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ORIGINAL RESEARCH

Rising to the challenge: The motivation to champion routine intimate partner violence screening in rural emergency departments

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Abstract

Objective: To understand the motivations of champions who worked to bring about system and practice change that supported routine screening for intimate partner violence (IPV) in two rural emergency departments (EDs).

Introduction: Practice changes are required to achieve routine and effective identification and response to IPV. Nurses play a significant role in affecting such practice change. This paper identifies the motivations of champions in the ED setting who successfully brought about such change.

Setting: The EDs of two Level 5 tertiary hospitals within a rural Local Health District (LHD) of New South Wales, Australia.

Participants: Twenty-three individuals who identified as champions and worked to introduce routine IPV screening in two rural hospital EDs.

Design: Qualitative longitudinal semi-structured interviews employing a process of constant comparison and an interpretive framework to analyse data thematically. Interviews were carried out between June and August 2017 and again between July and August 2019.

Results: Over the period of the study, routine screening was established, and screening rates steadily increased from a low baseline to a significantly higher rate. Three aspects of champion motivation emerged from the analysis: formation of an identity as a champion, making a difference to a significant social justice issue and providing quality and community-relevant care.

Conclusions: This study is the first study to report on champions and their motivation as they supported IPV practice change in the ED. The findings highlight the capacity for innovation in rural health services, with important implications for other settings looking to translate similar programs. Understanding motivating factors may assist in improved utilisation and support for champions. This is vital if champions are to bring about required practice change within their service and ensure the needs of individuals experiencing IPV are effectively met.

KEYWORDS
champion, change agent, domestic violence, emergency department, motivation, quality improvement, rural health, screening

1 | INTRODUCTION

Intimate partner violence (IPV), defined as coercive, abusive or violent behaviour by a current or former partner, is a global health issue that disproportionately affects women and children.[1] Worldwide, nearly one in three women are reported to experience some form of IPV in their lifetime.[1] IPV is also experienced by men, although for women, IPV rates are higher, and this abuse is often more severe.[1] Research confirms that IPV occurs regardless of sexual orientation,[2] with lesbian and bisexual women reporting greater risk than heterosexual women.[3] Highlighting the risk of harm from IPV for women, a review of IPV homicides in one Australian state reported that 80% of victims were women.[4] Similarly, data from the United States National Electronic Injury Surveillance System All Injury Program (2005–2013) reported that out of the 1.65 million ED visits for injuries due to IPV during this period, 83% were women.[5]

Policy and research evidence support nurses' role and clinical effectiveness in IPV screening programs.[6–8] Yet, systematic review evidence confirms that barriers to addressing IPV and disclosure of IPV persist in health care settings.[9–11] These barriers can be organisational issues such as a lack of training or supervision and debriefing, a lack of privacy and time, the dominance of biomedical care needs and health care providers' perceptions about their role.[11] Beyond evidence on barriers, health care provider readiness and motivation are said to be vital in enhancing confidence and capabilities to address IPV.[12] Health care providers' personal commitment and readiness to address IPV have been identified as important, particularly for nurses working in ED settings,[12] with readiness supported through collaborative team approaches and resources to assist responses.[12]

There are social and geographic issues specific to rural areas that compound the risk of experiencing IPV,[13] with some research confirming IPV occurs at a higher rate in rural areas compared with metropolitan areas.[13,14] Geographic distances and higher socio-economic disadvantage limit access to specialist services, resources and information in rural areas.[15] Isolation from services and the support of family and friends is exacerbated by the lack of public and private transport.[13–16] These factors all compound the risks associated with IPV. In addition, cultural norms such as patriarchal family structures and traditional gender roles[16,17] and the stoic culture of not interfering in the personal business of others can further isolate individuals, protect perpetrators, and silence and minimise the experience of IPV.[18] Conversely, there is a fear about lack of privacy,[13] with reports that women are less likely to disclose IPV to service providers in rural areas,[15] fearful that the service provider will know and protect the perpetrator.[13] These factors create unique challenges for health care workers seeking to identify or address IPV in their communities.

What is already known on this subject

- Clinicians often have altruistic reasons for working in rural areas and a strong desire to contribute and be connected to their community.
- IPV screening is difficult to implement within EDs and requires practice and culture change.
- Champions are effective at bringing about practice change and implementing quality improvement projects and innovations.
- Champions can have a positive impact on practice change in the area of IPV.

What this paper adds

- This is the first study to report the experience of IPV practice change champions in the rural ED setting.
- The paper adds novel knowledge on what motivates champions to go above and beyond their traditional role to support the implementation of IPV practice change within rural EDs.
- The findings have implications for utilisation of champions within health care settings to bring about practice change and ensure health services effectively meet the needs of individuals experiencing IPV.

Emergency departments (EDs) provide an important safety net for rural populations. They are often the first and only contact residents have when needing medical care[19] and are accessed more frequently by individuals experiencing IPV.[6,20] Routine IPV screening in antenatal, primary health and ED settings is widely adopted in the United States.[21] Assessment for IPV by emergency personnel is recommended by the American College of

Emergency Physicians[22] and the Canadian Association of Emergency Physicians.[23] Routine IPV enquiry for all women has also been national policy in New Zealand since 2016.[24] Whereas, in Australia and the UK, routine screening within EDs is currently not mandated, with opportunistic or case-finding screening practised instead. The Victorian Royal Commission into Family Violence recommended that public hospitals implement and resource a whole-of-hospital approach for responding to IPV, and this should be standard for all hospitals in Australia.[25]

It is recognised that frontline nurses are well-placed to identify and respond to the needs of individuals impacted by IPV,[20] and ED presentations provide an opportunity for identification and intervention to reduce future risk.[26] Evidence shows that routine screening for IPV within EDs is beneficial, feasible and acceptable to staff and patients.[27–29] A Cochrane review regarding IPV screening in health care settings[30] found moderate certainty that IPV identification in EDs is increased by routine screening (OR 2.72 [1.03–7.19]). This is supported by more recent systematic review evidence that confirm IPV screening at trauma centres and EDs' results in significant improvement in IPV identification.[31] An implementation-oriented review reported that of those who screened positive for IPV, a median of 32% were referred to follow-up service,[32] with referral frustrated by a lack of available resources and support services. Even so, screening for IPV in the ED remains a source of continued debate.[33] Arguments have been made in support of routine screening in the ED, whilst other suggest case-finding is more appropriate.

The implementation and sustainment of IPV screening by nurses within EDs can be difficult to achieve, with IPV screening often considered a matter of clinician choice rather than usual practice.[6] In many settings, screening for IPV is not generally considered within scope for ED nursing,[34] and it has been reported that nurses can hold prejudiced and judgemental attitudes towards individuals experiencing IPV. Nurses also report a lack of training and feeling unprepared for IPV screening[7,35] or possessing a limited understanding of the complexities of IPV.[36] Other barriers include the emotional burden of addressing IPV,[6] personal experience of IPV,[37] lack of time and competing demands,[10,34] lack of privacy and integration into electronic medical systems[8] and fear of women themselves not feeling comfortable to be screened or disclose IPV.[7,11,34]

A recent pilot of IPV screening in two rural and one metropolitan EDs in New South Wales, Australia, showed that screening rates were lower in both rural sites.[28] The study highlighted that, although staff strongly supported the screening process, changing screening practice in rural EDs was challenging, and further strategies were required in order for the practice change to be sustained.[8] The nature of rural EDs is that they have lower numbers of presentations. These, however, are often at the same level of acuity as their metropolitan counterparts. Staff within these departments are required to have a broad range of skills[38] and to work within an equipment and resource-poor environment. Innovation is important in rural EDs in order to meet the needs of their communities effectively despite the challenges faced. An example of this is the use of telehealth to connect patients to specialist care in a timely manner.[19]

It is argued that the adoption of change and innovation is more likely when key individuals in social networks, often referred to as champions, actively support the change.[39] Champions are employees of an organisation that can emerge formally or informally to promote innovation and change by building support, overcoming resistance and ensuring changes are implemented.[40] They typically go beyond their job requirements to influence others in their social network to adopt innovation or change.[40] Champions have been identified to play an important role in supporting and sustaining the uptake of innovation, quality improvement and practice change in a range of health care settings.[41–43] Our 2021 scoping review identified 11 studies reporting champions as a component of IPV project implementation.[40] This evidence showed that when clinical champions were used as part of a strategy to increase IPV screening rates within a clinical setting, screening rates improved, and improved practice was sustained over time.[44,45] The review identified provision of expert advice and personal and emotional support for clinicians, and acting as a mentor were roles that champions played.[40] In the studies reviewed, champions were identified as drivers of the implementation process, breaking down barriers and reinforcing clinician willingness to screen. The review also found that a less common role for champions was that of advocacy and strategic co-ordination. The factors that were noted to influence the success of champions were perceived management support, protected time and work redesign to provide clarity about the champion role.[40]

The review highlighted, however, that there is very little evidence about how champions influence the implementation and ongoing maintenance of IPV programs or address implementation barriers.[40] For the 13-year period of the review, only four studies specifically collected data on champions,[46–49] with most providing only scant detail. Whilst four studies utilised champions within the intervention, these champions were largely overlooked in the design and findings.[50–53] In the main, the champion construct was not consistently operationalised, and very few studies collected data from champions. The contribution of champions, if examined, was at a cursory level. For example, the MOVE study implemented an IPV nurse screening model and utilised a mentor at each of the four intervention sites. The authors report little detail on the operationalisation or evaluation of these mentors, apart from noting they had limited success, with 48% of nurses in the study preferring to discuss clinical issues with a co-worker rather than the mentor. Similarly, a recent qualitative study exploring IPV implementation strategies in women's primary health care services reported facilities with discrete IPV champions were early adopters of IPV screening programs, although the champion role and nature of their influence were not examined in any detail.[54] To date, there has been no substantive investigation of the role, influence or experience of IPV champions or the ways in which they work to support IPV practice change.[40,55]

In this study, we investigated the role and experience of champions who supported the implementation of routine screening of women aged >16 years in two Level 5 rural hospital EDs in New South Wales (NSW). At the time of this study, mandatory routine screening for IPV took place in Child and Family Health Nursing, Mental Health, Drug and Alcohol and Antenatal services in NSW. We aimed to understand whether champions could motivate and support nurses to drive change and overcome barriers to enquiring about IPV in the ED.

2 | METHOD

2.1 | Design

A qualitative study involving semi-structured interviews with 23 individuals who identified as champions of IPV practice change in the ED. In 2018, an IPV routine screening process was introduced at Site 1, and in 2019, the same process was introduced at Site 2. By 2019, a team of champions was well-established at both sites. The longitudinal design was chosen to enable the rich experience of IPV practice change champions to be captured over the 2-year period as the IPV screening process was implemented and embedded into routine practice at each site.

2.2 | Setting

The study took place in the EDs of two rural tertiary hospitals in NSW, Australia. In NSW, hospital clinical services are assigned a role delineation levels 1–6. The higher the level of role delineation is associated with higher level of resourcing, service scope, service requirements and workforce of the clinical services within a given hospital. Both hospitals in this study generally operate at a Level 5 role delineation, and both have an emergency medicine level of 5. In addition to their local population, they provide support for lower level networked services. Routine IPV screening of all women over the age of 16 was undertaken by nursing staff as part of routine clinical practice. This was supported by frontline nurse champions whose role was to support implementation and sustainability of IPV screening within the EDs. Frontline nurse champions were provided with a 4-h training session, and frontline nurses received a 45-min training session. A project officer champion provided support to champions and regular progress reports regarding the screening process. A short assessment tool called HITS was used to assess IPV.[56] It consisted of four Likert scale questions, which made up the acronym HITS and asked women how often their partner had hurt, insulted, threatened or screamed/sworn at them

TABLE 1 Demographic characteristics of the 23 participants.

	Site 1		Site 2		District executive		
	Per cent	*N*	Per cent	*N*	Per cent	*N*	Total *N*
Sex							
Female	70%	7	82%	9	100%	2	18
Male	30%	3	18%	2			5
Employment category							
Frontline nurse	50%	5	64%	7			12
Senior clinical nurse	10%	1	18%	2			3
Service manager	30%	3	18%	2			5
Service director	10%	1					1
Executive lead					100%	2	2
Total number of participants	10		11		2		23

in the previous year. A score of 10 or higher indicated the presence of IPV. If IPV was identified, women were offered referral to hospital social work for psychosocial services and a local non-government specialist IPV service for crisis care and follow-up case management.

2.3 | Sample

Twenty-three participants were identified through purposive sampling. All participants were individuals who identified as champions of IPV practice change. They had become champions through manager nomination, submitting a formal expression of interest or naturally emerging and self-identifying into the role. Participants included frontline nursing, service-level manager, executive and director-level champions. Table 1 summarises the demographic characteristics of participants. The majority of champions (78%, $n = 18$) were female, and just over half of them (52%, $n = 12$) were frontline nurses. There were five service-level managers, three senior nursing staff, and three executive and director-level managers. The role of frontline nursing champions was to ensure IPV screening practice was implemented and sustained in the EDs, and executive, director and service-level manager champions ensured that barriers were removed, and nursing champions were supported and empowered to carry out their role. Frontline nursing champions received IPV training and training regarding the IPV screening process.

2.4 | Data collection

Each participant was interviewed once, with nine interviews conducted in 2017 and a further 14 undertaken in 2019. Interviews were conducted face-to-face in a private area at the workplace of the participants. Each interview lasted between one and one and a half hours and was digitally audio-recorded (with permission) and transcribed verbatim.

An interview guide was developed to provide structure to the interviews. The guide included questions regarding individuals' role in the implementation of IPV screening, their motivation, capabilities and ways of working in championing IPV screening, and the barriers and facilitators individuals experienced. In addition, prompts such as 'Can you tell me a little bit more about that?' or 'Can you explain that to me?' were used to encourage participants to reflect deeply on their experience. Verbatim transcripts of interviews were provided to participants for review and approval for use during data analysis.

2.5 | Data analysis

Following a detailed reading of the narratives, salient sections of transcripts were identified and coded by the primary author. Through a process of constant comparison,[57] new topics were given a new code, and the same code was used when the topics were similar. Similar or comparable codes were grouped to form clusters, and the clusters were further refined to form themes. This thematic analysis was in line with the criteria set out by Lincoln and Guba.[58,59] Microsoft Office was used to undertake the manual coding. Colour highlight and text comments were used to tag text, which was then sorted into tables.[60]

2.6 | Ethics considerations

Ethics approvals were granted by the university and LHD Human Research Ethics Committees. Participants received written information about the study and gave written consent before participating.

3 | RESULTS

3.1 | Initiation of IPV screening

Prior to the systematic establishment of champions, the baseline IPV screening rate at Site 1 was 1% of eligible women (all women aged 16 years and above). Screening for IPV was not conducted at Site 2 prior to the establishment of champions.

Figure 1 below outlines rates of screening initiation for eligible women and each site in 2019 to 2020. At Site 1, in the first quarter of 2019, screening was initiated for 19% of eligible women. By the final quarter of 2020, the rate had risen to 57%, reaching a monthly peak of 70% in May. At Site 2, in the first quarter of 2019, screening was initiated for 16% of eligible women. By the final quarter of 2020, the rate had risen to 25%, reaching a monthly peak of 33% in May.*

3.2 | The motivation to champion

The motivation to champion IPV practice change was a process of forming an identity as a champion, being driven by a desire to make a difference to a significant social justice

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*The highest number of attempts to screen were achieved during May 2020 at both sites. This was during the first round of COVID-19 restrictions. During this time, patients were only seen alone.

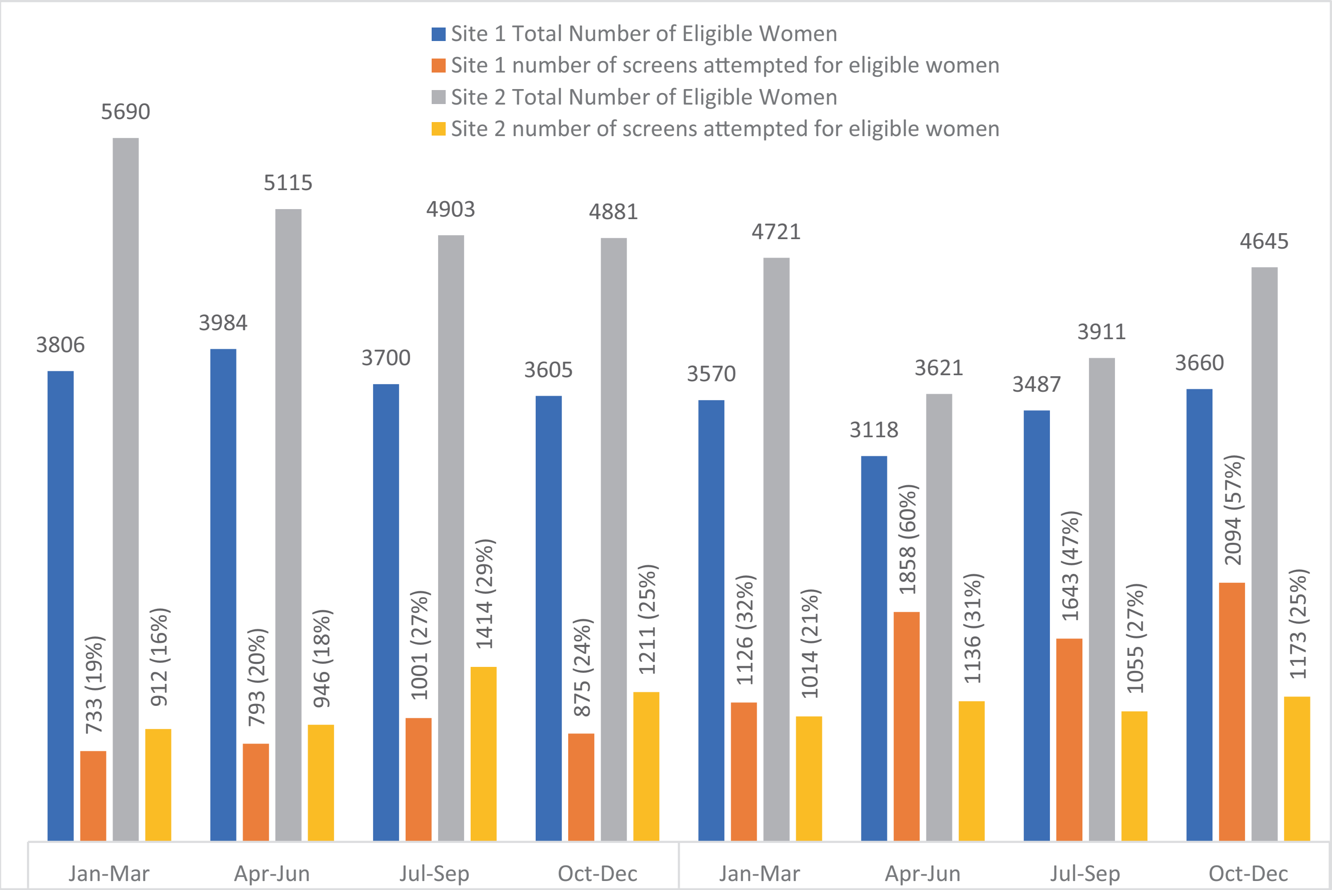

FIGURE 1 Quarterly number of IPV screens initiated for eligible women presenting to Site 1 and Site 2 emergency departments in 2019 and 2020.

issue, and providing quality and community-relevant care. These themes are reported below. Participant quotes used throughout these themes have been coded. Quotes are referenced to the type of champion who the quote is from and each champion has been given a number to provide anonymity.

3.2.1 | Forming an identity as a champion

Identifying as a champion was central to champion motivation. Most described how they transitioned from initially seeing themselves as merely implementing a project to eventually assuming a fuller champion identity. Those who had been appointed or nominated by others to the champion role detailed how their understanding of, and commitment to, championing the IPV screening practice change advanced over time. This process of identity formation involved conversations and relationships with colleagues, management and the project lead, which shaped participants' and others' understanding of expectations, roles, behaviours and the importance of IPV screening.

In order to effectively champion awareness about IPV and the need for practice change, participants identified how they sought to become and be seen by others as knowledgeable about IPV. Speaking of this process, one recalled the need to *'learn the process of how the IPV screening should be done...... I had to expand my knowledge and then pass that on to the staff members' (Participant [P]6, Nurse Champion).*

Another recalled how she first realised the limitations of her own knowledge and then detailed how she went about increasing her own knowledge and understanding, building her personal capability in order to become a credible resource for others:

> I went and met the girls next door at the Women's Health Centre .... and asked them, "What do you offer?" 'Cause I never knew'. I rang the IPV hotline and said to them, "I want to know what you offer because I'm a nurse in ED", and if I'm going to tell someone to ring your line, I need to know what you can offer. You know, just stuff like that so that you can then tell other staff.
>
> (P22, Nurse Champion)

In describing the personal shift in identity formation as a champion, participants also spoke of a shift in their thinking about their roles and the importance of screening for IPV within the ED. One executive participant (as identified in Table 1) explained how she initially thought of herself as an executive sponsor of the project and how, over time, her thinking shifted to seeing herself as an executive champion. Over time, she had bought into the project and took ownership of it rather than just seeing herself as leading and supporting someone else's project. She explained that her motivation and commitment increased because she could see how the change in practice had enhanced the services that the LHD was providing:

> I was the champion before, so it was a case of you know, go to the meetings – and yes in name – but I'm probably now a real champion, not just an executive sponsor, if that makes sense? .... That's probably the difference....... I think it's because I understand, as a champion you can see ...... how it has changed the outcome for the women but it's also empowered the staff... I think I'm now more of a passionate champion. I'm more invested in the process.... you light up a bit when you're a champion, more than you do if just an executive sponsor.
>
> (P18, Executive Champion)

Participants spoke of their unfolding personal recognition of the impact and importance of the IPV screening practice they were implementing. ED nursing staff were used to responding to IPV cases that were visually obvious or when IPV cases were brought in by police. These cases usually involved physical abuse that could be visually seen. The screening process, however, enabled identification of cases, which would not have otherwise been identified, and participants were surprised when this happened. This, in itself, strengthened their belief in the importance of screening and in bringing about the practice change. One participant recalled, 'I had a woman who was being financially abused. So that was a real wow! If I hadn't asked those questions, *I would never have realised' (P5, Nurse Champion)*.

Unexpectantly, unveiling IPV through the screening process strengthened the commitment of participants to identify as champions and serve in this way, ensuring that the practice of routine screening was implemented by staff.

> Once I identified somebody [through the screening] that I wasn't expecting to identify. That has made me more diligent in actually performing the tools and making sure they're actually done.
>
> (P11, Nurse Champion)

> What motivates me is when I identify women that are at risk that wouldn't have disclosed that they are experiencing IPV but because I have asked them the questions they disclose it to me. That's what motivates me.
>
> (P6, Nurse Champion)

Other participants reported that their ongoing motivation grew as they experienced positive outcomes from the screening process and through feedback from women about the importance of inquiring about IPV:

> The patients thanking me. And you know like I told you this one woman I did it for and she said, "No, no, you know what darling, I wish you had of done this ten years ago. My daughter would, my sister would still be alive." I said, Really? And then she told me the whole story and like we were both crying and her sister got murdered by the partner, ex-partner she had left.
>
> (P6, Nurse Champion)

3.2.2 | Making a difference to a significant social justice issue

As individuals identified more strongly with their champion role, visibly profiling the broader societal impact of IPV and social justice became part of their knowledge sharing role. Having a strong champion identity supported staff to recognise the interconnected societal systems that they were influencing. Champions recognised the impact they could have on society at large. They started to see themselves as having no boundaries in their ability to influence change beyond the hospital walls. Almost all participants expressed their primary motivation to influence the broader context of IPV. This was expressed as a desire to *'know that what we are doing can make a difference' (P22, Nurse Champion)* and of *'being a part of something bigger'* (P3, Nurse Champion). Becoming a champion to the change process in each ED allowed individuals to connect to these aspirations.

For some, the realisation that the ED nurse might be the one person who could be there for their daughters brought home the importance of enquiring about IPV:

> I've got two daughters, and I would want them to have the opportunity if they found

> themselves in a situation like this and not able to talk to me or their mother about it, that someone was looking out for them … And it may just be an interaction with a nurse in an ED.
>
> (P19, Nurse Champion)

Nurse participants were motivated to have a wider social influence and a ripple effect out into the broader community through screening for IPV in the ED. This was described in terms of:

> The more we make it public, the more we talk about it, the more we do, I think as ED nurses we can make a difference.
>
> (P22, Nurse Champion)

> It's not just about people that we're seeing and the people that we're screening. We're encouraging those women to then go home and talk about it with other people … Taking the taboo away from the topic … where it [IPV] becomes everybody's business.
>
> (P9, Nurse Champion)

At the time that the change in practice to undertake IPV screening of all women presenting to ED was rolled out, there was a lot of media attention on intimate partner and family violence, with Rosie Batty being announced Australian of the year. IPV was *'much more spoken about in the media with a lot more information and funding and different projects around IPV' (P7, Nurse Champion)*. Participants highlighted this as a motivator for champions and staff alike. Participants acknowledged that screening in the ED was a contribution that they could make to *'changing attitudes'* about IPV and a *'start to make the change' (P1, Nurse Champion)*. For many, making a difference was positioned as being part of a broader social change in attitudes about IPV:

> I'm aware that it's [IPV] been a major contributor to some elements of social decline. This is a part of the picture that drives me to be interested in this.
>
> (P15, Manager Champion)

> I've always had fairly strong social justice views … I'm looking at ways to positively live my life and impact on people and society. I'm doing something worthwhile and beneficial.
>
> (P19, Nurse Champion)

The issue of IPV and gender equity was a strong motivator. Speaking with some emotion, they spoke of their concern about women's vulnerability:

> Gender equality is very important to me. I don't think anyone's gender should affect the way they're treated.
>
> (P1, Nurse Champion)

> To see change. To have a safe, hopefully safe environment for my two daughters and my three sons.
>
> (P2, Nurse Champion)

3.2.3 | Providing quality and community-relevant care

The third theme presents the unique perspective of service-level manager champions. When asked about what motivated them to champion IPV practice change, the provision of quality and community-relevant care was uppermost in the minds of the service-level managers. As manager champions, they provided a system and change perspective, focused on harmonising and reshaping the service itself so it met the needs of their community. These individuals were all responsible for ensuring the quality and the achievement of the departmental key performance indicators, and championing IPV practice change was seen to contribute to this quality improvement. As manager one shared, championing the project provided *'… not just a data gathering exercise, but a supportive intervention for people'*. Manager one went on to share, *'So that represents to me a much more significant and proactive kind of participation' (P15, Manager Champion)*.

Thus, for this manager, championing IPV screening was motivated by a desire to improve the overall service response. Screening was a tool for driving improved care quality. For another manager, quality was aligned with relevance:

> …. the service being relevant…. that's really important. I do believe that there is a huge need in our community, in this regional area … It feels meaningful. It feels very community focused, which is important for me.
>
> (P16, Manager Champion)

This participant also identified that knowing that the service was meeting a previously unmet need motivated her. She shared that in the past, she had looked after the waiting room area and had seen patients who had potentially experienced IPV or had disclosed experiencing IPV, waiting for prolonged periods of time and leaving without being seen. She reflected:

> it became quite obvious to me that there is a large number of presentations to our emergency department that are potentially experiencing IPV or have disclosed IPV, and that due to our prolonged wait times or our lack of available resources, those individuals did not wait for treatment.
>
> (P16, Manager Champion)

Participants recognised that ED care predominantly focused on physical ailments and that the practice change they were championing was supporting staff to see beyond the physical needs, to consider broader issues such as the home environment, and to provide holistic treatment. As participant 15 explained, *'The very, very best level of care, the highest quality and most effective care that we (ED) can deliver, has got to be holistic……. if you're sending someone home to an unsafe environment or if you can avoid them going back into that kind of environment, that's going to be better for their health in the long run, so it should be just as much of a priority as dealing with their temperature'* (P15, Manager Champion).

Part of the project that was implemented was to refer patients who were identified through the screening process as experiencing IPV to specialist IPV services. The project to introduce screening into the ED was not solely focused on data collection or identifying IPV. Instead, it aimed to meet the needs of patients. This aim served as a motivator for champions. One manager participant expressed this by saying,

> I think that because of the fact that it then started to go hand in glove with some intervention opportunities, not just a data gathering exercise but an intervention would be offered or a supportive intervention for people who we were screening. So that represents to me a much more significant and proactive kind of participation.
>
> (P15, Manager Champion)

4 | LIMITATIONS

This study was conducted in two rural sites in NSW, Australia. This may limit the generalisability of the results to broader ED settings in other countries and in metropolitan areas.

5 | DISCUSSION

This is the first study to report in any detail the experience and motivation of IPV practice change champions in any health care setting.[40] As shown in Table 1, the rates of screening increased with the introduction of champions in rural ED settings. It is strongly evident that the rural ED setting can be a site of innovation, with clinicians and managers coalesced around a shared commitment to making a difference in their communities. Evidence from an Australian trial confirms that the likelihood of IPV identification within EDs is improved through the implementation of routine IPV screening by frontline nurses. The study demonstrated the benefits and feasibility of such screening in EDs, with 26% of women who repeatedly visited the ED disclosing IPV.[28] However, the study also emphasised the importance of further addressing barriers to screening.

Effective screening is one step in the health system's response to addressing IPV. Screening identifies IPV and provides the opportunity for referral to specialist support services. Our findings support previous research, which has highlighted the need for a system wide approach for IPV to be addressed effectively.[61] A system-wide approach would include IPV training for health care providers pre- and postqualification; ongoing IPV mentoring and support; policies, procedures and adequate resourcing and infrastructure to enable prioritisation of IPV issues and capacity to address these; leadership and governance; and partnership with specialist service providers.[61] Our findings highlight the benefits of having IPV champions at various levels of a health service and how a system wide approach can be supported through their efforts.

Previous evidence has highlighted the deep connection, attachment and affinity that rural clinicians feel towards their community.[62] Building on this evidence, our study found that central to the motivation of rural, IPV champions were forming a self and shared identity as a champion. The champion identity formed and strengthened over time as understanding about IPV and commitment to the screening process grew. Champions at all levels of the organisation experienced a shift in thinking about their role, the importance of screening for IPV within the ED and the impact of their efforts on their patients and their community. Evidence shows that rural clinicians are motivated by a sense of responsibility and loyalty to their community and have an altruistic desire to make a difference and meet the needs of what they know to be an underserviced population.[63,64]

It is recognised that the introduction and sustaining of IPV screening within complex clinical settings such as EDs is difficult to achieve.[45] Factors that support the implementation of IPV screening have previously been identified[12,46,48] as have system level and personal barriers.[10,11] The particular difficulties faced when attempting to introduce IPV screening into EDs have also been highlighted.[8,28,40] Previous funded pilots have implemented IPV screening within EDs without systematic support systems such as champions in place and have reported achieving low screening rates in rural sites.[28] Building on previous research,[61,65] which highlighted the positive effects of champions, the current study provides an exemplar of how rural clinicians serving as champions can drive significant innovation and practice change in their workplace. The low rates of IPV screening prior to the systematic identification and accompaniment of champions at both sites (1% of eligible women at Site 1 and no routine screening at Site 2) and the significant change in screening rates once champions were in place (peak screening initiation rate for eligible women of 70% for Site 1 and 33% at Site 2), confirms that champions may have an impact on addressing the barriers to IPV screening within EDs. The fact that peak screening rates occurred at both sites during COVID-19 hospital restrictions, where patients were seen alone at triage and visitor numbers were also limited, suggests that, with modifications to the environment, high rates of initiation of screening can be achieved in ED settings. Adding to previous evidence,[12] this study found that positive patient feedback and outcomes resulting from the screening process are a factor in sustaining motivation. This suggests system change to support outcomes may be an important factor in maintaining high screening rates.

Previous studies have highlighted lack of protected time, manager support and organisational support as barriers to champion effectiveness.[46] Building on this evidence, our study found that lack of time and the challenges of workload could be overcome with manager support. This support helped champions overcome barriers as it further motivated them and strengthened their resolve to act. This study builds on previous research, which highlights the importance of the establishment of champions as part of whole-system approach to identification and response to IPV.[61] Our findings suggest that organisational and manager support and a systematic approach to the establishment and support of champions is a critical factor in achieving sustained practice change in challenging clinical environments. This is particularly so when trying to address complex and challenging issues such as IPV.

This study mobilised nursing staff who wanted to make a difference to the issue of IPV and who were interested in improving rural emergency care. Adding to previous evidence regarding the altruistic motivations of rural clinicians,[63,64] this study provides new evidence regarding the factors that motivate rural clinicians to serve as champions, going above and beyond their traditional role and scope of practice to positively contribute to society on a significant social justice issue. The study found that champions were motivated by the desire to improve the quality of care for their patients and to ensure that care was relevant to the needs of their rural community. This meant building a culture where ED staff looked beyond the physical care needs of their patients in order to provide holistic treatment. This evidence provides a foundation on which further investigation could take place to identify whether the implementation of IPV practice change champions would have the same effect in metropolitan EDs.

6 | CONCLUSION

Findings from this study highlight the important role that champions have in facilitating IPV screening within rural ED settings. Through expanding their scope of practice, they reported making a difference to individual rural women, as well as to the wider community in which they lived. This practice change is required for identification and responses to IPV within rural health care settings to be effective. However, this practice change is not easily achieved and sustained. Champions reported intrinsic motivational factors around identity, making a difference and developing a sense of societal contribution. Understanding what motivates champions to engage in IPV practice change empowers managers to not only identify champions but also motivate them to continue their effective practice.

AUTHOR CONTRIBUTIONS

Elham Saberi: Conceptualization; investigation; writing – original draft; methodology; writing – review and editing; formal analysis; project administration; data curation. **Marie Hutchinson:** Formal analysis; supervision; writing – review and editing; methodology. **John Hurley:** Methodology; writing – review and editing; formal analysis; supervision.

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CONFLICT OF INTEREST STATEMENT

No conflict of interest has been declared by the authors.

DATA AVAILABILITY STATEMENT

Research data are not shared.

ETHICS STATEMENT

North Coast NSW Human Research Ethics Committee (Approval Number: LNR158) and Southern Cross University Human Research Ethics Committee (Approval Number: ECN-17-122) provided ethics approval.

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