Keywords

1. Child physical abuse
2. Screening
3. Systematic protocol

Abstract

Did you receive Institution Review Board (IRB) approval for this project?

- Yes

Educational Track

- Pediatrics

Purpose:

Children often present to the emergency department (ED) for treatment of abuse-related injuries. ED healthcare providers (HCPs) do not consistently screen children for physical abuse, which may allow abuse to go undetected and increases the risk for re-injury and death secondary to escalating abuse. The purpose of this evidence-based, quality improvement project was to implement a comprehensive program to increase ED HCP screening for and recognition of child physical abuse.

Design:

This was a quality improvement (QI) project that included ED HCP education on child physical abuse, implementation of a systematic screening protocol, and use of the validated Escape Instrument.

Setting:

The QI project was implemented in the pediatric ED (PED) of a children's hospital that is housed within a large, urban, academic level 1 trauma center.

Participants/Subjects:

All ED HCPs (physicians and nurses) were invited to participate in the project during regularly scheduled staff meetings. Participation was voluntary. Participants provided their consent for each phase of data collection through completion of anonymous project surveys. Limited demographic data was collected to protect the privacy of the ED HCPs. Fifty-two participants (39 physicians, 13 nurses) completed the pre/post-tests, and 14 participants (10 physicians, 4 nurses) completed the final project survey.

Methods:

A 20-minute in-person educational session on child physical abuse was offered to all ED HCPs during two staff meetings. A systematic screening protocol, including use of the validated Escape Instrument (6-item child physical abuse screening tool), was then implemented to screen all patients ≤ 18 years admitted to the pediatric ED. Impact of the screening program was measured by analyzing ICD diagnostic codes. ED HCP knowledge and confidence was measured with a 7-item pretest/posttest (5-point Likert scale to assess confidence; multiple-choice responses to evaluate knowledge). Utility of the program was measured with an 8-item multiple-choice evaluation survey.

Results/Outcomes:

There was a significant increase in ED HCP knowledge and confidence scores for child physical abuse screening and recognition ($p < .001$). There was no difference in diagnostic coding of child physical abuse by ED HCPs when evaluating a 30-day period before and after implementation of the screening protocol (access to ICD data was lost after 30 days due to EMR transition, resulting in insufficient data collection). The Escape Instrument and educational session were the most reported screening facilitators, while transition to a new electronic health system was the most reported barrier.

Implications:

Comprehensive child physical abuse screening programs, such as the one developed for this project, increase ED HCP knowledge and confidence in child physical abuse screening and recognition. This can result in improved detection of non-accidental childhood injuries. These programs can position emergency nurses to be at the frontlines of early detection and treatment of child physical abuse.
Screening instruments should be built into EMRs, and future research should focus on the impact of screening programs on diagnosis and treatment of child physical abuse. Emergency nurses and leaders should support best practice by implementing standardized child physical abuse screening programs throughout all EDs. Policy mandating screening in all EDs should also be considered.

References

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