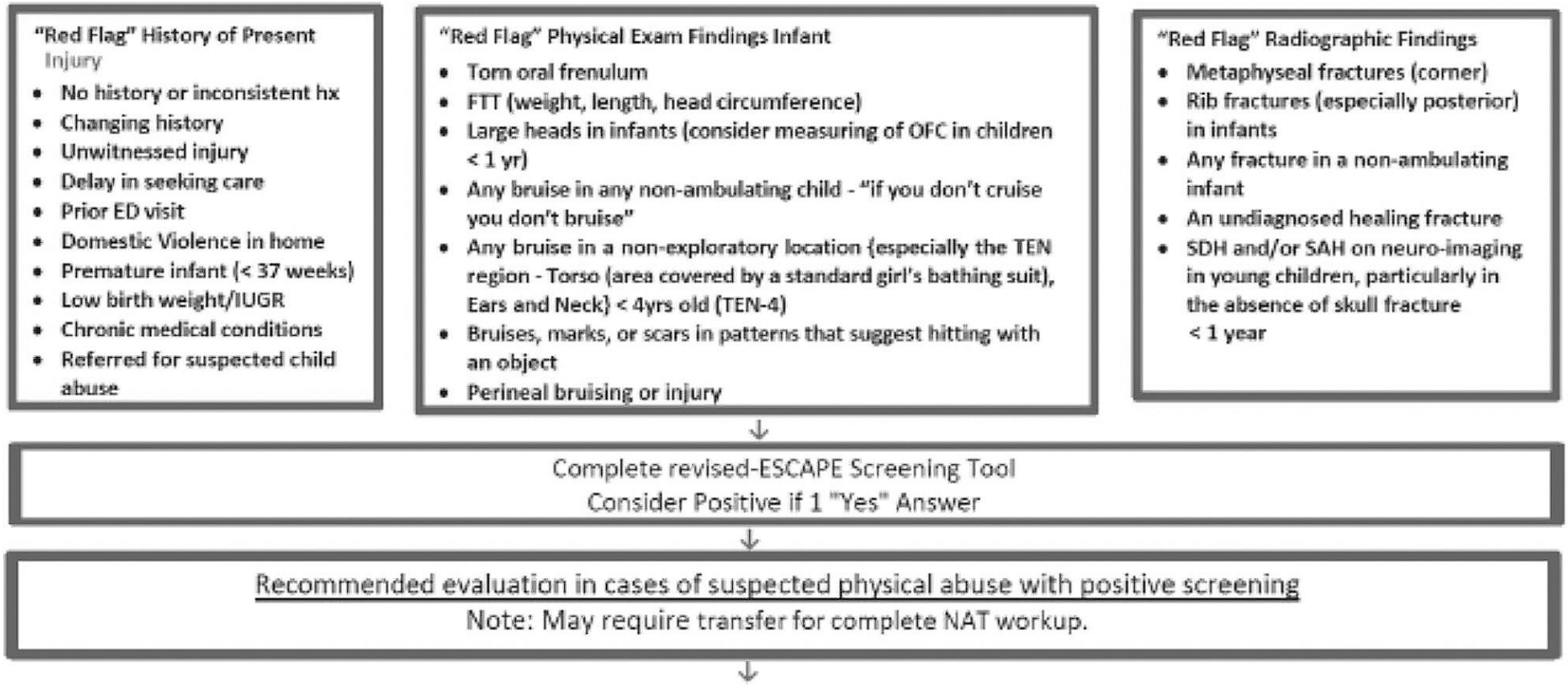
Texas Governor's EMS and Trauma Advisory Council (GETAC)

Pediatric Committee

Child Physical Abuse (CPA) Screening/Management Toolkit

Red Flags for Abuse

Increase suspicion when these histories/injuries are seen when completing screening for abuse



Content from American College of Surgeons Trauma Quality Improvement Program (2019). ACS Trauma Quality Programs Best Practices Guidelines for Trauma Center Recognition of Child Abuse, Elder Abuse, and Intimate Partner Violence.

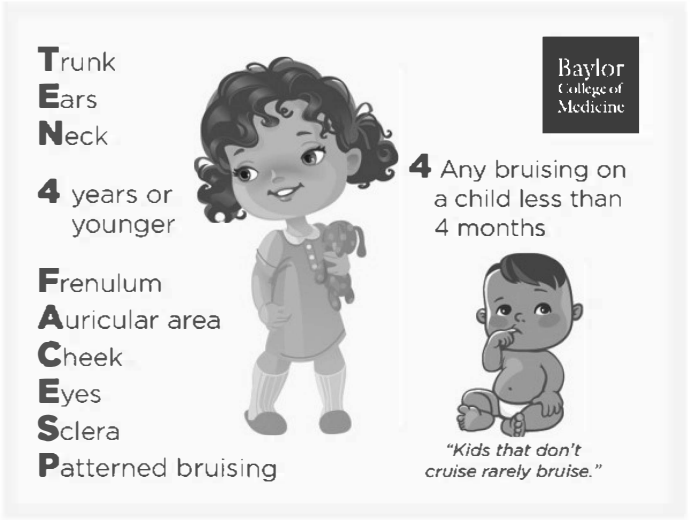
Child Safety and Needs Screening Tool (Modified from ESCAPE)

1. For children presenting for evaluation of a possible injury/illness, was there a delay in seeking medical attention given the severity of the injury/illness?
   ☐ Yes or Possibly ☐ No

2. Are you concerned that the reported history for this visit may not be consistent with this injury or illness?
   ☐ Yes or Possibly ☐ No

3. Are any of the following findings present on physical examination?
   ☐ Yes or Possibly ☐ No

   a. In a child under 4 months – ANY bruise, burn, subconjunctival hemorrhage, or frenulum injury
   b. Older than 4 months
      i. Bruises, burns, or other markings in the shape of an object
      ii. Bruises on non-bony prominences/protected regions (e.g., torso, genitalia/buttocks, upper arms, ear, neck)
      iii. More bruises than you would expect to see even in an active child



Undress all infants under 12 months

4. Are there findings that might reflect poor supervision, care, nourishment, or hygiene?
   ☐ Yes or Possibly ☐ No

5. Is there any other pertinent information regarding the well-being of the child, the child's family, and/or their environment which might help in guiding their care? Please include any explanations for "Yes or Possibly" answers.
   ☐ Yes ☐ No

Free Text Area

Modifications and image made by Baylor College of Medicine, Division of Public Health Pediatrics

Management Guideline

Management Guideline for Lab/Radiology/Consults

Laboratory

General for most patients:

- CBC & platelets; PT/PTT/INR (if concern of low/failing Hgb, repeat in am with retic)
- CMP (include Calcium & Amylase)
- Lipase
- Urinalysis – Dip, send for microscopic
- Comprehensive urine toxicology screen for <2 years old with altered level of consciousness

If fractures are present:

- Phos
- PTH
- Vit D 25-OH

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Radiology

- Skeletal survey for <2 years old (with 2 week follow up)
  - In ED if needed for disposition; or
  - Within 24 hours of admission
- Head CT (non-contrast with 3D reconstruction) if
  - <6 months old with other findings of abuse
  - <12 months old and bruising to face or head injuries
  - Neurologic symptoms >12 months old (including soft symptoms; e.g., vomiting, fussiness, etc.)
- Abdominal CT if
  - S/Sx of abdominal trauma
  - ALT or AST >80

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Consults

- Call your child abuse team if it is reasonable, with the available information, that the finding could be the result of abuse or neglect
  - Child abuse team should include Social Worker & Child Abuse Pediatrician
- Call Crisis Intervention Social Worker
- Report to CPS
  - All patient care providers are required by law to report suspected child abuse and neglect or cause a report to be made and are considered to be mandated reporters. Patient care staff have a duty to make reports but may participate collaboratively to assure that reports are made. Collaborative referral does not negate the responsibility of the individual if the call is later not completed. The threshold for reporting is if is it reasonable, with the available information, that the finding could be the result of abuse or neglect.
- Pediatric General Surgery for trauma evaluation
- If head CT is abnormal & abuse is being considered, call
  - Neurosurgery
  - Ophthalmology for retinal exam
  - Neuropsychology
  - Child Advocacy

*An Ophthalmology consult for a dilated eye exam is not necessary as part of the evaluation for physical abuse if ALL of the following criteria are met:

- No facial bruising
- Normal heat CT or CT with only a single, simple non-occipital skull fracture
- Normal mental status/neurologic exam

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Management Guideline

Management Guideline for Disposition and Family Notification

Disposition

- If any suspicion of NAT has been raised during the ED encounter, a face-to-face care team huddle must take place prior to ED discharge. All members involved in the patient's care should participate including (at minimum) the ED physician, ED RN, and Social Worker.
- For suspected abusive head trauma NAT cases that require admission as clinically indicated with either intracranial abnormality identified on a head CT or suspected seizures from abusive head trauma:
  - Medical/Surgical trauma service admission with Q4 hour neuro checks for further abuse work up
  - Consider PICU admission for:
    - Any child with intracranial injury/bleed or skull fracture(s) identified on head CT
    - Any child with normal head CT/no seizures but GCS <15
- For suspected NAT cases not involving head trauma, admission to Medical/Surgical or PICU after injuries are reviewed by ED MD and Pediatric General Surgeon as medically indicated.
- Prior to hospital discharge there should be a care team huddle including all members involved in the patient's care. Phone communication may be utilized as necessary.
- Outpatient child abuse team follow-up as needed.

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Notification of Family

This communication should clarify that medical professionals are not investigators; that is the role of CPS. They should explain that they are reporting because they are mandated reporters and must call when they see injuries such as these in children.

- Inform parents id a CPS referral has been filed and/or if Child Advocacy is consulted. Notification to family should be straightforward and non-punitive.
- Be direct and objective. Inform parents inflicted trauma is part of the diagnostic consideration.
- Keep the focus on the child. Avoid appearing judgmental. Assure parents of thoroughness of evaluation.
- If you are unable to have this conversation with the parents, ask the Social Worker or a senior colleague to do so.

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Management Guideline

One page Red Flags and Management

"Red Flag" History of Present Injury

- No history or inconsistent hx
- Changing history
- Unwitnessed injury
- Delay in seeking care
- Prior ED visit
- Domestic Violence in home
- Premature infant (< 37 weeks)
- Low birth weight/IUGR
- Chronic medical conditions
- Referred for suspected child abuse

"Red Flag" Physical Exam Findings Infant

- Torn oral frenulum
- FTT (weight, length, head circumference)
- Large heads in infants (consider measuring of OFC in children < 1 yr)
- Any bruise in any non-ambulating child - "if you don't cruise you don't bruise"
- Any bruise in a non-exploratory location (especially the TEN region - Torso (area covered by a standard girl's bathing suit), Ears and Neck) < 4yrs old (TEN-4)
- Bruises, marks, or scars in patterns that suggest hitting with an object
- Perineal bruising or injury

"Red Flag" Radiographic Findings

- Metaphyseal fractures (corner)
- Rib fractures (especially posterior) in infants
- Any fracture in a non-ambulating infant
- An undiagnosed healing fracture
- SDH and/or SAH on neuro-imaging in young children, particularly in the absence of skull fracture < 1 year

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Complete revised-ESCAPE Screening Tool
Consider Positive if 1 "Yes" Answer

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Recommended evaluation in cases of suspected physical abuse with positive screening
Note: May require transfer for complete NAT workup.

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Laboratory

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Guideline Gap Assessment Tool

Gap Analysis used to analyze your current state and identify progress of your goals

Child Abuse Screening in the ED	Met	Partially Met	Unmet	Priority	Comments
Guideline outlines the standardized screening for child abuse.					
Screening process is integrated in the electronic medical record.					
Guideline defines the timeliness for initial screening with processes for a focused assessment and continual screening during the continuum of care.					
Guideline identifies the need for a complete physical exam and history documentation requirements to include recording injuries and stage of injuries on a body diagram.					
Documentation includes the developmental stage of the child and the child's reaction and statement regarding the event.					
If the history of the event is provided by someone other than the child, the individual providing the history is documented and listed by role or name.					
Guideline identifies that a credentialed translator must be available to assist with the screening and history when language barriers exist.					
Strategies to communicate with family members are outlined.					
Guideline identifies the standard laboratory and radiological exams for suspected abuse.					
Guideline identifies the multidisciplinary child abuse response team and outlines the specific roles and priorities of the team and the team members.					
Transfer guidelines are defined for centers who have limited resources for child abuse screening, interventions, and resources necessary for managing this patient population.					

Content from American College of Surgeons Trauma Quality Improvement Program (2019). ACS Trauma Quality Programs Best Practices Guidelines for Trauma Center Recognition of Child Abuse, Elder Abuse, and Intimate Partner Violence.

All ED staff members receive annual education on abuse, screening tools, documentation of findings, and importance of trauma-informed care.					
Guideline discusses when follow-up for all children in same home/location of the child with suspected abuse is necessary.					
Health professionals participating in child abuse screening, interventions, and on-going management are competent in trauma-informed care.					
Child Abuse Management in the In-Patient Setting	**Met**	**Partially Met**	**Unmet**	**Priority**	**Comments**
An identified leader or interdisciplinary team (with specific skills and training for abuse) is responsible for the continuing communication and follow-through with the law enforcement agencies and identified resources until the patient's discharge from the hospital.					
Guideline defines the interdisciplinary team member responsible for completing the abuse mandatory reporting and the timeframe for its completion.					
Psychosocial support systems and behavioral health professionals are available to screen the child and family for acute stress disorder and posttraumatic stress disorder; and for provision of necessary interventions through the child's hospital stay to discharge and recovery.					
Referrals to facilitate safe discharge planning are initiated.					
Behavioral health professionals are integrated into the health care team's oversight and planning for discharge and referrals.					
All nurses in the pediatric inpatient areas providing continuum of care receive annual education on the red flags of abuse, screening tools, documentation of findings and trauma-informed care.					

Content from American College of Surgeons Trauma Quality Improvement Program (2019). ACS Trauma Quality Programs Best Practices Guidelines for Trauma Center Recognition of Child Abuse, Elder Abuse, and Intimate Partner Violence.

Guideline Gap Assessment Tool

Child Abuse Management Post-Hospital Discharge	Met	Partially Met	Unmet	Priority	Comments
Provisions to ensure a safe discharge and follow-up appointments for the continuum of care are outlined.					
Guideline defines the member(s) of the interdisciplinary team responsible for providing law enforcement agencies with requested information.					
Guideline defines the trauma registrar's education and resources needed for accurate abuse injury coding.					
Trauma registrars registry coders use the "best available information" at the time of discharge for injury coding.					
The interdisciplinary team and trauma registrars use the standard definitions of "suspected" and "confirmed" for accurate pediatric abuse injury coding.					
Guideline defines the abuse screening and reporting compliance outcomes to be reported at the trauma operations committee.					
Trauma centers participate in the local and/or regional pediatric abuse fatality reviews, pediatric abuse awareness and prevention programs.					

Content from American College of Surgeons Trauma Quality Improvement Program (2019). ACS Trauma Quality Programs Best Practices Guidelines for Trauma Center Recognition of Child Abuse, Elder Abuse, and Intimate Partner Violence.

Trauma Coder's Guide

Trauma registry coders need to follow the rules of the most current *NTDS Data Dictionary* and ICD-10-CM Official Guidelines for Coding and Reporting, found in the *ICD-10-CM Official Codebook*. These references give guidance on how to sequence diagnosis codes and external cause codes.

Additional custom elements regarding abuse can be developed within the trauma center's registry. These can be used to assist in identification of this patient population and further the center's guidelines for pediatric abuse, elder abuse, and intimate partner violence.

Confirmed abuse:

__ Abuse confirmed by a multidisciplinary team reviewing the case (members may include medical/law enforcement/child welfare)

__ Abuse admitted by perpetrator

__ Abuse witnessed by unbiased, independent observer

__ Abuse disclosed by victim

__ Abuse confirmed by the presence of injuries with a high-risk of associated abuse occurring without a reasonable explanation based on history

Suspected abuse:

__ Consideration of abuse when not meeting the criteria of "confirmed abuse" or "no abuse"

No abuse:

__ No abuse suspected or abuse ruled out by the hospital physician, social worker, or investigation by law enforcement or protective services

Mandatory reporting completed: ___Yes, ___ No, ___N/A

Performance Improvement Examples

RECOMMENDED TRAUMA PERFORMANCE IMPROVEMENT GUIDELINE INTEGRATION

Key Points

- The abuse guidelines are integrated into the Trauma Performance Improvement Patient Safety Plan to monitor compliance and outcomes.
- Mandatory reporting is tracked using the trauma center's trauma registry.
- Examples of the abuse guideline integration into the performance improvement measures include the following:
  - Compliance regarding the completion of the abuse screening
  - Compliance to recommendations for psychosocial referrals
  - Compliance to mandatory reporting of abuse to the authorities
  - Compliance to recommended injury description documentation standards
  - Abuse coding accuracy for suspected, confirmed, and no abuse that uses the best information available at discharge
- Cases of missed abuse recognition are processed through the second level of trauma performance improvement review. Cases are escalated to trauma peer review and system review when appropriate.
- Abuse screening outcomes are integrated into the trauma center's operations committee standing reports.

Table 19 reflects integration of the abuse guideline's compliance and outcome reviews into the trauma center's trauma performance improvement and patient safety plan.[3]

References

1. Prowd L, Leach D, Lynn H, and Tao, M. An interdisciplinary approach to implementing a best practice guideline in public health. *Health Promotion Practice,* 2017; 19(5): 645-653.
2. Centers for Medicare and Medicaid Services. (2018). ICD-10-CM Official Guidelines for Coding and Reporting. Retrieved from https://www.cms.gov/ Medicare/Coding/ICD10 Accessed April 6, 2019.
3. American College of Surgeons. *Resources for Optimal Care of the Injured Patient.* Chicago, IL; American College of Surgeons, 2014.

Content from American College of Surgeons Trauma Quality Improvement Program (2019). ACS Trauma Quality Programs Best Practices Guidelines for Trauma Center Recognition of Child Abuse, Elder Abuse, and Intimate Partner Violence.

Take Away Points

1. Emergency Departments are five times more likely to detect abuse if it is present when using a standardized screening tool

2. Mortality increases with recurrent episodes of nonaccidental trauma in children. We don't want to miss it the first time.

3. Reporting to CPS shouldn't be thought of as a punitive action. Many times CPS has information we do not have and can help in the investigation. CPS and the Social Workers are great resources for families in need (food, diapers, transportation, etc).

4. Transfer to a higher level of care may be needed to perform a complete abuse/neglect workup.

References

American College of Surgeons Trauma Quality Improvement Program. ACS Trauma Quality Programs Best Practices Guidelines for Trauma Center Recognition of Child Abuse, Elder Abuse, and Intimate Partner Violence. Released November 2019. Available at: abuse_guidelines.ashx (facs.org) Accessed December 7, 2020.

Berger RP, Lindberg DM. Early recognition of physical abuse: Bridging the gap between knowledge and practice. J Pediatrics. 2018; 204: 16-23.

Deans KJ, Thackeray J, Askegard-Giesmann JR, Earley E, Groner JI, Minneci PC (2013) Mortality increases with recurrent episodes of nonaccidental trauma in children. J Trauma Acute Care Surg 75(1):161–16

Escobar Jr MA, Pflugeisen BM, Duralde Y, Morris CJ, Haferbecker D, Amoroso PJ, Lemley H, and Pohlson EC. Development of a systematic protocol to identify victims of non-accidental trauma. Pediatric Surgery International. 2016 April;32(4):377-86. PMID 25809669.

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