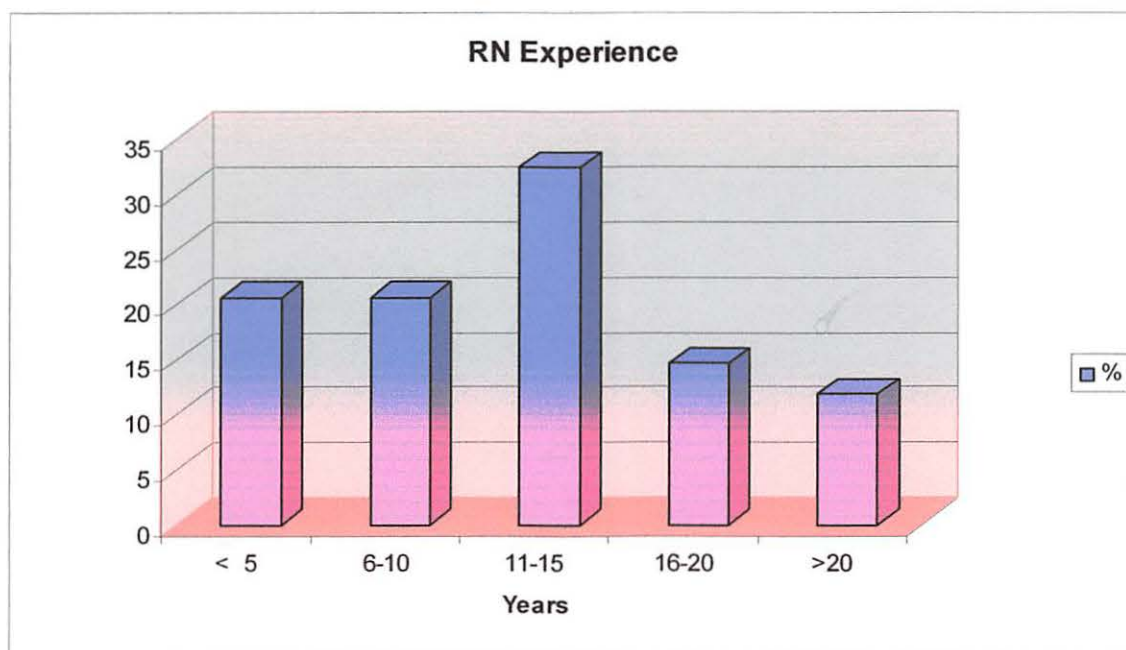*Figure 2.* Characteristics of Nurse Participants: Education (n=34)
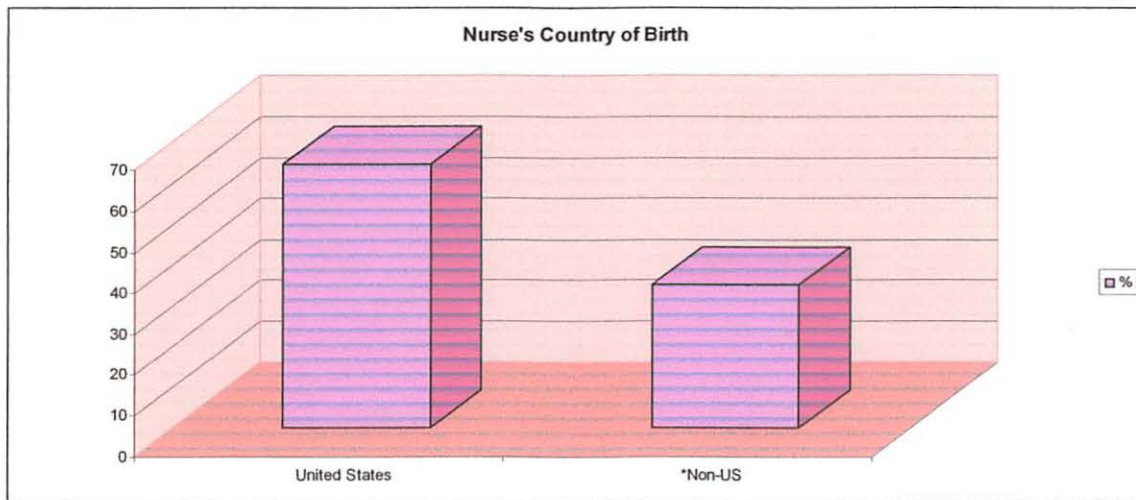ADN = Associate degree in nursing
BSN = Baccalaureate degree in nursing
MSN/MS = Master's degree in nursing or other related field
Other = Non-nursing associate and baccalaureate degree

Figure 3. Characteristics of Nurse Participants: Years of Experience (n=34)

Figure 4. Characteristics of Nurse Participants: Nurse's Country of Birth (n=34)
*Cambodia, Canada, Chile, Egypt, India, Korea, Nigeria, Philippines

Table 1

Comparisons of Nurse's and Patient's Language

Language Spoken	Nurses (n=34)		Patients (n=34)	
	n	%	n	%
English	34	100	6	17.6
Spanish + English	16	47	4	11.8
Spanish only	0	0	22	64.7
Korean + English	1	2.9	0	0
Korean only	0	0	1	12.9
Arabic	1	2.9	0	0
*Bini	1	2.9	0	0
Chinese	1	2.9	0	0
Filipino/Tagalog	2	5.9	1	2.9
French	4	11.8	0	0
Hindi	1	2.9	0	0
**Igbo	1	12.9	0	0
†Punjabi	2	5.9	0	0
**Yoruba	2	5.9	0	0
Vietnamese	1	12.9	0	0

Note. *Bini, Igbo and Yoruba are languages spoken in Nigeria, †Punjabi is a language of the Punjab regions of India and Pakistan.

Table 2

Barriers to Screening for Interpersonal Violence Identified by Nurses (n=34)

Barrier Description (based on survey questions)	Primary		Additional	
	n	%	N	%
1. Area on form not conveniently located	0	0	3	8.8
2. I don't feel it is really my job to screen	0	0	3	8.8
3. There is lack of privacy for screening in my heath care setting	10	29.4	10	29.4
4. I don't know what to do if the answer if yes	1	2.9	5	14.7
5. I don't feel I have the support from nursing management	0	0	1	2.9
6. I do not speak the patient's language well enough to ask sensitive questions	18	52.9	9	26.5
7. I feel the patient will stay with the abuser anyway	0	0	4	11.8
8. I feel uncomfortable asking the questions	0	0	2	5.9
9. A woman must try to deal privately with abuse in her own way	0	0	3	8.8
10. I don't know enough about the issues of interpersonal violence to assess for it	0	0	1	2.9
11. I cannot fix the problem anyway	1	2.9	2	5.9
12. I have been abused and do not feel can bring up the issue with my patients	0	0	2	5.9
*13. I don't feel I have support from my colleagues	0	0	0	0
14. In my culture it is not acceptable to ask about the relationships in this way	1	2.9	0	0
15. I do not have adequate training in this area	3	8.8	3	8.8

Note. *Based on data, nurses do think they have support from colleagues.