Summary of Recommendations

	RECOMMENDATION	*LEVEL OF EVIDENCE
Practice Recommendations	**1.0** Nurses implement routine universal screening for woman abuse in all health care settings.	IIb
	2.0 Routine universal screening be implemented for all females 12 years of age and older.	IV
	3.0 Nurses develop skills to foster an environment that facilitates disclosure. This necessitates that nurses know: ■ how to ask the question; and ■ how to respond.	IV
	4.0 Nurses develop screening strategies and initial responses that respond to the needs of all women taking into account differences based on race, ethnicity, class, religious/spiritual beliefs, age, ability or sexual orientation.	III
	5.0 Nurses use reflective practice to examine how their own beliefs, values, and experiences influence the practice of screening.	IIa
	6.0 Nurses know what to document when screening for and responding to abuse.	IV
	7.0 Nurses know their legal obligations when a disclosure of abuse is made.	IV
Education Recommendations	**8.0** Mandatory educational programs in the workplace be designed to: ■ increase nurses' knowledge and skills; and ■ foster awareness and sensitivity about woman abuse.	Ib
	9.0 All nursing curricula incorporate content on woman abuse in a systematic manner.	III
Organization & Policy Recommendations	**10.0** Health care organizations develop policies and procedures that support effective routine universal screening for and initial response to woman abuse.	IV
	11.0 Health care organizations work with the community at a systems level to improve collaboration and integration of services between sectors.	Ib
	12.0 Nursing best practice guidelines can be successfully implemented only where there are adequate planning, resources, organizational and administrative support, as well as appropriate facilitation. Organizations may wish to develop a plan for implementation that includes: ■ An assessment of organizational readiness and barriers to education. ■ Involvement of all members (whether in a direct or indirect supportive function) who will contribute to the implementation process. ■ Dedication of a qualified individual to provide the support needed for the education and implementation process. ■ Ongoing opportunities for discussion and education to reinforce the importance of best practices. ■ Opportunities for reflection on personal and organizational experience in implementing guidelines. In this regard, RNAO (through a panel of nurses, researchers and administrators) has developed the *Toolkit: Implementation of Clinical Practice Guidelines* based on available evidence, theoretical perspectives and consensus. The Toolkit is recommended for guiding the implementation of the RNAO guideline *Woman Abuse: Screening, Identification and Initial Response.*	IV

* For interpretation of evidence see p. 10

Interpretation of Evidence

Levels of Evidence

The following framework depicts the levels of evidence that have been used to classify the research that has been used in the development of this guideline.

Ia	Evidence obtained from meta-analysis or systematic review of randomized controlled trials.
Ib	Evidence obtained from at least one randomized controlled trial.
IIa	Evidence obtained from at least one well-designed controlled study without randomization.
IIb	Evidence obtained from at least one other type of well-designed quasi-experimental study.
III	Evidence obtained from well-designed non-experimental descriptive studies, such as comparative studies, correlation studies and case studies.
IV	Evidence obtained from expert committee reports or opinions and/or clinical experiences of respected authorities.

The underlying assumption implicit in this schema is that the randomized controlled trial (RCT) is the 'gold standard' against which all other forms of evidence are evaluated and compared. While this assumption may have a great deal of utility in the biomedical sciences, its relevance to the health and human sciences is less clear. In nursing, where multiple ways of knowing are not only valued, but desired, a hierarchical chart that ascribes a lower place to qualitative research is problematic. More importantly, the chart does not reflect the nature of nursing knowledge, particularly as it exists in the area of violence against women. Understanding health and human experiences requires a knowledge base that extends beyond the establishment of cause and effect relationships, the collection of quantitative data, and the conduct of intervention studies. While all of these are valued, they do not represent the sum total of desired or existing nursing knowledge. Rather, consideration must be given to the nuances and particularities of everyday lived realities. Such knowledge embraces the broader social and political contexts that shape health experiences in general, and those related to violence in particular. To date, much of the knowledge related to violence against women has been generated utilizing various research methodologies, including qualitative (stories) and quantitative (numbers) methods. Consistent with the panel's value of the importance of both stories and numbers, multiple sources of knowledge have been used to inform the development of this best practice guideline. The *Levels of Evidence* framework has been used within the context of these remarks.