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Hilton, Chelsea, W started transcription

Lee, Sarah, E LCSW, LSCSW 0:03

I have Doctor Mary Moffitt is here with us.
She is an Ed attending both in our scan clinic as well as our Ed.
Ed. Pediatric medicine.
I'm going to go ahead and let Doctor Moffit get started if you have questions you can add them to the chat, but we're going to save questions for the end.
And.
Without further ado, I'm going to let Doctor Moffat take it away.

RL

Rein, Suzy, L 0:35

Your thoughts?
Big.

Lee, Sarah, E LCSW, LSCSW 0:46

I can hear you Doctor Moffitt.

ME

Moffatt, Mary, E 0:52

See. Sorry. Yeah, I put me back on mute, OK?
Sorry about that.

Lee, Sarah, E LCSW, LSCSW 0:55

That's OK.

ME

Moffatt, Mary, E 0:56

So thanks a lot for the introduction and invitation to come chat today about skin injuries and Sentinel injuries.
Like Sarah said, I work both in the emergency department and on scan team and I have in a 5050% job split for a long long time.
And so I want to give thanks to some colleagues mentioned along the bottom of the

introductory slide for their contributions.
For some of my slides today, which have been either left intact or edited for today's presentation.
So I thought that we should go over accidental bruising versus bruising of concern.
And then recognize the importance of identifying Sentinel injuries and the consequences of missing Sentinel injuries and kind of help you better understand.
Sort of. The management of concerns from physical abuse largely focus on the physician or nurse practitioner provider role, but sort of in the context of the whole team.
So I thought it would start with bruises expected from accidental injury to kind of frame.
What do we expect to see?
So when we have active mobile infants and toddlers, they fall down. And what does mobile mean?
Does anyone hedge a guess?
So when you think of a mobile child, they're upright. They're not just horizontal, but they're upright in a vertical way.
So this means that they're pulling to stand on the furniture and probably walking by hanging on to something that we call cruising, which for most kids is a prelude to walking independently.
And.
Where do we expect to see bruises?
Anybody with kids in particular?
Around kids have a gasp of where we expect to see bruises.
So while you're thinking about that or go to the next slide because someone actually studied this to help us understand, if in case real life doesn't give us practical experience.
So these children came for, well, childcare. They weren't being evaluated by a child abuse Pediatrics team.
They were just being seen for, well, childcare in different age groups and obviously that means different stages of development and so someone was just doing.
Of observational.
Accounting, if any of the children had bruises and then they plotted it in this graph here with age along the X axis and the percent of children with bruises along the Y axis, and they kind of subdivided pre cruisers.

Into kids who were zero to maybe 14 months. But as you can see pre cruisers go down as we get older.
Cruisers, which because all children develop at different stages, kind of range from 6 to 18 months and then walkers from 9:00 to 2:00 to three years.
So what we see on the graph is that less than or equal to 1% of children less than six months of age had bruising.
So this really helps us understand that.
While children coming for, well, childcare in the less than six months of age group.
Rarely have bruises.
But then as they become more mobile with.
Crawling, pulling to stand, cruising, walking independently, they have opportunity to fall down, go boom and sustain bruises.
So then when we think visually as opposed to diagrammatically.
Where do we see those bruises? We see them over Bony prominences, particularly on the front.
To the body, like the forehead, the knees and shins. But children don't just fall forward, they can fall backwards.
So sometimes we see bruises in the body diagram in the right up corner shows us on the back of the body, such as the elbows and posterior forearms. The back of the head.
So in that diagram, in the top corner, red is bruises of high suspicion and orange or gold shows this areas the body.
Breezes for low suspicion as long as the child is mobile.
Sometimes things that we do to children in the name of medical procedure, such as Ivy starts and blood draws, cause bruises too.
So I just thought to throw these in to remind us that sometimes you will see sort of bruising and puncture marks that have been iatrogenically inflicted upon the children as part of taking care of them.
Gonna change gears now and go to Sentinel injuries, which I affect affectionately.
Call the other SI because obviously in social work and Ed we see all kinds of SI, but not the subject of today's talk.
So Sentinel injuries.
What is a Sentinel injury?
This is a relatively minor injury that is suspicious, kind of for one or two reasons we're talking about.

A really young child who isn't developmentally able.
To cause the injury to themselves through an accidental mechanism, probably because they're not yet mobile, they don't have the opportunity to really fall down and go boom on their own accord.
And or what we're told about how the child sustained this relatively minor injury just doesn't adequately explain the injury either because the injury doesn't look anything like we would expect for that type of accident or the kid is able to do things that we can't imagine.
In them doing because they're too young.
And so a Sentinel injury, you can think of like a red flag.
It's a warning that you might be encountering something that lies ahead.
Then again, you may be encountering that the coast is clear.
You don't know, but you kind of proceed with curiosity along with kindness, inclusion, integrity as a team. And yes, I've intentionally thrown the CMH values into this talk.
So there's a there's quite a few publications on fentanyl injuries.
I highlight this one.
They looked at 200 children.
They actually looked at 401 kids less than 12 months of age and about half of them were identified by a child protection team as having definitely been abused.
So these aren't all Comer kids who present to an Ed or an urgent care.
These are kids already.
There's concern for abuse.
They're being asked to be seen by a child protection team.
A child abuse Pediatrics team.
A scan team.
Whatever you want to call it, so about half of them were determined to be definitely abused.
And so then when they did a record review, they look back at prior healthcare visits prior to being labeled, definitely abused. They found that 27.5% of those children.
Had a history of a Sentinel injury and they were looking for Sentinel injuries that included bruising and they found 80% of those children who had a Sentinel injury had bruising.
Intra oral like mouth injury, 11% had prior intra oral injury and fracture 7% had prior fracture injury.

So the bruising was most commonly located on the face, forehead and ear.
Of note, 95% of the children with a Sentinel injury were less than six months of age, and this makes sense in the terms that the Sentinel injury was bruising for the most part and less than six months of age.
Children are pre cruisers, they're not yet mobile.
So now what happens when we do testing for abuse in children with Sentinel injuries?
So this paper looked at all the publications prior that were on Sentinel injuries, and I included table one here because it shows us what do others call Sentinal injury?
So bruising burns, oral injury fractures, intracranial hemorrhage, belly trauma.
Genital trauma and subconjunctival hemorrhage.
And so instead of looking with features that could be deemed subjective when a child presents with Sentinel injuries, I would agree with this quote from the paper then.
Alternative, more objective approach would be to routinely screen those children who are found to have injuries most associated with abuse.
Yes.
So they looked at a database of health visits to some of the 38 leading children's hospitals in America.
And so there was no specifics of name, date of birth, etcetera.
It was all on diagnostic codes and so that already presents a problem in the accuracy or completeness of the data, because we know that ICD 10 or this paper relied on ICD 9 codes.
Don't always capture abuse.
But regardless, the rates of abuse range from 3.5% in children less than six months of age, with burns to 56.1% of children less than 24 months of age with rib fractures.
And So what we see is this reflects the variability in the use of tests to determine or detect hidden what we call occult injuries in different presentations.
So they found that.
When you do a skeletal survey, when a skeletal survey is performed actually depends upon the type of injury the child presents. With more commonly presented in these type of presentations versus burn.
But also what they found is when you do a skeletal survey, diagnosis is of abuse is more readily made.
So another quote from their paper would be that the core.

Attribute of a Sentinel injury is that it should prompt the clinician.
To consider the possibility of physical abuse, and in most cases, to undertake testing for additional occult or hidden injuries.
So sometimes we hear it's just a little bruise.
Yeah, that may be true, but it's also a red flag little bruise because it warns us there could be stuff on the inside that we're not yet able to see because we haven't do done the test or there's things ahead that lay for this child that are not.
Safe. So identification of child abuse is a critical first step.
Yep. And then if if it's just a little bit.
It raises concern for abuse. We don't have to be diagnostic diagnostically 100% certain because we know that if we wait until we're 100%, diagnostically certain, there could be consequences for the child.
How do we know this?
We know this on missed rates of abuse, so about 31% of children with abusive head trauma are initially misdiagnosed.
28% almost 30% of children infants had prior visible injury, 75% of abused children have a history of physical evidence of prior injury.
And then there's a recurrence rate with physical abuse, such as about 35% of the time when there's no detection or intervention to try and prevent recurrence.
So when the child falls down and gets a scraped knee, that accidental injury only.
Has the.
Risk for a straight knee or a bruised knee where abusive injury often escalates and repeat injury occurs overtime.
There's a few papers that help us understand how often does child abuse occur re occur over time.
These papers tell us that in about 30% of abusive head trauma cases are missed.
But then later abuse of head trauma occurs and with a retrospective look back, we're able to figure out, whoops about 30% of these abuse.
Of head trauma cases are missed and about 20% of fractures are missed.
Then what is this?
Does anybody know what the finding is called in the child's eye?
And the CL clas I already said the word.
It's like a bruise on the conjunctiva.

Lee, Sarah, E LCSW, LSCSW 14:18
Subjunctival hemorrhage.

Moffatt, Mary, E 14:21
The skin on the eye, so it's called a sub conjunctival hemorrhage.
And then what is this?
This is a bruise where the arrow is on the jawbone.
And you can tell that this child and this child are very young infants.
And then this.
This is a frenulum injury, so it's a type of oral injury and above the three photos, this one might be the most obvious because you're seeing tissue damage, bleeding, redness, etcetera.
Again, a young infant with no teeth.
So bruising of concern, many stud studies are available to guide us.
When should we be concerned about bruising?
So I thought I would start about this paper, which and there's three papers I'm going to highlight next. And they're all by a Welsh group who looked at the evidence.
For why do we be concerned about bruising?
So what? This is bruising in children who are assessed for suspected child physical abuse.
So this paper looked at 519 kids less than six years of age who were referred for evaluation by two child abuse Pediatrics team.
And what they found was the odds of physical abuse for a child who had bruising to the buttocks or genitalia.
The left ear probably speaks to how many of us are right-handed in the world.
The left or right cheeks of the face.
The neck. The trunk, which you could call the back or the front of the body. The front of the thighs or the upper arms were significantly greater for the children who had PA as opposed to the children who had physical abuse excluded.
So this diagram helps us see by the dark shaded areas where the areas of the body with bruising of concern for physical abuse. By looking at a group of physically abused children and noting where did they have.
Bruising so patikii, which wear little red or purple dots, kind of like very small polka dots.

Linear meaning line or bruises with a distinct pattern like a loop shape or a round object shape.
Bruises when they occur in clusters.
And additional injuries in children known to Child Protective Services for previous child abuse concerns were also more significantly likely associated with.
Children who are diagnosed with physical abuse.
The next paper by some of the same authors looked at a lot of published literature, and that's what a systematic review is about.
You look for papers in the literature that are published and trying to answer a single question, and then you grade the quality of the papers that are available, including some in your systematic review, because they closely answer the question at hand and excluding others because they're not rele.
Event. So what they were trying to look for was bruising in relation to child abuse.
And So what they found is what the diagnos show the ears, neck, anterior chest, genitalia where areas of body that are rarely bruised accidentally, whereas ears neck, face, head, trunk, buttocks and arms.
Were more often.
Bruised and abused children and they also found that clusters of bruises were associated.
With abuse.
And in this paper, again, not all the same authors, some different authors, but also some the same authors. They looked at patterns of bruising in preschool children who had an inherited bleeding disorder.
So they asked parents to fill out this body map of their children, who had a bleeding disorder over a period of time.
That's what a longitudinal study was when the children were preschool aged, and then they just collected all the filled out forms by the parents.
So what they found is even in children who have a known bleeding disorder, like hemophilia or platelet disorder, bruises on the ears, eyes, cheeks, neck and genitalia are rare. Even when the kid has a bleeding disorder.
So then moving to another study by an American group of investigators, they looked at bruising based on nurses in the pic, you doing body maps for children who are admitted for trauma, not just abusive trauma, but accidental trauma.
And who are less than four years of age, and then they analyzed all those body maps and bruises done by the PICU nurses, and they found patterns.

So when the child was diagnosed with abuse.
Was more common for the children to have bruising in certain locations versus those who weren't diagnosed with abuse, and then they made a clinical decision rule to predict abuse in young children based on the bruising characteristics, which actually is a way to test. How does this rule of.
10 four faces P stand up when we apply it to a different population.
So I'm going to go through.
The acronym 10 Four Faces P. This is one that we teach very commonly.
And we hope that people maybe remember 10 four faces P when they have to think is this area of body with a bruise concerning or is it not so 10 stands for torso, ear, neck.
Four reminds us that the study was on kids admitted to the pick you less than four years of age, but it also tells us that infant less than or equal to four months of age with any bruising is of concern.
And faces stands for the frenulum, which are those bands of tissue under your upper lip.
Under your lower lip, under your tongue, angle of the jaw, bruising.
Soft tissue cheek bruising, eyelid bruising or our friend the subjunctival hemorrhage and P stands for patterned. So for a visual run through, I'm going to show you some pictures that help us with each of these.
Whoops, sorry 10 torso. Meaning the trunk anterior.
Posterior sides ear, meaning ear bruising and neck meaning neck.
Infants less than four months of age, any bruising anywhere. And why did they include children less than four in their study?
Because 80% of child abuse fatalities and neglect fatalities occur in kids less than 4.
But when you are less than equal to four months, this study tells us that any bruising anywhere on the body is of concern for possible physical abuse.
So here's the faces. So F stands for frenulum.
You saw this picture already.
This is the superior labial frenulum all torn up angle of the jaw.
Soft tissue cheek.
Eyelid bruising, both the upper eyelid and the under inferior under eyelid.
And then again, subjunctival hemorrhage, although this kid has some other stuff such as eyelid bruising on the right upper and right, lower eyelid.
On the left upper soft tissue, teak.

He just has a lot of breathing, but he also has a nice big sub conjunctival hemorrhage to help us understand faces.
Then P is patterned and I included a number of pattern type bruising here.
So sometimes it's the shape, right?
You see in this child in the bottom middle lines and they're roughly parallel over here in the bottom right of the screen looking out or looking towards.
On the bottom left of the baby's leg, you kind of see weird pattern bruising on the upper left hand corner. Looking at the screen, you do see round bruises with some scrapes or curvy linear scrapes in it. In the middle upper you see something that are concerning for.
Bite marks.
They are opposing arches, either bruising with or without breaking of the skin.
Top right hand corner are buttocks with some widespread bruising and bitikki eye as well.
Some linear bruising along the Back Creek.
And then on the bottom right, again, buttocks where you kind of see linear parallel lines again.
So these are all examples of pattern bruising. And when we think about accidental bruises, you can look on your own body.
Do they tend to be patterned? No.
So like we've talked about, there's a bruise balancing act because bruises in active mobile children are common.
But bruises are also one of the most common manifestations of child abuse, so this is a difficult game sometimes.
Going to change now into what should we do?
So when we see a Sentinel injury, one we should recognize it, and two, we need to get more information.
So in medicine, we call this additional work up.
So a detailed history which I'm going to talk through on the next page.
A very complete, thorough skin exam which is head to toe naked and oral exam and when we see things on the body we should do forensic photos or the Ed nurse should do forensic photos.
Sometimes we look inside the body. Depending on the age of the child. With a skeletal survey which is head to toe, X-rays of all their bones, a head CT to see if there's any skull fracture or bleeding on the brain, and if there is bleeding on the.

Brain, then, that child would be admitted to have a dilated eye exam to look for bleeding in the eyes.
Sometimes we'll get trauma lab screening for belly trauma looking at liver enzymes, pancreas enzymes, and then if the level.
Are elevated to a certain level. Will recommend an abdominal CT to look on the inside of the valley and then certainly we never want to call child abuse abuse without screening for a bleeding disorder. If screening for a bleeding disorder makes sense, so children with.
Bleeding disorder don't typically present just with pattern bruising, so sometimes I'll have Luke Marks and the child's been beat with about.
I don't usually recommend bleeding disorder screening labs then.
But if it's just a whole bunch of bruises and concerning locations and in normal locations, we might do screens for a bleeding disorder. If a child presents with multi system trauma such as head injury, broken bones, bruising belly trauma, I'm not probably going to screen for a BLE.
Disorder, because a bleeding disorder isn't going to cause broken bones, belly trauma, etcetera.
So in terms of the history, what do we mean?
So we're kind of thinking about the mechanics of the injury.
Where did it occur?
How did it occur if it was a fall, which is a very common way injuries are occur.
How high was the object?
How was the child left on the object?
How was the child found on the surface?
Typically the floor.
What type of floor was it?
Did anyone see it? And if not, did anyone hear it?
It, and if not, how did you find out about it?
What is your child typically able to do developmentally?
Sit alone typically starts at six months, crawling typically 7 to 9 months, pulling to stand somewhere around 7912 months walking alone, 12 to 18 months.
How did your child after seem after the injury and has your child had any prior injuries?
And what?
I asked.

There is for the children who are not yet mobile.
Has your child ever had any bruises in the past and I asked them like, tell me where point show me where and when was that?
Has your child ever had bleeding from the nose?
Has your child ever had bleeding from the mouth?
I'm looking for prior evidence of injury in a not mobile kit.
In addition, at Children's Mercy, we have a screening policy for abuse, and I put a hot pink box around all the physical abuse concerns, which are based on.
Age of the child and epidemiology of abuse and how does a policy help us?
Will it reduces the influence of our emotion and our relationships.
IE subjective information and tries to keep us as objective and fair in assessment of Sentinel injuries and other injuries as possible. And as you all really know already that any institutional concern for child abuse and neglect requires a social work, consult and then social work will do.
Consultation, which involves a patient at risk note.
So in addition, we have some medical work up that we do looking for occult or hidden injury.
So skeletal survey, when there's a concern for physical abuse, it should be pretty much automatic. And any kid less than two and two to five is on a case by case basis. And then we also tend to get a follow up skeletal survey when we have a pretty good suspicion for physical abuse in a kid less than two.
And the reason for the follow up is in the initial skeletal survey, when they meet us, they might have really fresh fractures, particularly rib fractures or little chips of bone fractures off of their long bones and their arms and legs that are hard to see on initial S.
Survey, but they're present in the kids body.
These fractures may not cause any outward signs, so we weighed about two weeks for the healing of those bones to begin, and when the body is healing.
Bones on the inside it.
It's kind of messy and you're able to see that healing in about two weeks. So we repeat in Scan clinic, the skeletal survey called a fuss which stands for follow up skeletal survey to look for healing fractures and certainly we're looking for any new fractures which there should.
Not be if the child is in a safe situation. So those are the skeletal surveys.
We also get a head CT, so when children.

Less than six months of age who are suspected victims of.
Physical abuse. It's really easy.
They need to have neural imaging from six months of age up to less than two years of age.
We're looking for something else.
Do they have a facial injury?
Do they have multiple fractures?
Do they have rib fractures?
If yes, then they need neuroimaging. If the neuroimaging shows that there's blood in or on the brain, most blood that we deal with in the child abuse world is laying on the surface of the brain beneath the skull, but not in the brain.
Then they're gonna get a dilated eye exam like I talked about earlier to see if they're bleeding. Also, in the eyes, the screening test for belly trauma really apply based on the couple of studies we have to guide us in kids lesson 5.
But there are certain times when we on scan team on call say just don't bother sticking the kid because it's probably not worth sticking them to get the labs. If the only thing we have is.
A suspicious bruise on an older child and then certainly if the lab show us elevated levels of those proteins, then we're going to want to look with abdominal CT.
So what happens when we look for additional injuries?
Well, we find them and that probably informs why we're doing all these tests for kids who appear to just a single bruise.
So this study looked at infants young that six months with bruising or bruises, who have additional medical work up and what they found is that 50% of them had at least one other additional serious injury. And we can kind of break it down 23% had. Fractures, 27%, had evidence for head injury and like 2.7%, had evidence for abdominal injury.
This might help you understand why sometimes we just say no for an older.
Child, I'm not going to stick them for the only reason of looking at the liver and pancreas enzymes.
So do you think we apply the same practice to burns?
So I'm gonna show you some pictures of accidental burns.
So they tend to have indistinct margins, so it doesn't like look like a cut off. They do not occur in multiples as you can see, this is all one side of the kids body. And as you can imagine, he reached up with his left hand and pulled Somet.

Very hot.
Onto his body, like a pot of macaroni, and the water ran down his arm and the left side of his trunk.
And they're usually on parts of body, not clothed, but not always are exposed areas like our hands, feet or face, depending on the time of year.
Indoor outdoor versus oops.
This one shows also how when you reach up in your toddler, you usually look up and then you pull the hot pan.
Or whatever.
Down on you and it can also get your face and this one is the iron fowl and fell onto his foot.
Which could look like someone put the iron on his foot.
I would understand if you thought that, but also if he's standing there barefoot and the iron falls down and lands squarely on his foot, we might kind of get this triangular shape burned.
Abusive burns tend to be well demarcated pattern and more severe.
It's a well demarcated, we're moving, we're saying, like you can tell, there's this clear line between burned and unburned skin, like in these hands.
Could be feet that were dipped in hot water or over here this is like.
A.
Patterned. But when we see kind of this grid thing and it's a colder time of year, we do wonder, did they accidentally run into a space heater in the home and in the bottom left hand corner, right hand corner, there's a cigarette burn.
So typically with abusive burns, the history doesn't match the burn. They're developmentally inconsistent.
With what the child can do, there's a delay in seeking medical care.
And the high risk areas, particularly around the time of toilet training.
Our hands, feet, genitalia and buttocks. So to answer the question that I started with, is this type of skin injury and skeletal survey very much go hand in hand? And so when we have concern of a burn injury that is a skin injury that needs a skeletal surve.
In kids less than two, if there's concern that the burn isn't accidental.
So reporting on scout or on Sentinel injuries?
So when we think about reporting, we're thinking of two things that we're asking of our team members or multidisciplinary team members, namely Child Protective

Services and or law enforcement.
So one is investigation is needed.
I can't go to the home social work. You can't go to the home.
But we need someone who can maybe go to the home, see the home.
Interact with other individuals in the home.
Who weren't present during the healthcare visit and also child safety is an issue.
So Sentinel injuries and reporting. So back to that Sentinel injury article that I showed the cover from.
A very number of slides ago, sometimes provider saw the Sentinel injury and did not report because they did not seriously consider abuse.
They did not recognize the significance of the injury. They diagnosed it as self-inflicted.
They didn't ask what happened to your child and then they accepted the proposed mechanism as plausible.
When it really didn't make sense.
And they considered abuse good.
They did a workout, but when the workout all came back negative, they were less concerned for the bruise being abusive.
So that's a problem, because an otherwise negative work up doesn't mean that the Sentinel injury that you see, namely the sub conjunctival hemorrhage, the oral injury, the bruising on a very young child, doesn't represent abuse.
It just means, thankfully, there's no internal injury to go along with the concerning skin finding.
So when we report, we want to wait for the work up that will come back in a reasonable time, like during the Ed visit, right?
The wording of our reporting is key.
We need to say there is a concern for physical abuse based on this finding. We are requesting assistance with investigation.
Please, we are requesting a safety plan, please, because we're worried that this child suffered abuse in their caregiving environment or environment.
In general.
Usually tell CMH employees that we are not in the business of making safety plans.
Exclamation mark. Rather, this is the purview or role of Child Protective Services and or law enforcement. When there is a concern for abuse in the child's caregiving environment or environments.

So sometimes medical tests are pending, but based on all the information that I'm relaying to you right now, Child Protective Services, there is concern for physical abuse.
We need help with an investigation and we're highly concerned about the child safety during the course of the investigation.
Can you please take it as that type of call?
We don't want them to take it as a non caretaker referral or other classification that doesn't result in investigation and consideration of the child safety.
So when we look at what happens when people don't report, it's a sad story really that because there is.
Evidence to tell us that.
The events that led to the first abuse are still present in the child's environment.
So that abuse recurs for a certain number of children, and then it doesn't just recur, it escalates.
So the children who present young children who present with a bruise initially may later present with a very serious or lethal head injury.
So I'll go back to this slide reminding us that about 30% of abusive head trauma cases are missed in about 20% of fracture cases are missed and therefore reporting is important.
So it's not our job to investigate or confirm abuse prior to making a report.
Most reports actually don't need to. Removal of the children. We get worried when the children are put on no safety plan.

MC **Metheny, Jacquelyn, C** 37:52
Great.

ME **Moffatt, Mary, E** 37:54
And then a helpful phrase for families is your child has an injury that I wouldn't expect from a trip from typical play or accident. And as mandated reporters, we're required by law to report these types of injuries.

MC **Metheny, Jacquelyn, C** 38:05
What?

ME **Moffatt, Mary, E** 38:10

We understand that families sometimes have different psychosocial risks and we understand accidents can happen. Medical problems can be present.
So that's part of our assessment, but sometimes it takes time to rule out a medical problem, and sometimes it takes more information.
While that will come later downstream, after the report that helps us figure out, you know what, after all this was an accident that makes sense.
Even though it doesn't look like it makes sense today.
And sometimes services may be helpful to improve the lives of those facing significant challenges.
Other similar situations need evaluation, and there's two.
I'm gonna mention one is siblings.
So when we have children sharing a caregiving environment, it's hard to know.
Is only the child I'm seeing right now in front of me the only victim, or are there other victims?
So someone's actually looked at the prevalence of abusive injuries in siblings and household contacts of children who are diagnosed with child physical abuse.
And what we know is that abused children who are less than two years of age when there's a contact, those children should have a skeletal survey, regardless of their own exam findings.
So the skeletal survey applies to concern for child physical abuse.
Your assembling our household contact of abused child.
You 2 need a skeletal survey to make sure your bones look healthy. Even if you have no bruising or oral injury.
Data would tell us that twins are at higher risk for abuse.
Fractures, particularly Brid fractures compared to non twin contacts.
Another situation that's similar is intimate partner violence, where the child is actually involved in the events. They're not in another room sleeping, they're in the same room as where the violence is occurring. And when we look at those children, guess what?
We find injury in those children too.
So we recommend that children who are caught in aipv event.
And have a thorough skin exam, oral exam, and if they're less than two, they got a skeletal survey. Even if their skin and their mouth doesn't show any injury. To make sure that they don't have any injury involving their bones as well.
So there's some job aids who can help us do this work? 'cause it isn't easy.

It's very rewarding work, but it's not easy work.
One is the child abuse toolkit that's really bigger than the screen shows right now.
But how do you find it?
So go to the scope and go to tools and apps which is in the Royal Blue Banner bar.
Click on tools and apps and then you'll get a list of all the tools and apps and their labeled.
Clinical, educational, etcetera.
So you'll find child abuse toolkit under the clinical 1.
You also at mercy have a team of child abuse. Pediatricians were available through the web on call outside of children's mercy. People like a physician or a nurse practitioner can talk to us by a 1800 go mercy. And then if you want social work, help.
By the people who are your colleagues who do child abuse, Pediatrics day in, day out, they have an intake line.
There's also an app called the Child Protector app, which is free, and this is to help both medical and non medical professionals figure out what is needed for children when there's concern for abuse.
Internally, we have a par brief, which is like a huddle between physician orders.
Practitioner taking care of the child.
Social work has been asked to do the social work consultation.
And sometimes also child abuse. Pediatrician on call.
And this too is found in the child abuse toolkit. The Gray box is at the bottom. Are.
Please be prepared to discuss the following topics in about 5 minutes.
This is the information to have a fruitful conversation, and then in order to decide together about the following next steps.
Above it talks about what to look for.
Who can start a par brief when to consider involving scan and how to?
Escalate if there disagreement among the care team members. Sorry.
Other aides are the patient at Risk Note review, which on call we do every day and we have a dual lens, a safety and a quality review.
So how do we find out about all the parses?
There's an e-mail that comes to us on call person Doc for Scan Team has to review this Excel spreadsheet for every par in the past 24 hours.
We want to know if the kid needed a safety plan.
Was there one?

Is it safe? And was the medical work up of good quality?
For example, if they're less than two and there's a concerning bird, did they gather skeletal survey?
It also allows us to discuss with law enforcement Child Protective Services the next steps in the case testifying court, and then also bring the kids back to our clinic who need to come back.
Protected notes actually are a job aid too, so that just tells HIM medical records don't put this in the portal and don't just hand out the note for anybody who asks for the note, you need to first check with the author to see is it safe.
For this note to be released.
So it's definitely A-Team effort, so I thought I would take this opportunity to tell you a little bit about child abuse, Pediatrics.
So what do we do?
We take care of children with suspected physical or sexual abuse, any type of neglect in general maltreatment.
We are a sub specialty of Pediatrics, just like pediatric cardiology, pediatric intensive care unit, pediatric emergency medicine.
What does this mean?
Is that somebody graduated from medical school?
And neither got AMD or AD O degree.
Then they took a three-year residency training program called general Pediatrics, the end of which they become a general pediatrician and take the board exam and general Pediatrics and become board certified in general Pediatrics. Instead of saying I want to go practice as a general pediatrician, some of.
Those individuals say I want to do child abuse Pediatrics so they sign up to do three more years of training called.
Fellowship in child abuse Pediatrics.
We have a big role.
Obviously we consult on cases we lend our forensic expertise to other teams. We provide education both to healthcare professionals and non medical professionals.
We participate multidisciplinary team work both within the healthcare setting and within society.
Yes, we go to court and testify.
We do research to bring new knowledge to the field, and we're also very active in advocacy for children and trying to prevent child abuse.

So in conclusion, I would like to hope that you walk away from today's talk with with recognition that Sentinel injuries may be the very first line of abuse of a child, even though the work up looking for additional injuries may be negative, it doesn't mean that that first.
Sign isn't concerning for physical abuse.
And making a diagnosis of abuse can put a child with are missing a diagnosis of abuse. Not making a diagnosis.
Can put a child at risk for significant harm, meaning ongoing abuse, even death.
So thanks a lot and I'm happy to take any questions or comments at this time.

Lee, Sarah, E LCSW, LSCSW 46:13
Thank you, doctor Moffett.
We're going to go ahead and I'm going to get started and if do you mind staying on for the next half hour and then we can answer questions at the end.

Moffatt, Mary, E 46:15
Yep.
Sounds good.
Thank you.

Lee, Sarah, E LCSW, LSCSW 46:24
OK.
Great. OK.
Let me get my screen shared.
OK.
So at this time I'm not able to see the chat or the.
The audience.
So I'm gonna go ahead and get started. My name is Sara Lee.
I'm a social worker in the Ed team.
I'm a team lead for the Ed after hours and today we're going to present on the core competency for child abuse and neglect. We're going to focus on child physical abuse and neglect.
So our objectives for today is to provide updates regarding practices.
Approaches. You know, I'm going to have a lot of things that are going to repeat a little bit what Doctor Moffitt shared.

And we're just going to emphasize the most important pieces of physical abuse and neglect.
We're going to increase knowledge, increase knowledge on skills and how to collaborate with law enforcement. Our child protection agencies and to enhance that documentation skills for our abuse, neglect consults.
I'm not going to go to these websites, but like Doctor Moffett shared, we do have the scope child abuse toolkit.
We have the CMH policy on child abuse and neglect and we also have our social work, child abuse, neglect and skills and knowledge that you can go to through this PowerPoint and everything will be shared as well in teams.
For practice standards, today we are identifying abuse safety plan issues.
And planning how to complete assessments. Our interventions documentation follow up and resources.
So I'm not gonna read these word for word, but just to overview our physical abuse, emotional abuse and neglect. Definitions are here, and like Doctor Moffitt had shared, physical abuse is non accidental infliction of physical injury to a child and also include dependent adults or dependent older child.
They are also vulnerable.
Victims as well.
I picked this statistics off the national child abuse neglect data systems as of 2022 or 24. We have the 2022 data.
Basically indicates that there was a slight decrease from 21 to 22.
In overall abuse findings, 74% were neglected.
Which is our highest amount of findings for abuse and neglect.
Second was physical abuse.
Third came in with sexual abuse and then 6% for psychological maltreatment.
That underneath I thought was interesting.
Unfortunately, even though the statistics have declined, the fatalities increased from 21 to 22.
Sorry about that. OK. And as Doctor Moffat pointed out, our most vulnerable victims are those that are one or less, which is why we go through extensive.
Treatments and medical work ups to identify the abuse and not to miss abuse on those kids because they are the most vulnerable.
And most as you can see, that kind of declines as a child gets older. As far as the physical abuse.

Findings.
So how is social work consulted?
Social work is going to be consulted for abuse and neglect anywhere in the health system. They're going to be contacted by a provider that has expresses concerns for physical abuse or neglect, and at the initial thing you want to discuss is is there immediate safety concern? Do we?
To implement a one to one, is there restrictions that need to be made?
Are there blackouts that need to be made? Those all fall under social work and the providers knowledge of the situation at the time.
Even prior to meeting with the parent or adult to get more information, we made it implement A1 to 1 immediately if we have.
Say you have a young child.
Non verbal that has injuries that the provider there, the person with them could potentially be the perpetrator.
So when social work does get involved with the family, they will meet with the parent guardian. Whoever's or the adult caregiver that may have brought the child in, and we complete a psychosocial assessment and we'll go on in a couple of slides about what the assessment includ.
But that is documented then, as a patient at risk and then after that is completed, we will collaborate back with the medical provider on what happens next.
So just a little overview.
Review on what we're identifying in our psychosocial assessment.
We want to look for risk factors, so we want to discuss with the provider, with the parent or guardian.
Is there any parental substance abuse in the home?
Is there domestic violence past involvement with Child Protective Services?
Past involvement with law enforcement mental health history.
Is there any current symptoms that are?
In the environment at the time.
Is the parent or caretaker isolated?
Do they lack supports from extended family from friends? Are there financial needs?
In the environment, are there safety rest such as firearms?
So those are the things that we want to assess for any risk factors that might heighten the the concern for abuse. It may not indicate abuse, but it could heighten the concern that we want to share with the provider.

And then we also want to look at the supports 'cause when we're looking at safety planning and what the next steps are, we want to identify who the family has as as a support system. The family and friends, what their parenting knowledge is, what their knowledge is for.
Child development. Do they have a faith community?
Are they connected with community partners already that involve some support like first steps?
Mental health treatments are they engaged already in mental health treatments?
Academic strengths for a child that's older that you know, are they doing well in school?
That's that's a positive.
Employment or financial means is also seen as a strength for the family financially, and we can also assess for any cultural pride.
At times, we may have to talk with the with an adolescent that's in the clinic or emergency room.
Because we don't know much about the abuse, but the abuse has been reported. Maybe it's been reported by our mental health crisis team our aims. Ames team may have. The child may have disclosed abuse, and we need to gather a little bit more information on that.
So sometimes we are talking with the team and we just want to make sure we have those same trauma sensitive practices to obtain that cursory information as we did. When we talked last week about trafficking concerns and sexual abuse.
Patient discloses maybe during admission.
So those are times that we might need to assess for safety immediately. If this is a new admission or a new disclosure after the child's been admitted. And then there's times where a patient is unaccompanied, maybe the parents already been arrested, so they're not going to be.
Presenting to the hospital and and the information is.
Is not known unless we, you know, get some information from the adolescent.
There may be times where police officers available and could gather information. Information from them as well.
So next steps once we have that information, we want to consult our scan team and collaborate with our medical providers.
We want to reassess the safety plan, whether that's adding a different safety plan or removing the safety plan.

Social work would then complete a hotline to children's division or Kansas Department for Children and Families.
Social work and medical team may decide to contact law enforcement, the law enforcement jurisdiction.
Is notified of where the incident has occurred and we also want to determine siblings as possible need for immediate assessment and safety planning.
And as Doctor Moffitt pointed out, siblings are at a higher risk when there is already identified abuse in another sibling.
So if the child is under 5 or, sorry if the siblings are under five, we want to determine with with the help of our scan.
On call, if we need to have those kids brought into the ER immediately, and how we can coordinate that with family or children's division to help with those things.
And if we can't get the kids immediately seen, can we have children's division or law enforcement?
Lay eyes on them at the home and do at least a follow up in the home immediately to assess for any immediate concerns.
So we're also going to be collaborating with those partners for law enforcement and our Protective Services.
This also could include transfer to the Ed. Say this is some occurred at urgent care center. We may need to decide to transfer that child to the Ed or an admission to children's mercy.
Are there safe careg caregivers identified by family and Protective Services?
I often talk about those things early on in my discussions with family.
To be transparent with the family, if we are looking at, we are definitely going to need a safety plan for this child.
Who in your life right now could provide that safety planning so we don't have to look at removing?
The placing the child into foster care right away so we can identify with the family.
Some safe caregivers provide that information to children's division so they can assist in they do some background checks and they can also confirm that these are indeed safe caregivers to to IMP.
With that safety plan.
So we do play a large role in that.
Safety planning 'cause we cannot discharge a child into the Community that has not been properly safety planned by children's division or law enforcement or some

some type of admission.
You know, we can't just discharge them home and expect that to happen within a few hours or the next day.
In Missouri, we can complete ACS 33 form that takes emergency protective custody. Those can be signed by physicians and medical providers in the state of Missouri only.
As opposed to Kansas.
And in Kansas, we'll talk about how emergency protective custody is taken.
So the physicians role in protective or social work, role protective custody as you can see, that's the form. If you're not familiar with it, that is included in teams that we can print off if the law enforcement doesn't have one.
Or, you know, children's divisions.
Not already involved. So in the state of Missouri Physicians, protective custody is temporary and allows Missouri Children's division to locate alternative care for that child if needed and develop a safety.
Safety plan. They do expire after 12 hours, but the family court can extend that another 12 hours. So usually that's about 24 hours that those.
Court forms are valid and can.
Adhere as a court order.
Social work and medical provider will collaborate with when physicians protective custody has is being considered.
Will assist with social.
Will assist with filling out those forms if needed for the provider.
They will, of course need to sign them.
Social work will then immediately hotline if it hasn't already been hotlined, and let the hotline know that.
Time that we have taken physician custody, social work will contact Jackson County Family Court to inform them that protective custody has been taken. If Children's Division's not already involved, we can. We can do that part.
There are some afterhours numbers located in teams on that protocol that's listed there for the social work, physician protected custody protocol.
For Kansas physicians out in Kansas, Cmk cannot take physicians custody, but for situations where there is extreme concern that a family may just walk out of the hospital with an abused child, we want to make sure that that we get them the same amount of protection as we.

Would here at Adele so we can notify?
Security.
And ask the security to contact police.
Explain the situation to police, express that we're requesting some support and clearly that protected custody may be needed.
Assess the safety of notifying the families. May be something we don't want to notify the family about before police get on site, and if Overland Park police take protective custody, they will work with their appropriate police jurisdictions as needed to create a an intervention and using staff support.
At Kansas, if we're offsite, work.
Doing the consult virtually, we may have to get some assistance from.
The nursing supervisor and providers to help with that process.
This.
So I wanna just highlight a few slides here on safety planning.
Initially, we want to discuss when a safe safety plan is needed for one to 1. So when there's concerns for physical or sexual abuse and the alleged perpetrators present.
Or the alleged perpetrator is not identified.
We don't know who's caused these these injuries, so we need to put them on a one to one, which is our staff providing that that supervision.
When transporting a child from one facility to another.
If we are suspecting the person that they're with to be the perpetrator, we need to make sure we do that safely and if we can get an EMS transport, that would be more ideal than having the perpetrator.
Transport the child.
Anytime Guardians, caregivers, parents, or visitors pose a threat to the well-being, we might want to.
Consider us a one to one safety plan, whether that's elopement or they're just not on board with the whole treatment process and 1:00 to 1:00 safety plans are evaluated weekly upon admission.
So that's something that's always looked at for reevaluation.
All abuse, neglect consults will need a discussion for safety planning. We want to collaborate with our providers or charge nurse scan providers and determining what that safety plan's going to look like and what is needed.
And then determine if their siblings in the home like we discussed before, we need to make sure we need to bring those siblings to the hospital if they are under 5 or if

they can be safely seen by child, children's division or and then can be scheduled for.
A later exam in our scan clinic.
And then obviously use the the template that we have in our social work consultation note to complete that put in the blackout orders a log is completed on the floors to document who is visiting at what time and.
Changes may occur to safety plans during admission.
Based on impending death concerns, and if you don't know this already.
We do have to provide that one to one supervision for the 1st 24 hours of admission.
After that 24 hours it is going to be dependent on our staffing availability and we do want to encourage parents to call ahead to ensure that staff is available to.
Provide that supervision.
OK.
So Doctor Moffitt went through par briefs, but par briefs are something that we can always request from provider if we have concerns. Maybe that haven't been identified by the provider yet and we want to discuss next steps and those could be.
Physical injuries.
Sentinel injuries like Doctor Moffitt discussed in detail those subjunctival hemorrhages oral injuries.
Fractures on a non ambulatory infant, fractures in a child less than one, bruising on a child less than six months on those vulnerable areas of the body and in a child.
Burns need to be evaluated, especially in children that are less than two.
Head injuries.
And social work can request those if, if we just need to all be on the same page, discuss the diagnosis, discuss what the next steps are going to be.
If there's any is the parent aware of the physical abuse?
Has the child made a disclosure and and just considered doing these as early as possible so that everyone is on the same page and can move forward if we are in disagreement? If the team is disagreeing on the next steps, you can escalate that to the you know.
To your appropriate chain of command or call the scan on call.
Ask for position safety officer, admin call if needed.
Get your manager involved and potentially an event report may be needed if there's some disagreements that are not.
Resolved at the end of the brief.
Oops.

OK, I'm gonna briefly just talk about our mat. Our maltreatment action team, which is when abuse occurs on site.
So this is not something that social work, frontline social work staff are going to be involved in, but it is important to know that if you are contacted by any children's mercy staff member that says that there's some concerns for child on site maltreatment occurring.
Then we need to escalate that to our managers, Contact Manager on call.
And they will know the next steps to to implement, but initially everyone's responsible for insurance safety at that time.
So whatever safety needs to occur, we need to establish that as well. When are, when there are these types of concerns.
So remember, if you see something, say something. If you're aware of it, please escalate it to your managers.
We are not going to be the ones completing the assessment part, but we need to escalate it and notify.
Managers of concerns and this is just their contact there that you can e-mail and then of course contact your manager.
So I'm going to shift a little bit to medical child abuse.
We're just going to talk briefly about.
Medical child abuse that which most social workers.
Are familiar with the term munch houses by proxy, but we do refer to that as medical child abuse.
It's when a caregiver is potentially damaging the child's health secondary to insistence on misrepresentation of symptoms or requesting unnecessary treatments and those kind of findings are a little bit more difficult to diagnose.
But if you're involved with a medical team that has concerns of that, definitely consult the scan team.
Make sure the provider is getting scan involved and determine as a team what the next steps are going to be when documenting anything you just want to be objective and document your observations. You don't want to document that you are concerned about medical child abuse or munchausen's.
And initially patient at risk may not be indicated because we do want to keep.
The medical record.
More.
Secure from any kind of potential involve you know that the family may see and then

we want to just have the guidance of the scan team.
Possible warning signs.
Maybe some dramatic but inconsistent medical history.
The appearance of new or additional symptoms following negative test results.
The presence of symptoms only when the patient is along with the parent or caregiver and eagerness for medical tests by the caregiver.
History of treatment in multiple locations.
Reluctance by the parent or caregiver to allow provider to speak with other providers or to speak with the patient or other family members.
Extensive knowledge of medical.
Terminology.
So we're gonna shift now to medical neglect.
Medical neglect is defined as a guardians failure to provide the adequate medical or dental or mental health needs that a child may need, depending on what the injury is or the illness is. Some of the examples is refusing or denying medical care, refusing to support the child's.
Medical expenses for an acute illness, ignoring medical recommendations by physician.
Or failing to administer medications.
Medical neglect.
Is often social work's consulted. I think a lot of this occurs in clinics when there's no shows and frequent misses to appointments. And then also we get it consulted in the ER, where a child may present days after an injury or burn.
So there's some neglect there that are often consulted for social work, and we do want to assess immediately for any elopement risks.
Based on the presence of some neglect concerns.
Social work will complete a child protective hotline and.
Will advocate it's important to try to advocate for some IIS services or court jurisdiction if we see this as a pattern we want to consult our scan team.
It may need a safety plan prior to discharge, so this may be something that we still need to safety plan even though it's not abuse, we still need to safety plan because of the concern it could lead to further ailment of the child or potentially death.
Refrain from documenting our judgments or speculation and try to limit the social work staff that are involved just to limit any kind of bias or or judgments made.
In the assessment you want to discuss with the family what barriers might be.

Occurring to to prevent them from obtaining the proper medical care.
Care where their financial needs.
Also, what treatments have already been done? So it's important to know like maybe it's a lack of knowledge of the medical.
System and kind of how to navigate that and they've tried some things at home and that's how their parents did it.
What are their cultural differences?
What are their beliefs and then consequences to a family not complying with the recommend recommended treatment?
Want to discuss that with the family?
You want to document the that support concerns for medical neglect in the patient's medical record to support the need for intervention.
So what are all the concerns?
And that's really important so that we know in the if they come in again that these these issues have have happened in the past.
Objective information obtained from the provider and the family and document those that information and the patient at risk.
So the next slide here is about our burn assessments and burns. As Doctor Moffitt showed, you are just can be extremely horrible to to visualize.
To see and can look so, so worse, so quickly and get bad really quickly.
And it is something that we do see often being having some neglect components to it 'cause people often treat them at home because they're scared or they don't know what the next steps are going to be.
The child's going to be taken away from them if they present to the hospital.
So we definitely want to be involved in all burns under three years of age.
So that is now a level one. I mean, we are a level 1 trauma center. So part of our certification is to ensure that social work's been completed.
Assessments on Auburn's that we're seeing under three years of age, so we need to complete those psychosocial assessments with the family. We want to document that in a patient at risk assessment.
It may not be that burns are reported to CPS or law enforcement, but we need to assess for concerns for non accidental trauma, for lack of supervision, neglect or non safe home environment. We want to obtain information on how the burn was sustained.
So we want to look at The Who is present, what happened.

When did it happen?
Where did it happen and how did the caregiver respond once they were aware of it?
So does a do they put ointment on it?
What kind of ointment was it that they put on it?
And as much as your knowledge is depending on where you are in the hospital, you might have more knowledge than other social workers.
It's not that you have to describe the burn team and the burn treatment process, but if you're an inpatient burn social worker, that may be in your role.
But in the ER you might just want to, you know, just introduce them.
Let the let them know that there's going to be a burn team involved and that there's going to be some burn treatments, but that doesn't have.
You don't have to go further than that.
You want to provide that crisis intervention?
And identify any community partners. If this was a fire house fire, you know, make sure that Red Cross is involved and then if Child Protective Services and law enforcement need to be involved, then we need to initiate those reports.
OK. And so our next neglect is involving Alyssa, substances in the home and that is something that we are seeing a high level of incidences within our hospital system is ingestions of illicit substances by toddlers. And these are considered adolescent or accidental ingestions.
So we do have an auto page for these now.
So the Ed after hours team does get an auto page when a drug screen comes back.
Positive for an illicit substance, but sometimes maybe they kids been here for four hours and they didn't get the UDS, you know, completed until you know back and everything until hour 5 or 6.
That may be when social work ends up getting involved.
Other times it may be right away that we get involved because of the presentation of the altered mental status and the young age and just the, you know, the provider's knowledge of what that might look like.
So it may get involved earlier on and then just wait for that drug screen.
Kinda confirm what is in the system.
So that requires a patient risk assessment.
It requires contacting Child Protective Services 'cause we're concerned for lack of supervision and potentially endangered child endangerment, and then law enforcement is also notified to assist in that investigation process to make sure that

the child is in a safe home.
Potential need for safety planning upon discharges is necessary.
A safety plan may look like for marijuana ingestion.
It may be that we complete those hotlines, but we still consider the child safely home with the provider or with the with the parent. You know, as if they're a Missouri resident, you know, we know that marijuana is legal for a parent to have. So we're, you know.
We can send them safely home as long as the parent is willing to store that marijuana safely. We can give them a lock box to do that.
But we're still making those reports and we still want to make sure we let the family know that we're making those reports so they can follow up in the home and make sure the child is not going to continue to have these types of ingestions now if it.
If it is a an ingestion of, say, fentanyl or something more illicit.
And not legal than we are looking at a safety plan outside of the home. So what? Whatever that might look like, whether the child was visiting father and are safe, going home with Mom.
They live in different homes or if they need to go home with a grandparent or another family member.
And then finally, gunshot wounds.
Social work is involved in all gun shot wounds.
We do receive auto pages for gunshot wounds, so whether that's a trauma or just comes into the hospital with a gunshot wound, we are going to get auto page for that consult and we need to do a patient risk and do the whole assessment like we would for.
Any kind of abuse or neglect?
We may or may not be reporting to children's division based on that. If it's something that parents are involved in, of course we're going to be doing a paid.
A child protective custody child protective.
Services report, but if it's something that was just, you know, child was in the wrong place at the wrong time on the street and got, you know, shot on a drive by, we may just be involving law enforcement and those types of gun shot wounds and then our.
Stab gun shot wound.
Stab wound policies are here.
We do report all these types of injuries because it is the law in Kansas and Missouri to report those injuries.

Where providers are providing that type of treatment.
For those types of injuries.
And then we have a cover packet.
That we provide to the family is that has some additional resources and.
For.
Sorry, the words escaping my mind, but for how crime crime advocates can can follow up with the family through.
The police jurisdiction. And then if it's in Kansas City, MO, we can refer to our social workers at Kansas City, MO, Police Department and they provide a lot of resources and follow up with the families.
We do at through the social work department offer follow up with the families at one week, one month or three month intervals, and if you are involved in a gun shot wound and you're not familiar with the follow up, please e-mail the information to myself and we can.
Get that information to the on the log sheet and to the.
Kansas City, MO. Police social work referral made if needed.
And contacting law enforcement.
Just a couple of extra slides on law enforcement contact, if a child discloses physical abuse to anyone that is and the child has concerning injuries for physical abuse, those can be concerning for needing a law enforcement report.
We do not report all.
Disclosures, if it depends on if there's injuries and how you know what the what the situation is with the person disclosing it.
But most disclosures of child physical abuse is going to be reported to law enforcement, and if based on exam, we have concerns for abuse, have any of those injuries that Doctor Moffitt went over or we would no, you know, no disclosure, but we have the concerns we still.
Would be reporting to law enforcement, and if there's any kind of scarring concerning for abuse, those two would be needing law enforcement even if there's no.
Current injuries.
If police are unable or unwilling to respond, just document that in your patient at risk, even if they're discharging to a safe location, police report still needs to be made.
Best practices is that we make the reports and not put that on Child Protective

Services or the family to do to ensure that those reports are being made.
And then real briefly and handing off, oftentimes were as our social workers were handing off.
Consults for abuse and neglect that occur at one area of the hospital. Say that's a clinic, and they need to come to the ER. This slide is just states, you know, go through the same steps as we talked about in this presentation.
Complete the patient at risk hotline to children's division.
Discuss with the Ed social work staff how that child's going to be transferred if they're going to be directly admitted and then notify.
The social worker and then discuss how the child's going to be transferred, whether it's going to be EMS or private vehicle, and do the police still need to be still need to respond.
Has law enforcement been notified and then send through our message center protocol? Send that hand off as appropriate.
Often from the ER, we're doing a lot of hand offs to scan clinic for that follow up piece that occurs after.
They're seen in the ER like Doctor Moffitt was sharing that.
They come back for that.
10 day follow up after they're seen in the ER for fractures and bruising.
Patient at risks are completed.
Ensure that documentation is completed by the end of your shift so the next shift when things kind of always typically sometimes questions are asked or informations needed even hours later.
And we have to have that information from the patient at risk and make sure we have all the demographic information that's necessary, whether that's the safety plan, demographics or the parents information.
Ensure that Protective Services.
Report numbers. Law enforcement numbers are in there.
And then all pars are reviewed by your manager team, your leadership team, as well as our scan providers.
And then for abuse, neglect safety plans when we're completing any kind of on site safety plan that's documented as well as putting those orders in for blackout if needed.
And a couple extra.
Notes that may be needed is our bridge screen. Follow up if IPV is.

Is involved, and if there's legal information that is needing to be charted as well.
OK.
So we have about 7 minutes left.
Trying to think of the best way to do this, let me see if I can.
In the slideshow.
That.
OK.
You guys can still see the case scenario is a patient that's two-month old infant, twin infant cmpcc clinic for viral respiratory infection upon physical exam provider observes two small bruises on their torso. Parents do not have an explanation for the bruising and report to provider that patient.
Is cared for by them and them only in the home.
Provider consult social work.
Social work completes assessment with the family discovers there's a twin and two additional siblings in the home, all under age 5.
What steps does social work in the primary care doctor need to take next? If you guys want to put something in the chat or raise your hand or just shout out, that's fine.
But if you could share with all of us what you've learned today and what needs to be in the the next steps for social work.
OK, so Sarah Shaffer shared the provider would consult scan. Social work would complete a par.
Do we need to involve?
A plan for seeing the siblings.
Yes, we do.
We need to get the sibling scene as soon as possible. In this situation we have a twin that's going to be highly vulnerable to abuse as well, and then this will be, you know, kind of one of those examples of the Sentinel injury.
And then we want to make a plan of how, how they going to be seen, are they going to be seen in the scan clinic, the emergency room, how quickly can we get children's division involved to determine if.
If the siblings can be located and and how quickly they can be seen.
OK.
So next scenario is a 15 month old toddler presents via EMS for alternal status provider orders.

A UDS that returns positive for marijuana social work receives the auto page for positive drug screen.
What are the next steps taken by social work?
Anyone wanna share what they've learned?
Yes, Danica.

Harris, Danica, LCSW 1:27:00
I'm happy to play along, Sarah.
We would respond in person to the Ed to complete an assessment just to determine what the family may or may not know about how this occurred, and from there it's possible we may need to do some safety planning and additional reporting to both CPS and law enforcement depe.
On the nature of the situation.

Lee, Sarah, E LCSW, LSCSW 1:27:27
Yep, that's correct. Thanks, Danica.
And we can provide a lock box as well for that family.
OK.
There's probably enough time to do one more. A patient a 10 year old presenting an ortho clinic for a referral for right humerus fracture. According to the medical record, patient's been had, had previous fractures and three previous fractures in the last six weeks.
Patients, non verbal, significant medical history limiting the patient's ability to complete daily activities without full assistance from a caretaker patient does not walk on their own.
Patient's total care for feeding, bathing, toileting.
Social work consulted by the clinic provider for an assessment due the nature of the injury as concern for physical abuse.
Social work meets with the parent reports they noticed the injury or the patient was not using the arm.
Parent reports provides no other history for the injury or the previous fractures.
What's the next step by social work?
Angela.

Bradford, Angela, M LMSW 1:28:54

I.
My understanding is you'd meet with the provider, see what they would say about the.
Coming three previous fractures, given that the child, even though they're 10 years old, is completely dependent, I would probably hotline the situation, given that the direct primary caregiver is unable to provide.
An adequate explanation as to how the injuries could have occurred.
And I would check to see if there were other kids in the home to make sure that to check to see if there were need for sibling exams as well.

Lee, Sarah, E LCSW, LSCSW 1:29:34
Sarah, you had your hand up too.
Did you have something else to add?

SE

Shaffer, Sarah, E 1:29:38
Yeah. So like in this case, I'm sure scan will want a skeletal.
I know that there's been some back and forth on who orders that I didn't know if there was any clarity on that.
Mary, I think you and I had a situation like that a couple months ago.

ME

Moffatt, Mary, E 1:30:00
So if it's a 10 year old, no.
But if it's a less than two year old and there's a concerning fracture, absolutely, and I have no relationship with the patient yet as the on call telephone answering person right.
So it is not right that I order a skeletal survey.
So the person who is with the patient.
Providing the care when the concern is identified.
Has a responsibility to order the tests. So we went in order for the Ed.
We wouldn't order for ortho clinic.
It would be the provider in those settings that is responsible for ordering the test when they don't order the test because they've left for the day already or refused.
That's a problem.
Hmm.
That hopefully doesn't occur very frequently.

Lee, Sarah, E LCSW, LSCSW 1:30:59
And this could be a situation.

Moffatt, Mary, E 1:31:00
But you can see then how notification after the fact puts us all behind the 8 ball.
Because now we're like, oh, you're gone. But the patient is still here.
Social work is charged with telling the family you need a skeletal survey.
But the provider isn't around.
Or other sort of awkward moments.
So you bring up a really good memory. There hopefully won't be an instance that we see very often.

Lee, Sarah, E LCSW, LSCSW 1:31:33
Be a situation.
If it did, you know, started in clinic but may.
You have a a par brief, so you discuss with the providers you involve scan.
You may determine it's best to transfer that patient to the ER to have further, if you can't get the skeletal survey done in the in the clinic, do we need to transfer him to the ER to get the skeletal survey completed at that time?
So that might be a transfer to the ER if from the clinic if needed.

Shaffer, Sarah, E 1:32:02
OK.

Lee, Sarah, E LCSW, LSCSW 1:32:06
All right.
Any other questions for Doctor Moffitt or myself before we adjourn?
There's just one other scenario, but you guys can have that.

Moffatt, Mary, E 1:32:13
I just want to raise one more thing.
Sometimes pacu will call us that.
There was bruising notice during the surgery. While we don't go to pack you and do consults.

We've been nice and done this in the past and it just ends up being a debacle. So we've kind of set.
In play a way to approach bruising notice during a surgery.
Someone in pack you should have access to the capture app.
We asked the nurse.
Whoever the surgeon, whoever's concerned of bruising noticed during surgery to please take a capture.
App photo, not a forensic photo, just a capture app photo.
So we can look and see what it is.
Sometimes we're able to say up. We're not worried about that.
Other times, we're like, Yep, we're worried.
We're not going to pack your OR or whatever to do consults.
The person who has a relationship with the family, namely the surgeon or the anesthesiologist, has to have a conversation with the family and then the kid really needs to go to an area of the hospital, probably the Ed, where the whole assessment work up can be done. The.
Pack UN 0.
R is not conducive to that, so I just thought of that as we talked about weird situations that we sometimes encounter.

Lee, Sarah, E LCSW, LSCSW 1:33:29
Yeah.

ME

Moffatt, Mary, E 1:33:30
Thanks.

Lee, Sarah, E LCSW, LSCSW 1:33:34
All right. Well, if there's no other questions, I want to thank everybody for attending today.
And you can always e-mail if you have any other questions.
And then I will.
You'll have this PowerPoint additional information on teams and if you need anything, just reach out.
You guys have a great rest of your afternoon. Thanks, doctor Moffat.

Ramphal, Areli 1:33:55

Thank you.

Hilton, Chelsea, W stopped transcription