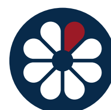
BLUEPRINT MODEL OF CARE – CLINICAL NURSE PARTNERSHIPS DOMESTIC VIOLENCE PROJECT



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PURPOSE

The purpose of this document is to provide a blueprint of the model of care embodied by the Clinical Nurse Partnerships - Domestic Violence Project. In this blueprint, the scope of practice of the Clinical Nurse leading the project is articulated, along with the philosophy underpinning the project, the logistical and resourcing considerations, success factors and challenges encountered.

The contents of this blueprint are based on the experiences of those involved in delivering the Clinical Nurse Partnerships - Domestic Violence Project, along with the testimonials of participants who have used the service. An evaluation of the project is currently underway, led by Associate Professor Jane Currie and Dr Olivia Hollingdrake, Queensland University of Technology. This blueprint is based on data gathered through qualitative interviews, which have been analysed thematically (Braun & Clarke, 2006). Ethics approval has been provided through Queensland University of Technology (4278-HE21).

DEVELOPMENT OF THE CLINICAL NURSE PARTNERSHIPS DOMESTIC VIOLENCE PROJECT

In 2021, Micah Projects secured funding from St Vincent's Health Australia to implement a three-year community nurse-led model of care titled the 'Clinical Nurse Partnerships - Domestic Violence Project'. This nurse-led service aims to improve access to healthcare for women and children experiencing domestic and family violence living in short-term crisis accommodations such as hotels, public housing, and private rental properties. The nurse-led service is embedded within two of Micah Projects' service arms; the Brisbane Domestic Violence Service (BDVS), located in West End and the Inclusive Health and Wellness Hub, in South Brisbane.

The Project was conceived in response to the complex physical and mental health needs identified by existing Micah Projects clinicians, which impact women and children experiencing domestic and family violence and limit their access to healthcare services. The Clinical Nurse Partnership – Domestic Violence Project specifically targets women that are at greater risk of domestic, family, and sexual violence. These include Aboriginal and Torres Strait Islander women, young women, pregnant women, women separating from their partners, women with a disability and women experiencing financial hardship. The Project intends to ensure women and children experiencing domestic, and family violence have their health needs assessed soon after an incident of domestic and family violence and are supported to access the health care they require. As with all Micah Projects services, the Clinical Nurse Partnerships - Domestic Violence Project includes people who are not eligible for Medicare, Australia's publicly funded universal healthcare system.

Implementation commenced in February 2021 and will continue until the end of February 2024. The nurse-led service comprises a Clinical Nurse with primary healthcare experience serving vulnerable populations and a Health Services Manager.

PHILOSOPHY OF CARE

The philosophy of care of the Clinical Nurse Partnerships - Domestic Violence Project centres on three principles, Respect, Equality and Safety. Underpinning these principles is a patient-centred approach to care, in which each woman and child's trauma is acknowledged, and each family's own unique journey to wellness is supported. The philosophy is embodied through shared decision-making, acknowledgement of each woman and child's fundamental right to feel safe, and every woman and child's right to access health care. In this way, the service nurtures; equality, empathy and acceptance without judgement, independent decision-making and autonomy, and cultural responsiveness.

AIMS OF THE CLINICAL NURSE PARTNERSHIPS DOMESTIC VIOLENCE PROJECT

The Clinical Nurse Partnerships - Domestic Violence Project aims to:

- Respond flexibly to the immediate health needs of women and children in emergency accommodation (e.g., hotels) prior to their transition to alternative safe housing options.
- Support women accessing BDVS programs who may be experiencing an array of physical and mental health needs, including alcohol and other drugs (AOD), that require health assessment and direct intervention.
- Provide navigation through the health care system to support coordination of women's care and improve understanding of their own healthcare needs.
- Provide vital linkages with hospital and health systems in the overall safety and recovery planning for women and children impacted by domestic and family violence.
- Advocate with Hospitals and Health Services and the Primary Health Networks within Brisbane on the unmet health needs and the improved outcomes achieved through this pilot community nursing response.
- Provision of education to tertiary healthcare providers on optimising first-line response to domestic and family violence for frontline healthcare providers, including pastoral carers, social workers, nurses, and doctors.

MODEL OF CARE

The Clinical Nurse Partnerships - Domestic Violence Project service operates five days a week (Monday to Friday, 8 am-4 pm). While the Clinical Nurse role is based at the Micah Projects premises on Boundary Road, the role is designed to practice collaboratively with BDVS, and the Inclusive Health and Wellness Hub as follows:

- 2-days a week, the Clinical Nurse practices from the Integrated Health Cluster, facilitating interactions with Micah Projects' nursing and allied health staff members and general practitioners.
- 2-days a week, the Clinical Nurse practices with the BDVS team and collaborates with the Domestic Violence Support Workers who provide case planning coordination and respond to any crisis presentations.
- 1-day a week, the Clinical Nurse practices with the Young Mothers for Young Women clinic (Coorparoo) in collaboration with the Women's primary health care community-based clinic.

The Clinical Nurse operates in an outreach-based role, providing care to women and their children who are experiencing domestic and family violence and are often temporarily accommodated in hotels. The Clinical Nurse Partnerships - Domestic Violence Project embodies the principles and practices shown in Figure 1 and described below.

Figure 1: Principles of the Clinical Nurse Partnerships - Domestic Violence Project

Trauma Informed Practice

- Recognise the signs and symptoms of trauma and respond appropriately to ensure women's experience of the nurse-led service is not re-traumatising.

Person-centred Practice

- Engaging authentically in a way that recognises the uniqueness and value of each woman. Responding to cues that maximise coping resources through the recognition of important agendas in each woman's life.

Holistic Practice

- Provision of treatment and care that is considerate of the whole person, including women's physiological, psychological, sociocultural, developmental, and spiritual dimensions. Clinical treatments are incorporated within interactions that also seek to address participants' emotional and practical support needs.

Health Service Navigation

- Ensuring women experience smooth transitions within and between health and social services, recognising that access to healthcare is underpinned by social determinants such as socio-economic status, housing insecurity, access to transport and childcare responsibilities.

Shared Decision Making

- Facilitates women's involvement in decision-making concerning their care and that of their children, by seeking to understand their values, experiences, concerns, and future aspirations. This approach seeks to help women take control and be active in their healthcare, rather than passive service recipients.

Flexibility

- Provide flexibility in interactions with women. Interventions reflect a balance between the best available evidence and resources, professional judgement, local information, safety and her preferences and needs.

Advocacy

- A woman's expectations and her needs are used to guide each healthcare encounter. Support is provided to engage with health services, including appropriate referrals, transport and physical presence, to optimise access to care.

REFERRALS

Participant referrals to the Clinical Nurse Partnerships - Domestic Violence Project come through BDVS. Referrals to BDVS may originate from a range of providers, including self-referral, Safer Option Service (SOS), Safer Lives Mobile Service (SLMS), and the community workers embedded within the Police and Brisbane Youth Service, or through hospital emergency departments.

The Brisbane Domestic Violence Service refer participants needing further health assistance to the Clinical Nurse Partnerships - Domestic Violence service. Participants may remain in the care of the Clinical Nurse Partnerships - Domestic Violence service for as little as three days and up to three months. All referrals from BDVS involve a telephone conversation between the Clinical Nurse and the BDVS provider. This allows for a detailed dialogue and handover of the specific situation of the woman being referred.

Those participants at risk of homelessness are referred to internal Micah Projects services such as the Families Homeless Team or Individual Homeless Team. For those needing ongoing health support, the Clinical Nurse continues supporting participants while they access these other services.

FIRST CONTACT

The first contact between the participant and the Clinical Nurse is usually made within 24 hours of referral (90%). The first contact is made via telephone, with a face-to-face visit within 24 hours. Over the phone, the Clinical Nurse introduces themself and begins with a question intended to be direct but non-threatening, such as: *"So the team at BDVS said that you needed more support with this health concern, did you want to go through that with me and maybe see what we can do from there…?"* Once an appointment is made to meet the participant, the Clinical Nurse sends a text message to let the participant know that she has arrived at their location and will be knocking on their door. When the participant answers the door, the Clinical Nurse introduces herself again and produces her ID card before requesting to go inside the residence. These steps are extremely important in gaining trust with the participant and ensuring the participant's sense of safety. This first face-to-face contact usually occurs at a hotel or other crisis accommodation and occasionally in public spaces.

To ensure the safety of the Clinical Nurse, each visit is subject to a risk assessment and safety planning to establish the safest means of connecting with the participant. This careful and non-threatening approach to the initial encounter has proven instrumental in establishing trust and rapport with participants and has been pivotal to the success of any ongoing interventions or referrals.

SERVICE COORDINATION

The Clinical Nurse conducts a morning handover with Safer Lives Mobile Service – specialist domestic violence service (SLMS) to discuss any new presentations overnight. Communication is maintained for informal care coordination activities throughout the day and any concerns are escalated to the SLMS team leader. If a high-risk situation is identified, a care planning and coordination meeting is held, and joint outreach planned.

PARTICIPANT MAP

Figure 2 is an example of a participant journey, from initial contact with the Clinical Nurse Partnerships - Domestic Violence service to referral for ongoing care and support.

Figure 2. Participant Map

PROVISION OF CARE

The Clinical Nurse provides participants with detailed health assessments, direct clinical care, health education, health service navigation and advocacy, with the end goal of empowering them to be able to self-manage their own health. Typically, consultations take around 40 minutes to an hour, but can last up to 90 minutes for participants with complex needs.

COMPREHENSIVE NURSING ASSESSMENT

Assessment is facilitated by the digital Efforts To Outcome (ETO) software platform and involves one or more of the following:

- Head-to-toe physical assessment
- Vital signs (temperature, pulse, blood pressure, respiratory rate, oxygen saturation)
- Health history screening
- Mini-mental status examination
- Neurological and cognitive screening (e.g., Glasgow Coma Scale)
- Psychosocial assessment
- Drug and alcohol screening
- Body Mass Index
- Medication assessment
- Vaccinations

CLINICAL NURSING CARE

Clinical care provided includes simple wound care, urinalysis, organising pathology (e.g., blood-borne virus screening), and medication management. Alcohol and other drug support, access to medications, maternity care, strangulation assessment and support, and women's health screening are also provided.

PRACTICAL SUPPORT

The Clinical Nurse assists participants with transport to appointments and access to food and clothing. Advocacy, service navigation, identification of cultural needs and linking to appropriate services. Childcare equipment, such as strollers, baby clothing, and car seats.

ONWARD REFERRALS

Referrals include follow-up for strangulation and facial injuries, antenatal care, Women's reproductive health and pregnancy care, general practice, and specialist care. An active approach to referral is undertaken whenever possible, for example, making phone calls to services on behalf of participants, driving participants to their appointments when appropriate and waiting with them if needed.

EQUIPMENT REQUIRED

The Clinical Nurse has a designated car for outreach, in which she can hire baby seats as required. The Clinical Nurse carries a nursing bag with equipment and documents. These typically include:

- Blood pressure machine
- Stethoscope
- Thermometer
- Oxygen saturation monitor
- Foetal doppler
- Pathology sampling equipment (e.g., wound swabs, specimen containers, urinalysis sticks, pregnancy tests)
- Pathology forms
- Wound assessment tools
- Wound care equipment (e.g., simple dressings, bandages, Steristrips)
- Educational resources (e.g., strangulation symptoms, 13HEALTH, mental health support, maternity support, alcohol and other drug resources)
- Scales

CLIENT SNAPSHOT

All participants (n=126) were female, 78% of whom were born in Australia, 18% had citizenship status which was not determined, 18% of participants identified as an Aboriginal or Aboriginal and Torres Strait Islander person, with 41% of participants stating they did not know. Participants were aged between 17 and 57 years old. The most commonly reported dwelling types were emergency accommodation funded through DV Connect or BDVS (44%), self-funded hotel/motel/bed and breakfast (26%) or house/townhouse/flat (24%).

Table 1: Demographic and Health Snapshot of Participants

	n (%)
Main Source of Income	
Government	119 (94.4)
(JobSeeker, Youth Allowance, Parenting Payment, Disability Support Pension, Carer Payment)	
Employee Income	1 (0.8)
Nil Income	3 (2.4)
Don't know	3 (2.4)
Living Arrangement	
Lone person	98(77.8)
One parent with dependents	28 (22.2)
Instances of Injured Dependents	7 (5.6)
Tenure	
No tenure	42 (33.3)
Renter – public housing	38 (30.2)
Don't know	23 (18.3)
Renter – private housing	17 (13.5)
Renter – boarding/rooming house	5 (4.0)
Rent free – public housing	1 (0.8)
Emergency accommodation/women's refuge/shelters	1 (0.8)
Owner – being purchased/with mortgage	1 (0.8)
Currently Pregnant	23 (18.3)
Not reported	4 (17.4)
Regular GP	33 (26.2)
Presence of a DV Injury	58 (46.0)
DV Injury Types	
Facial injury	25 (43.1)
Throat injury/strangulation	23 (39.7)
Head injury	6 (10.3)
Rib and flank pain	6 (10.3)
Body bruising and abrasions	5 (8.6)
Sexual assault	3 (5.2)
Other	8 (13.8)
History of Mental Health (n=125)	52 (41.6)
Anxiety	37 (71.2)
Depression	19 (36.5)
Bipolar disorder	15 (28.8)
Schizophrenia	10 (19.2)
Post-Traumatic Stress Disorder	10 (19.2)
Psychosis	3 (5.8)
Obsessive Compulsive Disorder	1 (1.9)
Dissociative Identity Disorder	1 (1.9)
Suicidal ideation	1 (1.9)
History of Alcohol and Other Drugs (n=124)	41 (33.1)
Alcohol	17 (41.5)
Amphetamines	10 (24.4)
Methamphetamines	9 (22.0)
Marijuana	5 (12.2)
Opiates/Opioids	4 (9.8)
Unable To Access Prescribed Medications	41 (32.5)

SUCCESS FACTORS

Feedback from the participants suggests that the Clinical Nurse Partnerships - Domestic Violence Project has successfully promoted access to healthcare for women experiencing domestic and family violence. Key factors that have contributed towards this success include:

- **The person-centred model of care**.
  This model, including a trauma-informed approach, ensures that each interaction between the Clinical Nurse and a participant focuses on meeting the needs expressed by that participant in that moment. Alongside evidence-based clinical care, the nurse provides practical and emotional support to meet the holistic needs of the woman and her children.
- **The knowledge, skill, and commitment of the Clinical Nurse**.
  The well-developed attributes of the Clinical Nurse ensure that they can quickly establish trust and rapport with participants, identify priorities for care, and deliver interventions targeted towards the most pressing needs while ensuring that pathways for less urgent care are put into place. The Clinical Nurse is cognisant of power differentials and respectful of professional boundaries when working with clients.
- **Health service navigation and transport**.
  The Clinical Nurse has a car, which means that when they put a referral in place, they can also accompany participants to their appointments to remove barriers and ensure a smoother transition between health services. Through transport, the Clinical Nurse also helps participants meet their basic needs, such as access to shops for groceries and medicines.
- **The flexibility of the role.**
  The Clinical Nurse operates under a flexible model that allows care to be tailored to participants' interactions in terms of their duration, relevant health assessments, clinical interventions, social support activities, educational interventions, practical assistance, and onward referrals.
- **Recruit the right person.**
  Much of the project's success to date can be attributed to the Clinical Nurse's skills, knowledge, and personal qualities. This points to the importance of employing people with the necessary skills and experience in community nursing roles and the attitude and temperament to work closely with vulnerable women experiencing complex life trajectories.
- **Embeddedness within Micah Projects.**
  Working between the various branches of Micah Projects means that the Clinical Nurse fosters collaboration between services to meet participants' needs and ensures they experience a smoother pathway between available services.

CHALLENGES AND CONSIDERATIONS

Challenges encountered during the first 12 months of the Clinical Nurse Partnerships - Domestic Violence Project have included:

- **Limitations of the Clinical Nurse's scope of practice.** The flexible model of care adopted by the Clinical Nurse operates is limited by restrictions on performing some activities, such as pathology collection, simple prescribing, and ordering investigations. Since commencing in the role, the Clinical Nurse has undergone training in venepuncture and cervical screening, with a view to incorporating these into role guidelines.
- **Lack of health service integration.** The Clinical Nurse has experienced some challenges accessing participants' health-related information and histories because they do not have access to primary or hospital-based client records, impacting continuity of care.

- **Homelessness and precarious housing.** Many women accessing the service are precariously housed, including 'couch surfing' or living in temporary accommodation. This can make it difficult to keep in contact and to arrange follow-up care, particularly when women move further away from health services.
- **Hours of service.** The limited (daytime weekday) hours of the service mean there are large blocks of time where the Clinical Nurse is unavailable. Referrals often come through after hours and on the weekend, creating backlogs and gaps in service provision.
- **Lack of domestic violence awareness among health care staff.** Poor understanding of the challenges facing women experiencing domestic and family violence, coupled with inadequate knowledge of local services available to support women, means that healthcare staff are not always well-positioned to intervene in ways that positively benefit women.

CLIENT TESTIMONIALS

In Boxes 1 & 2 below, we provide examples of how the model of care optimised access to health and social services for women experiencing domestic and family violence.

Box 1

Practical barriers to accessing services were overcome by providing a safe means to access appointments.

"I was in domestic violence housing, and I was pregnant with my fourth child, and was given access to Micah through DV Connect. Because of lack of transport - and I had a fifteen-month-old daughter at the time - my barriers were kind of building up to meet all of my healthcare needs during that time of pregnancy. I found that Micah, they basically took care of everything so, [the Clinical Nurse] was able to just be there with the vehicle at the front of my accommodation, she was just helpful. It really made my health experience easy and just helped me to facilitate my daughter who needed full time work. I can't even begin to explain how appreciative, oh my goodness I can't even speak at the moment, it just takes away the stress, it gives the ability to just have someone else to talk to, it has so many qualities."

"I was pregnant for three months, and don't have any opportunity to get any medical attention, no income, no Medicare. [Clinical Nurse] called me the same day. I thought that it would take a longer time, but she called immediately and then that very day she was ready to come back and see me. She ran the tests for me, my urine, and the next day she came again and immediately that same week was when they started making effort for me to get the hospital attention. Whenever I have appointments at the hospital, she would come at the refuge, pick me [up for] the appointment. When I needed help, she came. She showed care to me. Before we met, she called me, she knew that somebody that's coming from a tense situation. No one to listen to you and then she gave all the cares, the attention. She has been very good to me. She listens to me, pays attention. I told her this is not a service, it's like you're my sister."

Box 2

Providing assistance with immediate needs and building trust and rapport facilitated a sense of safety.

"She just let me know that she'd arrived at the location that I had been put, and those things aren't given out to people. She let me know that she'd arrived, that she'd be coming to the door. When she did that, she also showed me her identification, made sure I was comfortable. She made sure I was ok physical wise and, you know, mental health, that I had medication, so making sure everything was ok and she gave some numbers of some doctors just in case, including, like a mental health line. When she had finished doing all her dressing and thing, she left a few things there for me in case I needed to change it and had made time to come out the next day, and if I wasn't going to be in that location and I'd been moved to another one, then she'd come to the other location and continue the care."

"She's someone I get along with. If I don't get along with them, I just don't show up. She has more time for me, she sits with me if I need to talk. She does a good job, you know? I'm not just another number in a line. I don't like this 'changing nurses' all the time, you know? You've got to be able to relate to someone before you feel comfortable. "

CONCLUSION AND NEXT STEPS

The Clinical Nurse Partnership - Domestic Violence Project model of care has facilitated access to healthcare for women and children experiencing domestic and family violence. Elements of the model will be useful to inform ongoing efforts to improve access to care, promote smoother pathways through healthcare services, and ultimately improve health outcomes for women and families. Further, the relationships forged between partners involved in delivering the Clinical Nurse Partnerships - Domestic Violence Project will have benefits for participants' care beyond the scope and timeline of the current project.

If you have any questions relating to the Clinical Nurse Partnership Domestic Violence Project model of care, please contact:

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APPENDIX: BRISBANE DOMESTIC VIOLENCE SERVICE OVERVIEW

BDVS is an activity of Micah Projects Ltd. A collection of teams within BDVS focus on unique areas within the domestic and family abuse arena. The teams are:

1. Safer Families Initiative (SFI)
2. Safer Community Culture (SCC)
3. Safer Options and Support (SOS)
4. Safer and Accountable Justice Systems (SAJS)
5. Safer Lives Mobile Service (SLMS)

The Safer Options and Support (SOS) team works with adults, who are experiencing domestic and family violence within an integrated service response. SOS partners with Queensland Police Service (QPS) and co-locate with the QPS Domestic and Family Violence and Vulnerable Person's Unit (DFV and VPU) in both north and south Brisbane to provide support to people following DFA callouts by police. SOS work with women to assist them in managing their own safety and provide support for individuals to a point where they are safe and stable in the context of DFA. SOS provides women and their families with coordinated case management, risk assessment and safety planning, information and referral to other services, advocacy and crisis support.

The Safer Lives Mobile Service (SLMS) team works with women and children, who are escaping domestic and family violence within an integrated service response. SLMS partners are DV Connect, a 24-hour crisis service supporting women and children to access safety in refuge, Queensland Police Service and Queensland Health. SLMS work with women and children to assist them to explore their options considering safety and risk. SLMS provides women and their families with information and advice, safety planning and assessment, advocacy and support, safety assessments in their home, emergency relief, and technology and digital safety.