

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

**Executive summary: research report and good  
practice recommendations**

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August 2020

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## Acknowledgements

Thank you to the Pathfinder consortium for commissioning and funding this work, and for supporting with its dissemination. Thank you to all stakeholders, expert advisory group members, and survivors who informed the research and recommendations.

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# Aims of the project

The aims of this project were to use multiple methods to form national recommendations, finalised via a consensus process with expert advisors, on good practice around recording domestic violence/abuse in different healthcare settings and sharing information within the health service and between health and other agencies/services. The aim of the recommendations is to benefit and reduce harm to victims/survivors and children.

# Context and setting

We focus our research and recommendations primarily on recording in and sharing between:

- Primary care (namely general practitioners [GPs] and practice nurses)
- Emergency medicine
- Maternity (particularly antenatal care)
- Mental health services
- Health visiting, sexual health, and paediatrics (but to a lesser extent) and safeguarding staff working across these areas.

We also explore and make recommendations on sharing information with police, social care, multi-agency risk assessment conferences (MARACs), and domestic violence/abuse services.

The recommendations will support healthcare professionals in recording and sharing information about domestic violence/abuse **for direct patient care** in cases where there is:

- **Disclosure:** the recommendations will primarily support healthcare professionals to record and share information about disclosures of domestic violence/abuse. It will secondarily support healthcare professionals to record and share information if after **enquiry** no disclosure is made
- **Consent or no consent:** the recommendations will support healthcare professionals to share information when the patient has given consent for such sharing, when the patient has not given explicit consent, and when the patient has withheld consent
- **Cases that fall within and outside of formal safeguarding processes**

# **Target audience for our recommendations**

Our recommendations target healthcare professionals, including senior staff with additional responsibilities (e.g., chief medical information officers, clinical leads), in general practice, acute trusts, community trusts, and mental health trusts. The recommendations are also relevant to allied healthcare professionals, administrators, managers, commissioners, researchers, and policymakers. We focus on England, but the research findings and recommendations are relevant to other United Kingdom (UK) nations.

## **Methods**

A meeting with an expert advisory group informed the priority areas for this research, as outlined in the Context and Setting section. We used multiple methods and drew on numerous evidence sources to conduct and inform the research. These methods included a policy analysis of guidance documents from national (e.g., Department of Health) and professional (e.g., Royal Colleges) bodies; analyses of domestic homicide reviews, serious case reviews, and safeguarding adults reviews; a review of recent academic literature from the UK; discussions with key stakeholders; and an outline of current initiatives that may facilitate recording and sharing. We drew on this work to produce draft recommendations, targeted at specific groups of professionals, for improved practice. We finalised the recommendations through a multi-stage consensus process involving an adapted version of the nominal group technique (World Health Organization, 2014) with a group of expert advisors and a group of survivors.

## **Outline of the executive summary**

In this executive summary, we outline the key findings from our research, focusing on areas where good practice has not been implemented or where good practice is not determined. We first present research about recording information, and then present research about sharing information. Finally, we present the recommendations for improving practice produced through the consensus process.

# **Recording information: summary of research and key issues**

## **National guidance on recording domestic violence/abuse information**

The British Medical Association (BMA, 2014) and Department of Health (2017) both advise what healthcare professionals should document about domestic violence/abuse. Both ask healthcare professionals to document 12 items about domestic violence/abuse but do not indicate which of these should be prioritised if time is limited, for example. Neither recommend that healthcare professionals use diagnostic codes. The Department of Health recommends that healthcare professionals use the victim/survivor's own words to record the detail of injuries, but also recommends they 'document whether the injury and patient's explanation is consistent', which may undermine the former recommendation. Moreover, the guidelines are ambiguous about which healthcare professionals should have access to domestic violence/abuse information.

## **Professional groups' guidance on recording domestic violence/abuse information**

Six professional groups' guidelines/resources mention recording domestic violence/abuse information. They include the Royal College of General Practitioners guidance (2020, forthcoming; 2017) on recording domestic violence/abuse information; the Department of Health (2013) guidance for health visitors and school nurses; the National Institute for Health and Care Excellence (NICE, 2010) guidelines for pregnancy and complex factors; the Royal College of Emergency Medicine (2015) guideline; the 'Linking Abuse and Recovery through Advocacy for Victims and Perpetrators' or LARA-VP (Yapp et al., 2018) resource for mental health professionals; and the British Association for Sexual Health and HIV (BASHH; 2016) sexual violence group guidance. Some of these guidelines are specific to domestic violence/abuse; some are general. Aside from the LARA-VP resource, no guideline indicates what items should be prioritised for documentation. Except for the Royal College of General Practitioners guidance, none of these resources indicate where to document domestic violence/abuse. Only the Royal College of General Practitioners and LARA-VP has guidance on whether and how to document information about perpetrators, as well as what information to document.

## **Issues from domestic homicide reviews on GPs and recording information**

All analyses of domestic homicide reviews (e.g., Sharp-Jeffs and Kelly, 2016; Neville and Sanders-McDonagh, 2015) cited GPs' poor record keeping as a factor in failing to prevent harm or death. But, in most reviews, GPs did not know about domestic violence/abuse. Rather, their poor record keeping led to missed opportunities to *enquire* about abuse: GPs had not coded risk factors for abuse accurately and had not linked records between intimate partners. Another issue was that information about perpetrators and victims/survivors' risk factors was lost in transfers between GP practices. Awareness of domestic violence/abuse in health did not always lead to domestic violence/abuse service provision. Interestingly, analyses of serious case reviews and safeguarding adults reviews held no relevant issues or guidance around recording information in healthcare.

## **Research on views and practices around recording domestic violence/abuse information in general practice**

Domestic violence/abuse is under-recorded in general practice (Chandan et al., 2020). General practice staff use diverse and inconsistent methods for documenting abuse. Some are uncertain about documenting domestic violence/abuse at all because they do not see it as a health issue or are unsure about taking disclosures at face value (Szilassy et al., 2015). General practitioners often become aware that their patients are experiencing or perpetrating domestic violence/abuse through third-party reports (e.g., from MARACs) and are especially unsure about how to record this information (Pitt et al., 2020). The Royal College of General Practitioners guidance may resolve these uncertainties, but knowledge and implementation of guidance often varies.

## **Issues from domestic homicide reviews on emergency departments and recording information**

The number of different healthcare professionals a patient sees on their journey through emergency departments makes recording and sharing information more difficult but more important. One domestic homicide review showed that a patient attended an emergency department after a partner assault. Ambulance staff did not hand over information about his domestic violence/abuse disclosure to triage staff: the patient requested that nothing be done about his disclosure, and because he had 'capacity', ambulance staff decided not to share the information. Triage staff failed to document a second disclosure of domestic violence/abuse within the same care episode. The patient absconded before the consulting clinician saw him, and the emergency department sent a discharge letter to the wrong general practice. Since

the review, all ambulance arrivals are formally handed over to hospital staff in the trust: all patient notes are handed to a nurse, and when there are sensitive circumstances, handover is face to face. Moreover, any information on assault or domestic violence/abuse is noted separately and addressed at a later assessment (Croom, 2014).

## **Research on views and practices around recording domestic violence/abuse information in the emergency department**

Olive (2017) analysed emergency department records where the patient had disclosed partner assault. This research showed that information about assault, and therefore about domestic violence/abuse, can be lost along the patient's journey through the emergency department. As with earlier research (Boyle et al., 2009), clinical notes often lacked detail. Often consulting clinicians documented the term 'assault' in clinical narratives/case notes and GP discharge letters without mention of the perpetrator's identity. Information was often missing, such as referrals to children's services, frequency of violence, and whether the presenting assault was the first episode. Proformas may improve practice if coupled with training (Basu and Ratcliffe, 2014; Ritchie et al., 2013), but our expert advisory group emphasised that any such form would need to be concise.

## **Alerts and flags in the emergency department (and hospital trusts more widely)**

In some trusts (or in emergency departments) healthcare professionals can use alerts or flags on patients' records to indicate risk information. Some alerts/flags are visible across the hospital and sometimes just in the emergency department. Sometimes only patients heard at MARACs are flagged. Some trusts could use alerts/flags but do not use them because no one has been assigned the responsibility to flag and unflag patients. Independent domestic violence advisors/advocates (IDVAs) in some trusts have access to electronic patient records and can flag/unflag patients, but some have no access at all to these records, or no editing access. No research or audit has explored flagging practices and their potential to benefit victims/survivors and children.

## **Emergency department frequent attender/high-impact user/high-intensity user teams**

Some emergency departments have teams to identify patients who attend frequently and have an additional risk or vulnerability. Domestic violence/abuse cases may be identified through such teams. A dedicated team will place alerts on a patient's record and create support plans for these patients in coordination with other agencies/services, GPs, and other healthcare professionals. Again, no research or audit has determined how this practice may benefit victims/survivors and children.

## **Research on views and practices around recording domestic violence/abuse information in maternity**

There has been no academic research from UK maternity settings about domestic violence/abuse since 2013. This research showed that midwives do not always enquire about domestic violence/abuse, even though NICE recommends (2014) routine enquiry in this setting. Systems-based approaches are emerging that mandate midwives to answer questions about domestic violence/abuse in the electronic patient record. However, these will not overcome the common barriers to routine enquiry: the presence of a partner; language barriers and lack of interpreters; and lack of privacy and time (Baird et al., 2013). Work is underway to replace maternity handheld notes—common unless the pregnancy is complicated—with an interoperable digital maternity record. Research is needed to explore how domestic violence/abuse can safely be documented in these records. Another example of novel practice in maternity is online self-referral for antenatal care, which circumvents the GP. Discussions with stakeholders highlighted that in one trust using self-referral, women have been frank in disclosing personal details, and the quality of information was better than expected. However, an evaluation of safety is needed, since perpetrators sometimes monitor online activity.

## **Medical records and court**

The potential for records to be used in court affects how healthcare professionals document domestic violence/abuse (Reed, 2020), such as taking care not to document ‘opinion’ or ‘extraneous details’ for incidents that may go to court. Several research studies have shown that healthcare professionals use the term ‘alleged’ and other terms to imply doubt (e.g., ‘patient claims’; e.g., Olive, 2017), which, according to victims/survivors, has led to records being seen as less reliable evidence of domestic violence/abuse in court (e.g., Bacchus et al., 2010). Victims/survivors who request their records report feeling disbelieved, which compounds a sense of trauma.

## **Patient online access to general practice electronic medical records**

Patients can access their partial general practice electronic medical record online and will be able to request access to their full general practice record from 2020/21. Easier access to medical records has intensified fears about coercion and breaches in confidentiality in relation to domestic violence/abuse—namely perpetrators getting access to the victim/survivor’s record or seeing abuse documented in children’s records (Pitt et al., 2020; Drinkwater, 2017; Feder, 2015). General practitioner guidance asks GPs/practice nurses to use redaction and the ‘hide from online access’ function for domestic violence/abuse information, but this relies on the practice having a reliable redaction policy and on GPs/practice nurses knowing how to use this function and remembering to use it. The function does not apply to

previously coded information, so unless GPs/practice nurses in earlier consultations used the function, domestic violence/abuse information may still show in the patient-facing record. Hiding information and redacting information retrospectively will likely be resource-intensive and prone to human error (Paul, 2019).

## **Access to general practice electronic medical records and hospital electronic patient records by different healthcare professionals**

The NHS Long Term Plan (2019) reaffirms the commitment to a fully digitised NHS by 2023/24. Systems are increasingly enabling a wide range of healthcare professionals to access patients' general practice electronic medical records (via shared record systems) or hospital electronic patient records (e.g., through interoperability platforms). A lack of joined-up care in the NHS is a perpetual problem. Domestic homicide review analyses frequently cite the lack of linkage between different health services as a factor in failing to prevent homicide or harm (e.g., Sharp-Jeffs and Kelly, 2016). However, making information accessible to other healthcare professionals also poses a challenge. There is no nationwide policy on how sensitive information will be managed in digitised records. A healthcare professional who has not had training on how to broach domestic violence/abuse could use this information inappropriately, such as raising it in an insensitive way, talking about it in front of a third party, or not realising it is visible to a third party on their screen. Trained healthcare professionals may worry about recording information if other healthcare professionals can see it.

# **Sharing information: summary of research and key issues**

## **National guidance on sharing domestic violence/abuse information**

National guidelines give subtly different advice on when sharing without consent can happen. Generally, such sharing can happen in the 'public interest' or when there is risk of 'serious crime' or 'serious harm'. But these terms are broad and ambiguous. No guideline mentions coercive control and how it can influence the decision of a patient with capacity to withhold consent. Safeguarding-specific guidelines advise healthcare professionals to share information with carers, family, or friends unless there are good reasons not to do so: however, in some domestic violence/abuse cases, one of these parties may be a perpetrator. The guidelines also give subtly different advice on when sharing information for MARACs is acceptable. Medical defence bodies and medical councils can advise healthcare professionals on sharing, but sometimes give directly conflicting advice. Along with Caldicott guardians, advisors in these bodies and councils may have limited understanding and training around working with domestic violence/abuse victims/survivors and perpetrators.

## **Professional groups' guidance on sharing domestic violence/abuse information**

Eight professional groups have guidelines that variably cover sharing information: the Royal College of General Practitioners (with IRISi and SafeLives; 2014), the Royal College of Nurses (2017), the Department of Health (2013; for health visitors/school nurses), NICE (2010; for GPs, midwives, and other primary care staff seeing pregnant patients), the Royal College of Obstetricians and Gynaecologists (2016), the Royal College of Emergency Medicine (2015), BASHH (2016), and the LARA-VP (Yapp et al., 2018) resource. They variably cover sharing information in an emergency, sharing information with MARACs, sharing with domestic violence/abuse services, sharing with other healthcare professionals, and sharing with other agencies/services. All guidelines mention which other agencies/services healthcare professionals should consider sharing information with. Otherwise, guidance is patchy. Most notably, only two of eight guidelines (Royal College of Nursing, 2017; Department of Health, 2013) mention anything about sharing information with other healthcare professionals, and only the LARA-VP resource for mental health professionals (Yapp et al., 2018) mentions anything specific about perpetrators. No other royal college or professional group has domestic violence/abuse guidance.

## **Issues from domestic homicide reviews, serious case reviews, and safeguarding adults reviews on sharing information**

Domestic homicide reviews, serious case reviews, and safeguarding adults reviews have found that information sharing is poor between health and other agencies/services. Reviews highlighted that MARAC and safeguarding referrals were sometimes not made, but even when they were, there was insufficient information sharing post-MARAC. Similarly, when information was shared between health and other agencies/services, there was no corresponding assignment of actions. Analyses also highlighted the additional complexities around how much to involve carers in care planning for vulnerable adults—who, as the reviews illustrate, can be victims or perpetrators. Overall, cases of inadequate sharing involved general practice, emergency departments, mental health, maternity, and health visiting. Notably, across all analyses, most cases of inadequate sharing *within health* were about inadequate sharing about the perpetrator, not the victim.

## **Research on views and practices around sharing domestic violence/abuse information**

Very little research explicitly explores whether and how healthcare professionals share information about domestic violence/abuse within healthcare and with other agencies/services. Pitt et al. (2020) found that GPs are unsure what to do upon receiving MARAC and police reports about domestic violence/abuse: reports rarely make clear whether the sending party expects the GP to take any action and whether the patient knows the information has been shared. Another study on the health visitor response to domestic violence/abuse (McFeely, 2016) showed that health visitors have little interaction with other agencies aside from occasional joint visits to families with social workers. Discussions with stakeholders indicate that some sharing happens between GPs, health visitors, midwives, school nurses, and paediatricians. These discussions and the limited available research suggest that the reorganisation of primary and maternity care has impeded effective sharing and means contact is now via phone call or email, which can be unreliable. Good practice around sharing is better determined when there are children under 18, as healthcare professionals can then fall back on child safeguarding processes. Sharing in cases that fall outside of formal safeguarding appears to be on an ad-hoc basis.

## **Conclusions**

This work has highlighted several areas where more research is required. We present these before turning to a set of recommendations for improving practice.

# Audit and research recommendations

🔍 Research to explore commissioning incentives for recording and sharing information such as linking good practice to the Quality Premium scheme and/or the Quality and Outcomes Framework, and to make DVA recording mandatory in national datasets, such as the Maternity Services Dataset and Emergency Care Data Set.

🔍 Research with general practices to determine whether they implemented the RCGP 2017 guidelines for recording DVA information, and what issues they encountered, if any. This work could inform practices in general practice and potentially other areas, and future versions of GP guidance.

🔍 Research in maternity to identify the barriers to recording DVA in maternity, with an audit of the EPR systems maternity units are using, and these systems allow midwives to skip questions about DVA, as well as research to evaluate maternity staff's use of such systems. This work can inform practice around accurate recording.

🔍 Audit of all ED frequent attender/high-impact user/high-intensity user programmes to determine the level of DVA training staff have to support victims/survivors and children, and the percentage that work with DVA specialist services (including health-based IDVAs). This audit can highlight which teams need more DVA training and which teams need to set up partnerships with DVA services.

🔍 Audit of trusts to identify the percentage of hospitals that have IDVAs, the percentage of IDVAs who have access to information relevant to DVA in EPRs, and the processes IDVAs need to go through to gain access. The audit can inform a strategy to enable easier access to EPRs for IDVAs.

🔍 Audit and research with general practices and trusts that use alerts/flags to indicate DVA to identify whether only high-risk victims/survivors are flagged, whether *suspected* victims/survivors are flagged, whether perpetrators are flagged (and the safety implications therein), whether alerts/flags expire or prompt manual review, who adds and removes alerts/flags, to whom these alerts/flags are visible, whether information from alerts/flags in hospitals auto-populates GP discharge letters, and whether the information that alerts/flags contain transfers if the patient moves general practice or trust. This work can inform recommendations about the safe use of alerts/flags and highlight technical support needed to address challenges.

🔍 Research with mental health trusts to determine whether using an equivalent of the HARKS template may facilitate safe and effective recording of DVA.

🔍 Research with general practices and trusts to determine how HCPs are managing sensitive information in shared medical records and trust-wide EPRs, which are accessible to a wide range of HCPs. Research should explore victims/survivors' views about good practice and the information patients are given about hiding information in their EPR. This work could inform safe, feasible, and acceptable practices around recording information and highlight the technical support needed to address any challenges.

🔍 Research with general practices and trusts on HCPs' practices and victims/survivors' views around recording DVA in EMRs/EPRs that are accessible to patients online. This work could inform safe, feasible, and acceptable practices around recording information and highlight technical support needed.

🔍 Research with victims/survivors, perpetrators, and HCPs to explore what they see as appropriate sharing within the health service, including what information should be shared, how, and based on what types of consent. This research can inform additional recommendations for improving practice.

🔍 Research with nationwide MARAC chairs to determine numbers of MARACs with health representation, who these health representatives are, and numbers of MARACs that invite GPs. This research can facilitate mutual learning.

🔍 Research to devise appropriate DVA training for Caldicott leads and Caldicott guardians. This work will improve their ability to support HCPs with recording and sharing DVA information.

🔍 Research with victims/survivors and HCPs to explore recording and sharing DVA when the victim/survivor is migrant with no recourse to public funds to identify additional issues faced by, and inform ways to support, such victims/survivors.

🔍 Research to explore the feasibility of a system like CP-IS to make HCPs aware when a patient has been heard at a MARAC. This work will shed light on ways to improve information sharing between health and other agencies.

# Recommendations for improving practice

## 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 the safety, care needs, and safeguarding issues for all parties

Disclosures of DVA will infrequently be spontaneous or overt (e.g., people will not always use the terms 'abuse' or 'violence') and will rely on HCPs identifying and enquiring about DVA. Domestic violence/abuse may be current, but even if it is not (i.e., if it is 'historic'), the effects can be long-lasting. While the recommendations below are about recording and sharing, specific training around identifying and enquiring about DVA is crucial—particularly identifying coercive control, which can be difficult for professionals to identify. Good practice around recording and sharing rests on good practice around identifying and enquiring.

## 1. Overarching recommendations for healthcare organisations

- 1.1 Commissioners should fund ongoing DVA training, supervision, and support for HCPs. Training should:
- Cover safe and effective recording of DVA information as relevant to that organisation, including examples of how and where to record information
  - Include how to share information safely, and what consent is needed for sharing
  - Cover how to engage patients in decisions around recording and sharing

- Encompass technical elements, such as how to hide DVA information from others in electronic medical records (EMRs) and electronic patient records (EPRs) and how to use redaction for subject access requests confidentially

Computer monitor privacy screens should be made available to general practices where possible to support implementation of good practice around recording information.

- 1.2 Clinical directors/managers should ensure monitoring and evaluation of training to assess its effectiveness (e.g., evidence of HCPs' behaviour change regarding coding and sharing) and to identify where training needs revision.
- 1.3 Clinical directors, and managers should ensure DVA training is in place for administrators and DVA coordinators, DVA leads, and DVA advocates to enhance implementation of recommendations.

## **2. Overarching recommendations for all HCPs**

- 2.1 General practice staff should use these recommendations in conjunction with Royal College of General Practitioners guidance on recording domestic abuse in the electronic medical record, Mental health professionals should use them in conjunction with the [LARA-VP resource](#) on identifying and responding to DVA.
- 2.2 All recommendations should be read in conjunction with safeguarding guidelines around sharing information with other agencies/services.
- 2.3 Information about DVA should not be visible (e.g., on screen or on paper notes) to people who accompany the patient in consultations. Additionally, DVA information from third parties should not be visible to the patient unless the patient knows that the HCP in question has the information.
- 2.4 Information about DVA should be hidden from online access (in EMRs and hospital EPRs that patients can access online). Information about DVA may also require redaction from records if a subject access request is made.
- 2.5 In cases where there is any imminent risk of harm or danger, HCPs can share information without consent (e.g., with police).

### **3. Recommendations for all HCPs on recording information**

3.1 If a patient discloses that they are experiencing DVA, HCPs should routinely document the following items:

- 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' (vulnerable adults; as per the Care Act, 2014)
  - v. Pragmatic assessment of immediate risk and ongoing risk
  - vi. Action the HCP takes or plans to take (action may include referrals, signposting, safety-planning advice given, and information shared. If the HCP takes no action, they should document 'no action' plus the reason for taking no action)
- 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

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

- HCPs should use phrases like 'patient says', 'patient describes', or 'patient discloses', followed by their own words. Verbatim quotes should be indicated with quotation marks
- When documenting what a patient discloses, HCPs should avoid phrases like 'patient claims' or 'patient alleges', which imply doubt
- Where possible, HCPs should tell patients what they are documenting and explain that they will use quotation marks to signify their words

3.3 Healthcare professionals should record DVA in the patient's medical record such that it is visible to other HCPs in the care team, so the team can respond appropriately and be aware of current/ongoing risk should they see the patient in future.

- 3.4 If a third party (including multi-agency risk assessment conference [MARAC], police, and other HCPs) sends information about DVA to a general practitioner (GP) or another HCP, and there is any doubt over whether the patient knows that the third party has shared the information, the information should not be visible (on screen or in paper notes) to the patient in subsequent consultations. The information should be recorded in the third-party section of the medical record and be redacted/hidden from records that patients can access.
- The GP may consider arranging a discussion with the patient upon receiving this third-party information if it presents an opportunity to increase safety and support and reduce harm
- 3.5 If a HCP suspects and enquires about DVA victimhood or perpetration, but the patient does not disclose, the HCP should document in the medical record (e.g., in free text that they have asked about DVA). Healthcare professionals in departments that use Systematised Nomenclature of Medicine (SNOMED) codes should also use the 'family is cause for concern' code, rather than a specific DVA code. (NB: practice staff trained on Identification & Referral to Improve Safety [IRIS] can use the humiliation, afraid, rape and kick, and safety [HARKS] template to record enquiry even if no disclosure is made.) If the HCP thinks re-enquiry would be beneficial, they can consider adding a note for any HCPs who subsequently see the patient, or for themselves in future, to re-enquire. Such patients should be considered for discussion in general practice clinical meetings.
- 3.6 If a patient who has previously disclosed experiencing DVA requests online access to their EMR, GPs/practice nurses should consider refusing access if there is a risk that the perpetrator could gain access to the record. If a patient who already has online access discloses experiencing DVA, GPs/practice nurses should consider withdrawing their access. Practice staff should have a policy on safely responding to any resulting complaints from patients, but where possible should make decisions about online access with patients. Since online access is available to under-18s in some practices, the same recommendation applies to any children whose parents/guardians have disclosed experiencing or perpetrating DVA.
- 3.7 If printing out parts of the patient's EMR (e.g., to refer them to another department or for their admission for acute care), GPs/practice nurses should redact information about DVA unless the information is relevant for their direct care or if the patient has said they want that information shared. Redaction may need to be done manually.

- 3.8 If making e-referrals that are auto-populated with information from the EMR, HCPs should delete information about DVA—again, unless the information is relevant for their direct care or if the patient has said they want that information shared.
- 3.9 General practice ‘shared records systems’ make information in EMRs directly accessible to other organisations. Trust-wide EPRs make information available to all HCPs within that hospital’s trust. General practices and trusts using these systems should decide whether to record DVA information such that it is visible to other HCPs. Healthcare professionals should balance the risk of other HCPs not having access to the DVA information against the risk of HCPs who do not have DVA training having access to it. Healthcare professionals should consider involving patients in such decisions.
- 3.10 If EMR/EPR software allows, HCPs should consider using (i) role-based/tailored access, whereby only groups of HCPs who are likely to have had DVA training have access to DVA information, and/or (ii) a DVA indicator that only trained HCPs would recognise.
- 3.11 Healthcare professionals should use alerts/flags in the EMR/EPR for all patients who disclose experiencing or perpetrating DVA, if safe to do so. To determine safety, HCPs should consider whether alerts/flags would make DVA disclosure visible to people who accompany the patient to future consultations. HCPs should also consider whether the alert/flag can be hidden or redacted if the patient has, or requests, access to their medical record.
- Trusts should use or develop alerts/flags specific to DVA, rather than generic flags. 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
- 3.12 Information about DVA should be recorded in a part of the medical record that will transfer to a new general practice or trust if the patient moves. Alerts/flags are sometimes localised to a general practice or trust’s software system and will therefore not transfer.

## **Specific recommendations for emergency departments**

- 3.13 If a patient who has experienced or perpetrated DVA is referred to mental health liaison within the emergency department (ED) but absconds before being seen, mental health liaison should record as much information as they can in their records, including the minimum set of DVA information mentioned above.
- 3.14 In EDs where time is limited and patients may only present once, staff may consider using a short standardised form (either electronic or paper to be uploaded) to capture the minimum set of DVA information mentioned above. The form could also provide guidance for HCPs around the relevant actions to consider (such as onward referrals) and contact details for support.

## **Specific recommendations for maternity**

- 3.15 Maternity units should devise markers to record DVA enquiry and disclosure discreetly, consistently, and safely in handheld notes such that only other midwives in the team will recognise the markers.

## **4 Recommendations for all HCPs on sharing information**

### **4.1 Sharing within the health service**

- 4.1.1 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.
- 4.1.2 If a patient discloses to a GP/practice nurse that they are experiencing or perpetrating DVA, the GP/practice nurse should consider whether to share this information with HCPs in other clinical departments involved in the patient's direct care.
- 4.1.3 Sharing DVA information can be based on implied, rather than explicit, consent if the sharing will inform direct care. However, it is usually good practice for HCPs who receive a disclosure of DVA to seek the patient's explicit consent before sharing this information with other HCPs.
- 4.1.4 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.
- 4.1.5 If a patient still withholds consent for sharing DVA information with the GP/another HCP, the HCP should consider arranging a follow-up appointment to revisit concerns. In the ED, this follow-up appointment can be with an independent domestic violence advisor/advocate (IDVA) or DVA lead.
- 4.1.6 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). Healthcare professionals who decide to share information without the patient's consent should follow guidance from their own profession (e.g., the General Medical Council). 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.

- 4.1.7 Any correspondence about DVA between professionals within the health service and between agencies/services should make extremely clear:
- The set of DVA information above
  - Actions the sending party has taken in response to DVA, or actions they 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.
- 4.1.8 Healthcare professionals in hospital trusts should organise regular in-house meetings for staff who see or manage patients affected by DVA (e.g., from ED, maternity, paediatrics, mental health, and safeguarding). Meetings should enable information sharing about patients affected by DVA to build a picture of risk, harm, and safety. Discussions should include cases that do not reach the threshold for MARAC referral. Discussions should also include cases that have been heard at MARAC to ensure all post-MARAC actions are undertaken. If feasible, chairs of the in-house meeting should communicate relevant outcomes of the meetings with patients' GPs.
- 4.1.9 Healthcare professionals should seek advice from DVA leads, safeguarding leads, or Caldicott leads and guardians if they are unsure about recording and sharing information in DVA cases.

## **4.2 Sharing between healthcare services and other agencies**

- 4.2.1 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.
- 4.2.2 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.
- 4.2.3 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.

- 4.2.4 Healthcare professionals should apply caution if sharing information with the carer for any adult at risk if there is any suspicion that they are perpetrating DVA.

## **5 Recommendations for DVA-trained administrators and DVA leads/coordinators**

5.1 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.

- Roles for general practice-based DVA administrators/leads should include processing incoming DVA notifications (e.g., from MARAC); ensuring any such correspondence is recorded in EMRs as third-party information; ensuring DVA information is redacted where appropriate; scheduling reviews of EMRs that contain DVA information to ensure the 'hide from online access' function is applied and to help ascertain risk of others gaining access to the record; and highlighting key information about DVA from incoming letters to the appropriate GP or practice safeguarding lead
- Roles for hospital DVA leads/coordinators should include reviewing DVA information contained in trust-wide EPRs; reviewing alerts/flags; supporting HCPs with writing to the GP to inform them of DVA disclosures; organising in-house meetings to discuss DVA cases
- 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

5.2 In the ED, if a patient discloses that they are experiencing DVA (or there is indication of DVA (e.g., assault by [ex] partner or family member), an advocate, IDVA, or DVA nurse specialist should facilitate the recording and sharing of information between ambulance and ED staff and staff within the ED. Responsibilities should also include communicating with the consultant in charge and clinical team (e.g., radiographers) about any risk, facilitating and recording handover to the next responsible person at 'shift end', assigning follow-up care for when the patient leaves the ED, and ensuring continuing named responsibility for action completion and confirmation of action completion.

## **6 Recommendations for other professionals**

- 6.1 All Caldicott leads and Caldicott guardians should have training on DVA so that they can effectively support decisions around recording and sharing DVA information.
- 6.2 All Caldicott leads and Caldicott guardians should ensure that their organisation is effectively engaged with the MARAC process and should help to set up referral pathways to DVA services.
- 6.3 National bodies such as the General Medical Council, the Nursing and Midwifery Council, and the British Medical Association should appoint trained DVA champions who can help with more consistent advice on recording and sharing information.

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