



Recording and sharing information about domestic violence/abuse in the health service

Research report and good practice recommendations for healthcare

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Why is recording and sharing DVA information important in health?

- Reduces survivor/child need to retell story
- Makes holistic care more likely
- Build up a picture of risk and harm
- Protection and safety
- Prevent domestic homicides?

Aim of the work

Use multiple methods to inform national recommendations on good practice around recording DVA in healthcare settings and sharing information within the health service and between health and other agencies/services

Research that informed the recommendations

- Domestic Homicide Reviews, Serious Case Reviews, Safeguarding Adults Reviews
- National guidance
- Professional groups' (e.g. Royal Colleges) guidance
- Academic research about health professionals' views & practices
- Policies for shared and local care records
- Discussions with key stakeholders

Sharing with whom?

- Clinicians- same team, different team, different trust
- Safeguarding
- Non NHS substance / mental health
- Adult social services
- Children's services
- School
- Police
- MARAC
- MATAC/MAPPA
- Family/carers (at risk)



Under what circumstances might information be recorded and shared?

Sharing with
explicit consent

Sharing with
presumed consent

Sharing without
consent

Sharing with
explicitly refused
consent

Domestic homicide reviews

- Eight 'case analyses' of DHRs – most victims had children, many under 10 years old
 - Poor practices around recording and sharing were common: healthcare often implicated
 - Basic info e.g., presence of children, often missing from medical records
 - Parents and children's GP records not linked
 - Lack of coordinated care and sharing between NHS departments
 - ...and same between adult and child focused services
 - Inadequate referrals to, or follow ups after referrals to, MARAC / SG
 - Most DHRs cite inadequate sharing about perpetrators in health

What does national guidance say about recording DVA information?



Useful but also inconsistent, patchy, unrealistic



“notes on DVA should be kept separately from the main patient record.”

“ensure that the record can only be accessed by those directly involved in the victim’s care.”



“document whether the injury and patient’s explanation is consistent.”

“When I needed the notes for the injunction, everything was ‘alleged this’ and ‘alleged that’. But I felt having the midwife’s report did help actually ... I was able to give the judge other instances of things that had happened. He was satisfied at the initial hearing that this event had taken place” (survivor mother, Bacchus et al., 2010)

“you would always write alleged assault because that’s what it is, it’s alleged assault by the patient. And a lot of the times it’s blatantly obvious that it is actual assault.” (ED doctor, Olive 2017)

“ Some GPs and mental health professionals just didn’t believe me. Words like ‘alleged domestic abuse’ ... are actually on my medical records now. The whole experience traumatised me more than I already was. ” (survivor, Pathfinder 2020b)

“The solicitors said there just wasn’t enough evidence on my health records. Nothing to suggest my ex was to blame for my injuries. I was so let down. I thought my doctor had written down everything I said” (survivor, DH 2017)

What does national guidance say about sharing DVA information?



What does national guidance say about sharing DVA information?

- If children are at risk of **significant harm** as a result of DVA, protection should normally take precedence over confidentiality of victim/survivor's information.
- But guidelines suggest more restricted sharing of **perpetrators' information** (risk of harm vs risk of significant harm).

What academic research has found

- Victims/survivors anxious about disclosing in healthcare if child could go on child protection register.
- Health professionals said child protection concerns were a reason for breaching confidentiality & were occasions in which they felt **relatively more comfortable in breaching** (Reed, 2020).
- But...“A&E were really bad, they didn't take on at all what I was saying. Even, when you're pregnant even the hospital they didn't do anything. My GP listened and, yeah, she was kind and caring, and the psychiatrist listened - but when you're physically presented with someone bleeding and bitten and bruised and beaten and babies, the NHS were supposed to contact other services, they did nothing, So, yes, A&E and the hospital terrible, terrible ” (survivor, Reed 2020).



What academic research has found

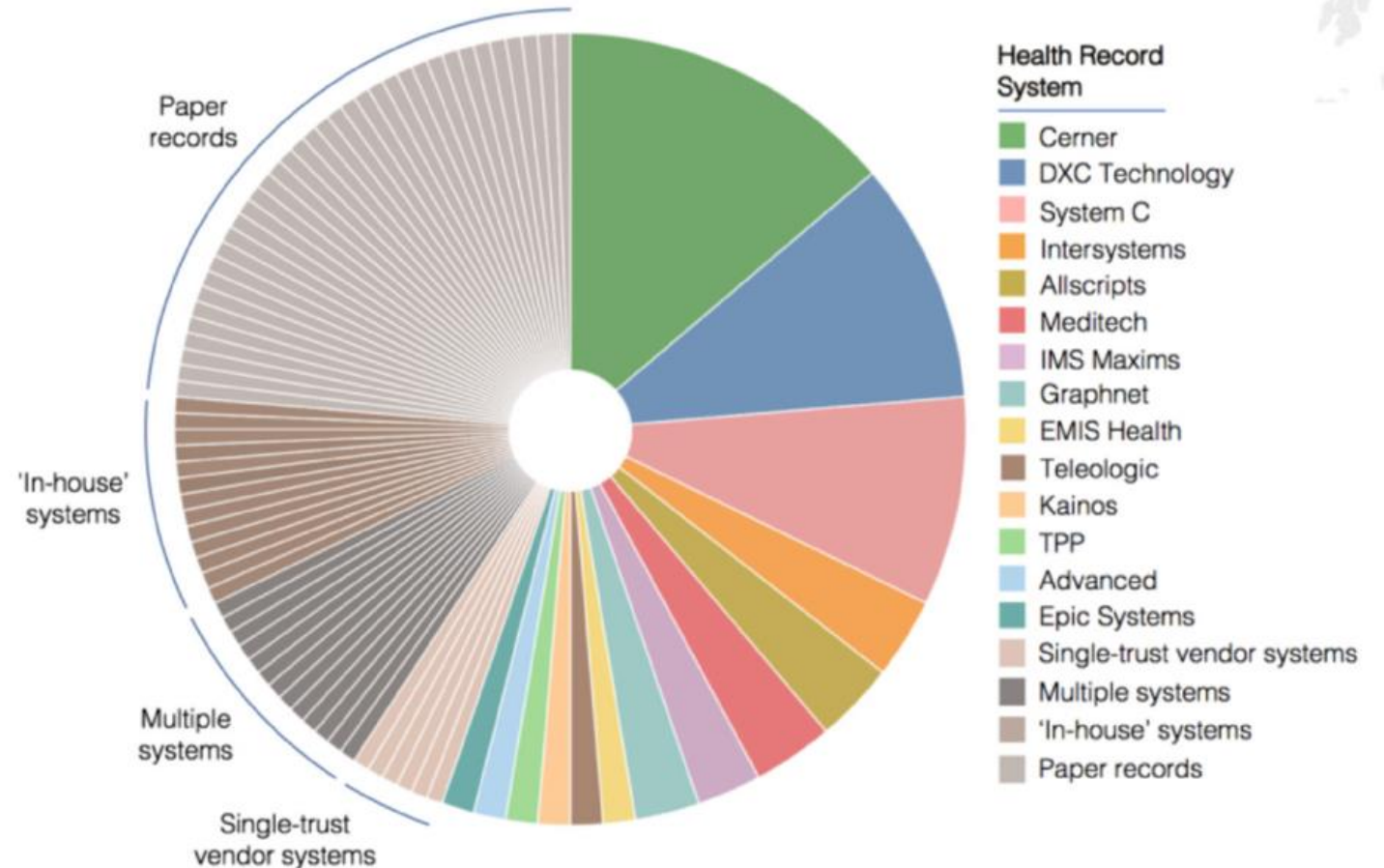
- ED: disclosures were lost along patient's journey through ED. Notes lacked detail even about presence of children.
- Maternity: no recent research but systems-based approaches that make documentation easier are emerging.
- GP: DVA and child maltreatment under-recorded. GPs unsure how to document DVA from 3rd party reports e.g., from children's services and how to talk to children identified as at risk from reports.

“the reality is that we probably don't ask the children enough and don't hear their voice enough” (GP, Pitt 2020)

No universal IT system - a barrier to recording and sharing

- St George's Trust uses Cerner
- Epsom and St Helier uses DXC
- But share 69435 patients

20 pairs of trusts that commonly share patients, only 2 pairs use same system!



Alerts and flags

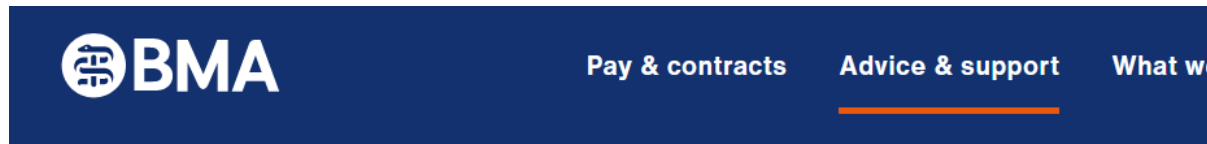
Some trusts use flags

- across hospital vs ED
- for MARAC cases vs all
- routinely unflag vs indefinite flag.

Some trusts don't flag because no one's been assigned the responsibility to flag/unflag.

IDVAs sometimes have no access/no editing access to records so can't flag.

Unclear policies on how DVA information will be managed in digitised records

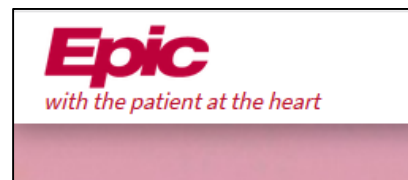


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Local Health and Care Record

Sharing electronic patient records for direct patient care



Sharing from ED to community safety partnerships and violence reduction units

- Information sharing helps to deploy a multi-agency response, such as additional police presence in certain areas.
- Some EDs use DVA information to refer victims/survivors to services, MARAC, and safeguarding (Quigg et al., 2016) or to establish new posts e.g. nurse liaisons.
- Cardiff model - postcode data can be used to target residential districts with high rates of DVA for increased health visitor coverage (BMA, 2014).

Forming the recommendations



**A selection of the
recommendations**

Key principles

- DVA damages health and wellbeing
- Recording DVA information is as important as recording any other information in clinical records
- DVA information should be recorded and shared in a way that protects patients and makes information visible and accessible to HCPs to provide holistic care
- Information should be recorded and shared in a way that is safe (i.e., does not increase risk to victims/survivors and children)
- Each recommendation leaves room for professional judgement. Some recommendations will require a case-by-case assessment to ensure safety of implementation
- It is not always clear who is experiencing and who is perpetrating DVA. Our recommendations address safety, care needs, and safeguarding issues for all parties

Recommendations for all HCPs on recording information

HCPs should routinely document :

- i. Patient has disclosed DVA
 - ii. Who else is present during the consultation
 - iii. Victim and perpetrators' relationship
 - iv. Who else is in the household, noting any children and their ages and any 'adults at risk'
 - v. Pragmatic assessment of immediate risk and ongoing risk
 - vi. Action the HCP takes or plans to take
- If a patient discloses that they are perpetrating DVA, HCPs should routinely record the same items
- If a child discloses there is DVA in their household (e.g., between their parents), HCPs should routinely record the same items but acknowledge that relying on a younger child's perspective may make it more difficult to accurately assess risk
- Healthcare professionals should document if the patient discloses that they are experiencing *and* perpetrating DVA



Recommendations for all HCPs on recording information

Whenever possible, HCPs should record brief details about the patient's DVA disclosure in their medical record.

→ HCPs should use phrases like 'patient describes', or 'patient discloses', followed by their own words. Verbatim quotes should be indicated with quotation marks

Recommendations for all HCPs on recording information

If EMR/EPR software allows, HCPs should consider using (i) **role-based or tailored access**, whereby only groups of HCPs who have likely had DVA training have access to DVA information, and/or (ii) **a DVA indicator** that only trained HCPs would recognise.

Healthcare professionals should use **alerts/flags** in the EMR/EPR for all patients who disclose experiencing or perpetrating DVA, if safe to do so.

→ Since the effects of DVA can be long-lasting, HCPs **should not routinely unflag** patients or set flags to expire, but may set reminders to review alerts/flags manually.

Recommendations for all HCPs on sharing information

If a patient discloses to a HCP that they are experiencing or perpetrating DVA, the HCP should inform the patient's GP. Healthcare professionals who see a patient during pregnancy or perinatally should consider also informing the patient's midwife and health visitor.

If a patient says they do not want the HCP to share DVA information with the GP/another HCP, the HCP should try to clarify the patient's concerns, keeping in mind that victims/survivors may be withholding consent due to fear or coercion. Healthcare professionals should address any concerns and emphasise the benefits of sharing, such as to their care and risk.

Recommendations for all HCPs on sharing information

In some cases, it will be appropriate for the HCP to share the DVA information without consent (e.g., because sharing is needed for the patient's benefit, to prevent harm, or to raise a formal safeguarding concern). The HCP should document their decision and its reasoning in the patient's medical record. The HCP should inform the patient of their decision and its reasoning unless doing so would increase the risk of harm.

Any correspondence about DVA between professionals within the health service - and from health to other agencies/services - should make extremely clear:

- The set of DVA information on previous slide
- Actions the sending party has taken/will take and by when
- Actions they expect the recipient to take in response to DVA and by when
- Whether the patient knows they have shared the DVA information.

Recommendations for all HCPs on sharing information

Healthcare professionals in hospital trusts should organise **regular in-house meetings** for staff who see or manage patients affected by DVA ... Discussions should include cases that do not reach the threshold for MARAC referral and those that have been heard at MARAC to ensure all post-MARAC actions are undertaken.

Sharing between healthcare services and other agencies

In many cases where a patient discloses that they are experiencing DVA, it will be appropriate for HCPs to refer them to DVA services, who can then make an onward referral to MARAC. However, **HCPs can refer victims/survivors to MARAC themselves** and can do so without the victim/survivor's consent, even if only the victim/survivor is at risk. Healthcare professionals should **tell patients** that they are referring them to MARAC unless this would itself increase the risk of harm.

Agencies such as social care, DVA services, and MARACs should send the referring HCP, referring care team, or designated DVA lead in the general practice/trust an email **to confirm receipt** of any referrals.

Regarding 'adults at risk' (vulnerable adults; Care Act 2014), if there is a suspicion of DVA, or if the adult discloses that they are experiencing or perpetrating DVA, **HCPs should work closely with adult social care** to manage risk and to plan care for the adult in question.

Sharing between healthcare services and other agencies

All healthcare settings should have posts that include a **role in the response to DVA**. This includes administrative posts and, in trusts, DVA leads or IDVAs. These post-holders should support HCPs with recording and sharing DVA information.

→ In both settings, the role could include **contacting agencies/services to which a HCP has made a referral** to confirm that they have received and actioned it, and to track the outcome of the referral.

**Download the executive
summary with full set of
recommendations from
www.tinyurl.com/rasdiH**

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