CHILD PHYSICAL ABUSE CLINICAL PATHWAY

EXECUTIVE SUMMARY

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Primary Objective

Create a pathway for the workup and reporting of suspected physical child abuse cases in order to better protect this vulnerable patient population.

Recommendations

Medical Stability:

- Clinicians should first ensure suspected victims of physical abuse are medically stable.
    - Medical care takes precedence over Child Advocacy Team (CAT) workup.

Personnel Involvement:

- In ED:
    - Contact Social work (SW), law enforcement (LE), and Child Protective Services (CPS)
    - Utilize Assessing for and Reporting of Child Abuse/Neglect/Sexual Assault, ED-C20
- In CP/UC:
    - If patient medically stable, contact SW, LE, and CPS
        - If after hours, call on-call SW if after hours
        - In UC, Utilize the Child Abuse/Neglect, URG049 policy
        - At CP, utilize the Abuse, Assessment and Documentation, PC 01 policy
- Social work to follow the Child Abuse/Neglect, 617-007 Policy
- Social work may facilitate making contact with law enforcement and Child Protected Services, if indicated.
- For Children's Physicians: If social work is not in clinic, call his/her cell phone. If still unreachable, call the social worker on-call.

CLINICAL ASSESSMENT

Consider physical abuse:

- Infants
    - Unexplained Irritability in infants < 6 months
    - Brief resolved, unexplained event (BRUE)
    - Altered mental status
    - Respiratory distress
    - Unexplained vomiting
    - Any physical injury
- Children
    - All children < 5 years old presenting with injury, especially:
        - No history of injury
        - Unwitnessed injury
        - Injury inconsistent with history and/or child's developmental age

History and Physical:

- History of present illness
  - Detailed description of illness/injury from the time the child was last well.
  - Avoid copying previous history notes
  - Note inconsistencies and changing histories as well as delays in care
- Past medical history
  - Birth history
  - Prior hospitalizations/ED visits/injuries/wellness visits
  - Development (normal vs abnormal)
- Social history
  - All caregivers and others who live in the household
  - Domestic violence
  - Prior CPS/police contact
- Physical exam
  - Review vital signs
  - Neurologic exam
  - Thorough skin assessment including ears and frenula (Narang)
  - Assess injury if present
- Physical exam findings/injuries suggestive of abuse:
  - Bruising
    - TEN-4-FACESp [8, 9]
      - Torso Ears or Neck of any child under 4 years
      - ANY bruising in a child less than or equal to 4 months
      - Bruising on the frenula, angle of the jaw, cheek, eyelid or sclera
      - Patterned injuries
  - Multi-organ system trauma without sufficient history
  - Skeletal injuries [8, 9]
    - Rib fractures
    - Multiple fractures
    - Any fracture in non-ambulatory child
    - Metaphyseal fractures/common metaphyseal lesions
    - Scapular fractures
    - Vertebral fractures
    - Sternum fractures
    - Fractures of hands/feet
    - Fractures with different stages of healing
  - Head injuries
    - Subdural hematoma with or without skull fracture
    - Unexplained intracranial injury

SUMMARY OF IMAGING RECOMMENDATIONS

- Skeletal survey is indicated in the initial imaging evaluation of a child 24 months of age or younger. In older children (≥ 2 years), it is usually appropriate to target imaging to the area(s) of suspected injury.[7, 8, 9, 10, 11]

- Schedule repeat limited/focused skeletal survey in Child Advocacy Team (CAT) clinic at two weeks for children ≤ 24 months with high clinical suspicion for abuse and equivocal/negative initial screen.[8]

- Abdominopelvic injuries
  - Contrast-enhanced CT recommended in acute evaluation
    - Non-contrast CT is not adequately sensitive in detection of intrathoracic or intra-abdominal trauma.[8]
  - Skeletal survey and contrast-enhanced CT of chest/abdomen/pelvis are indicated if there are signs or symptoms of intrathoracic or intra-abdominal visceral injury
    - Pain
    - Distention
    - Bruising
    - Hypoactive/absent bowel sounds
    - Abnormal liver transaminases and/or pancreatic enzymes in occult abdominal trauma
- Head injuries
  - **Refer to CNS Imaging Guidance in Evaluation of Suspected Abuse**

Bleeding Disorders

- If a child has bruising/bleeding concerning for abuse, a thorough medical history should be obtained. Lack of history does not rule out a disorder.[4]
- If a child has bruising concerning for abuse, assessment for lab testing should focus on[4]:
  - Specific history of bruising
  - Location and pattering of bruising
  - Mobility and developmental status of child
- If laboratory testing is warranted, refer to the AAP recommendations for evaluation for bleeding disorders in suspected child abuse.[23]
  - Factor IX testing is not performed with initial screening labs at CHMC due to the rarity of factor IX deficiency; expectation that screening PTT would be prolonged in severe hemophilia; and test cost and turnaround time.
- If a mobile child has bruising, the possibility of abuse should be assessed using the locations and patterns of the bruising.[4]
  - Less suspicious: Forehead/chin/nose, elbows, lower arms, hips, shins, ankles.
  - More suspicious location: Cheeks, angle of the jaw, ears, neck, upper arms, torso, hands, genitalia, buttocks
  - More suspicious patterns: slap or hand marks, object marks, bite marks, bruises in clusters, multiple bruises of uniform shape, large cumulative size of bruising, petechial bruising

DISPOSITION

Emergency Department Discharge

- Patients who are medically stable for discharge **and** have a plan for safe discharge in place may be discharged after follow-up instructions are discussed with child's caregiver(s).

- A written agreement developed between SW and the family which clearly describes the safety services for families to use to develop protective capacities. Protective capacities are caregiver strengths which help buffer and support families. Following the plan helps mitigate and eliminate threats to the child.[5]

Admission

- Patients who are not medically stable for discharge-admit to Trauma service for management of symptoms of injury or care of injury.
- Patients who are medically stable for discharge but do not have a plan for safe discharge in place should either be admitted to Pediatric Surgery team or to Hospitalist service after consultation with the Trauma team.

Inpatient Management

- Children admitted with abuse should follow the Emergency Department order sets specific to each type of injury (i.e., head injury, bruising, or fracture).
- When evaluation is complete, social work should be contacted for assess child placement and discharge. (Van Pelt)
- Consult Child Advocacy Team (CAT).

Inpatient Discharge

- Patients who are finished with medical workup, medically stable for discharge, and have a safety plan in place may be discharged after follow-up instructions are discussed with child's caregiver(s).[5]

DOCUMENTATION

Additional documentation for suspected abuse cases:

- Who is providing history
- Attribute the statement to the source (i.e., "Mrs. Smith stated Johnny told her…")
- What happened, when it happened, who was involved
- Use quotation marks to document exact words when child or caregiver directly discloses information

Review of Systems and Physical Exam

- Describe, draw, and/or photograph any injuries-prefer photographs in EPIC of injuries

Impression

- Provide summary statement that includes patient's gender, age, and reason for evaluation findings
- Offer appropriate interpretation of findings in context of the history, such as:

- 4-month-old boy who presented with seizure. Noted to have facial bruising on examination. CT scan with acute SDH with skull fracture. Skeletal survey with rib fractures. Multiplicity and severity of injuries extremely concerning for inflicted trauma. Report filed with DHS and police.
- 18-month-old girl who presented for evaluation due to refusal to walk after a fall from standing. Right femur fracture. Injury is consistent with developmental ability and history and is consistent with accidental injury.

SOCIAL WORK ASSESSMENT

- Any employee who has concerns regarding patient abuse or neglect issues is to contact the Social Work Department. After hours and on weekends, these concerns are reported to the on-call social worker (available via Voalte). CAT is available for consults on inpatients, outpatients, and Emergency Department patients. Social Work will assist with coordinating concerns with CAT. (PolicyStat ID 10813955 – Child Abuse/Neglect Policy)
  - The Social Work assessment for suspected child abuse/neglect function is to identify concerns for abuse or neglect which is considered "the most critical step in any child protection response".[6]
- Social Work will complete an assessment for suspected child abuse/neglect, which includes gathering the following information:
  - Type of concern
    - Physical Abuse – Bruises
    - Physical Abuse – Skull Fracture(s)
    - Physical Abuse – Other Fracture(s)
    - Physical Abuse – Burns
    - Physical Abuse – Bites
    - Physical Abuse – Nonspecific
    - AHT – Abusive Head Trauma
  - History of the concern provided, and any variances provided to other hospital staff
  - When and where the concern occurred.
  - Who was present during the incident of concern and are there any suspected perpetrators or additional victims
    - If the perpetrator is identified, when is the next time they would have access to the victim(s).
  - Family demographics.
  - History for the patient and the caregiver(s):
    - Child Protective Services involvement (Past or current)
    - Law Enforcement involvement (Past or current)
    - History of physical or sexual abuse
    - History of neglect
    - History of emotional abuse
    - History of Domestic violence
    - History of witnessing Domestic violence
    - History of chemical dependency or substance abuse
    - History of mental health concerns

        - Suicidal thoughts
        - Homicidal thoughts
        - Accessibility to medications
        - Accessibility to weapons
- During the assessment, Social Work will be making clinical observations of the following information:
    - How willing or reluctant the historian is while providing information
    - The historian's mood/affect during the assessment
    - The historian's quality and rate of speech
    - Behavioral observations of historian
    - The patient's mood/affect during the assessment (if age appropriate)
    - The patient's quality and rate of speech (if age appropriate)
    - Behavioral observations of patient
    - Interactions between child and parent/guardian/caregiver and concerns for bonding or attentiveness
    - Caregiver insight to injuries/illness/concerns (Noting any denial of concern, no history, blame to the child or others or justification of maltreatment).
        - Social Workers utilize the National Association of Social Workers (NASW) Code of Ethics, which consists of ethical principles and standards, to inform their professional practice. Two principles of note when discussing child abuse or neglect are that Social Workers respect the inherent dignity and worth of the person and Social Workers recognize the central importance of human relationships.[17]
        - While completing their assessment, Social Work will treat the patient and family with respect regardless of the family member's role in the concerns. Social Work will also be mindful of the positive relationships for the patient and family (i.e., extended family, friends, professionals, etc.) because they are considered protective factors[11] and can be part of the plan for safe discharge if it is deemed necessary. Creating a plan for safe discharge can help prevent further abuse or neglect by putting stable supports in place for the patient[1] and this can be accomplished through Social Work coordinating with the medical team, CPS, and Law Enforcement.
- Social Work will then discuss the information with the medical team and assist in making any CPS or Law Enforcement reports if it is deemed necessary. Social Work will be the main point of contact for the responding CPS and Law Enforcement staff to assist in coordinating a plan for safe discharge.
    - Social Work can assist in identifying supports through talking with the patient and family, but CPS must complete their own assessment to determine the patient's safety and risk for future abuse or neglect, which includes placement and Law Enforcement coordination if needed.[18]

ADDITIONAL NOTES

- Families and caregiver(s) of suspected abuse should not be treated any differently than others!
- Clinicians should consider having the senior resident or staff be the primary provider for these patients.
- An on-call social worker or Child Advocacy Team (CAT) provider may contacted via Voalte for questions related to the patient disposition or treatment
- If a clinician is uncertain about how to evaluate an injury or if they suspect a fracture was caused by child abuse, he/she should consult the Child Advocacy Team (CAT) to assist in the evaluation, particularly if the child is non-ambulatory or younger than 12 months.

Rationale

- Safety: a thorough medical workup coupled with appropriate reporting prevents children from returning to harmful environments
- Quality: reducing unnecessary variation or diagnostic testing and procedures improves quality of care
- Cost: variations in treatments can lead to potential delays in care and increased length of stay
- Engagement: the evaluation and treatment require a multi-disciplinary team
- Patient/Family Satisfaction: appropriate assessments and treatments ensure that patients are not reported unnecessarily

Metrics

- Maintain ≥ 85% skeletal survey utilization in children < 1 year who present with fractures by January 2024. (Process Metric)
- Reduce time from admission to date of ophthalmology consult (when applicable) to <24 hours by January 2024. (Outcome Metric)
- Monitor skeletal survey completed <1 year with fracture and no CPS report made. (Balancing Metric)

Tools available:

CAT – ED Physical Abuse
CAT – Inpatient Physical Abuse
CAT – Outpatient Physical Abuse

Team Members

Physician Champion:

- Suzanne Haney, MD, MS (Child Abuse Pediatrics Division Chief, Medical Director Children's Advocacy Team, Palliative Care Interim Division Chief & Medical Director of Project Harmony)

Members:

- Lynn Fullenkamp, MD, JD (Child Abuse Physician, Children's Advocacy Team & Hospitalist)
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- Lauren Maskin, MD (Medical Director Medical Surgical Units)
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- Kristi Aldridge, APRN (Children's Advocacy Team Nurse Practitioner)
- Jessica Boger, PCMSW, PLMHP (Children's Advocacy Social Worker)
- Sabrina Schalley, LCSW (Care Coordination Director)
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- Taelyr Weekly, PhD, MPH, BSN, RN (Clinical Effectiveness Project Manager)

Evidence

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