

Quality Improvement Project Improving Care for Victims of Domestic Violence at Bakewell Medical Centre

Introduction

Domestic violence is an important but often hidden issue that is thought to affect 1 in 4 women and 1 in 6 men in their lifetime. Despite this statistic it would seem only a small proportion come to the notice of the GP practice. Domestic violence can have a significant detrimental affect on the whole family including children within the same household, even if they are not directly the subjects of domestic abuse. Collaboration between relevant healthcare professionals including social workers, health visitors, GPs and practice nurses is fundamental to helping those who are brought to our attention.

Currently at Bakewell Practice any concerns regarding domestic violence amongst patients is discussed at the weekly multi – disciplinary team meeting (MDT). In addition, the Health Visitor (HV) would attend this meeting on a monthly basis to share any child related concerns, of which she keeps a list. There is however, no formal documentation or collated list of possible adults or children over the age of 5 at risk. Neither is there a process to link or follow up patients or family members of children of concern, raised by the HV. If a parent is flagged as a potential victim of domestic violence (DV), it is reliant on the practitioner reading the MDT entry on the notes of the child – which is unlikely. This risks missing important concerns being followed up opportunistically in a busy surgery and consequently the welfare and safety of patients is under threat.

This project is also relevant, as I have taken on the role of Domestic Violence lead for the practice.

Aim

This qualitative QIP aims to identify and improve the holistic patient care that victims of domestic violence receive at Bakewell Medical Centre. It aims to improve the safety, the effectiveness, and the efficiency of their care.

Objective

To develop a robust method of identifying patients whom are at risk of domestic violence in the practice.

To develop a tool that will collate the identified patients and that will allow easier communication within the MDT members at the practice. This will ultimately aim to improve the care and support these patients require.

Methodology

Initially, I needed to brainstorm all the ways we currently hear about patients at risk of DV. The place to start was to run a read code search of EMIS web. I used the following read code's: Vulnerable adult, vulnerable child, at risk of domestic violence, notification received of alleged domestic violence in the household.

This highlighted a couple of patients staying at a local women's refuge, so I added this address to the read code search. This search can be modified each time I come across a new read code used. I aim to run the search each month to see if it highlights any new patients that have been coded in the surgery in that time.

I then asked the Health Visitor for all her monthly patient lists that contain the information on at risk children, which she has brought to the MDT meetings for the last 6 months. This enabled me to cross reference these lists within the EMIS search I had ran. Obviously not all children on her list are directly at risk of DV, and I excluded these. However, many are at risk. This was where it was also highlighted that we have no information on who the children's parents are, who are the ones potentially more at risk of DV as opposed to the children.

I have designed a table which collates these two systems and brings all these patients together (appendix 1). I have ensured that it incorporates and highlights a column that requires the parents details of the children discussed.

I will take the list to the monthly MDT that the HV attends and will add any new patients she highlights. In addition, I will also ensure that any new patient older than 5 years old, ie that the HV wouldn't know about, and is raised at any weekly MDT meeting is highlighted to me via a patient task.

This project is a continuum of PDSA cycles – each month or even week, the list will be tweaked, new search codes will be identified, and new members of staff will be involved at different points.

Discussion Points

One of the key issues this project has highlighted is the lack of efficiency in the current way of doing things in being able to identify patients at risk of DV. This is evident in the variation of read codes used. There seem to be a huge number of different codes that ultimately are describing the same thing. In addition, there are a few read codes that do actually say the same text but have different actual read codes. This ideally needs standardising. This will take time. I have included a column on the table so that the read code used for a new patient is documented. If one not previously used, this can then be added to the read code search list for the monthly search. I also need to ask and send an e-mail to all clinical staff asking what read codes they are aware they use themselves already, in particular the two members of staff that are the current leads for adult and child safeguarding. This will hopefully improve the efficiency and effectiveness in finding and identifying the at risk patients.

As the PDSA cycles are repeated and developed, the need for communication within the MDT team will increase. I will need to communicate which codes appear to be the most used, and are in fact the most helpful and aim to standardise what we all use. I also will not be able to attend all the MDT clinical weekly meetings when my hours change and therefore need to communicate to the MDT team that the way to liaise with myself is via patient tasks. I also need to communicate this to all members of staff that if they have concerns a patient is at risk of DV, and it isn't necessarily appropriate to raise the patient at the MDT then the method of communication would again be via patient task to myself.

The other main key area of concern highlighted is that there is no system in place to identify and discuss any parents of children that are known to be in a family situation where DV is a current issue. Therefore these patients are a group of patients that are going under the radar of the clinical staff and are a very vulnerable group of patients. We have access to the information on whom the parents are but until its realised we don't actively seek to find out and document them, then nothing is done to highlight them. I have therefore included on the table designed a column for the parents details and what is known about them via any of the MDT members. Also, it asks you to log if they are known to the GP surgery. The patients on the list I have collated already needs to be discussed at the next MDT with the HV and have the parents details logged with retrospect.

Alongside this, I realised that when we log adult patients who are highlighted as being vulnerable or at risk of DV, we need to consciously ask if there are any other family members, which again I have included a column for.

Future

Now that I have formulated a method of identifying and a table to log patients at risk of DV, the crucial part is that as a practice we work out what we can do for these patients once they are highlighted. My proposal will be that there will be a flagging system in form of a note on the screen when you open the patients record, which will highlight they are on the list. This will have to be in code ' eg on zebra list' which all members of staff knows this means they are at risk of DV, but this isn't obvious the patient or anyone potentially sitting with them in a consultation. This would be to protect the patient at potential risk.

The main priority for the clinician seeing the highlighted patient would then be to sensitively enquire as to their health and domestic situation when an opportune moment came in the consult.

I am anticipating that as our awareness of these patients is heightened, the need for training on how to manage and confidently deal with this patient group will increase. I believe this will be a potential area I can develop within my new role at the practice as DV lead.

Other ways of developing this project as time goes on, will be to ask what other practices do to highlight and care for this vulnerable group of patients.

This again may be something I come across as I develop my DV role and attend training sessions.

I also need to look into other ways that we could potentially actively find out other patients that are at risk of DV. Examples include resources such as school nurses, or Multi Agency Risk Assessment Conferences (MARAC's) and potentially open up communication with police. This is a very sensitive area of patient care. They may not be disclosing information to the GP for a reason, however we need to ensure that we give patients the confidence that they can confide in us and by doing so we can help them move forwards.

By formulating this identification method of vulnerable DV patients and collating their information, this will standardise the system. This will enable me to communicate and teach this to other staff members making it a much more efficient, effective and safer system in situ.