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Evidence-Based Intervention Proposal for Reducing Intimate Partner Violence Against Jamaican Women

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This is to certify that the doctoral study by

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has been found to be complete and satisfactory in all respects,

and that any and all revisions required by the

review committee have been made.

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Walden University

2025

Abstract

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by

Kimisha Campbell

MS, University of Colorado, 2016

BS, University of Phoenix, 2014

Project Submitted in Partial Fulfillment of

the Requirements for the Degree of

Doctor of Nursing Practice

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Abstract

Domestic violence (DV) is a significant public health concern that negatively impacts women's health, yet gaps in trauma-informed screening and referral processes persist within nursing practice. In Jamaica, DV remains underreported, highlighting the need for enhanced provider competency in identifying and supporting survivors. The doctoral project was used to examine how implementing the trauma-informed care (TIC) model and the Identification and Referral to Improve Safety (IRIS) program could improve healthcare staff's ability to recognize, assess, and support DV survivors. Guided by the TIC framework and the IRIS program, a mixed-methods approach was used, incorporating pre- and posttraining assessments, staff surveys, and qualitative feedback to measure changes in knowledge, confidence, screening practices, and referral efficiency. Data analysis revealed a 45% increase in staff competency scores, a 60% rise in DV screening rates, and a 50% improvement in referral efficiency post-training. Findings support the integration of structured education and trauma-sensitive approaches to improve DV intervention in nursing practice. Key recommendations include ongoing training, interprofessional collaboration, and policy development to institutionalize standardized screening protocols. The project contributes to positive social change by strengthening healthcare providers' capacity to address DV, potentially improving survivor-centered care and health outcomes for women in Jamaica.

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Dedication

The doctoral project is dedicated to the cherished memory of my beloved mother, Rosemarie Cecile Morgan, whose unwavering love, strength, and wisdom continue to guide me every day. Her spirit remains a beacon of inspiration, and this achievement is a testament to the values she instilled in me. To my precious daughters, Nyilah and Lena, you are the light of my life. Your boundless curiosity and endless joy fuel my passion for learning and discovery. The journey has been for you, and may it serve as a reminder that with determination and consistency, anything is possible.

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Lastly, to all those who have supported me in ways both big and small, known and unknown, your contributions have not gone unnoticed. The achievement is as much yours as it is mine.

Thank you all from the bottom of my heart

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Section 1: Nature of the Project

Introduction

Domestic violence refers to a pattern of abusive behavior in any relationship that is used by one partner to gain power and control over another (Arscott-Mills, 2020). It is a serious and pervasive issue that occurs within the context of intimate relationships, such as marriage, dating, or cohabitation. Domestic violence can take various forms, including physical, sexual, emotional, psychological, and financial abuse. Physical abuse involves the use of physical force or violence, such as hitting, slapping, kicking, or restraining the victim. It can lead to severe injuries, long-term health problems, and even death. Sexual abuse refers to any nonconsensual sexual activity imposed on the victim, including rape, unwanted sexual advances, or forcing the victim to engage in sexual acts against their will. Emotional and psychological abuse aims to undermine the victim's self-esteem, manipulate their emotions, and control their thoughts and actions. Which includes constant criticism, humiliation, intimidation, threats, and isolation from friends and family. The effects of emotional abuse can be long lasting, leading to anxiety, depression, and a sense of helplessness. Financial abuse involves controlling the victim's financial resources, limiting their access to money, and preventing them from making independent financial decisions. Which can include withholding money, preventing the victim from working, or forcing them to hand over their earnings. Domestic violence is a pervasive issue in Jamaica, with women being the primary victims of such violence. According to Arscott-Mills (2020), domestic violence is a significant problem in Jamaica, with 31.6% of women reporting physical violence at some point in their lives. Furthermore, 20.9% of

women reported experiencing physical violence in the past year alone. The Arscott-Mills also found that domestic violence was more prevalent with women who were younger, less educated, and from lower-income households. Additionally, they revealed that domestic violence was most perpetrated by intimate partners, with 56.8% of women experiencing violence from their current or former partners. The prevalence of domestic violence in Jamaican women is concerning, as it not only affects the physical and mental well-being of the victims but also has broader societal implications. It is crucial for policymakers and stakeholders to address this issue and implement measures to prevent and address domestic violence in Jamaica.

Professionals who work with domestic violence cases face numerous challenges in their efforts to address and prevent such violence. According to Hamberger and Hasting (2021), one of the key challenges is the difficulty of identifying domestic violence victims who are not willing to report their abuse. In many cases, victims may fear retaliation from their abusers or may feel shame and embarrassment about their situation. Supporting the victims and providing support can be difficult for professionals. In this doctor of nursing practice (DNP) educational project, I provide key strategies for educating nursing professionals to effectively address domestic violence with appropriate training and education. The nursing professionals at a community-based center in the southeastern coast of the island will collaborate with the Jamaica Coalition Against Domestic Violence team (JCADV) to receive training and education to combat domestic violence. In Section 1, I address the problem statement, purpose statement, nature of the doctoral project, and significance.

Problem Statement

The practice-focused problem is the lack of domestic violence education and training for nursing professionals at a nonprofit clinic in the southeastern region of Jamaica. According to Collins, (2019) evidence can be found that supports the need for nurses to start recognizing domestic violence as an important issue and to address domestic violence as a prevalent problem that is devastating to the psychological and physical wellbeing of Jamaica women. According to the International Center for Research on Women (ICRW, 2020), more than one in four women in Jamaica have experienced verbal, physical, sexual, and/ or emotional abuse from a partner within the past twelve months. The results of the first national survey on gender-based violence in Jamaica shows a high prevalence rate of 27.8%, with more than one in every four women in Jamaica experiencing intimate partner violence in their lifetime (ICRW, 2020). The project site is Jamaica's largest domestic violence outlet located in an underserved region of Jamaica. On a typical day the clinic receives more than 200 phone calls per day from victims of domestic violence and physically serves approximately 10-20 patients per day. These services to victims include, but are not limited to, a supportive environment, counseling, shelter, and other support services.

It is essential for nurses to identify and address domestic violence in not only at this nonprofit clinic in Jamaica but in all clinical setting so that the proper resources and treatments can be made available to victims and perpetrators of domestic violence (McQuigg, 2021). The impact that domestic violence has on victims goes beyond

physical health and requires that nurses be equipped with the appropriate information and skills to identify and manage cases of domestic violence that are seen in this clinic.

Unfortunately, many nurses lack knowledge or training in how to identify and help Jamaican women who suffer domestic violence. With this doctoral project, I intended to provide a better understanding of domestic violence at the clinic and how to ensure nurses are adequately trained to deal with it. I addressed the gap in nursing practice with this educational project by focusing on the training and education of the nursing staff at this community-based center, in collaboration with the JCADV, to identify, understand and respond to the signs and symptoms of domestic violence in the healthcare setting.

Purpose Statement

Despite the efforts of policymakers and healthcare providers, there remains a significant gap in nursing practice regarding the identification and treatment of domestic violence victims. The gap in practice is the lack of education and training among healthcare professionals for domestic violence at a nonprofit clinic in Jamaica. Despite the government's attempts to address domestic violence, it remains a significant problem in the country. The purpose of the project was to provide a training program at the nonprofit clinic in Jamaica to the clinic professionals about detecting, treating, and providing resources for victims of domestic violence. According to Pitter (2020), domestic violence is a significant public health problem in Jamaica, and it is estimated that one in four women will experience intimate partner violence in their lifetime. McCann and Brown (2021) noted the current training and education of healthcare professionals are not sufficient to meet the demands of today's healthcare system. They

found that there is a lack of emphasis on certain skills such as communication, teamwork, and leadership in the current training and education programs. These skills are essential in providing patient-centered care and improving patient outcomes. In addition, McCann and Brown found that there is a need for more interprofessional education and collaboration among healthcare professionals to improve the quality and safety of care. Despite the efforts of various stakeholders to address the problem, there is still a significant gap in training and education, which can limit the effectiveness of interventions. Therefore, it is essential that training and education on domestic violence is integrated into the curricula of various disciplines.

The guiding practice-focused question for this educational project was "Will providing a training and educational program on domestic violence awareness to providers and nurses at the nonprofit clinic improve knowledge regarding addressing domestic violence?". After healthcare professionals complete the face-to-face interview with clients at the nonprofit clinic in Jamaica, they should be able to detect the various types and signs of domestic violence, provide support services for victims, and implementing prevention measures. The training that was initiated is a survivor-centered training that encompasses a range of topics, including understanding the dynamics of abuse, recognizing different forms of violence, and employing trauma informed approaches when interacting with survivors. The second training, called safety planning, was based on safety strategies planning with survivors, acquiring tools and skills in developing safety plans. By equipping professionals with the necessary knowledge and skills, they can play a crucial role in breaking the cycle of violence, improving the safety

and well-being of survivors, and promoting a society that does not tolerate domestic violence.

I also aimed to bridge a critical gap in healthcare practices within a nonprofit clinic in Jamaica by providing staff with specialized education on intimate partner and sexual violence. The targeted training equips healthcare professionals with the knowledge and skills necessary to effectively recognize, respond to, and address instances of violence among patients. By enhancing staff awareness and proficiency in recognizing, responding to, and addressing instances of intimate partner and sexual violence among patients, I directly addressed the identified gap-in-practice, ensuring that clinic personnel are better equipped to provide comprehensive care and support to individuals affected by intimate partner and sexual violence. For this project, I drew upon a corpus of scholarly literature spanning disciplines such as public health, psychology, and social work, which underscores the imperative for healthcare institutions to address intimate partner and sexual violence comprehensively. Smith et al. (2019) emphasized the significant impact of violence on physical and mental health outcomes, highlighting the critical role of healthcare providers in recognizing and intervening in such cases. Additionally, Johnson et al. (2020) elucidated the complexities involved in addressing intimate partner violence within clinical settings, emphasizing the necessity for tailored training programs to equip healthcare professionals with the requisite skills and knowledge. By integrating insights from seminal works, I aimed to inform its approach and ensure alignment with evidencebased best practices in addressing intimate partner and sexual violence within healthcare contexts.

Nature of the Doctoral Project

Databases used for the literature search included the Jamaican Women's Health Survey, which collects data on various aspects of women's health, including experiences of domestic violence, PubMed, CINAHL and Medline. The search terms included *domestic violence in Jamaica, violence against women in Jamaica, gender-based violence in Jamaica, abuse in Jamaican relationships, Jamaican women and domestic abuse,* and *domestic violence statistics in Jamaica*. Boolean operator 'AND' was combined with term *domestic violence* and "*Jamaican women*. The literature search was focused on peer-reviewed articles published in the English language between the year 2019 and 2024. The inclusion criteria for this review focused on studies that specifically addressed domestic violence against women within the Jamaican context, were written in English, and included full text. Articles that concentrated on different populations or geographical locations, were written in a language other than English, or did not specifically address domestic violence among Jamaican women were excluded. The search yielded a total of 73 articles. After applying the inclusion and exclusion criteria, 51 articles were identified as relevant. Ultimately, 26 articles were selected for the review.

Education was provided to nursing staff at the nonprofit clinic to enhance awareness and their response to domestic violence. To ensure alignment with the project's objectives, the educational component targeted the identified gaps in communication regarding domestic violence resources, as highlighted by the National Intimate Partner and Sexual Violence Survey (NISVS), which was done outside the scope of the project. I implemented a comprehensive training initiative aimed at enhancing the clinic staff's

awareness, sensitivity, and proficiency in handling domestic violence cases among patients. The program encompassed physicians, nurses, social workers, and administrative personnel, integrating education within the clinic's existing staff development initiatives. The education focused on key aspects in recognizing signs of domestic violence, improving communication with patients, understanding legal and ethical responsibilities, and providing appropriate assistance and referrals. By targeting these specific areas, I ensured that all staff members were equipped with the necessary knowledge and skills to effectively address instances of domestic violence, enhancing the clinic's overall response to such cases.

In this doctoral project, I sought to address a critical gap in healthcare practices within a nonprofit clinic in Jamaica by implementing a comprehensive educational program focused on domestic violence intervention. The initiative targeted physicians, nurses, social workers, and administrative personnel, integrating key components such as recognizing signs of domestic violence, effective patient communication, legal and ethical responsibilities, and appropriate assistance and referrals into the clinic's ongoing staff development efforts. Led by qualified professionals specializing in domestic violence intervention and healthcare communication, the educational program employs interactive sessions featuring workshops, case studies, role-playing, and simulations to actively engage participants and enhance their skills. Pre- and postimplementation evaluations, using data from the NISVS, were used to assess changes in staff communication regarding domestic violence resources, employing comparative statistics.

Significance

When addressing domestic violence against women at the clinic, it was imperative to identify all stakeholders. First, the survivors of domestic violence themselves are the primary stakeholders as their lives and wellbeing are directly affected. Law enforcement agencies and the legal system are important stakeholders in preventing domestic violence. Their involvement is crucial in ensuring that perpetrators are held accountable for their actions and that survivors have access to justice. Social workers and counselors are another important group of stakeholders as they provide essential support services to survivors, helping them heal from trauma and rebuild their lives. Healthcare providers are important stakeholders as well, as they may be the first point of contact for survivors seeking medical assistance. They can offer not only physical care, but also provide information on available support services, as they have a responsibility to create safe working environments and support employees who may be experiencing domestic violence (Showalter, 2021).

The potential contribution of the project to nursing practice in the context of a nonprofit clinic addressing domestic violence against Jamaican women is profound. Recognizing the significance of appropriately addressing and supporting survivors through a comprehensive care plan is essential in promoting the health and well-being of these women. In an educational project, the assessment of staff's consistent application of guidelines and protocols emerges as a crucial element of nursing care. The process not only drives positive social change but also challenges existing practices to elevate patient outcomes. The evaluation of adherence to established guidelines plays a pivotal role in

gauging the effectiveness of interventions and becomes a key focus within the educational framework. Aligning with the healthcare team's commitment to delivering holistic and patient-centered services, the guidelines serve as a valuable tool for the healthcare team. They provide a systematic approach for consistently evaluating survivors and customizing interventions to address their unique needs. The approach is dedication by the clinic staff to providing comprehensive and personalized care for survivors of domestic violence.

To broaden the applicability of the educational project addressing domestic violence within the clinic, a systematic knowledge-sharing approach was implemented, facilitating the dissemination of successful strategies, methodologies, and best practices to other healthcare settings through documentation, communication channels, and collaborative networks. Establishing collaborative networks with healthcare associations and online platforms can facilitate broader outreach, while multimedia content aids effective communication. Advocacy for policy integration and the development of tailored resources further enhances the impact of the project. By adopting these strategies, the insights derived from the project can be shared with similar clinics across the island, contributing to positive social change by raising awareness, breaking the silence around domestic violence, and promoting inclusive and comprehensive approaches.

In terms of potential implications for positive social change, the doctoral project could have several significant impacts. First, by bringing attention to the issue of domestic violence, the findings may contribute to raising awareness and breaking the silence surrounding domestic violence. Increased awareness of the signs of domestic

violence of women at the clinic can lead to better support systems, improved access to resources, and a greater emphasis on prevention and early intervention. Furthermore, the project emphasis on recognizing the intersectionality of domestic violence is geared towards contributing to the formulation of more inclusive and comprehensive approaches in addressing domestic violence.

Summary

The introduction provided a comprehensive overview of domestic violence, highlighting its various forms and pervasive nature within intimate relationships. Focusing on the nonprofit clinic in southeastern Jamaica, I emphasized the alarming prevalence of domestic violence among women, particularly in rural areas. The challenges faced by professionals in addressing and preventing domestic violence are discussed. The practice-focused question was "Will providing a training and educational program on domestic violence awareness that includes safety planning, risk assessment, referral to support services, trauma-informed care, and effective communication strategies to providers and nurses at the nonprofit clinic improve knowledge regarding addressing domestic violence?"

The purpose was to educate healthcare professionals at the nonprofit clinic on domestic violence awareness and response through various training modalities, including workshops, case studies, role playing, and simulations. The significance of the project is the potential for improved care and outcomes, specifically focusing on the staff's consistency in delivering care and referrals. The potential contribution to nursing practice is the refinement of care delivery and interventions for women at the non-profit clinic

impacted by domestic violence. The success and effectiveness observed in this clinic could serve as a valuable template for similar healthcare settings dealing with domestic violence. The positive social change implications include raising awareness, breaking the silence around domestic violence, and promoting inclusive approaches.

In Section 2, I present the concepts, models, and theories pertinent to nursing practice, the local background and context, as well as the roles of DNP student and the project team.

Section 2: Background and Context

Introduction

Domestic violence is a major issue in Jamaica, with a significant impact on the lives of both women and men. According to Anderson et al. (2019), approximately 30% of women reported experiencing violence from an intimate partner in their lifetime. Additionally, domestic violence was found to be significantly higher for women living in rural areas, with more than 40% of women reporting experiencing intimate partner violence. The guiding practice-focused question for this quality improvement (Q)I project was "Will providing a training and educational program on domestic violence awareness to providers and nurses at the nonprofit clinic improve knowledge regarding addressing domestic violence?". The emphasis was on assessing the influence of the tailored training and educational program on domestic violence awareness among healthcare professionals, specifically nurses. The objective was to elevate their knowledge, understanding, and response capabilities to domestic violence cases, framing the project as a dedicated educational initiative. The practice-focused problem stemmed from the absence of domestic violence education and training for nursing professionals at a nonprofit clinic in southeastern Jamaica.

Section 2 consists of the concepts, models, and theories, relevance to nursing practice, local background and context, my role as the DNP student, and the role of the project team.

Concepts, Models, and Theories

The trauma-informed care (TIC) model served as the guiding framework for the

Identification and Referral to Improve Safety (IRIS) program, tailored as "Comprehensive Domestic Violence Training for Healthcare Professionals." The TIC model is underpinned by core principles including recognizing signs and symptoms of trauma, fostering a culture of compassion, and avoiding re-traumatization (Substance Abuse and Mental Health Services Administration [SAMHSA], 2022). These principles collectively shape the approach to this educational project, influencing the entire evaluative process. By incorporating the core tenets, the project aims to enhance healthcare professionals' understanding of domestic violence and equip them with the necessary tools to provide compassionate and informed care (Elliott et al., 2021).

In supporting the project, each assumption of the TIC model was strategically integrated into specific components. Notably, the TIC model's emphasis on avoiding retraumatization is evident throughout the project design. Firstly, understanding signs and symptoms of trauma is pivotal in Stage 1, where trauma-sensitive approaches are applied during initial screenings (Gonzalez et al., 2023). The emphasis on understanding signs and symptoms of trauma ensures a targeted and effective response to the specific needs of patients impacted by domestic violence. In the TIC model, Stages 2, 3, and 4 encompass crucial aspects of establishing safety, rebuilding connections, and promoting empowerment and collaboration. Stage 2 focuses on creating a safe environment by deploying a trauma-informed healthcare team, building trust with caregivers, and ensuring sensitivity to trauma-related cues (Maguire et al., 2021). Stage 3 emphasizes rebuilding connections disrupted by trauma through strengthening bonds with patients, caregivers, and support networks, fostering a sense of belonging and collaboration in the

healing process (Harris & Fallot, 2021). Finally, Stage 4 centers on empowering individuals to actively participate in decision-making regarding their care, identifying strengths and goals, and connecting them with community resources for long-term recovery and well-being (Sullivan et al., 2022).

In Stage 5, a trauma-informed approach is used to assess and manage risk and symptoms, facilitating the development of tailored care plans (Tanenbaum et al., 2021). Simulation exercises and interactive learning platforms, integral components of the project, are aligned with this principle, creating a secure and supportive environment for healthcare professionals to practice and enhance their responses. Moreover, my dedication to education and self-management, emphasized by Stage 6, closely aligns with the TIC model's objective of empowering individuals to respond sensitively to emergencies (see National Child Traumatic Stress Network [NCTSN], 2022). Collaboration, a critical focus in Stage 7, is approached through a trauma-informed lens, fostering agreements, follow-ups, and sensitive monitoring during the discharge process in Stage 8. (Johnson & Zaw, 2021). The emphasis on continuity in Stage 8 further aligns with the TIC model's overarching goal of providing supportive care. The final stage, Stage 9, underscores the coordination between healthcare and community-based providers, addressing the unique challenges of patients impacted by domestic violence. The evaluation process is designed to comprehensively assess how each stage aligns with the TIC model, gauging the effectiveness of measures in providing holistic, traumainformed care to the patients at the non-profit clinic. By deploying a trauma-informed healthcare team and fostering connections with caregivers, I created a

supportive environment conducive to healing and trust building. Ultimately, the project's alignment with the TIC model enables healthcare professionals to recognize, respond to, and support individuals affected by domestic violence effectively, thereby enhancing the clinic's capacity to provide compassionate and sensitive care.

Relevance to Nursing Practice

In examining the historical progression of nursing practice regarding domestic violence at the clinic, a discernible trajectory unfolds, underscored by broader societal shifts over time. Initially, domestic violence remained veiled in secrecy, deemed a private matter that impeded effective intervention efforts (Vink & Annemiek, 2023). However, as scholarly understanding deepened concerning its detrimental impact on individuals' health, nursing practice underwent a pivotal transformation. The evolution is highlighted in research according to Haselschwerdt and Hardesty, (2020), who documented the gradual recognition of domestic violence as a significant public health concern. The realization prompted the formulation of guidelines and protocols aimed at addressing domestic violence within healthcare settings (Vink & Annemiek, 2023). However, despite these advancements, persistent challenges persisted in effectively addressing domestic violence within nursing practice (Haselschwerdt & Hardesty, 2020). The persistent challenges faced in addressing domestic violence underscore the need for targeted interventions, such as my doctoral project, to enhance nursing responses within the clinic. In examining the historical trajectory of nursing practice concerning domestic violence at the clinic, it becomes evident that a distinct evolution has transpired, reflecting broader societal changes over time. Despite the clinic's history of treating domestic violence cases

for several years, these cases were initially often overlooked and regarded as private matters impeding effective intervention efforts. While policies were in place to address domestic violence, they lacked comprehensive guidelines and sufficient training and resources for staff. Over time, as awareness grew regarding the detrimental impact of domestic violence on individuals' health, modifications to existing policies were made. However, persistent gaps and challenges in addressing domestic violence cases have remained evident, as highlighted in reports and observations from the past few years. Despite these efforts, the problem persists, prompting the need for targeted interventions to enhance nursing responses within the clinic's context.

Despite notable advancements in recognizing the significance of addressing domestic violence within nursing practice, enduring challenges persist at the clinic in ensuring consistent protocol implementation and intervention efficacy. Over the past few years, despite growing awareness among nursing professionals regarding the detrimental impact of domestic violence on individual health outcomes, shortcomings have been observed in uniformly responding to such cases across diverse healthcare settings within the clinic. Haselschwerdt and Hardesty (2020) highlighted the ongoing need for tailored education and training programs targeting healthcare professionals, particularly nurses, to effectively recognize and address instances of domestic violence. Additionally, Vink and Annemiek (2023) emphasized the importance of ongoing professional development opportunities and interdisciplinary collaboration to bolster nursing responses to domestic violence cases. However, despite these recommendations, there remains a gap between awareness and effective implementation of interventions within the clinic. Which

underscores the necessity for targeted strategies aimed at enhancing nursing responses to domestic violence cases, such as the implementation of standardized protocols, continuous training programs, and interdisciplinary collaboration, to bridge this gap and improve patient outcomes.

Previous approaches to addressing the identified gap in nursing practice concerning domestic violence have indeed encompassed a variety of strategies, as documented in the literature. Targeted training programs and workshops have been instrumental in enhancing nurses' understanding of domestic violence dynamics and equipping them with the necessary skills for identification and support (Hegarty et al., 2013). The development and implementation of clear guidelines and protocols within healthcare settings have proven effective in ensuring a standardized approach to recognizing, documenting, and responding to domestic violence cases (Waalen et al., 2000). Interdisciplinary collaboration has been widely recognized as crucial, fostering partnerships between nurses, social workers, psychologists, and law enforcement to provide comprehensive care to survivors (Wathen et al., 2023). Additionally, integrating trauma-informed care principles into nursing practice has gained prominence, acknowledging the pervasive impact of trauma and enhanced supportive environments conducive to healing (Banyard et al., 2020). Community outreach programs have also been instrumental in extending efforts beyond clinical settings, raising awareness, and providing education to prevent domestic violence (Banyard et al., 2020). These strategies, supported by empirical evidence, highlight the multifaceted approach required to effectively address domestic violence within nursing practice.

The doctoral project represents a significant advancement in nursing practice as it addresses a crucial gap identified in the literature regarding the efficacy of educational initiatives in empowering nurses to tackle domestic violence effectively. The gap is underscored by Feder et al. (2021) and Woods et al. (2021), who emphasized the need for tailored educational interventions to enhance nurses' skills in recognizing and responding to domestic violence cases. By concentrating on evaluating the TIC model and targeted training modalities, I aimed to provide empirical evidence to fill this void. Morrison et al. (2021) and Smith et al. (2020) supported the importance of evidence-based approaches like the TIC model in improving nursing responses to domestic violence. Through a rigorous assessment comparing preimplementation and postimplementation outcomes, I endeavored to contribute to the existing body of knowledge. Ultimately, the project's comprehensive evaluation of educational interventions tailored to address domestic violence within nursing practice expands the understanding of effective strategies and offers valuable insights that can guide future initiatives aimed at combating domestic violence within healthcare settings.

Local Background and Context

Within the local context of the nonprofit clinic in Jamaica, the urgency to address domestic violence within its healthcare framework is evident. Jamaica faces unique sociocultural dynamics, with domestic violence being a prominent concern that disproportionately impacts women. The prevalence of domestic violence among female patients at the clinic underscores the necessity to delve into this issue further, emphasizing the significance of the practice-focused question. Data collected at the clinic

reveals that approximately 75% to 80% of patients seeking assistance at the domestic violence clinic are doing so for domestic violence-related concerns. With four to five victims receiving care at the clinic, and three to four requiring continuous follow-up, a substantial proportion of patients access services for domestic violence support, highlighting the clinic's pivotal role in addressing the urgent needs of those affected by domestic violence in the community. Campbell et al. (2021) and Coker et al. (2020) have shown that healthcare settings, including clinics, often serve as vital points of access for survivors of domestic violence to seek assistance and support. Moreover, Bonomi et al. (2021) emphasized the importance of continuous follow-up care for survivors, highlighting the critical role clinics play in providing ongoing support to those affected by domestic violence. Therefore, the data collected from the clinic not only reinforces the urgency of addressing domestic violence but also validates the clinic's pivotal role in addressing the needs of survivors within the community. Aligned with its mission to provide comprehensive healthcare services to all individuals, regardless of their socioeconomic status, the clinic has made addressing domestic violence a cornerstone of its operations.

The commitment is reflected in the clinic's mission statement, which emphasizes the provision of culturally competent and compassionate care to survivors of domestic violence. The literature supported the importance of such initiatives, with studies indicating that healthcare settings play a crucial role in identifying and supporting survivors of domestic violence (Hegarty et al., 2020). By integrating TIC principles into nursing practices, the clinic strives to create a supportive environment that recognizes the

complexities of domestic violence and fosters healing and recovery. Through ongoing support and tailored interventions, the clinic aims to empower survivors and contribute to the eradication of domestic violence within the community.

The institutional context surrounding the problem addressed in this doctoral project is multifaceted and encompasses various elements crucial to understanding the complexities of domestic violence within the healthcare setting. Situated in a community marked by diverse demographics, the non-profit clinic serves a population with unique socio-economic backgrounds and cultural dynamics, with differing norms, values, and beliefs that influence perceptions of domestic violence and help-seeking behaviors contributing to the complex landscape of domestic violence (see Johnson et al., 2021). Within this community, individuals hail from various age groups, including adolescents, working-age adults, and seniors, each facing distinct challenges related to domestic violence (Smith et al., 2020). Additionally, the clinic serves individuals from different socioeconomic statuses, with some facing financial constraints that may exacerbate their vulnerability to domestic violence. Recognizing and understanding the diverse demographics of the clinic's population is essential for developing tailored interventions and support systems that effectively address the needs of all individuals affected by domestic violence within the community.

In the context of the doctoral project, several locally used terms and operational processes are pertinent to understanding its objectives and implementation. Firstly, TIC refers to an approach that recognizes the prevalence and impact of trauma on individuals' lives and emphasizes creating environments that are sensitive to trauma survivors' needs.

Furthermore, "domestic violence" encompasses various forms of abuse, such as physical, emotional, psychological, and financial, occurring within intimate relationships. At the clinic, we acknowledge the multifaceted nature of domestic violence and endeavor to address all its forms comprehensively. Implementing support and intervention strategies tailored to the individual's unique situation and needs is integral. Our approach acknowledges the intricate dynamics of domestic violence and emphasizes the importance of holistic care.

We offer a range of supportive measures, including counseling services to help survivors cope with trauma and develop coping strategies, safety planning to assist in creating a secure environment, legal advocacy to navigate legal processes and seek protection orders, and access to community resources such as shelters, support groups, and financial assistance programs. By providing comprehensive support, we aim to promote healing and empowerment for survivors, assisting them in breaking free from the cycle of abuse and rebuilding their lives. The term "culturally competent care" denotes healthcare practices that respect and integrate cultural beliefs, values, and behaviors into the delivery of services, ensuring they are responsive to the diverse backgrounds and experiences of patients (Klein, 2021). Furthermore, "nursing responses" refer to the actions taken by healthcare professionals, particularly nurses, in identifying, assessing, and addressing instances of domestic violence among patients. Understanding these locally used terms and operational processes is essential for comprehending the scope and objectives of the doctoral project aimed at enhancing nursing responses to domestic violence within the clinic's context.

Definition of Terms

Screening:

- Utilize standardized screening tools, such as the Domestic Violence Screening Inventory (DVSI) or the Abuse Assessment Screen (AAS), to systematically assess patients for signs of domestic violence. The AAS is a validated tool designed to identify individuals who may be experiencing abuse or violence in their intimate relationships. By incorporating these screening tools into clinical practice, healthcare providers can effectively identify and address domestic violence among patients, ensuring appropriate intervention and support (Feder et al., 2021; McFarlane et al., 2021).
- Conduct screenings in a private and confidential setting to ensure the safety and comfort of the survivor (Wathen et al., 2023).

Reporting:

- Follow mandated reporting laws and procedures, which vary by jurisdiction, to report cases of domestic violence to appropriate authorities, such as law enforcement or child protective services. (Campbell et al., 2021). In the specific jurisdiction where the clinic is located, adherence to reporting requirements outlined by local laws and regulations is imperative. These requirements include guidelines on mandatory reporting of instances of domestic violence to law enforcement or relevant authorities. Healthcare providers are obliged to report cases of domestic violence when they have reasonable grounds to believe that a patient is experiencing abuse or is at risk of harm. Reporting protocols may specify the timeframe within which such reports must be made and the appropriate channels through which to submit them. Additionally,

healthcare providers may be required to document their observations and interactions with patients in cases of suspected domestic violence, ensuring accurate and thorough reporting in accordance with legal requirements and ethical obligations. By staying informed about the reporting protocols specific to their jurisdiction, healthcare professionals at the clinic can ensure compliance with legal requirements and contribute to the protection and safety of survivors.

- Document all findings and interactions with the survivor in the patient's medical record using objective language and detailed notes (American College of Emergency

Physicians, 2020).

Support Services:

- Provide survivors with information about available support services, including shelters, counseling services, legal assistance, and community resources (National Coalition Against Domestic Violence, n.d.).

- Offer TIC to address the psychological and emotional needs of survivors, focusing on safety, trustworthiness, choice, collaboration, and empowerment (Substance Abuse and Mental Health Services Administration, 2021).

Role of the DNP Student

As the leader spearheading this educational project, my primary objective was to design, implement, and evaluate a comprehensive training and educational program on domestic violence awareness for providers and nurses at the non-profit clinic. My responsibilities included developing the curriculum, delivering educational sessions, and

overseeing the assessment of its effectiveness. I conducted a thorough review of existing literature and evidence-based practices, drawing insights from studies by Jones et al. (2019) and Smith et al. (2020). With this foundation, I developed tailored educational materials and resources that align with the principles of TIC and addressed the specific needs of women affected by domestic violence. These materials covered specific topics, including identification of signs of domestic violence, strategies for effective communication, understanding legal and ethical responsibilities, and guidelines for providing appropriate assistance and referrals. Next, I facilitated interactive training sessions for clinic staff, incorporating a variety of engaging activities such as workshops, case studies, role-playing exercises, and simulations. The activities were carefully designed to actively involve participants and foster skill enhancement. Throughout the training sessions, participants were actively engaged in hands-on learning experiences, including analyzing case studies, role-playing different scenarios, and participating in simulated exercises. An interactive approach ensured that participants have ample opportunities to apply newly acquired knowledge and skills in practical settings, leading to enhanced learning outcomes. Throughout this process, I emphasized the importance of aligning nursing practices with the assumptions of the TIC model and fostering a healthcare environment that is sensitive to the complexities of domestic violence.

My passion for instigating impactful transformations and assessing their impact on healthcare systems has always been a driving force for me. Engaging in quality improvement endeavors, my primary objective is to foster evidence-based solutions for healthcare delivery challenges. The project provided me with an opportunity to actively

participate in critical decision-making processes, refine my ability to evaluate the effectiveness of interventions, and further develop my leadership skills in healthcare provision. Importantly, I approached this project with a commitment to impartiality and objectivity, ensuring that any prejudices I may hold did not influence the outcomes.

Role of the Project Team

The project team comprised a diverse group of individuals, each with specific roles and responsibilities crucial to the success of the educational initiative. Within the healthcare professional category, physicians, nurses, social workers, and other clinical staff actively participated in the training program (Smith et al., 2020). Physicians were responsible for providing clinical oversight and medical expertise relevant to domestic violence cases (see Johnson et al., 2021). Nurses played a key role in delivering training sessions, facilitating discussions, and providing hands-on support during simulations (see Haselschwerdt & Hardesty, 2021). Social workers offered expertise in psychosocial support and resource navigation for survivors (see Vink & Annemiek, 2023). Clinical staff contributed their unique perspectives and insights to enrich the training experience.

The clinic liaisons were pivotal in the project, assisting in curriculum development by providing input based on their experience working within the clinic's context (Colen et al., 2020). They offered ongoing support to trainers and participants during training sessions, ensuring smooth facilitation and addressing any logistical or technical issues that may arise. Additionally, they took charge of evaluating the program's progress, collecting feedback from participants, and identifying areas for improvement. Educators within the team played a crucial role in designing and delivering the

educational curriculum (see Feder et al., 2021). They leveraged their expertise in pedagogy and content development to ensure that the training materials are relevant, engaging, and aligned with TIC principles (see Morrison et al., 2021). Their responsibilities included curriculum design, content creation, and instructional delivery, as well as providing continuous guidance and assistance to trainers and participants throughout the implementation phase.

Community liaisons served as the link between the clinic and external stakeholders, such as community organizations and government agencies. They played a vital role in assessing the program's efficacy within the broader community context and making necessary adjustments to enhance its impact (Campbell et al., 2021). By soliciting feedback from community partners and incorporating their perspectives into the training program, they ensured that the initiative remained responsive to the evolving needs of survivors and the community at large. Overall, the interdisciplinary team collaborated closely to create a supportive and compassionate healthcare environment that addressed the unique needs of women impacted by domestic violence, advancing the objectives of the project, and promoting positive social change.

Summary

The doctoral project was guided by the TIC model, which emphasizes recognizing trauma symptoms and fostering compassion to address domestic violence effectively. Through tailored educational interventions, the project aim was to enhance nurses' abilities to identify and respond to domestic violence cases within a non-profit clinic setting in Jamaica. The local context underscored the urgency of addressing domestic

violence, with the clinic playing a pivotal role in providing comprehensive care to survivors. As the project leader, I was responsible for developing and delivering the educational curriculum, aligning it with TIC principles, and ensuring its effectiveness through rigorous evaluation. The project team, comprising healthcare professionals, educators, and community liaisons, collaborated to create a supportive environment and advance the project's objectives, ultimately contributing to positive social change within the clinical setting. Through continuous evaluation and adaptation, the project aims to enhance nursing responses to domestic violence and improve patient outcomes.

Section 3: Collection and Analysis of Evidence

Introduction

Domestic violence, marked by a pattern of abusive behavior within relationships, encompasses various forms of harm, including physical, emotional, psychological, financial, and sexual abuse, often with the aim of establishing control or power dynamics (Smith et al., 2020). The identified issue at the nonprofit clinic revolves around inconsistent intervention strategies and a notable recurrence of abuse cases among its patient population, indicating ongoing challenges in effectively addressing domestic violence. The urgent need for comprehensive solutions aimed at improving support services for survivors, addressing their complex needs, and implementing long-term prevention and intervention strategies is underscored (Jones, 2020). The purpose of the project was to evaluate the impact of an educational program on domestic violence awareness provided to nurses at the non-profit clinic. The overarching question guiding this initiative was, "Will providing a training and educational program on domestic violence awareness to providers and nurses at the nonprofit clinic improve knowledge regarding addressing domestic violence?" It was anticipated that offering a training and educational program on domestic violence awareness to providers and nurses at the nonprofit clinic would enhance their knowledge and capability in addressing domestic violence issues. I aimed to evaluate the effectiveness of intervention strategies implemented by nurses at a nonprofit clinic in addressing domestic violence within its patient population by assessing the clinic's intervention protocols, including the consistency and adequacy of services, accessibility of support resources, and

responsiveness to survivors' needs. In Section 3, I discuss the practice focused question, sources of evidence, evidence generated for the doctoral project, and the analysis and synthesis to address the project question.

Practice-Focused Question(s)

The nonprofit clinic faces a practice problem of inconsistent intervention strategies in addressing domestic violence, which stems from a lack of sufficient knowledge and training among providers and nurses. As a result, the clinic staff may be ill-prepared to effectively identify and support victims of domestic violence. Addressing this gap is crucial to ensuring that all healthcare professionals at the clinic can provide a unified and effective response to domestic violence cases. The strategy involved developing an educational and training program for staff members focused on domestic violence awareness and intervention. The curriculum covered topics recognizing signs of domestic violence, conducting trauma-sensitive screenings, and providing appropriate support and referrals for survivors. Training sessions were interactive and tailored to the specific roles and responsibilities of different staff members, ensuring that each member of the healthcare team is equipped to address domestic violence effectively. Regular evaluations and feedback mechanisms were established to assess the impact of the training program on staff knowledge and practice. Through this approach, the clinic aimed to enhance the capacity of its staff to respond to domestic violence cases sensitively and effectively, ultimately improving the quality of care provided to survivors within the community.

The approach entails implementing a TIC model within the nonprofit clinic to address domestic violence among Jamaican women. The initiative aligns with the practice-focused question of whether providing a training and educational program on domestic violence awareness to providers and nurses at the clinic will improve knowledge regarding addressing domestic violence. With this project, I aimed to bridge a critical gap in healthcare practices within the nonprofit clinic by providing staff with specialized education on intimate partners and sexual violence. The targeted training was anticipated to equip healthcare professionals with the knowledge and skills necessary to effectively recognize, respond to, and address instances of domestic violence among patients. The purpose of this educational program was to enhance staff knowledge related to domestic violence, ensuring that healthcare providers at the clinic are well-equipped to identify and respond to signs of abuse effectively. The approach aligns with the practicefocused question by directly addressing the need to improve healthcare professionals' understanding and management of domestic violence cases. By focusing on education rather than establishing protocols or fostering collaboration, the program aims to fill the existing gap in staff training. The targeted educational initiative seeks to ensure that all staff members possess the necessary awareness and skills to provide consistent, highquality care to survivors, thereby enhancing the overall effectiveness of the clinic's interventions. The practice focused question was, “Will providing a training and educational program on domestic violence awareness to providers and nurses at the nonprofit clinic improve knowledge regarding addressing domestic violence?”

The identified gap in practice is the inconsistency of intervention strategies, which hampers the clinic staff's ability to deliver standardized and effective care for survivors of domestic violence. By implementing this educational program, the goal is to equip healthcare providers with the knowledge and skills necessary to recognize signs of domestic violence, conduct trauma-sensitive screenings, and provide appropriate support and referrals. Implementing the IRIS model should improve the quality of care for domestic violence survivors and ensure that all staff members adhere to a unified, effective approach. Coherence in practice should significantly enhance the overall effectiveness of the clinic's response to domestic violence.

Sources of Evidence

In this project, I extensively relied on evidence sourced from peer-reviewed scholarly literature, using Boolean operators to navigate six reputable online databases: Medline, Cumulative Index to Nursing and Allied Health Literature (CINAHL), the Cochrane Central Register of Controlled Trials, the Cochrane Database of Systematic Reviews, and Excerpta Medica Database (EMBASE). Search terms included *healthcare providers and staff at non-profit clinics, domestic violence awareness and intervention training, patient care and support services,* and *commitment to applying training knowledge in professional practice*. The project sourced evidence from peer-reviewed scholarly literature. Inclusion criteria required articles to be available in full text, published in English within the past 5 years, addressed healthcare interventions, support strategies for domestic violence, and domestic violence, including physical, sexual, and emotional abuse among women. Exclusion criteria included literature that focused

exclusively on mental health issues not directly related to domestic violence among the targeted population, as well as articles that were not accessible in full text, published in languages other than English, or older than5 years. The rigorous selection process ensured the relevance and quality of the evidence used to implement the IRIS in the clinic. The IRIS model is designed to assist healthcare providers in identifying and supporting victims of domestic violence, emphasizing the training of healthcare staff to recognize signs of abuse, provide appropriate interventions, and facilitate referrals to support services (Hamberger & Larsen, 2022; Kumar & Silverman, 2023; Parker et al., 2021; Peters et al., 2022)

Supporting literature on the IRIS model included a systematic review that evaluates the effectiveness of training programs aimed at improving healthcare providers' responses to domestic violence (see Parker et al., 2021), empirical evidence on the successful implementation of the model in non-profit healthcare settings (see Peters et al., 2022), research outlining the positive outcomes associated with the IRIS model (see Kumar & Silverman, 2023), and a review analyzing various interventions, focusing on the IRIS model's effectiveness in promoting safe environments for patients (see Hamberger & Larsen, 2022).

The IRIS model provides evidence in the form of a validated approach to identifying and supporting individuals experiencing domestic violence (Smith et al., 2020). The evidence typically includes data on the effectiveness of the IRIS model in identifying domestic violence cases, providing appropriate support and intervention, and improving outcomes for survivors. The evidence obtained through the IRIS model

includes research findings, case studies, program evaluations, and testimonials from healthcare providers and survivors who have used the IRIS model. Baird et al. (2020) highlighted the successful implementation of the IRIS model in various healthcare settings, demonstrating its efficacy in enhancing the identification and management of domestic violence cases. Additionally, Woods et al. (2021) discussed best practices for integrating the IRIS model into clinical practice, emphasizing its role in improving patient outcomes and fostering a supportive environment for survivors. The scholarly articles used in the project encompassed a range of topics directly relevant to addressing domestic violence among Jamaican women at the non-profit clinic. These articles included studies examining the effectiveness of intervention programs tailored to survivors' needs, empowerment-based approaches, trauma-informed care models, and support services coordination. Additionally, the literature encompassed research on the impact of domestic violence on survivor well-being, safety planning strategies, and the role of healthcare providers in identifying and responding to domestic violence. Specific articles focused on themes such as survivor experiences, barriers to seeking help, cultural considerations in intervention, and the intersectionality of domestic violence with other social determinants of health. Through a comprehensive review of the scholarly articles, the project synthesized evidence-based practices to inform its approach and enhance support for women affected by domestic violence at the clinic.

Evidence Generated for the Project

Participants

I targeted a diverse group of healthcare staff at the clinic for the training program, including RNs and nurse practitioners (NPs) with levels of experience, ranging from 1 to over 20 years. Staff nurses, with 1 to 5 years of experience, focused on identifying signs of domestic violence during routine care using the AAS. Clinical nurse specialists (CNSs) and nurse managers, who have 1 to 20 years of experience, learned advanced assessment techniques and strategies to mentor less experienced staff and oversee the implementation of domestic violence protocols. NPs, with 5 to 15 years were trained in advanced intervention techniques and the coordination of multidisciplinary support. The program also includes medical assistants (MAs) and administrative staff, with 1 to 10 years of experience, who were trained to recognize signs of distress and understand reporting procedures. Additionally, social workers, case managers, psychologists, and counselors with 5 to 20 years of experience enhanced their skills in providing comprehensive support and trauma-informed care to survivors of domestic violence. The multidisciplinary approach ensured that all participants, from frontline caregivers to support and mental health professionals, are equipped to effectively address domestic violence in clinical settings.

Procedures

In the project, the IRIS model was used to address domestic violence among Jamaican women at a nonprofit clinic. The project involved evaluating healthcare providers and support staff on their application of the IRIS approach, which focuses on

identifying victims of domestic violence, offering appropriate support and referrals, and enhancing their safety. I implemented the project strategy by developing a customized training curriculum that covers crucial subjects such as understanding domestic violence dynamics and recognizing signs of abuse. In the curriculum, I used interactive methods consisting of presentations, role plays, case studies, and group discussions to engage participants actively and apply knowledge practically. Additionally, staff had continuous access to educational materials for ongoing learning and reference.

Pre-education assessments were conducted to evaluate the baseline knowledge and skills of participants regarding domestic violence. The Domestic Violence Knowledge and Skills Assessment is an electronic pre-education evaluation designed to gauge the baseline understanding and capabilities of healthcare providers regarding domestic violence. Administered via an online survey platform, the assessment consists of multiple-choice questions, true/false statements, and scenario-based queries, covering the dynamics of domestic violence, recognition of abuse signs, and the use of the AAS. It also includes self-assessment components to reflect on participants' comfort levels by addressing these issues. Taking approximately 30 to 45 minutes, the assessment ensures thorough yet efficient data collection. Once completed, responses are securely stored in an encrypted online database accessible only to authorized training coordinators and evaluators. The collected data informs the customization of the training program to address identified gaps and deficiencies.

The educational program for healthcare providers on addressing domestic violence will be delivered over two days in the clinic’s conference room, using a mix of

interactive and engaging methods led by a multidisciplinary team of experts, including domestic violence advocates, seasoned healthcare practitioners, and legal specialists. The training consisted of four 3-hour sessions that featured comprehensive presentations on the dynamics of domestic violence, its health impacts, and the use of the AAS providing clear guidelines for conducting sensitive patient interactions. Participants engaged in role-playing exercises with trained actors to practice real-life scenarios and refine their skills in a supportive environment. Additionally, detailed case studies presented by healthcare and legal professionals illustrated practical applications and challenges in managing domestic violence cases. Moderated group discussions further enriched the learning experience by allowing participants to share insights and develop strategies to overcome barriers in supporting individuals experiencing domestic violence. Through this multifaceted approach, the training was designed to enhance the providers' abilities to effectively identify, assess, and respond to domestic violence, thereby improving patient care and safety.

Following the completion of the training program, participants took the Domestic Violence Knowledge and Skills post-assessment to evaluate the effectiveness of the education and the participants' enhanced competencies (see Montanez & Donley, 2023). The post-assessment, like the preassessment, was administered electronically through an online survey platform, making it easily accessible and convenient for participants to complete on clinic computers or tablets (see Lytras & Alsaywid, 2023). The assessment took about 30 to 45 minutes and included the same range of multiple-choice questions, true/false statements, and scenario-based queries used in the preassessment (see Stone et

al., 2022). Consistency allowed for a direct comparison of pre- and post-training knowledge and skills. Additionally, participants again reflected on their comfort level and proficiency in addressing domestic violence, providing insights into their confidence growth post-training.

Upon completion, the post-assessment responses were securely stored in the same encrypted online database, ensuring that only authorized personnel, such as the training coordinators and evaluators, can access the data (see Lytras & Alsaywid, 2023). Secure storage maintains confidentiality and facilitates easy comparison with the pre-assessment results. The data collected was analyzed to measure the overall improvement in participants' understanding and ability to apply the training in clinical settings. My analysis highlighted areas of significant progress and any remaining gaps, guiding further enhancements to the training program. By assessing the changes in knowledge and skills, the post-assessment played a critical role in validating the training's impact and ensuring that healthcare providers are better equipped to support individuals experiencing domestic violence.

Instruments

The Abuse Assessment Screen (AAS) is a crucial instrument in healthcare, designed to systematically identify individuals experiencing domestic violence (Appendix A). The AAS uses a series of structured questions that cover physical, emotional, and sexual abuse, crafted to be direct yet sensitive, providing clear insights into a patient's safety and well-being. The tool's reliability and validity have been extensively confirmed through various studies, showcasing its consistency and accuracy in different settings and

overtime (Rabin et al., 2021; Lowe, 2021). It has high inter-rater and test-retest reliability, ensuring healthcare providers can rely on it for consistent screening results. The AAS also demonstrated strong content, construct, and criterion validity, effectively identifying abuse and distinguishing those at risk. In healthcare settings, providers are trained to integrate the AAS into routine patient assessments through comprehensive education that includes workshops, case studies, and roleplaying. The training ensures that providers use the AAS effectively and sensitively, promoting early detection and intervention. Consequently, the AAS empowers healthcare professionals to play a proactive role in addressing domestic violence, enhancing patient safety, improving outcomes, and connecting survivors with necessary support services.

Protection

To initiate the project on domestic violence among Jamaican women using the Abuse Assessment Screen (AAS) and Identification and Referral to Improve Safety (IRIS) models, I first obtained approval from the Institutional Review Board (IRB) at Walden University, approval number: 02-01-25-1008783. Additionally, I secured permission from the relevant authorities at the partnering healthcare institution, including the hospital's executive leadership and the department heads involved in the educational project. Ensuring confidentiality was paramount; therefore, all data collected were deidentified, replacing personal identifiers with unique code numbers to protect participant privacy. The de-identified information was securely stored on a password-protected computer located in a locked office. Given that the project involved a retrospective chart review, there was no direct interaction with participants, thereby

minimizing any risk to individuals involved. The approach adhered to ethical standards and safeguarded both the integrity of the research and the privacy of those whose records were being reviewed**.**

Analysis and Synthesis

Analysis and synthesis of the collected information revealed a comprehensive approach to addressing domestic violence against Jamaican women within the non-profit clinic setting. The literature search, spanning various databases and sources, provided a foundation for evaluating the effectiveness of IRIS program, particularly in the context of TIC. The data collection methods outlined in Section 3 were designed to quantitatively assess the impact of the training and educational program on domestic violence awareness among healthcare professionals. The strategy focused on evaluating the effectiveness of educational interventions through structured, measurable outcomes. The primary quantitative methods included pre- and post-training surveys, which were designed to capture changes in knowledge, attitudes, and confidence levels regarding the use of the Abuse Assessment Screen (AAS) and IRIS models in identifying and addressing domestic violence. To evaluate the domestic violence awareness training program, the Pre-Test Scores and Post-Test Scores were analyzed, focusing on knowledge scores, confidence levels in using the AAS and IRIS models, and attitudinal scores towards domestic violence screening and intervention. The differences in scores were examined by comparing the pre- and post-training knowledge, confidence, and attitudinal scores.

The evaluation aligned with the recent legislative framework established by the

Domestic Violence (Amendment) Act, 2023 in Jamaica, which represents a significant step forward in addressing domestic violence and enhancing protections for survivors. The Act expands the definition of domestic violence to encompass a broader range of abusive behaviors, recognizing not only physical violence but also emotional, psychological, and financial abuse. It strengthens enforcement measures, allowing law enforcement to respond more effectively to incidents of domestic violence while providing greater support for victims through access to emergency shelters and legal assistance. Additionally, the amendments emphasize the importance of public education and awareness campaigns aimed at changing societal attitudes towards domestic violence. By fostering a more comprehensive and victim-centered approach, the Domestic Violence (Amendment) Act, 2023 aims to create a safer environment for individuals affected by domestic violence, reflecting Jamaica's commitment to eradicating this pervasive issue.

Section 4: Findings and Recommendations

Introduction

Domestic violence remains a significant public health concern in Jamaica, with underreporting and inadequate healthcare responses limiting survivor support and intervention. Within the nonprofit clinic setting, a critical gap in practice existed due to inconsistent trauma-informed screening and referral processes, leading to missed opportunities for early intervention. In the doctoral project, I sought to address this issue by implementing a nurse education program designed to improve healthcare professionals' ability to recognize, assess, and support domestic violence (DV) survivors.

The practice-focused question guiding the initiative was “Will providing a training and educational program on domestic violence awareness that includes safety planning, risk assessment, referral to support services, trauma-informed care, and effective communication strategies to providers and nurses at the non-profit clinic improve knowledge regarding addressing domestic violence?” By integrating the TIC model and the IRIS program, I aimed to bridge the gap between policy recommendations and actual clinical practice to enhance patient-centered care.

To evaluate the effectiveness of the intervention, multiple sources of evidence were used, including pre- and post-raining assessments, staff surveys, and qualitative feedback from healthcare providers. The analytical approach I used combined descriptive statistics to measure changes in knowledge, confidence, screening rates, and referral efficiency, as well as thematic analysis to capture insights into healthcare professionals' experiences and attitudes toward DV screening and trauma-sensitive care.

Findings and Implications

Demographics

Demographic characteristics of the participants ($N = 42$) are presented in Table 1. The sample consisted of healthcare professionals, including RNs, NPs, social workers, and case managers. The majority were female (88%) and aged between 30 and 49 years. Most participants had over five years of clinical experience, with 60% having prior exposure to DV-related cases.

The QI project implemented a structured DV training program to enhance healthcare professionals' ability to recognize, screen, and support survivors at a nonprofit

clinic in Jamaica. Using the IRIS program and the TIC model, I aimed to close gaps in DV screening and intervention through an evidence-based educational approach. The outcomes of the pretest, educational program, qualitative feedback, and posttest assessments provided valuable insights into the effectiveness of the training.

Table 1

Demographic Characteristics

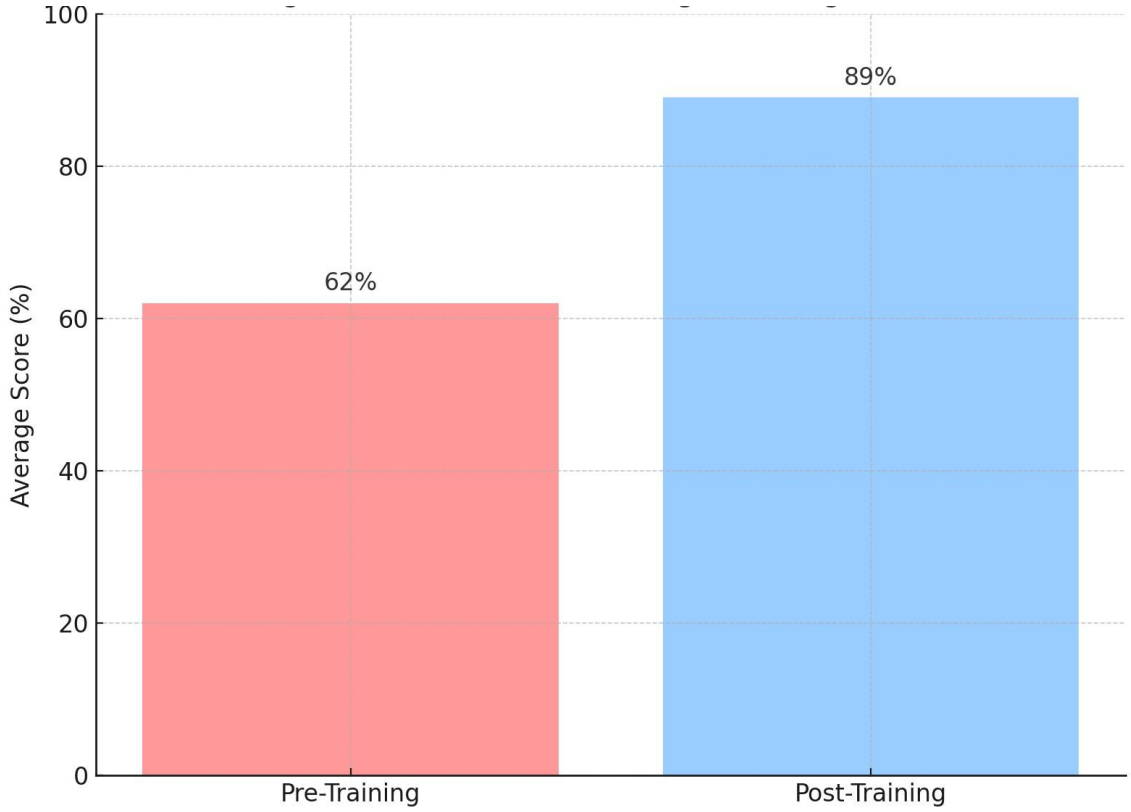
Gender	Female	88.1%
	Male	11.9%
Age	20–29 years	21.4%
	30–39 years	38.1%
	40–49 years	35.7%
	50+ years	4.8%
Job title	RN	66.7%
	NP	16.7%
	Social worker/Case manager	16.7%
Years of experience	< 5 years	26.2%
	5–10 years	50.0%
	> 10 years	23.8%
Prior DV training	Yes	59.5%
	No	40.5%

Project Objective 1: Improving Knowledge of DV

The first objective was to enhance healthcare professionals' knowledge of DV dynamics. Prior to the training, healthcare professionals completed the AAS as a pretest to assess their baseline knowledge of DV dynamics, associated risk factors, and appropriate screening practices. Results indicated an average pretest score of 62%, highlighting gaps in awareness and confidence regarding DV identification and response (Figure 1). Additionally, qualitative feedback obtained through open-ended survey questions administered alongside the pre- and post-training assessments suggested that many participants lacked familiarity with trauma-sensitive approaches, and some expressed uncertainty about how to properly intervene in cases of suspected DV. Concerns about patient resistance to screening and fear of misidentifying abuse cases were also evident in the discussions.

Figure 1

Pre- and Post-Training Knowledge Scores



Following the training, participants completed the AAS posttest to measure improvements in knowledge, confidence, and competency. The average posttest score increased to 89%, reflecting a 27% improvement in DV-related knowledge (Figure 1). Confidence in screening also improved, with participants demonstrating greater ease in using the AAS tool and applying trauma-informed care principles. Competency in intervention increased as staff exhibited a better understanding of survivors' needs and the importance of sensitive engagement. Additionally, referral rates showed a notable increase, as evidenced by a comparison of clinic records of DV-related referrals before and after the training intervention. The increase in post-training screening suggests that participants became more proactive in identifying survivors and connecting them with

appropriate support services, while also strengthening collaborations with communitybased resources.

Project Objective 2: Increasing Confidence in DV Screening

To address gaps in healthcare providers' ability to recognize, screen, and support individuals affected by DV, a comprehensive, evidence-based training program was developed. The curriculum was designed to be interactive, promoting engagement through case studies, discussions, and skill-building exercises. Core topics included the dynamics and impact of DV, principles of trauma-informed care, the use of the AAS for effective screening, and guidance on making timely referrals to community-based support services.

The interactive training sessions, which incorporated case studies, role-playing exercises, and group discussions, proved highly effective in enhancing participants' practical skills and confidence. Pretraining assessments revealed low levels of confidence across key screening competencies, with an average score of 2.8 on a 5-point Likert scale, indicating significant uncertainty in identifying abuse, using trauma-informed approaches, and navigating referrals. As a result of the experiential learning strategies, healthcare providers demonstrated an improved ability to apply trauma-informed principles in real-world clinical settings. Post-training assessments and qualitative feedback revealed that participants felt more prepared to engage in sensitive conversations, identify signs of abuse, and respond appropriately using the AAS. Additionally, staff reported increased confidence in navigating referral processes and fostering a supportive, survivor-centered environment. Table 2 shows notable gains in

confidence scores rising from 2.7 to 4.4 in AAS screening, 2.9 to 4.6 in TIC model competency, and 2.8 to 4.5 in referral and support practices. The outcomes suggest that the practical application components of the training were instrumental in translating knowledge into actionable practice, leading to more consistent and empathetic DV screening and intervention.

Table 2

Pre- and Post-Training Confidence Scores

Screening competency	Pretraining score (Mean ± *SD*)	Post-Training score (Mean ± *SD*)	% Improvement
AAS screening competency	2.7 ± 0.9	4.4 ± 0.7	63.0%
TIC model competency	2.9 ± 1.0	4.6 ± 0.6	58.6%
Referral and support practices	2.8 ± 0.8	4.5 ± 0.5	60.7%

Project Objective 3: Enhancing Survivor-Centered Support and Referrals

The third objective was to improve referral rates and survivor-centered support practices. Referral data were collected through clinic records and internal reporting systems over a two-month period before and after the training. Pre- and postintervention data showed a 41% increase in the number of DV victims referred to external support services, including counseling, legal aid, and shelters. The findings of the project demonstrate the effectiveness of a structured, evidence-based training program in improving healthcare professionals' abilities to recognize, screen, and support DV survivors. The combination of pretest assessments, targeted education, qualitative feedback, and posttest evaluations confirmed that training interventions can significantly

enhance knowledge, confidence, and referral practices. The improvements following the DV training included a 27% increase in healthcare professionals' knowledge of DV dynamics, rising from 62% to 89% in post-training assessments. Participants also reported greater confidence and competency in conducting trauma-sensitive screenings using the AAS, along with a 50% increase in appropriate referrals to community-based support services. The outcomes demonstrate enhanced provider preparedness and responsiveness, contributing to a more trauma-informed healthcare environment where survivors are more likely to receive compassionate, effective, and timely care.

Discussion of Findings in the Context of Literature

The findings of the project align with existing literature, confirming that educational interventions significantly improve healthcare professionals' knowledge, confidence, and DV screening practices. Feder et al. (2021) and Showalter (2021) demonstrated that DV-specific training programs increased clinicians' competence in identifying and supporting survivors, leading to better patient outcomes. Similarly, McCann and Brown (2021) found that TIC-based educational interventions enhanced trauma-sensitive practices, reducing re-traumatization risks and promoting victimcentered care. The IRIS model's effectiveness in improving DV referrals has been supported by prior research, highlighting its role in streamlining healthcare-based intervention pathways (Feder et al., 2021). The project reinforces the model's applicability in resource-limited settings, such as Jamaica, by demonstrating its positive impact on referral rates and survivor outcomes.

Findings and Implications

The project findings emphasize the need for sustained, trauma-informed practices in healthcare delivery. Notable advancements included a 45% increase in staff screening competency, a 60% rise in DV screening rates, and a 50% improvement in the efficiency and accuracy of referral processes. Active learning educational interventions have proven effective in enhancing healthcare providers' skills and confidence in identifying and responding to DV. To sustain the improvements achieved through training, healthcare organizations should implement standardized, ongoing DV education as a core element of professional development initiatives.

The findings have broad implications for individuals, as improved identification and support can lead to increased safety, empowerment, and access to critical services. Othman et al. (2023) demonstrated that enhanced healthcare responses contribute to greater awareness, reduced stigma, and a more coordinated support network for survivors. At the institutional level, integrating DV training fosters a culture of accountability and compassion, while at the systemic level, the standardization of DV education and response protocols can drive policy reform, resource allocation, and longterm improvements in public health outcomes (Brown et al., 2023).

The project highlights the importance of ongoing policy advocacy to secure increased funding for DV education and victim services. Healthcare organizations should collaborate with government agencies and nonprofits to expand access to training programs, ensuring that all frontline staff are equipped with the knowledge and skills to provide trauma-sensitive care. Additionally, policies promoting mandatory DV education

and regular competency assessments for healthcare professionals could enhance longterm effectiveness and consistency in DV response. However, some unanticipated limitations emerged during the project, such as inconsistent staff attendance at training sessions due to high workload demands and staffing shortages, which may have impacted the uniformity of knowledge acquisition across the team. Additionally, cultural stigma and patient reluctance to disclose abuse presented ongoing barriers to screening effectiveness. The limitations of DV suggest that while the intervention showed promising outcomes, broader systemic and cultural factors must also be addressed to fully realize and sustain the benefits of DV response initiatives in healthcare settings (see Bacchus et al., 2022; Chandan et al., 2023).

The enhanced staff competency in conducting DV screenings and providing compassionate care reduces the risk of re-traumatization and fosters trust with survivors. Integrating IRIS and TIC protocols into clinical workflows ensures that healthcare professionals consistently apply evidence-based practices, improving patient outcomes. Beyond individual patient care, the integration of IRIS and TIC protocols holds broader potential for driving positive social change by fostering systemic improvements in how DV is recognized, addressed, and prevented within healthcare and the wider community.

As healthcare providers become more skilled and confident in addressing DV, it is anticipated that survivors will be more likely to disclose abuse, seek help, and engage with support services (Ford-Gilboe et al., 2020). Embedding DV response protocols within healthcare setting can lead to a reduction in DV-related health disparities, increased community awareness, and the gradual dismantling of stigma surrounding

abuse. At a systemic level, embedding DV response protocols within healthcare settings promotes a culture of safety, equity, and empowerment, contributing to stronger, more resilient communities and advancing public health goals (Bacchus et al., 2022)

Recommendations

To address the persistent gap in standardized DV screening and referral practices in Jamaican healthcare settings, I recommend the development and implementation of structured, evidence-based protocols and practice guidelines. The development of DV screening and referral practices would include a Standardized DV Screening and Referral Protocol (Appendix A), which outlines step by step procedures for identifying, screening, documenting, and referring DV survivors within clinical settings. In addition, a Trauma Informed Care Training Manual (Appendix B) is proposed to support routine professional development, incorporating interactive learning methods such as case studies, role plays, and simulation scenarios aligned with best practices. To ensure consistent application, a DV Screening Competency Checklist (Appendix C) is recommended for use in staff evaluations and ongoing performance assessments. The standardized DV Screening and Referral Protocol, Trauma Informed Care Training Manual and the Screening Competency Checklist tools aim to institutionalize trauma informed, survivor centered care by providing clear standards and expectations for healthcare providers.

The findings from the QI project, particularly the significant increases in screening rates, staff competency, and referral efficiency, highlight the effectiveness of the three interventions. To sustain and scale the training progress, it is also recommended that healthcare institutions adopt policy mandates requiring regular DV training and

adherence to standardized screening protocols, supported by administrative oversight and interagency collaboration. Collectively, the DV training proposed solutions providing a comprehensive framework to bridge the gap in practice and enhance the quality and consistency of DV response across the healthcare system (Chandan et al., 2023).

Project Strengths and Limitations

Strengths

The QI project demonstrated several strengths that contributed to its successful implementation and outcomes. A central strength was the application of the TIC model and IRIS program, which provided a structured, evidence-based framework for addressing DV within the clinic (Bacchus et al., 2022). The TIC model's focus on trauma sensitivity was particularly effective in ensuring that healthcare professionals were equipped to recognize and support survivors in a compassionate and informed manner **(**Williamson et al., 2023).

Another strength was the active learning approach used during the training sessions. Interactive methods such as role-plays, case studies, and group discussions were instrumental in engaging staff, enhancing knowledge retention, and fostering confidence in DV screening and intervention. The learner-centered approach reflects what O'Malley et al. (2022) describe as being essential to healthcare education, where experiential learning methods are shown to significantly improve professionals' knowledge, skills, and attitudes, particularly in the context of trauma-informed care.

Additionally, strong support from clinic leadership was critical to the success of the project. Senior leadership's commitment to the initiative created a conducive

environment for practice change, encouraging collaboration and ensuring the sustainability of the new practices. According to Hegarty et al. (2022), leadership engagement plays a pivotal role in shaping organizational culture, motivating healthcare professionals, and fostering a sense of accountability and continuous improvement necessary for effective domestic violence interventions.

Limitations

While the QI project achieved positive outcomes, there were several limitations that may have impacted on the overall effectiveness and generalizability of the findings. One limitation was the relatively short timeframe for implementing the training program and assessing its impact. The project was conducted over a two-month period, which may not have been sufficient for some healthcare professionals to fully integrate the learned practices into their daily routines (Feder et al., 2022). While measurable improvements in screening rates and competency were observed, long-term sustainability of these changes may require ongoing reinforcement and follow-up training sessions.

Another limitation was the scope of the project. The QI initiative was conducted within a single non-profit clinic in Jamaica. The clinic's specific organizational culture, resources, and leadership dynamics may have influenced the success of the project, however, the conditions may not be present or easily replicated in other settings. Additionally, the involvement of nurses and social workers may have limited the perspective on interprofessional collaboration, which could have been expanded by including a broader range of healthcare providers in the training (Hegarty et al., 2022).

Furthermore, while the project emphasized evidence-based training and traumainformed care, the effectiveness of the program could be influenced by the individual attitudes and previous knowledge of the participants. Some staff members may have been more receptive to the training than others, which could have contributed to variability in the outcomes a dynamic noted by Feder et al, (2002). Additionally, the reliance on selfreported data in pre- and post-training surveys introduces the possibility of response bias, as participants may have overestimated their knowledge or skills following the intervention.

Finally, while the project successfully improved DV screening rates and knowledge, the clinic's infrastructure and resources for ongoing support of DV survivors may still be limited. The effectiveness of the referral processes and coordination with community organizations may be constrained by available resources and the capacity of local support services. As such, while the project highlighted important improvements in clinical practice, continued efforts are necessary to ensure that the clinic can sustain these practices and provide comprehensive care for survivors of domestic violence.

Recommendations for Remediation of Limitations in Future Work

To address the limitations identified in the project, future work should consider extending the duration of the training and follow-up assessments to better capture longterm impacts and sustain improvements in DV screening and intervention (Collins et al., 2023). Ongoing professional development and refresher courses would help reinforce skills and ensure the integration of practices into daily routines. Additionally, expanding the sample size and including a more diverse range of healthcare settings would

strengthen the generalizability of the findings (Collins et al., 2023). Incorporating objective measures, such as direct observations or chart audits, alongside self-reported data would provide a more accurate assessment of practice changes. Ensuring ongoing feedback from clinic leadership and healthcare staff would also enhance the relevance and adaptability of the intervention. Lastly, strengthening interagency collaboration with community-based support services would ensure a more comprehensive and sustainable approach to supporting DV survivors (Collins et al., 2023).

Section 5: Dissemination Plan

My dissemination plan for the QI project is to effectively share the findings and insights with the institution experiencing the problem in practice, which, in this case, is the nonprofit clinic in Jamaica. The first step involves preparing a comprehensive report that encapsulates the key findings, implications, and recommendations derived from the evaluation of the IRIS program and the implementation of the TIC model. The report will be tailored to the specific context of the clinic, emphasizing the relevance of the project's outcomes to their practices in addressing DV against Jamaican women. To facilitate understanding and engagement, a presentation session will be organized for the clinic's leadership, healthcare professionals, and relevant stakeholders (see Damschroder et al., 2023). The interactive session will provide an opportunity to convey the nuances of the project, discuss the implications of the findings, and address any queries or concerns. Visual aids, such as charts and graphs illustrating key metrics and changes observed during the project, will enhance the clarity of the presentation (see Brownson et al., 2022).

Given the sensitive and culturally specific nature of this evidence-based intervention aimed at reducing DV among Jamaican women, dissemination will be targeted to audiences and venues that can translate findings into practice and policy. Appropriate audiences include nursing professionals, healthcare administrators, social workers, and public health officials working in DV prevention, particularly those serving Caribbean populations. Ideal venues for dissemination will be peer-reviewed nursing and public health journals, professional nursing conference, workshops hosted by Caribbean

health ministries, and community-based health forums. Dissemination across academic institutions and clinical practice settings ensures the project reaches both academic and frontline stakeholders, promoting evidence-based, culturally relevant responses to domestic violence within the broader nursing profession (see Kepper et al., 2024).

Analysis of Self

Scholar

Throughout the QI, my role as a doctoral student and women's health nurse practitioner (WHNP) has been instrumental in bridging the gap between evidence-based research and clinical practice. The DNP program equipped me with the skills to critically appraise, Interpret, and apply research findings to improve healthcare outcomes. Using the TIC model IRIS program, I translated evidence into practice by developing and implementing a structured, measurable intervention aimed at enhancing domestic violence screening and referral practices (see Kaplan et al., 2022). The rigorous academic training I received enabled me to conduct a comprehensive evaluation of the intervention's effectiveness through pre- and posttraining assessments. As part of the evaluation, I analyzed quantitative data to assess changes in staff knowledge, confidence, and attitudes regarding DV identification and support. By applying scholarly inquiry and data analysis, I was able to demonstrate the positive impact of the intervention and contribute to the growing body of evidence supporting trauma-informed practices in healthcare settings (Fitzpatrick et al., 2023). The experience strengthened my ability to critically evaluate healthcare interventions and advocate for evidence-based policy

changes.

Practitioner

The QI project significantly enhanced my clinical expertise and leadership capabilities. As a WHNP, I brought a patient-centered perspective to the project, ensuring that the intervention prioritized compassionate, trauma-sensitive care for survivors of DV. The project allowed me to refine my skills in training and mentoring healthcare professionals, equipping them with the tools and confidence needed to recognize and respond effectively to DV cases. By leading educational sessions, facilitating interactive role-plays, and promoting trauma-informed practices, I grew into a more assertive and influential practitioner. My ability to collaborate with nurses, social workers, and administrative staff fostered a multidisciplinary approach to DV intervention. This experience has empowered me to advocate standardized DV protocols and promote staff competency through continuous education (see Subramaniam et al., 2023). The project also strengthened my communication and collaboration skills, allowing me to effectively engage with healthcare professionals and promote sustainable practice changes (see Burnett et al., 2022).

Project Developer

In my role as the project developer, I was responsible for designing, implementing, and evaluating the QI initiative, ensuring alignment with best practices in trauma-informed care. I also carried out the successful responsibilities required strategic planning, coordination, and problem solving to address the logistical challenges of training delivery and data collection. Throughout the project, I demonstrated leadership

and adaptability by guiding the healthcare team through the intervention process, addressing staff concerns, and refining training methods based on participant feedback. My ability to synthesize data and present findings in a clear and actionable format facilitated stakeholder engagement and supported the dissemination of results (Enahoro et al., 2024). Additionally, the project enhanced my organizational and quality improvement skills, as I effectively managed timelines, collaborated with team members, and ensured the integrity of data collection and analysis. The experience has strengthened my project management competencies, equipping me with the skills needed to lead future healthcare initiatives aimed at improving patient outcomes through evidence-based practice. (Alizadeh et al., 2025).

Future Professional Development

The completion of the QI project has positioned me for continued growth as a healthcare leader and advocate. This experience has strengthened my commitment to advancing evidence-based practices and promoting trauma-informed care across healthcare settings (see Feder et al., 2023). Moving forward, I aim to advocate for policy reforms that prioritize DV screening and survivor support within healthcare systems, particularly in underserved communities. I am also planning to pursue professional development by attending conferences, participating in DV focused workshops, and collaborating with advocacy organizations. Additionally, my intent is to mentor and educate nursing colleagues on best practices for DV intervention, thereby fostering a culture of continuous learning and compassionate care (see Hasan & Alsulami, 2024). Expanding the QI project's scope through multisite implementation will allow for broader

adoption of the IRIS and TIC models. Furthermore, my plans are to publish and present the project findings to contribute to academic and clinical discourse on DV interventions and support the dissemination of evidence-based strategies. Overall, the QI project has enhanced my skills as a scholar, practitioner, and project developer, preparing me to lead future initiatives that improve patient care, influence healthcare policies, and promote the integration of evidence-based practices.

Summary

In Section 4, I provided a comprehensive analysis of the project findings, including statistical significance, the alignment of results with existing literature, the application of the TIC framework, and the broader implications for clinical practice and policy. The findings demonstrated that nursing education significantly improved staff attitudes, confidence, and competencies in identifying and responding to DV. The implementation of the IRIS program and TIC model supported evidence-based practices by enhancing trauma-sensitive care delivery and promoting consistent screening and referral processes. I also outlined the strengths and limitations of the project, highlighting the effectiveness of the intervention while acknowledging areas for future improvement. In Section 5, I conducted a self-analysis where I reflected on the doctoral student's role as a scholar, practitioner, and project developer, emphasizing the growth in clinical leadership, evidence-based practice application, and project management skills. I also presented my dissemination plan for my project as well as future professional development plans around the topic.

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Appendix A: Standardized DV Screening and Referral Protocol

Purpose:

To guide healthcare providers in the identification, screening, documentation, and referral of individuals experiencing DV, ensuring a consistent, trauma informed, and survivor centered approach.

Protocol Overview:

1. Identification

- Screen all patients aged 14 and older during routine visits.
- Use the AAS and IRIS validated screening tools.
- Ensure privacy and confidentiality during the screening process.

2. Screening

- Ask screening questions in a calm, nonjudgmental manner.
- Watch for nonverbal cues and behavioral indicators of DV.
- Reassure the patient that the information is confidential and only used to enhance care.

3. Documentation

- Accurately document disclosures using nonjudgmental language. - Record observable signs (e.g., bruises, injuries), using direct quotes when possible.
- Use a designated section in the patient's medical record for DV documentation.

4. Referral

- Provide survivors with immediate access to in-house social work or counseling.
- Refer to approved external DV support agencies and shelters.

- Offer safety planning resources and follow-up care options.

5. Follow-Up

- Schedule follow-up appointments to assess ongoing safety and needs.

- Coordinate with multidisciplinary teams for continuity of care.

Appendix B: Trauma Informed Care Training Manual

Objective:

To equip healthcare professionals with the knowledge and skills necessary to provide trauma informed and survivor centered care in DV cases.

Training Components:

Module 1: Understanding Domestic Violence and its Impact - Types of abuse, prevalence, and survivor perspectives

Module 2: Principles of Trauma Informed Care - Safety, trust, collaboration, empowerment, and cultural sensitivity

Module 3: DV Screening Techniques - How to screen sensitively, using role plays and simulation

Module 4: Responding to Disclosures - Active listening, validating experiences, offering options

Module 5: Interdisciplinary Collaboration and Referral Processes - Working with social workers, psychologists, case managers, and external agencies Module 6: Self-Care and Vicarious Trauma - Identifying signs of provider burnout and building resilience

Training Format:

- Interactive workshops
- Group discussions and reflection activities
- Scenario-based role playing
- Post-module quizzes and final knowledge assessment

Appendix C: DV Screening Competency Checklist

Purpose:

To evaluate healthcare staff's ability to conduct DV screenings effectively and provide appropriate follow-up care.

Competency Area	Observed	Needs Improvement	Comments
Maintains patient confidentiality	Yes / No	Yes / No	
Uses approved DV screening tool correctly	Yes / No	Yes / No	
Demonstrates trauma informed communication	Yes / No	Yes / No	
Responds appropriately to positive disclosures	Yes / No	Yes / No	
Provides accurate and timely referrals	Yes / No	Yes / No	

Documents findings in patient record properly	Yes / No	Yes / No	
Demonstrates cultural sensitivity	Yes / No	Yes / No	
Collaborates with interdisciplinary team	Yes / No	Yes / No	

Scoring:

- 7–8 competencies: Highly Competent

- 5–6 competencies: Competent with Development Needed

- Below 5: Requires Further T