



## REVISTA DE LA FACULTAD DE CIENCIAS DE LA SALUD

Vol. 27(1):32-41, April – July 2024  
i-ISSN 0123-7047 e-ISSN 2382-4603



*Special Article*

# Adaptation and Implementation of the RNAO woman abuse best practice guideline: A critical reflection

Adaptación e Implementación de las Guías de Buenas Prácticas Clínicas de la RNAO sobre el abuso de las mujeres: Una reflexión crítica

Adaptação e Implementação das Diretrizes de Boas Práticas Clínicas da RNAO sobre o abuso de mulheres: Uma reflexão crítica

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### ARTICLE INFORMATION:

Article received: February 26, 2023

Article accepted: July 31, 2024

DOI: <https://doi.org/10.29375/01237047.4652>



**How to reference.** Foster W, Dyer S, Williams N, Minkus A, Wood J. Adaptation and Implementation of the RNAO woman abuse best practice guideline: A critical reflection. MedUNAB [Internet]. 2024;27(1):32-41. doi: <https://doi.org/10.29375/01237047.4652>

## Author contributions

*WF, NW and JW. Study conception and design, and the draft manuscript. WF, NW, SD and AM. Data Collection. Analysis and interpretation of results. All authors reviewed the results and approved the final version of the manuscript.*

## ABSTRACT

**Introduction.** Domestic violence impacts approximately 30% of women globally. In Australia, reports indicate that one in every six women will experience physical or sexual abuse. Many instances of domestic violence, however, are not reported. Pregnancy and new motherhood are periods of increased risk in a woman's life. Identifying appropriate methods for screening and responding to domestic violence is a high priority, especially in maternity services. This paper aims to provide a critical reflection on the implementation of the Registered Nurses Association of Ontario's 'Woman Abuse: Screening Identification and Initial Response' Best Practice Guideline at the Women's and Children's Health Network (WCHN), Adelaide, South Australia. **Division of the topic covered.** This study used the Registered Nurses Association of Ontario's six-phase Knowledge-to-Action Process structure for critical reflection. Each phase was evaluated using written reports and reflective conversations. Following the Knowledge-to-Action Process, the WCHN successfully demonstrated improvement in staff knowledge and understanding of domestic violence and appropriate methods of screening and responding to disclosure. Further, there was significant growth in leadership, partnership with key stakeholders, and capacity building. Although cost remained a limiting factor, sustainability through cultural change was overwhelmingly encouraging for longevity. **Conclusion.** This reflection has demonstrated passion, leadership, and organisational commitment to implementing evidence-based care. Key stakeholder partnership, leadership, and scaffolding education and training are pivotal to successful and sustainable implementation.

### Keywords:

Exposure to Violence; Pregnancy; Midwifery; Domestic Violence; Women

## RESUMEN

**Introducción.** La violencia doméstica afecta aproximadamente al 30% de las mujeres a nivel mundial. En Australia, reportes indican que 1 de cada 6 mujeres experimentará abuso sexual o físico. Sin embargo, muchos casos de violencia doméstica no han sido reportados. El embarazo y la maternidad son periodos que incrementan el riesgo en la vida de las mujeres. Identificar métodos apropiados para detectar y responder a la violencia doméstica es una gran prioridad, especialmente en los servicios de maternidad. El objetivo del artículo es proporcionar una reflexión crítica sobre la implementación de la Guía de Buenas Prácticas de la Asociación de Enfermeras Registradas de Ontario "Abuso de Mujeres: Identificación y Respuesta Inicial", guía de práctica clínica de la Red de Salud de Mujeres y Niños (WCHN por sus siglas en inglés), Adelaide, Australia del Sur. **División de temas tratados.** Este estudio empleó la estructura de seis fases del Proceso de Conocimiento a la Acción de la Asociación de Enfermeras Registradas de Ontario para realizar la reflexión crítica. Cada fase se evaluó mediante informes escritos y conversaciones reflexivas. Después del proceso de conocimiento para la acción, la WCHN demostró con éxito una mejora en el conocimiento y la comprensión del personal sobre la violencia doméstica y los métodos apropiados para detectar y responder a la divulgación. Además, hubo un crecimiento significativo en el liderazgo, la colaboración con entes clave y el desarrollo de capacidades. Aunque el costo sigue siendo un factor limitante, la sostenibilidad a través del cambio cultural fue significativamente alentadora para la longevidad. **Conclusión.** Esta reflexión ha demostrado pasión, liderazgo y compromiso organizacional para implementar atención basada en evidencia. La asociación con entes clave, el liderazgo y el andamiaje de la educación y la capacitación son fundamentales para una implementación exitosa y sostenible.

### Palabras clave:

Exposición a la violencia; Embarazo; Partería; Violencia Doméstica; Mujeres

## RESUMO

**Introdução.** A violência doméstica afeta aproximadamente 30% das mulheres em todo o mundo. Na Austrália, os relatórios indicam que 1 em cada 6 mulheres sofrerá abuso sexual ou físico. No entanto, muitos casos de violência doméstica não são denunciados. A gravidez e a maternidade são períodos que aumentam o risco na vida das mulheres. A identificação de métodos apropriados para detectar e responder à violência doméstica é uma grande prioridade, especialmente nos serviços de maternidade. O objetivo do artigo é fornecer uma reflexão crítica sobre a implementação da Diretriz de Boas Práticas da Associação de Enfermeiras Registradas de Ontário "Abuso de Mulheres: Identificação e Resposta Inicial", diretriz de prática clínica da Rede de Saúde da Mulher e da Criança (WCHN em inglês), Adelaide, Austrália do Sul. **Divisão dos tópicos abordados.** Este estudo empregou a estrutura de seis fases do Processo de Conhecimento para a Ação da Associação de Enfermeiras Registradas de Ontário para conduzir a reflexão crítica. Cada fase foi avaliada por meio de relatórios escritos e conversas reflexivas. Após o processo de conhecimento para ação, a WCHN demonstrou com sucesso melhorias no conhecimento e compreensão do pessoal sobre violência doméstica e métodos apropriados para detectar e responder à divulgação. Além disso, houve um crescimento significativo na liderança, na colaboração com entidades-chave e no desenvolvimento de capacidades.

Embora o custo continue a ser um fator limitante, a sustentabilidade através da mudança cultural foi significativamente encorajadora para a longevidade. **Conclusão.** Esta reflexão demonstrou paixão, liderança e compromisso organizacional para implementar cuidados baseados em evidências. Parcerias com entidades-chave, liderança e estrutura da educação e do treinamento são fundamentais para uma implementação bem-sucedida e sustentável.

**Palavras-chave:**

Exposição à Violência; Gravidez; Tocologia; Violência Doméstica; Mulheres

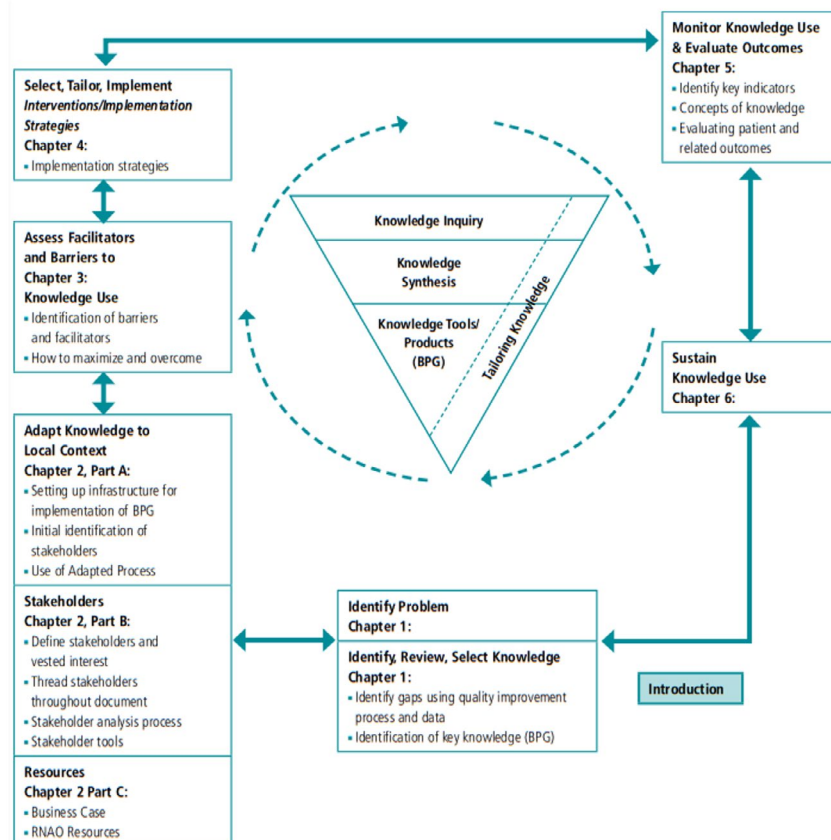
**Introduction**

The research-practice divide and the ability to translate quality research into practice are barriers to progressing health care delivery and outcomes (1). While the research to guide practice is more readily available than ever, it remains limited in its clinical application and translation (1). Barriers to the application of evidence-based practice include both organisational and personal factors. From an organisational perspective, the primary barriers identified include workplace culture, resistance to change, and the absence of administrative support (2). Personal factors include a lack of knowledge about emerging research and a low capacity to critique and apply evidence (3).

One method of overcoming barriers to implementing evidence into practice is the development of best practice

guidelines (BPGs) (3,4). To develop BPGs, organisations should identify and integrate the highest quality of research available, including original research, systematic reviews, and expert consensus (3,4). The use of BPGs has been shown to improve clinical practice by promoting care that has proven positive outcomes (4-6).

Recognizing the importance of evidence-based practice and the benefits of BPGs, in 1999, the Registered Nurses' Association of Ontario (RNAO) developed the BPGs program (7,8). The program includes access to the BPG tool kit to be used along with the BPG implementation. The tool kit uses a systematic approach to the implementation. It is established to enhance the ability for health care organisations to develop, disseminate, pilot, and assess evidence-based clinical practice guidelines (Figure 1) (4,7,8).



**Figure 1.** RNAO BPG Toolkit: Knowledge-to-Action Process (9)

**Source:** [https://rnao.ca/sites/rnao-ca/files/RNAO\\_ToolKit\\_2012\\_rev4\\_FA.pdf](https://rnao.ca/sites/rnao-ca/files/RNAO_ToolKit_2012_rev4_FA.pdf)

As part of the BPG program, in 2003, the Best Practice Spotlight Organisation® (BPSO®) program was developed (9). The BPSO® program is a competitive model that seeks applications from across the world from health care organisations committed to implementing and assessing BPGs. Successful candidates to the BPSO® commence a three-year candidacy through which they receive guidance in facilitating, implementing, assessing, and maintaining BPGs within their organisation.

To assist with the global nature of the BPSO® program, local BPSO® ‘hosts’ were engaged to act as a support and liaison between the RNAO and the BPSO® candidate. In 2012, the Australian Nursing and Midwifery Federation of South Australia (ANMFSA) became the first BPSO® host organisation outside Canada. With the assistance of the ANMFSA, the BPG program was adapted for use in the Australian health care system. In 2015, the first two BPSO® s from South Australia completed their candidacy (10). In 2015, two additional sites, also from South Australia, submitted proposals to participate in the BPSO® program (10,11).

The WCHN is South Australia’s leading provider of specialty care health services for women, babies, young people, and their families across 180 sites. One of the services operating within WCHN is the Women’s and Children’s Hospital (WCH), the largest tertiary-level maternity and pediatric service, providing care for 33,000 admissions, including 4,678 births and 230,000 outpatient appointments (12).

The ANMFSA supported WCHN as the host organisation. This support involved monthly meetings with the ANMFSA to facilitate progress in meeting the candidacy deliverables. Additionally, the WCHN attended monthly knowledge exchange meetings with other BPSO network leads across South Australia, assisting with developing a solid leadership network. To support their BPSO® candidacy, the ANMFSA provided \$150,000.00 over three years. The WCHN contributed a further \$150,000 in in-kind funding.

Recognising the global and national importance of protecting women and families from domestic violence, the WCHN senior executive leadership group endorsed the implementation of the ‘Woman Abuse: Screening Identification and Initial Response’ (WASIIR) BPG as one of the three clinical BPGs to be a priority. The Nursing and Midwifery Clinical Practice Development Unit and the Youth, Women’s Safety and Wellbeing Division worked collaboratively to implement a clinical procedure embedding routine domestic violence screening. At the time of implementation of the WASIIR BPG, the WCHN was in its third year of BPSO® candidacy (2017), having successfully implemented the Person and Family Centred Care (PFCC) (13) and Care Transitions (CT) (14) BPGs in the preceding two years.

The current *National Plan to Reduce Violence against Women and their Children (2023-2033)* defines domestic violence as any behaviour within an intimate relationship [past or current] that causes physical, sexual, or psychological harm. Globally, statistics show that approximately 30% of all women have experienced physical and/or sexual domestic violence (15). In Australia, approximately one in every six women have experienced physical or sexual abuse from a partner since the age of 15 (16). While it is known that domestic violence occurs in all cultural, social, and economic demographics, some populations are considered to be at a higher risk (16). Two of these at-risk populations include pregnant women and children; the primary service recipients at the WCHN.

The aim of this paper is to provide a critical reflection on the implementation of the ‘Woman Abuse: Screening Identification and Initial Response’ (WASIIR) BPG (17) at the Women’s and Children’s Health Network (WCHN), Adelaide, South Australia.

## Division of topics covered

The RNAO Knowledge-to-Action Process outlines six phases for implementing BPGs (9). The six phases include: Identifying the problem, adapting knowledge to the local context, assessing facilitators and barriers to implementation, selecting, tailoring and implementing strategies, monitoring knowledge use, evaluating outcomes and sustaining knowledge. Information regarding each stage of the Knowledge-to-Action Process was discussed and evaluated using reflective conversations and written reports.

### *Identify the Problem*

The first phase of the Knowledge-to-Action process is to identify the key issue, including any gaps in service delivery, knowledge, or implementation (9). Most commonly, this is identified either through existing quality improvement strategies or identifying a relevant BPG and the bench marking of existing services against this evidence (9). This phase sets a foundation for identifying the best available evidence, types of participation required, existing tools, guidelines, and education that may be required (9).

The first step in the RNAO BPG implementation framework is to undertake a gap analysis (9). In this step, the health service must assess current practice against the associated practice, education, and organisation/policy recommendations outlined in the BPG (9). Through the WCHN gap analysis, three out of four recommendations from each area (practice, education, and organisation/policy) were assessed as partially met, while one out of the four in each area of recommendation was unmet.

To thoroughly understand the issue of Woman Abuse at an organisational level, the WCHN undertook consultation

with key stakeholders. As part of a strategic gap analysis, nursing and midwifery staff, consumers, and Aboriginal Health Divisions and services were all engaged.

Concerns were raised by nursing and midwifery staff regarding their scope of practice, preparedness to respond if there was a disclosure of domestic and family violence, and fear of causing harm. Consumers indicated they wanted to feel safe to disclose, but also highlighted that in many instances, they needed staff to ask about their relationship and home environment rather than expecting them to volunteer the information. Through consultation with staff from the Aboriginal Health Division, concerns were raised regarding the language in the title of the Woman Abuse BPG. This finding is also related to adapting the BPG to the local context.

In addition to consultation, the WCHN identified an evidence-based screening tool successfully implemented in the emergency department of another Local Health Network (LHN) in 2006. This tool is based on the validated Domestic Violence Identification Tool (DVIT) (18). While the DVIT included six yes/no questions, the tool used in this study included only three questions adapted from these six (18). These questions were presented as follows: Has a partner or significant other ever done any of the following? 1. Made you feel afraid, 2. Hurt you physically or throw objects, 3. Constantly humiliated or put you down? A yes response to any of these questions was considered a confirmation of domestic and family violence. This tool was adapted for use in the Women's Assessment Service (WAS) prior to the BPSO program. However, the implementation was limited, and the tool was not frequently used in practice. Given the service delivery similarities between the two organisations, this tool was considered necessary for the WASIIR BPG implementation.

Gaps identified included a lack of clear organisational procedures to address domestic and family violence, a need for additional executive support, division-wide advocates for the WASIIR BPG, and ongoing consumer involvement with the implementation process.

### ***Adapt Knowledge to Local Context***

The second phase of the Knowledge-to-Action process involved adapting the chosen BPG to fit the cultural, economic, or sectoral context (9). This phase involved key stakeholders, the development of a business case, and use of appropriate resources, i.e., training, education and interventions (9).

To undertake this phase, the WCHN acknowledged feedback from their initial consultation with the local Aboriginal Health Division and the language change of the WASIIR to 'Domestic and Family Violence; Ask, Assess, Respond' (DFV: AAR). This change acknowledges and includes the presence and impact of violence within families.

Given the sectoral context of WCHN providing care to women, babies, and young people, changes were made regarding who would be screened for DFV and in what situations it was considered safe and appropriate to ask. While the WASIIR BPG indicated that all women should be screened (17), additional guidelines were needed to include responding to children disclosing DFV and young people 16 years and older.

### ***Assess Facilitators and Barriers to Implementation***

Assessing facilitators and barriers to implementing a BPG is pivotal to success (9). This step ensures that any facilitators to the implementation of the BPG are maximised, while any barriers are minimised or eliminated where possible (9).

Facilitators to the implementation of this BPG at the WCHN occurred at a national and local level. From a national perspective, there was a growing awareness of domestic and family violence, such as national frameworks, including the National Plan to Reduce Violence Against Women and Their Children and the National Framework for Protecting Australia's Children. At the state level, the Family Safety Framework to enhance risk assessment and information sharing between key organisations, the South Australian Women's Safety Strategy, and the introduction of paid domestic violence leave all contributed to awareness around domestic violence.

On a local level, facilitators to the implementation of the BPG included a team of highly motivated individuals to lead the steering of the BPG across the WCH division of the WCHN, using the previous implementation of the PFCC and CT BPGs and the organisational preparedness to build on this existing culture change. Furthermore, WCHN had already taken a strong position regarding gender equality and respect in the workplace through its work to become accredited as a White Ribbon organisation in 2017. White Ribbon Accreditation enhanced the organisation's position of zero tolerance of violence towards women and children. It enabled a deeper understanding of gender inequality as a critical driver of domestic and family violence.

Despite numerous facilitators, there were barriers to implementing the BPG, including staff turnover and staff release for education and training sessions. Additionally, through an audit process consisting of a random selection of consumer demographics and compliance with the procedure, some units did not meet the organizational benchmark for screening. This led to robust conversations across the organization and exploring how implementation could be better supported. While conflict was not common, there were some communication and unit engagement barriers at times.

## Select, Tailor, and Implement Interventions/Strategies

Selecting, tailoring, and implementing interventions and strategies considers the previous three phases of the knowledge-to-action framework (9). This phase considers the implementation of staff training, consumer-mediated interventions, and the integration of organizational processes (9). Strategies utilized by the WCHN included enhancing the visibility and dissemination of information and resources, staff training, and consumer support tools.

To enhance knowledge of and engagement with the DFV: AAR, the WCHN used a strategic, targeted communication approach. This strategy allowed for timely, detailed information to all staff via multiple methods, including employee bulletins, the hospital intranet service, CEO communications, and online education platforms. This extensive communication system promoted staff engagement and reinforced the importance of the DFV: AAR procedure across the WCHN.

A multifaceted approach was employed throughout implementation, based on the findings of auditing processes and stakeholder consultation. Trauma-informed care was embedded in all training and education. This approach was used to support staff’s feeling safe in sensitively questioning

women while also increasing awareness of the need for trust, empathy, and responsiveness from the health service to encourage women to disclose DFV.

Training occurred across two sessions. In the first session, staff were required to read the AAR clinical procedure and then watch a video presentation on the background and implementation of the procedure. Part two involved attending a face-to-face workshop. Staff who successfully completed this training were recognized as DFV: AAR champions. Reports indicate 63% level 1 registered nurse/midwife, 21% level 2 registered nurse/midwife, 11% level 3 registered nurse/midwife, and 4% level 4 registered nurse/midwife or higher.

The AAR initiative was a structured approach to screening for DFV. Information, education, and training regarding who, when, and how to ask screening questions related to DFV was provided to staff (Table 1). A universal statement was provided to staff to reassure women that the WCHN was a safe place to disclose DFV. This statement was combined with the general conversation or the three-key question approach. To assist engagement with this process, lanyards with the three key questions were given to staff who had completed the training. Additionally, these questions were detailed on newly developed clinical documentation to ensure all critical information was collected.

**Table 1.** Adapted from WCHN Clinical Procedure: Domestic and Family Violence – Ask, Assess and Respond

Who to ask	
<p style="text-align: center;"><b>Ask:</b></p> <ul style="list-style-type: none"> <li>All women age over 16 years</li> <li>All antenatal consumers</li> <li>Parents, guardians and caregivers (excluding those identified as perpetrating violence) are to be asked the questions if safe to do so.</li> </ul>	<p style="text-align: center;"><b>Don’t Ask:</b></p> <ul style="list-style-type: none"> <li>If not medically stable</li> <li>If not alone</li> <li>If children 2 years and over are present (with the woman)</li> <li>If interpreters are not available</li> </ul>
When to ask	
<ul style="list-style-type: none"> <li>At initial intake and/or</li> <li>During continuum of care and/or</li> <li>Upon discharge</li> </ul>	
How to ask	
Universal Statement	
<p>‘We are aware that women may experience violence or abuse from a partner or ex-partner at any time. In light of this, we let all women know as part of their health care that there is a national helpline called 1800RESPECT you can contact for support at any time. You can also speak with any member of staff if domestic violence or family violence is impacting on your safety and wellbeing. We are here to listen and link you in with support. Do you mind if I ask you some questions? You are not required to answer these questions if you don’t want to. Please know your personal information will not be shared without your consent unless you are at risk of harm to yourself or others’.</p>	
Three Questions	
Has a partner or significant another person ever:	
<ol style="list-style-type: none"> <li>1. Made you feel afraid?</li> <li>2. Hurt you physically or thrown objects?</li> <li>3. Constantly humiliated or put you down?</li> </ol>	

**Source:** Women’s and Children’s Health Network Intranet, Clinical Procedure: Domestic and Family Violence – Ask, Assess and Respond

A clear response and referral process were implemented. A flow chart detailing actions following the disclosure of DFV was available to all staff. This flow chart included information to assess safety and support, including the involvement of other organizations, e.g., child protection services. Critical considerations for responding to the disclosure of DFV were provided, including the importance of listening and empathy, support, the use of additional services, referral pathways, and documentation.

After reviewing evidence and consulting, it was established that many women do not disclose their DFV in direct contact with a healthcare worker. Further, it was established that consumer information/pamphlets should be discreet. In recognition of these issues, the WCHN developed a small pocket-sized information card for women. They also educated staff to offer these to women to give to others if they knew or were concerned about friends/family/colleagues who may be experiencing DFV.

A key message in the AAR policy was the need for the woman to be alone, without a partner or child older than two years in attendance. This was both a complexity in practice and a safety concern for clinical staff as they indicated it could cause conflict to ask a partner to leave the appointment. In response to this, staff were educated on different/creative methods to speak with women alone, such as walking with them to the bathroom when urine samples were required and the development of posters for the back of toilet doors with information on DFV and how to seek help.

### ***Monitor Knowledge Use and Evaluate Outcomes***

Monitoring knowledge use and evaluating outcomes was the fifth phase of the Knowledge-to-Action process (9). This phase involves auditing any interventions and gauging knowledge development across the organization and how this translates to consumer outcomes (9). This phase can help identify adjustments or additional strategies, linking to phase four (9).

To evaluate the outcomes of the DFV: AAR procedure, the WCHN undertook a pre-post evaluation of knowledge and understanding of staff completing the AAR training and a clinical records audit to use the new documentation. The pre-evaluation occurred before part one of the training and identified the base knowledge and understanding of staff concerning DFV and the use of trauma-informed care. Staff demonstrated a significant increase in knowledge of barriers to leaving a violent relationship, appropriate timing to ask women about risk and safety in their relationships, knowledge of safety planning for women disclosing DFV, appropriate reporting to child

abuse services, identification of support services for women and families, the role and obligations of the nurse/midwife in supporting women experiencing DFV, and supporting the ability to identify and seek supports for the practitioners own mental and emotional wellbeing. Further, confidence and awareness were increased across the areas of the Family Safety Framework, as well as asking and responding to disclosure of DFV.

A clinical audit measuring compliance was undertaken to assess four key indicators: asking alone, assessing for DFV, responding to DFV, and documenting reasons if not assessed. The audit also demonstrated a 10% increase in exploring DFV with women using the AAR procedure in community and acute services. Further, the audit highlighted a need for additional screening and inquiry at multiple time points throughout the care journey.

### ***Sustain Knowledge***

The final phase of the Knowledge-to-Action process refers to the sustainability of the change. The relevance, benefits (to an individual/organization/society), appropriate attitude towards the change, networking, and leadership have all been highlighted as critical factors in sustaining organization change (9).

Given the national and local investment in recognizing and responding to DFV, the relevance and benefits to women, families, the WCHN, and society are apparent. As an organization, the WCHN had a solid foundation for a culture of person and family-centered care. This assisted with the staff's willingness to embrace change, demonstrating this concept's ethos. Further, there was a change from a compliance perspective to a best practice perspective that embodied the concept of supporting clinicians through training, education, and evidence to support better health outcomes.

Following the implementation of the DFV: AAR procedure at the WCHN, a further 10 LHNs implemented the AAR. A senior executive network across South Australia was developed to review, assess, implement, and respond to DFV as a health issue. Each LHN has executive and Aboriginal health representatives, ensuring continued leadership, partnership, and collaboration.

The AAR process has been implemented to train new graduate nurses, midwives, and final-year medical students. Training in the AAR process has also been provided to a diverse range of health professionals at the university level. Standardizing this education and training has fostered a safety culture for the disclosure of DFV for staff and women accessing services.

## Discussion

This reflection reports on implementing the DFV: AAR process at the WCHN using the knowledge-to-action process. The key facilitators to implementing the DFV: AAR procedure were multiple levels of consultation, teamwork, and collaboration, scaffolded education and use of previous BPGs, strong leadership, and an organization-wide commitment to evidence-based best practices.

The following discussion will use the Framework of Implementation Outcomes (19) to evaluate the implementation of the DDFV: AAR process. This framework consists of seven critical indicators for implementation: acceptability, adoption, appropriateness, feasibility, fidelity, implementation cost, penetration, and sustainability (19).

### *Acceptability*

Acceptability in implementation research refers to stakeholders' perception that the suggested intervention, service, etc, is acceptable (19). A primary consideration of the WCHN BPG leadership groups was the need for consultation with key stakeholders across all phases. The consultative period in the first phase provided the WCHN with an understanding of the issues from a broad perspective from staff, consumers, and Aboriginal health divisions. Consultation was the foundation of all training, education, and consumer support tools. This partnership level has been demonstrated to improve quality, legitimacy, and uptake within an organization (19) and is a strength of the WCHN implementation.

### *Adoption*

Adoption is an essential implementation feature as it demonstrates practice engagement (19). Barriers to adopting a BPG in practice can occur at multiple levels, including inconsistent reporting of key performance indicators (KPIs) and a lack of clinical champions (11). Using the Knowledge-to-Action framework, the WCHN implemented an audit process to monitor and evaluate outcomes from the BPG. One of the key outcomes of the auditing process included the demonstrated improvement in screening across the implementation period. Further, the strong network of champions assisted with staff concerns, evaluation, and sustained engagement.

### *Appropriateness*

The appropriateness refers to the relevance of the project as perceived by stakeholders (19). If a project is not deemed as appropriate by stakeholders and end users, they are less likely to engage with it. A lack of appropriateness can occur due to a lack of training and education, an

organizational culture that is resistant to change, or a lack of understanding of why the project is appropriate for the service (11,19-21). As identified in this reflection, the DFV: AAR was scaffolded to ensure staff had adequate foundational knowledge in trauma-informed care and PFCC. This scaffolding raised awareness and influenced the appropriateness of the program by healthcare staff.

### *Cost*

The issue of cost in implementation refers to the financial implications and considerations when introducing a new service or intervention (19). The financial implications of introducing BPGs into an organization are primarily related to the release of staff and work allocation cover to attend education and training (20,22). As previously noted, the WCHN BPSO® candidacy received funding from the ANMF (SA) and in-kind funding from the WCHN. This funding assisted with training products, evaluation, communications, reporting, and consumer resources. However, the funding did not cover staff leave to attend training, which remained a barrier. While there are known benefits to service delivery and outcomes with implementing BPGs in health care services (4), there must be additional investment to assist in effective implementation.

### *Feasibility*

The extent to which a project can be successfully implemented is known as 'feasibility' (19). Measurement of feasibility often relies on KPIs and benchmarking to establish aspects such as participation rates (19). The feasibility of the DFV: AAR procedure can be validated through the demonstrated uptake in the acceptability, adoption, and appropriateness at the WCHN. While it has been noted that poor leadership, negative staff culture, and a lack of trust can harm feasibility (20), these factors were not highlighted in this reflection. Instead, the leadership of the WCHN and the ANMF(SA), together with dedicated and motivated clinical staff, enhanced the feasibility of this project.

### *Fidelity*

Fidelity refers to how a project was implemented compared to how it was originally intended (19). To achieve a high level of fidelity, the WCHN adhered to the Knowledge-to-Action Process and the fundamental aspects of the WASIIR BPG to create and implement the DFV: AAR. This approach, combined with evidence-based frameworks from the WASSIR, contributed to the fidelity of this project. The WCHN demonstrated responsiveness to staff and consumer concerns while developing training and support tools for successful implementation.

## Penetration

The penetration of a project refers to the extent to which it has impacted a service or related service networks (19). The development of BPG Champions across the division, capacity, and practice development of staff, as well as the implementation of the AAR screening in 10 LHNs across South Australia, are testaments to this project's penetration.

## Sustainability

Sustainability in implementation refers to the extent to which the project or intervention is maintained within the organization (19). A key influencing factor in achieving sustainability is 'Social movement action for knowledge uptake and sustainability' (23). The social movement demonstrated through this reflection is evidenced by the organizational commitment to change and the subsequent culture shift across the WCHN and other LHNs. These changes, together with the development of networks and leaders to support the ongoing change and sustainability of the project, further demonstrates the social movement of knowledge application and implementation.

## Conclusion

This paper has provided a critical reflection on implementing the DFV: AAR project at the WCHN. The Knowledge-to-Action Process was used to outline the decisions and outcomes in the organization's context. The reflection has demonstrated the passion, leadership, and organizational commitment to implementing evidence-based care. Further, key stakeholder partnerships and the scaffolding of education and training were identified as facilitators to the successful and sustainable implementation of the DFV: AAR project. Using the Framework of Implementation Outcomes, the success of this project has been conceptualized and justified.

## Acknowledgements

This article has not received prior publication, nor is it under review for publication elsewhere. That all authors have seen and approved the manuscript being submitted. The authors abide by the copyright terms and conditions of Elsevier.

## Conflicts of interest

The authors declare that they have no conflicts of interest.

## Funding

No external funding was provided to the authors for this study.

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