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OSF HEALTHCARE

Child Abuse or Neglect - Assessment of Possible Victims

PURPOSE:

To provide information for actions to be taken when abuse of any individual is suspected at SFMC.

DEFINITIONS

Department of Family / Child Services [DCFS] Site

1. Child: Any person under the age of 18 years
2. Abuse: Mistreatment of a child under the age of 18 by: a parent, an immediate family member, a caretaker, someone living in their home, or someone who works with or around children who is responsible for the care of the child. The mistreatment must cause injury or must put the child at risk of injury. Child abuse can be physical (such as burns or broken bones), sexual (such as fondling or incest) or emotional.
3. Neglect: Neglect happens when a parent or responsible caretaker fails to provide adequate supervision, food, clothing, shelter, medical care or other basics for a child.

POLICY:

1. Abuse, neglect, and interpersonal family violence are assessed by medical personnel on any patient presenting to OSF Saint Francis Medical Center. Abuse includes the intentional, non-accidental maltreatment of dependent individuals by a parent, immediate family member, a caretaker, someone living in their home, or someone who works with or around children who is responsible for the care of the child, a family member or a significant other, or long term care provider. This abuse includes child physical and sexual abuse, neglect and domestic violence.
2. Pediatric Abuse Screen is completed in electronic health record (EHR) when a pediatric abuse or neglect case is suspected.
3. Any OSF healthcare professionals who suspect a patient is a victim of abuse and / or neglect are mandated to report the suspicion of abuse / neglect to the appropriate agency, which is the Department of

Children and Family Services (DCFS) for Illinois children. The victim has the right to refuse to talk to the police.

4. The Pediatric Resource Center is to be consulted for assistance and guidance regarding evaluation and treatment of victims of child abuse and neglect with utilization of Emergency Department resources as necessary.

Abused Children

5. The State of Illinois requires notification by professionals regarding child abuse or neglect. The person reporting such information is legally protected from litigation by virtue of statutory law.
6. Any child presenting for care in the office / clinic / hospital setting in whom abuse or neglect is suspected, is reported immediately by contacting the Illinois DCFS hotline at 1-800-252-2873. The DCFS hotline is open 24 hours a day.
   a. See: DCFS Written Confirmation of Suspected Abuse / Neglect Report form: Medical Professionals. Forms are available in the Emergency, Pediatric, and Social Service Departments. The forms are also available electronically at the following links.
   b. Medical Providers may access the form at: http://www.illinois.gov/dcfs/aboutus/notices/Documents/cants4.pdf
   c. Other Mandated Reporters may access the form at: http://www.illinois.gov/dcfs/aboutus/notices/Documents/cants5.pdf

PROCESS:

Initial Assessment:

1. Collect nursing and medical history concerning suspected or actual injury of child. Complete Pediatric Abuse Screen.
2. Consult the Pediatric Resource Center immediately to facilitate the medical evaluation.
   a. This includes necessary tests to document injuries.
   b. These tests, such as skeletal survey and lab tests, are ordered by the physician.
   c. Pediatric Resource Center facilitates interdisciplinary meeting with the physician, nurse, and / or social service staff to coordinate child's evaluation and examines the child's safety.
3. Notify hospital social services if patient has been admitted. Social service involvement may also originate in the ED.
4. Review child's entire past and current OSF medical records for possible repetitive injury / patterns of injury.
5. Protect the child if the immediate environment is thought to be dangerous or non-supportive.
   a. Contact law enforcement if immediate environment for child is thought to be dangerous or non-supportive.
   b. Physicians, law enforcement and DCFS investigators are authorized to take protective custody, if needed.

c. Document name of person and agency who took protective custody; reason for protective custody, date, and time.

6. File Suspected Abuse / Neglect Report if indicated.
   a. Person with the best information is to file the report.
   b. Reporting to supervisor(s) does not satisfy the obligation of mandated reporting.

Reporting the Suspected Abuse / Neglect:

7. Refer to Attachment - Outline for Reporting Child Abuse.
8. Contact DCFS by phone as soon as it has been determined that suspicion or neglect exists and there is a need to report. 24-hour number is 1-800-252-2873.
   - Phone contact is documented in patient's electronic health record (EHR) and on DCFS report form.
9. After reporting suspicion of child abuse or neglect to the Hotline, reporter completes and signs the mandated reporter form.
   a. Photocopy may be used as a second copy.
   b. Instructions are on reverse side of the form.
   c. Hospital caregiver may inform parent or guardian that a DCFS report has been filed; based on the circumstances.
   d. Original copy of the report is mailed within 48 hours to nearest Illinois DCFS office.
   e. The photocopy is scanned into the EMR.
10. Contact law enforcement if concerned that a crime may have been committed. Security contacts law enforcement.
    a. In this situation, OSF-SFMC staff consults medical center social services and / or Pediatric Resource Center (PRC) as soon as possible for additional action.
    b. To assure safety of other children in the home
    c. To expedite investigation of alleged perpetrator.

Non-Admission

11. May release child when a child does not require admission for medical treatment and is in no imminent danger per judgment of physician.
12. If child is determined to be abandoned and does not require admission for medical treatment, call Illinois DCFS hotline at 1-800-252-2873 and tell Hotline that "Action is needed" after which a DCFS worker comes to the facility to assume custody.

Admission

13. Admit child to hospital when warranted if further medical evaluation is needed or safety of child is in question, or if conditions exist to justify a physician taking custody.
14. If a parent or guardian does not consent to admission, then physician considers taking protective custody.
    a. Physician may take protective custody if in his / her judgment the child's release would jeopardize the child's safety.

b. When taking custody, the parent / guardian, DCFS, Nursing Supervisor, and Administrator on-call are notified as soon as possible.

c. Precision documentation regarding whom took custody, at what time, and for what reason is necessary to document in EMR and reported to DCFS.

d. Copy DCFS safety plan or protective custody and include copy in OSF-SFMC medical records.

Additional Information:

15. Make referral to PRC at 309-624-9595 for evaluation of possible abuse and neglect as well as coordination of abuse and treatment planning.

16. Identify medical or non-medical indicators as well as parental factors listed below of suspected abuse and/or neglect.

- Note: None of these indicators necessarily provide conclusive evidence, but rather are understood in the context of the information which the hospital has available concerning the child and his/her family.

Possible Child Abuse / Neglect Indicators

17. Identify any medical indicators listed below:

a. Traumatic injury in a child (especially infants and children under 5 years) with special attention to head injuries, burns, bruises, and fractures.

b. Injury incompatible with explanation/medical history.

c. Injury not mentioned in the history or injury for which there is no explanation.

d. Injury or poisoning occurring as a result of gross lack of supervision.

e. Child with malnutrition, dehydration, or delayed development without obvious organic cause.

f. Child with an advanced disease state, not under medical care.

g. Child given inappropriate food, drinks, or drugs

h. Child where there is disclosure or evidence of sexual abuse.

i. Child who tests positive for sexually transmitted diseases.

j. Parent or caregiver who appears to be altered, due to possible substance abuse.

k. Newborns: The following are signs and symptoms that staff member(s) need to report to the physician for further investigation. Drug screen may be required depending on agency. This is not necessarily the case with DCFS.

i. Irritability, tremors, hyper tonicity, poor attention, bizarre eye movements, staring spells, hypertonic ankle reflexes, and depressed grasp and rooting reflexes.

ii. Diaphoresis, episodes of agitation alternating with lassitude, miosis, and vomiting.

iii. Abnormal sleep patterns, tremors, poor feeding, hypertonia, sneezing, high-pitched cry, frantic first sucking, tachypnea, loose stools, fever, yawning hyperreflexia and excoriation.

iv. Excessive cry, poor sleep, tremors, increased muscle tone, excoriated skin, yawning, sweating, sneezing, vomiting, diarrhea, irritability, and poor feeding.

18. Identify non-medical indicators listed below:

a. Anger / defiance or acting out
b. Extreme clinging
c. Extreme fear of everything (hospital, physician, etc.)
d. Indifference to caregiver.

19. Identify significant parental factors:
    a. Parent or guardian's explanation concerning the injury is unlikely, conflicting, or contradictory.
    b. Parent or guardian admits that they have abused or neglected the child.
    c. Parent or guardian demonstrates lack of concern, detachment, or overreaction to the child's injury or the situation.
    d. Delay in seeking medical help, lack of cooperation concerning the child's treatment, or lack of visitation once the child is hospitalized.
    e. Evidence of psychosis, severe developmental disability, or chronic alcohol or drug abuse on the part of the parent / guardian.
20. Identify factors relating to child listed below:
    a. Child is unusually hyperactive, aggressive, or withdrawn.
    b. Child appears unusually detached, fearful, or lacks discrimination relating to people.
    c. Child shows evidence of unhygienic or improper care.
    d. Child exhibits major developmental lags.
    e. Child makes statements indicating that a parent or guardian has been abusive toward him / her.

Documentation

21. Date, time of reporting call, and name of the caseworker notified, is included in EHR documentation and on DCFS form.
22. Reflect notification of appropriate agencies, referrals made, and address safety issues (i.e., the patient has a safe place to be discharged) in EHR.

REFERENCE:

1. Department of Child and Family Services (2012). *Child Protection*. Retrieved from http://www.state.il.us/dcfs/child/index.shtml
2. Christian, C.W., Committee on Child Abuse and Neglect (2015). The evaluation of suspected child abuse. *Pediatrics, 135* (5), e1337-e1354. Retrieved from http://pediatrics.aappublications.org/cpmtemt/135/5/e133
3. Jenny, C., Crawford-Jubiak, J.E., & Committee on Child Abuse and Neglect (2013). The evaluation of children in the primary care setting when sexual abuse is suspected. *Pediatrics, 132* (2), e558-e565 Retrieved from http://pediatrics.aappublications.org/content/132/2/e558.full
4. Jenny, C. (2007). Recognizing and responding to medical neglect. Pediatrics, 120 (6), 1385-1389. Retrieved from http://pediatrics.aappublications.org/content/120/6/1385.full

RESOURCES:

SUSPECTED CHILD ABUSE/NEGLECT ALGORITHM

CHILD ABUSE AND NEGLECT POLICY & PROCEDURE GUIDELINES/TOOLKIT

1. Document complete
- **medical history**
- **physical exam (including body chart and/or photo documentation)**

2. Child Abuse/Neglect suspected

3. Follow ED/Hospital child abuse policy & procedure
- Consider flight risk

4. Contact
- Social Services
- Illinois DCFS **1-800-25-ABUSE or 1-800-252-2873**
- Law enforcement

5. Determine need for admission or transfer
- Do injuries require hospitalization?
- Is child thought to be at imminent risk for further injury?
- Consider admission for non-ambulatory children for additional work-up and interpretation.

YES

Parental consent for admission?

YES

Admit to hospital

NO

6. Take protective custody
- Document reason for taking protective custody
- Inform parents/caregivers
- Inform Illinois DCFS and law enforcement
- Inform hospital administrator/staff and/or risk manager

NO

6. Assure Illinois DCFS safety plan and follow Illinois DCFS recommendations
- Contact primary care/physician re: ED visit and Illinois DCFS report
- Establish follow-up visit (recommended within 2 weeks)

7. Referral
a. Attending physician
b. Child Abuse Pediatrician
c. Social Services

Tips:
- If the child is admitted, review the ICD codes in Table G.
- Consider transfer to a facility with a medically directed child protection team.
- Taking protective custody requires that the physician inform Illinois DCFS that they are taking protective
- [illegible] should update Illinois DCFS and law enforcement on admission status.
- Consider involving others who are trained in abuse/neglect (e.g., child life specialists, pastoral care.)

OSF HEALTHCARE

ED Child Abuse/Neglect Checklist

☐ **Notify Charge Nurse**

☐ **Complete Appropriate Documentation**

- ☐ Review Medical History and EPIC encounters for previous injuries
- ☐ Physical Exam, which includes a full skin assessment
  - Just state that the child was undressed and assessed for any injuries
- ☐ Pediatric Abuse and Neglect Screening Tool in EPIC Assessment-**(Nursing)**
- ☐ DCFS CANTS Form: Make 2 Copies
  - ☐ One Copy to Stefanie Clarke
  - ☐ Mail Original to the Local DCFS Office—give this to the PCL in addressed envelope

If the patient comes in with a form from DCFS, please make a copy of the completed form for Stefanie, scan in a copy to medical record, and fax original to DCFS Contact listed on page 1 (or give to DCFS Caseworker in ED). Do not give this to patient/family!

☐ **Contact/Referrals**

- ☐ Place Order: IP Consult Social Work or Case Management
- ☐ Call DCFS Hotline: 1-800-252-2873
  - TIP for faster reporting: Give them an end timeframe to be reached. Do not give your cell phone or allow them to call you the next day. If you do not hear back by the end of your shift. Call again and tell them you are a SECOND TIME CALLER
  - If you have any concerns about the reporting process, ask to speak to the Hotline supervisor
- ☐ Contact the Pediatric Resource Center (PRC)–**(Physician)**
- ☐ Notify the Primary Care Physician–**(Physician)**

TABLE A. The indicators listed below are clustered for easier recall and recognition.

BEHAVIORAL AND PHYSICAL INDICATORS OF POTENTIAL ABUSE/NEGLECT	
BEHAVIOR OF CAREGIVER	▪ Aggressive, hostile or evasive ▪ Apathetic, indifferent or unresponsive ▪ Overly concerned about child ▪ Overwhelmed by problems of life
BEHAVIOR OF CHILD	▪ Shy, withdrawn or provocative ▪ Fearful ▪ Indiscriminant attachment ▪ Speech, sleep, eating disorders

HEAD INJURY	▪ Evidence of abusive head trauma
	  ▪ altered level of consciousness
	  ▪ closed head injury
	  ▪ CNS hemorrhage
	  ▪ retinal hemorrhages
	▪ Cerebral edema

SKELETAL INJURIES	▪ Posterior rib fracture ▪ Metaphyseal fracture ▪ Two or more fractures, different stages of healing ▪ Multiple skull fractures ▪ Long bone fracture in non-ambulating child
WOUNDS/TRAUMA	▪ Blunt trauma to chest/abdomen ▪ Intrauterine abuse ▪ Drug-dependent newborn ▪ Gun shot wounds ▪ Stab wounds ▪ Bites ▪ Lacerations
BRUISES	▪ Periorbital ecchymosis ▪ Skin bruises/lacerations in shapes ▪ Bruises to the face, head, ears, neck, and torso or other non-bony prominence(s) ▪ Bruises, inaccessible, varying stages healing ▪ Circumferential injuries of extremities, neck ▪ An injury resulting from discipline
THERMAL BURNS	▪ Cigarette burns ▪ Glove/sock patterned liquid burn ▪ Iron burns ▪ Diaper area, doughnut-shaped burns ▪ Burns to back of hand/sole of foot ▪ Bilateral burns or injuries to hands
NEGLECT	▪ Delay in seeking medical care ▪ Long periods without supervision ▪ Abandonment ▪ Failure to immunize

TABLE F. This CHILD ABUSE mnemonic is a resource that promotes thorough interviewing and documentation.

CHILD ABUSE MNEMONIC

CONSISTENCY OF INJURY WITH DEVELOPMENTAL STAGE	▪ Is the incident as described plausible for age and development of the child? ▪ Refer to normal developmental milestones. ▪ "Non-cruisers are non-bruisers!"
HISTORY INCONSISTENT WITH IN JURY	▪ Does the medical history of the child, or the incident history change from person to person? ▪ Is there a previous history of fractures, ingestions or injuries? ▪ Is the injury consistent with the presenting history?
INAPPROPRIATE PARENTAL CONCERNS	Do parents/caregivers: ▪ Ask pertinent questions? ▪ Seem concerned about outcomes? ▪ Offer comfort measures to the child?
LACK OF SUPERVISION	Question family member/caregiver as to: ▪ Who was present? ▪ What happened? ▪ When did it happen? ▪ Where did it happen? ▪ Why did it happen?
DELAY IN SEEKING CARE	Is the time frame between when the injury occurred and when medical care was sought reasonable? Note unusual delays.
AFFECT/ATTRIBUTIONS	▪ Document negative attributions. ▪ Document reaction of child to all family members/caregivers present. ▪ Document response and behavior of family members/caregivers present.
BRUISES	Document findings/absence of findings of head to toe exam with patient unclothed. In documenting bruises note: ▪ Location ▪ Pattern ▪ Presence over bony or non-bony prominence(s) ▪ Size ▪ Color ▪ Number ▪ Non-cruising or non-ambulatory
UNUSUAL INJURY PATTERNS	Describe injury characteristics and diagnostic testing performed. Differentiate between non-intentional versus inflicted patterns, e.g., belt loops, bites, iron burns, hand imprints.
SUSPICIONS	Remember that a report to Illinois DCFS is for "suspicion" of abuse or neglect. YOU do NOT have to prove it. You are a mandated reporter for reasonable suspicion of abuse and neglect. Complete physical exam including body chart and/or photo documentation. Document location, size, color and shape of abnormalities.
ENVIRONMENTAL CU…	If a run report from EMS is present, does it contain any contributing information about the environment in which the injury occurred? Gather information from EMS prior to their departure from the ED.