JOHNS HOPKINS ALL CHILDREN’S HOSPITAL

Physical Child Abuse Clinical Pathway
Johns Hopkins All Children’s Hospital
Physical Child Abuse Clinical Pathway

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Last updated: September, 2022
Owners: Danielle Mercurio, DO; Holly Wasilenko, LCSW
Johns Hopkins All Children’s Hospital

Physical Child Abuse Clinical Pathway

Rationale

This clinical pathway was developed by a working group consisting of members from pediatric emergency medicine, child protection team and social work to standardize the management of children with possible physical child abuse or neglect. It addresses the following clinical scenarios:

1. Which injured children require a non-accidental trauma evaluation?
2. Which laboratory and imaging studies should one obtain when non-accidental trauma is suspected?
3. Which types of subspecialty care are needed for each patient?
4. When to report and the resources available at JHACH regarding non-accidental trauma patients.
5. Understand the various roles of individuals involved in non-accidental trauma patients, including the social worker (SW), the child protection investigator (CPI) and the child protection team (CPT).
6. Provide clear and precise treatment options and follow up needs for every patient who receives a clinical evaluation for non-accidental trauma.

Background

Child abuse and neglect can pose a risk to a child’s health, ultimately impacting the child’s development. Therefore, a thorough history (interviews with patient and/or family, how the injury occurred, etc.) and examination of the injured children is essential. This practice guideline will outline the essential elements of the evaluation for non-accidental trauma. Once the child has been stabilized and the identification of physical abuse through diagnostic methods has occurred then treatment, intervention, and protection should be provided to the patient.
Getting Started

“…Child abuse consultations are complex in that they are sensitive in nature while having both clinical and forensic/legal significance.”

Council on Child Abuse and Neglect and Section on Minority Health Equity and Inclusion
March 01, 2021

Many of those who work with children and families struggle with investigating and reporting concerns of child abuse. Long-term care providers often worry they will lose the family’s trust and urgent/emergency providers deal with maintaining cooperation amongst the family members and care team during a stressful time. According to CARES (2008), child abuse is under-reported in the United States. Those of us at Johns Hopkins All Children’s Hospital who work with such families understand these struggles. We encourage all providers to call the Transfer Center (727-767-7337) to discuss these concerns with any in-house social worker or emergency center specialist. We maintain the perspective that reporting a concern is always in the best interests of the child as it generates a multidisciplinary screening process. It brings resources to the family which in many cases, are all that are needed. It is not a medical provider’s duty to decide who is guilty. Instead, it is our duty to advocate for those most vulnerable whenever possible.

On the next page, you will see a listing of circumstances in which medical providers should consider evaluating for child abuse and neglect. These are mostly high-risk circumstances. This is not an exhaustive list. If, when considering nonaccidental trauma, the provider feels that the family is reliable and an accidental etiology is an appropriate explanation, then no further investigation is necessary. This often occurs when evaluating a very worried parent who has dropped or fallen while holding an infant. Another example is a toddler, presenting straight from the park with a Toddler’s fracture. Sometimes, consultation with social work may be necessary to evaluate for previous DCFS reports (patients with high use of emergency services, frequent visits with vague complaints or history of domestic violence in the home).

This pathway is intended as a guide for physicians, physician assistants, nurse practitioners and healthcare providers. It should be adapted to the care of specific patients based on the patient’s individualized circumstances and the practitioner’s professional judgment. Rationale for adapting the pathway should be documented in the medical record.
Medical Risk Assessment for Child Abuse and/or Neglect
Higher Risk Situations for Non-Accidental Trauma

“Red Flag” History of Present Injury
- Inconsistent or changing history
- Unwitnessed injury
- Delay in seeking care
- Prior ED visits with vague concerns
- Domestic Violence in home
- Premature infant (<37 weeks)
- Low birth weight/IUGR
- Chronic medical conditions
- Injury not consistent with reported mechanism
- Injury not compatible with developmental age
- Previous DCF Involvement

“Red Flag” Radiographic Findings

<table>
<thead>
<tr>
<th>High specificity</th>
<th>Moderate specificity</th>
</tr>
</thead>
<tbody>
<tr>
<td>Classic metaphyseal lesions</td>
<td>Multiple fractures</td>
</tr>
<tr>
<td>Multiple posterior rib fractures</td>
<td>Fractures of differing ages</td>
</tr>
<tr>
<td>Scapular fractures</td>
<td>Epiphyseal separations</td>
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<tr>
<td>ternal fractures</td>
<td>Vertebral body fractures</td>
</tr>
<tr>
<td>Clavicular fractures</td>
<td>Digital fractures</td>
</tr>
<tr>
<td>Spinous process fractures</td>
<td>Complex skull fractures</td>
</tr>
<tr>
<td>Any undiagnosed healing fractures</td>
<td></td>
</tr>
<tr>
<td>Any fracture in a non-ambulating infant</td>
<td></td>
</tr>
<tr>
<td>SDH and/or SAH in young children without reasonable history, particularly in the absence of skull fracture &lt;1 year</td>
<td></td>
</tr>
<tr>
<td>Femur fracture in patients &lt;15 months</td>
<td></td>
</tr>
</tbody>
</table>

“Red Flag” Physical Exam Findings

- Torn frenulum
- FTT (weight, length, head circumference)
- Large heads in fussy infants (consider head circumference in children < 1 yr)
- Any bruise in any non-ambulating child- “if you don’t cruise you don’t bruise”
- Any bruise in a non-exploratory location. Think: TEN-FACES, especially in a < 4 yr
  - Torso (area covered by a standard girl’s bathing suit), Ears, Neck, Frenulum, Angle of jaw, Cheek, Eyelid, Subconjunctiva,
- Bruises, marks, or scars in patterns that suggest hitting with an object, hand or fist
- Multiple injuries to multiple organ systems or multiple parts of body
- Patterned or circumferential burns
- Adult bite marks (inter-canine distance >3cm, arch width >4cm)

Special Considerations for Non-Accidental Trauma Patients:

Do siblings require evaluation?
- Discuss with Social Work and CPT
- Plan with Emergency Center Charge Nurse/Attending (#727-767-7280).

If NAT is of concern for an admitted patient, consult Trauma Team as soon as possible.
If NAT is of concern for a patient who presents for outpatient services not already referred to JHACH by CPT (OCC, Radiology, Phlebotomy, Audiology) call Social Work (#727-767-4147) & make arrangements for Emergency Center evaluation (#727-767-7280).
If patient from EC or direct admit to PICU, must be admitted to either the Trauma or Neurosurgery Service for at least 24 hours.
Prior to discharge from inpatient or EC, the care team should discuss follow up appointments with social work for patient safety. Use attached appointment sheet as needed (Addendum #1).

If there are special circumstances, JHACH Transfer Center is available 24/7 to connect you with an EC social worker or child protection specialist at 727-767-7337.
How to Make a Report to the Florida Department of Children and Families Child Abuse Hotline

Per JHACH Clinical Policy - Handling of Child and Adult Victims of Alleged or Suspected Abuse, Neglect, or Abandonment (Policy # CLNPOL030).

1. If patient is receiving services at Main Hospital, OCC Clinics and Tampa Clinic, and there is concern for suspected child abuse and/or neglect, JHACH Social Work should be consulted to conduct assessment and determine need to file DCF report.

2. If JHACH staff member witnesses in-person child abuse, while patient is at JHACH, that staff member is required to make a DCF report and contact law enforcement. All staff members are mandated reporters.

3. If patient is receiving services at any other JHACH location and there is concern for suspected child abuse and/or neglect, where JHACH Social Work is not present, then staff should contact JHACH Social Work Department (#727-767-4147) to receive guidance on making a DCF report, if necessary.

4. If patient is initially receiving care and services at any facility other than a JHACH affiliate and there is concern of child abuse or neglect, the healthcare team should contact FL DCF Child Abuse Hotline directly.

When making a DCF report to the FL DCF Child Abuse Hotline (1-800-962-2873) the Hotline counselor will ask for the following information:

- Patient name
- Demographic information
- D.O.B./SSN
- Address
- Current location
- Parent/guardian information
- Reason of concern for suspected child abuse and/or neglect.
# Clinical Evaluation for Suspected Physical Child Abuse, By Injury Type

<table>
<thead>
<tr>
<th>Presentation</th>
<th>Labs</th>
<th>Radiology</th>
<th>Consults</th>
</tr>
</thead>
</table>
| Suspected Abusive Head Trauma (AHT) / Shaken Baby Syndrome | [Standard Labs\(^1\)](https://example.com)  
  - Urine Drug Screen  
    - If negative, consider ordering Toxicology Profile if altered mental status is present at any time and normal CT/MRI results | [Skeletal Survey if child 2 years of age\(^2\), Consider for 24-36 months](https://example.com)  
  - Brain CT, Trauma, w/o contrast | Trauma Neurosurgery, as needed  
  - Ophthalmology for all skull fracture/head injuries in patients <12 months\(^5\)  
  - Social Work\(^7\) |
| Suspected Abusive Fracture | [Standard labs\(^1\)](https://example.com)  
  - Phosphate  
  - Calcium  
  - Magnesium  
  - Alk Phos  
  - PTH  
  - Vitamin D 25-OH | [Skeletal Survey if child 2 years of age\(^2\), Consider for 24-36 months](https://example.com)  
  - Brain CT, Trauma if:  
    - Age < 12 months  
    - Facial bruising  
    - Altered mental status | Trauma Orthopedics  
  - Social Work\(^7\) |
| Suspected Abusive Bruising | [Standard labs\(^1\)](https://example.com)  
  - Von Willebrand diagnostic evaluation  
    - vWF Antigen & Activity (ristocetin co-factor)  
    - Factor VIII level  
    - Factor IX level  
    - Platelet function assay  
    - Factor XIII  
    - Troponin, if bruising on chest wall | [Skeletal Survey if child 2 years of age\(^2\), Consider for 24-36 months](https://example.com)  
  - Consider Brain CT, Trauma if:  
    - Age < 12 months  
    - Facial bruising  
    - Altered mental status | Social Work\(^7\)  
  - Consider Hematology Consult |
<table>
<thead>
<tr>
<th>Presentation</th>
<th>Labs</th>
<th>Radiology</th>
<th>Consults</th>
</tr>
</thead>
</table>
| Suspected Abusive Abdominal Trauma | **Standard labs**¹  
*Consider* trending AST/ALT and lipase if patient is suspected to have severe injury without laboratory evidence, or delay to care  
*Consider* troponin if bruising on chest wall | **Abdominal/pelvic CT with IV contrast:**  
- AST/ALT >80  
- UA >20 RBCs  
- significant abdominal injury/bruising  
- comatose patient  
- suspected delay of care⁶ | Trauma, if labs/CT positive or patient presents in unstable condition  
**Social Work**⁷ |
| Suspected Abusive Burns | **Standard labs**¹ | **Skeletal Survey if child <2 years of age**², *Consider* for 24-36 months | **Social Work**⁷  
*Consider transfer to Burn Center per Trauma Burn CPG* |
| Unexplained fussiness or altered mental status in child (+- transient) <12 months | *Consider Standard Labs*¹  
UDS if altered or breastfeeding | *Consider* skeletal survey²  
*Consider* Brain CT, Trauma < 2 yrs | Also consider:  
- hair tourniquet  
- corneal abrasion  
- starvation/FTT  
- abnormal head circumference |
### Clinical Evaluation for Suspected Physical Child Abuse, By Age

<table>
<thead>
<tr>
<th>Age</th>
<th>Labs</th>
<th>Radiology</th>
<th>Consults/Other</th>
</tr>
</thead>
<tbody>
<tr>
<td>0-12 months</td>
<td>Standard Labs(^1) See injury-type table, as needed</td>
<td>Skeletal Survey Brain CT, Trauma &lt; 2 yrs. Abdominal/pelvis CT with IV contrast if: • Signs of abdominal trauma • AST/ALT/Lipase &gt;80 • Positive FAST • UA &gt;20 RBCs o Get delayed CT images</td>
<td>Social Work(^2) Trauma Ophthalmology, as indicated Neurosurgery, as indicated</td>
</tr>
<tr>
<td>12-24 months</td>
<td>Standard Labs(^1) See injury type table, as needed</td>
<td>Brain MRI w/o contrast(^3) for clinically stable patients with suspected abusive head trauma. Include NAT concern in order &quot;Comments.&quot; MRI is an adjunct and should not be used in place of CT scan. Should be used to confirm and further delineate findings on CT, as well as reveal suspected diffuse axonal injury, ligamentous injury of the neck and brain edema.</td>
<td>Social Work(^7) Trauma, if admitted or clinically indicated Neurosurgery, as indicated</td>
</tr>
<tr>
<td>24-36 months</td>
<td>Standard Labs(^1) See injury type table, as needed</td>
<td>Consider Skeletal Survey Brain CT, Trauma/3D &gt; 2 yrs. if: • Altered mental status present Abdominal/pelvis CT with IV contrast if: • Signs of abdominal trauma • AST/ALT/Lipase &gt;80 • Positive FAST • UA &gt; 20 RBCs (get delayed CT images)</td>
<td>Social Work(^7) Trauma, if admitted or clinically indicated Neurosurgery, as indicated</td>
</tr>
<tr>
<td>36+ months</td>
<td>Standard Labs(^1) See injury type table, as needed</td>
<td>Focused imaging based on H&amp;P and evaluation</td>
<td>Social Work(^7) Trauma, as indicated Neurosurgery, as indicated</td>
</tr>
</tbody>
</table>

\(^1\) Consider UDS for altered mental status (AMS), breastfeeding infants; if UDS is negative, consider Toxicology profile if imaging and other labs normal

\(^2\) Social Work

\(^3\) MRI is an adjunct and should not be used in place of CT scan. Should be used to confirm and further delineate findings on CT, as well as reveal suspected diffuse axonal injury, ligamentous injury of the neck and brain edema.
Clinical Evaluation Footnotes

1. **Standard Labs:** CBC, CMP, lipase, UA (bagged specimen), Coagulation studies (PT/PTT/INR) (Recommendation: strong; Evidence: moderate). Screening Labs that warrant abdominal/pelvis CT with contrast: AST/ALT > 80, Lipase > 80, UA blood > 20. If UA positive for blood but negative for RBCs, order myoglobin.

2. **Skeletal Survey:** All radiographs should be in accordance with the collaborative practice parameter issued by the American College of Radiology and the Society for Pediatric Radiology and American Academy of Pediatrics. This study is recommended for all children up to age 24 months and considered in children ages 36 months and older if they have communication impairment or other developmental delays (Recommendation: strong; Evidence: moderate). A **repeat skeletal survey** is indicated in 2 weeks when abuse is suspected on clinical grounds and/or initial findings are abnormal or equivocal. **Radiological examination may be ordered without consent of a child’s parent or legal guardian if there is reasonable cause to suspect that an injury was the result of child abuse.**

3. **Brain Imaging:** If abusive head injury is suspected, order Brain CT without contrast for Trauma, which will give 3D reconstructive views (Recommendation: strong; Evidence: strong). This has high specificity and sensitivity for intracranial hemorrhage and can also easily demonstrate cranial and facial fractures. If there are any abnormalities on CT scan, plans for a FULL Brain MRI w/o contrast **not** a Fast MRI. should be arranged once clinically stabilized. MRI is the best imaging modality to identify and diagnose diffuse axonal injury and brain edema. Therefore, if CT is normal but there is altered mental status can cannot be attributed to another medical cause, an MRI should be ordered urgently (Recommendation: strong; Evidence: moderate). Please include concerns for NAT under “Comments” Section of such orders.

4. **Admission:** If admitted, must be admitted to a surgical service (i.e., trauma, neurosurgery, orthopedics)

5. **Ophthalmology Exam:** Recommended by the American Academy of Pediatrics for any patient < 12 months of age with concerns for abusive head trauma or as per CPT. However, consultation can be delayed until discussion with Child Protection Specialist for patients between ages 12-36 months at the physician’s discretion. Should not be used to screen for abusive head injury.

6. **Abusive abdominal trauma:** Evidence of trauma with delay in care (liver function tests may have decreased to normal levels). AST/ALT/Lipase levels >80 and/or UA > 20 RBC’s warrant abdominal/pelvic CT with IV contrast to evaluate for injury (Recommendation: strong; Evidence: moderate). If there is concern for renal injury, additional delayed abdominal CT images should be obtained.

7. **Child Protection Team** can be consulted for any questions for any patient in JHACH at any time. This service, however, may differ from the team required to continue work up as an inpatient, since this is determined by the county from which the abuse occurred in. Please discuss any concerns with the Social Worker. If any JHACH staff person is concerned for suspected child abuse and/or neglect of a patient, staff should consult Social Work. The Social Work team will **assist** with reporting, coordinating care, and appropriate documentation.
Non-Accidental Trauma Definitions and Evaluation Process

1. **Definition of Child Abuse and/or Neglect**
   The harm or threatened harm to the child’s physical or mental health or welfare by acts or omissions of a parent, adult household member, or any adult responsible for the child’s welfare.

2. **Definition of Stakeholders**
   A. **JHACH Social Worker** - Works as liaison between medical team, patient, family, DCF, CPT, and law enforcement.
   B. **Department of Children and Families (DCF) Florida Abuse Hotline** - Determines whether a report meets criteria to be accepted or not. If report is accepted, then the following stakeholders may have a role in the investigation.
   C. **Child Protection Investigator (CPI)** - A member of the Child Protection Division in the County in which the abuse and/or neglect occurred. The CPI investigates the allegations of child abuse and/or neglect. The CPI collaborates with the designated law enforcement agency when necessary.
   D. **Law Enforcement** – A city or county law enforcement officer will present if the allegations of abuse and/or neglect warrant a criminal investigation.
   E. **Child Protection Team (CPT)** - Group of multidisciplinary providers trained specifically in providing medical examinations, assessments, and family evaluations to assist law enforcement in the investigation and prosecution of child abuse. CPT may present to JHACH for the aforementioned services or schedule a follow up appointment at their local office.

3. **Non-Accidental Trauma Evaluation Process at JHACH**
   If risk factors for suspected child abuse and/or neglect are present, a Social Work consult will be initiated. The following steps will occur:
   A. JHACH Social Worker will complete an assessment of the patient and family and collaborate with the medical team regarding medical findings concerning for non-accidental trauma.
   B. If there is suspected child abuse or neglect, JHACH Social worker will make a report to the Department of Children and Families Florida Abuse Hotline where a hotline counselor will determine whether the case meets statutory criteria for DCF investigation.
   C. If the report is accepted, the case is referred to the Child Protection Division and the case is assigned to a Child Protection Investigator (CPI) in the County that the abuse and/or neglect occurred. If the abuse and/or neglect occurred outside of Pinellas County and the child is here at JHACH the primary county may request that a Pinellas County CPI do a courtesy face-to-face visit with patient and family.
   D. JHACH Social Worker will facilitate communication between JHACH medical team and all stakeholders regarding the investigation and disposition. JHACH SW documents whether a CPI must provide clearance prior to patient’s discharge. An FYI flag will be placed in patient chart with updated information.
   E. When a patient is medically cleared in the EC and there is CPI involvement, JHACH social worker will attempt to contact CPI and determine response time of CPI. JHACH care team and JHACH social work can discuss if patient can have follow up investigation at home.
   F. If CPI presents to JHACH for investigation, CPI will identify the appropriate individual for the patient to be discharged.
G. If patient is admitted to the hospital for further evaluation and care, it must be to a surgical service.
H. Most cases of suspected child abuse or neglect that are being investigated by Pinellas County CPI will automatically generate a Child Protection Team referral by assigned CPI. However, referral should be confirmed with the JHACH Social Work team. If referral is needed, it will be placed by primary surgical service.
I. JHACH Social Worker will communicate necessary updates regarding the patient and the investigation. The CPI communicates directly with the family regarding case updates. Law enforcement may be involved, if the allegations of abuse and/or neglect warrant a criminal investigation and they may present to JHACH at any time.
J. JHACH Social Worker will provide necessary information regarding patient visitation, custody, and with whom medical information may be discussed. An FYI flag will be placed in patient chart with updated information.
K. If patient is not evaluated within 24 hours of arrival to the hospital by the CPT, please call the CPT and discuss patient evaluation and management with team to ensure they are aware of patient. Please place consultation order in EPIC if indicated.

For any process concerns, please discuss with JHACH Social Worker and/or reference the JHACH Clinical Policies and Practice Guidelines Handling of Child and Adult Victims of alleged or Suspected Abuse, Neglect, or Abandonment (Policy # CLNPOL03).

Disposition

Disposition Scenarios
1. Patient is screened and found to have no evidence of injury or concern for suspected child abuse and/or neglect and can be discharged home.
2. Patient is screened and found to have evidence of injury or concern for suspected child abuse and/or neglect and is medically cleared for discharge. JHACH Social Work will obtain clearance for discharge from assigned CPI, when able. Patient requires close follow-up from outpatient services (i.e., appointment with CPT, repeat skeletal survey in 2 weeks, close orthopedic follow-up, complicated psychosocial circumstances). Disposition will be determined by CPI.
3. Patient has injuries that are concerning for suspected child abuse and/or neglect and is admitted to the hospital.
Inpatient Checklist

Medical
1. Admission: Trauma patients must be admitted to a surgical service. Patients with multisystem trauma or incomplete workup for non-accidental trauma must be admitted to the General Surgery service. Patients will remain on a surgical service until acute trauma issues are addressed, typically a minimum of 24 hours.
2. Laboratory studies:
   1. Have all the necessary laboratory studies been ordered?
   2. Have all abnormal values been addressed?
   3. Were any additional studies required by the CPT?
3. Radiology Studies:
   1. Have all necessary radiology studies been ordered?
   2. Have all injuries been addressed?
   3. Do they require follow up?
4. Consultations: Discuss with CPT for specific ongoing needs.
   1. Neurosurgery
   2. Ophthalmology
   3. Orthopedics
5. Be sure to review all histories and physical exams in notes for accuracy.

Social
1. Identify JHACH Social Worker who will be following patient.
2. Communicate any new medical findings to the assigned JHACH Social Worker, so that this information can be provided to the appropriate stakeholders in the investigation.
3. JHACH Social Worker will communicate necessary updates in regard to the patient and the investigation. Law enforcement may be involved, if the allegations of abuse and/or neglect warrant a criminal investigation and they may present to JHACH at any time.
4. JHACH Social Worker will provide necessary information regarding patient visitation, custody, and with whom medical information may be discussed.
5. JHACH Social Worker will place an FYI Flag in EPIC to provide basic information and inform care team of DCF involvement.

Discharge
1. At the time of Discharge, follow up appointments will be listed on the After Visit Summary.
2. JHACH SW will provide a copy of the After Visit Summary to CPI or DCF case manager, upon request.
Concern for Child Abuse and/or neglect outside of JHACH:
Call JHACH Social Work Department at 727-767-4147 for guidance

Concern for Child Abuse and/or neglect at JHACH
Consult Social Work (SW)
*If outpatient in radiology, see radiology pathway on next page*

Social Work Assessment:
Are risk factors for suspected child abuse and/or neglect present?

YES
SW makes report to Florida Child Abuse Hotline

DCF Report Accepted:
CPI assigned to case

Patient Medically Cleared:
SW will collaborate with CPI to receive clearance for discharge

Patient NOT Medically Cleared:
Patient must be admitted to surgical service (general surgery), If admitted to other service, must have general surgery/trauma consult within 24 hours

NO
Education and resources given to patient and family

DCF Report NOT Accepted:
-Education and resources provided to patient and family
-Documentation of report being made and screened out in SW note

SW is liaison between JHACH and CPI and able to provide updates on the investigation, visitation and discharge disposition when medically cleared.
Pathway for Suspicion of Non-Accidental Trauma (NAT) in Outpatient Radiology

Any imaging results that are suspicious for NAT and are not currently under the care of Child Protective Team (CPT), call DCF and do the following based upon site:

Radiologist to attempt to contact referring provider with critical result of possible NAT

Provider directs family to Emergency Center for appropriate care

Patient leaves after appointment/results

Radiologist to document discussion with provider

Recommendation to go to EC accepted

Radiologist will contact EC for transfer
Tech will obtain room number from EC for direct transfer
Tech escorts patient and family to EC designated room
Radiologist will document in patients imaging report – via critical result reporting pathway

Recommendation to go to EC NOT accepted

Radiologist to notify family of obligatory DCF report and allow family to leave

Radiologist to call to make hotline report 1-800-962-2873 or complete report online https://reportabuse.dcf.state.fl.us/Child/ChildForm.aspx
Can collaborate with CPT via phone call to Suncoast Center: 727-544-3900
JHACH social work can be contacted for case discussion

On main campus

Off-site/outpatient OCC

Can collaborate with CPT via phone call to Suncoast Center: 727-544-3900
JHACH social work can be contacted for case discussion

Radiologist to document steps taken in imaging report
Patient Status

- Observation status: The patient should be placed under Observation status if expected length of stay is less than 24 hours, or no formal CPI involvement.
- Inpatient status: The patient should be placed under Inpatient status for length of stays expected to be greater than 24 hours, including objective evidence of injury, and formal CPI/SW involvement.

Documentation/Coding

- Document the acuity, character, laterality and location of all injuries (i.e., acute, non-displaced right parietal skull fracture)
- Document any co-morbidities or circumstances that necessitate hospital admission (i.e., frequent neuro checks, IV pain medication, surgical intervention, etc.)
- Code suspected or confirmed abuse, consider ICD-10 Codes:
  - Child neglect or abandonment, confirmed, initial encounter T74.02XA
  - Child neglect or abandonment, suspected, initial encounter T76.02XA
  - Child physical abuse, confirmed, initial encounter T74.12XA
  - Child physical abuse, suspected, initial encounter T76.12XA

Outcomes

1. For NAT admission from the JHACH age <12 months, percent that have a complete lab evaluation (CBC, CMP, amylase, lipase, UA)
2. For NAT admission from the JHACH age <12 months, percent that have complete imaging evaluation (head CT, skeletal survey)
3. For NAT admission from the JHACH age <12 months, percent that have a trauma consult within 24 hours of admission
4. For NAT admission from the JHACH age <12 months, percent that are admitted to surgical service
5. For NAT admission from the JHACH age 12-24 months, percent that have a complete lab evaluation (CBC, CMP, amylase, lipase, UA)
6. For NAT admission from the JHACH age 12-24 months, percent that have complete imaging evaluation (skeletal survey)

Order Set

Order set currently in EPIC: Peds ED Non-Accidental Trauma - JHH-BMC-ACH.

References


16) Johns Hopkins All Children’s Hospital Risk Assessment for Potential Child Abuse/Neglect


18) JHACH Clinical Policy: Handling of Child and Adult Victims of Alleged or Suspected Abuse, Neglect or Abandonment
Physical Child Abuse Clinical Practice Guideline  
Johns Hopkins All Children’s Hospital

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Disclaimer

Clinical Pathways are intended to assist physicians, physician assistants, nurse practitioners and other health care providers in clinical decision-making by describing a range of generally acceptable approaches for the diagnosis, management, or prevention of specific diseases or conditions. The ultimate judgment regarding care of a particular patient must be made by the physician in light of the individual circumstances presented by the patient.

The information and guidelines are provided "AS IS" without warranty, express or implied, and Johns Hopkins All Children’s Hospital, Inc. hereby excludes all implied warranties of merchantability and fitness for a particular use or purpose with respect to the information. Johns Hopkins All Children’s Hospital, Inc. shall not be liable for direct, indirect, special, incidental or consequential damages related to the user's decision to use the information contained herein.
## Risk Assessment for Possible Child Abuse and/or Neglect

<table>
<thead>
<tr>
<th>Skull Fractures</th>
<th>Upper Extremities</th>
<th>Ribs &amp; Spine</th>
<th>Lower Extremity</th>
<th>Bruises</th>
<th>Burns</th>
<th>Other</th>
</tr>
</thead>
<tbody>
<tr>
<td>Complex fractures with inconsistent history</td>
<td>Scapula fractures</td>
<td>Lateral and posterior rib fractures &lt; age 5</td>
<td>Femur fractures &lt; 15 months</td>
<td>All bruises with a handprint or fist pattern</td>
<td>Pattern burns (except palm burns from stove top burner) e.g. grid, flame</td>
<td>Parafalcine subdural hematomas</td>
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<tr>
<td>Depressed skull fractures with inconsistent history</td>
<td>Humerus fractures, child &lt; 15 months</td>
<td>Sternum fractures</td>
<td>“Corner” or “bucket handle” fractures</td>
<td>All bruises which suggest an object; whip, belt, stick, buckle, cord, etc.</td>
<td>Pattern burns from iron or curling iron of the dorsum of hand, back, or buttocks</td>
<td>Blunt abdominal and/or chest trauma (except as above) without verifiable cause</td>
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<tr>
<td>Multiple fractures or fractures which cross suture lines</td>
<td>“Corner” or “bucket handle” fractures</td>
<td>Vertebral fractures</td>
<td>Metatarsal fractures &lt; 4 years old</td>
<td>All bruises which suggest an object; whip, belt, stick, buckle, cord, etc.</td>
<td>Circumferential burns of hand or feet: stocking/glove patterns</td>
<td>Catastrophic injury with history of routine fall</td>
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<tr>
<td>Skull fracture with intracranial hemorrhage and inconsistent history</td>
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<td>Delay in seeking care for a serious injury</td>
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<td>Anything suggesting abusive head trauma (unexplained altered state of consciousness, intracranial hemorrhage, retinal hemorrhage)</td>
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<td>Apparent life-threatening injury in which the history is not clear or social factors seem to be present</td>
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<td>Hair loss/baldness related to trauma</td>
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<td>Fictitious illness suspected</td>
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<td>History changes in the course of the work-up</td>
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<td>Caretakers appear incompetent or under the influence of substances</td>
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<td>Failure to thrive (primarily non-organic)</td>
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<td>Repeat injuries or repeat ingestions</td>
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<td></td>
<td>Injury is attributed to another child, related or non-related (Other than common minor household injuries)</td>
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<td>At the discretion of the physician</td>
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<td></td>
<td>Linear fractures in children under 15 months with inconsistent history</td>
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<td>Linear fractures associated with other injuries, at the discretion of the physician</td>
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<td></td>
<td>Linear fractures</td>
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<td>Fractures with a verifiable mechanism</td>
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<td>Other upper extremity fractures (e.g. older children)</td>
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<td>Other fractures of the trunk</td>
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<td>Other lower extremity fractures</td>
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<td>Other bruises that raise concern (e.g. large, multiple, etc.)</td>
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<td>Other burns that raise concern (e.g. large, multiple, etc.)</td>
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</tbody>
</table>
ADDENDUM #2 Appointment Follow Up Worksheet, use as needed.

Patient Follow-Up Recommendations for Child Protective Investigators

Discharge Date:

Patient’s Name: DOB:

Child Protective Investigator: Phone: Fax:
JHACH Social Worker: Phone: Fax:

Follow-up appointments:

☐ Primary physician: Date: Time: Location:
☐ Radiology: Date: Time: Location:
☐ Lab/bloodwork: Date: Time: Location:
☐ Neurosurgery: Date: Time: Location:
☐ Ophthalmology: Date: Time: Location:
☐ Trauma surgery: Date: Time: Location:
☐ Orthopedic surgery: Date: Time: Location:
☐ Plastic surgery: Date: Time: Location:
☐ Child Protection Team (CPT): Date: Time: Location:

Completed by: Date:
Title: Department: