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How can coding within an electronic patient record (EPR) be improved to provide better care for patients with a diagnosis of domestic abuse?

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Abstract

Background: The aim of this project was to investigate the efficacy of domestic abuse (DA) coding within the electronic patient record, EMIS, used in the general practice the researcher was based and make recommendations on how the process can be improved. There is a significant amount of literature available on the identification of domestic abuse, the recommended interventions and the possible consequences of experiencing domestic abuse. However, the literature on coding within EMIS, in relation to domestic abuse, is very limited, prompting the purpose of this project – to begin bridging this gap in the literature. Thus, the question this project aimed to answer was: How can coding within an electronic patient record be improved to provide better care to patients with a diagnosis of domestic abuse?

Methods: The researcher wanted to explore how the processes coding the witnessing and exposure to domestic abuse can be improved in general practice. However, the limited literature and lack of national standards prevented this from being conducted as a clinical audit. Therefore, it was conducted as a quality improvement project. Ethical approval for the project was obtained from the Medical School ethics committee. Data access was granted by following the National Data Opt-Out Guidance. This project utilised an inductive approach (observation-driven) and represented all of the collected data quantitatively, as frequencies and percentages.

Results: The findings from this project strongly indicated that there were definite improvements to be made to the coding processes within EMIS. Firstly, the process had been overcomplicated by a large quantity of available codes, most of which were not utilised across the sample. Secondly, there were many patients with no record entry of support/intervention after their disclosure of domestic abuse. This could either be because they didn't receive any, the clinician failed to record it or because external agencies, where primary disclosure occurred, did not inform the GP surgery. Finally, there were many children who were witnesses to episodes of domestic abuse, who were not coded as having a domestic abuse diagnosis. This is important because even when the abuse is not directly

affecting a child, they are still considered a victim and are therefore susceptible to a wide and long emerging range of consequences of domestic abuse. The researcher, therefore, recommends that they be coded and supported accordingly.

Conclusions: In conclusion, this project found that there were several improvements that could be made to the coding process, surrounding domestic abuse, to improve the care of these patients and enable better clinical outcomes. This project has added to the limited knowledge base of EPR coding, in relation to domestic abuse in general practice. Further longitudinal research is needed to examine if these recommendations were adopted and whether they would improve administrative and clinical outcomes.

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