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Nurses are key players in intervention: Don't miss child abuse in your ED

Recognize both subtle and obvious signs for physical and sexual abuse; know how to intervene when you suspect abuse

When you suspect a child is abused, it is one of the most challenging situations you'll encounter, both medically and emotionally, says **Julie Ann Cantlon, BSN,** manager of the Children at Risk Evaluation Services (CARES) at St. Luke's Regional Medical Center in Boise, ID. "It requires thinking in a crisis about a subject that is very uncomfortable for most people," she notes.

Emergency department (ED) nurses are key players in this difficult intervention, says **Elizabeth Nicholson, MS, SW, LISW,** director of Care House, a child advocacy center at the Children's Medical Center in Dayton, OH. "As a social worker in the ED setting, I am a threatening person to the family, because they can't differentiate between me and protective services who could remove their child," she explains. "But a nurse traditionally is viewed as the least threatening member of the health care team, more so than the physician."

Nurses also have the first contact with patients, says Nicholson. "Nurses are the first responders in the ED setting, so they may have the opportunity to connect with families in a way the rest of us don't have."

It's imperative for nurses to be proactive in detecting child abuse, Cantlon stresses. "In addition, the Joint Commission has come out with criteria that all medical facilities need to identify, assess, treat, and plan for any victim of abuse or neglect, so we can no longer be in denial," she reports. "Also, the American Nurses Association has recognized SANEs [Sexual Assult Nurse Examiners] as a subspecialty for the first time, so there is a real recognition of forensic work done by nurses."

Abuse does not discriminate, says **Michael Altieri, MD, FACEP**, an ED physician at Fairfax Hospital in Falls Church, VA. "Some clinicians feel that they will see a lot of abuse if they practice in an inner city, but not in the suburbs," he notes. "The truth is that nobody is immune from abuse."

Studies have estimated that as many as one out of five children [that] come to the ED are there for reasons related to abuse, notes Altieri. "That is a staggeringly high number," he says. "Abuse takes on many faces, including physical, sexual, and emotional. It can also take the form of neglect, which accounts for about 60% of abuse cases." *(See chart on categories of child maltreatment.)*

EXECUTIVE SUMMARY

- Nurses are key in child abuse intervention because they have initial contact with the patient, are seen as non-threatening.
- Red flags include a history inconsistent with findings, domestic abuse, and inappropriate reactions by caregivers.
- Nurses should not shoulder the burden of intervention alone, but work as a multidisciplinary team.
- If a child is abused and there is no intervention, it could be life-threatening.

Use protocols for child abuse

Protocols can ensure that appropriate steps are followed when abuse is suspected, says **Brenda Barton, RN, BSN,** an ED nurse who developed a protocol for child abuse at St. Luke's Regional Medical Center. *(See ED's policy in this issue.)* "We view abuse as a low frequency, high risk situation. So we have a step-by-step policy so there is no need to leave the victim from the time the evaluation is started, to turning over evidence to the police,' she explains.

The policy also streamlines charting. "We don't have to repeat in our charting every single thing we did. Instead, we just note 'evidence collected as per protocol,'" says Barton.

When abuse is suspected, a confidential cursory triage is done. "We then try to get the child back to a room as quickly as possible so we can get more in-depth information," Barton explains. "A triage system breaks it down into different groupings of sexual abuse, physical abuse, abuse without a medical complaint, and abuse with a medical complaint."

Like many EDs, St. Luke's does not have SANES to rely on. "We don't have a very high incidence of abuse in our population, so it's not cost effective to have specialized people at this point," says Barton. All ED nurses receive a four-hour course on preserving evidence that is updated yearly, she notes.

In addition to collecting evidence, the patient must also receive effective medical treatment, stresses Barton. "We have instituted a policy where [we] can collect evidence but also treat the patient medically," she says. "We are one of few EDs which administer Nonoxynol 9, to individuals sexually assaulted within a 24-hour period," she says. "This has been shown in the literature and the lab to be a very effective anti-HIV agent, viricide, and spermicide."

Charts are flagged into categories of physical or sexual abuse for review. "I critique all of those, to make sure procedures were appropriately followed," says Barton. "If there is any problem area, I can tailor education of nurses to address that."

A good working relationship with community resources is key, says Barton. "If the state labs have any issues at all with the kit, they call me, so I can talk to the nurse or physician about it," she explains.

Here are some ways to improve detection and management of child abuse in the ED:

Look for inconsistencies. "There are cases when a parent or guardian is going to bring in a child and say the baby-sitter hit the child, but a case that is advertised as child abuse is the exception," says Altieri. "In the majority of child abuse cases, the story you're given doesn't fit with what you see. That is the biggest red flag."

For instance, an infant who has limited mobility comes in with bruises, and his parents insist he fell off the changing table, says Altieri. "But you notice bruises in multiple stages of healing, and you know the developmental abilities of a kid doesn't fit with that because he isn't walking around," he explains. "There is a disconnect between the history and what you're seeing."

If a child has a femor fracture, the parents may explain it a number of ways, Altieri notes. "The parent may say, we were at the playground and he was up on the slide and fell 8 feet onto ground, hitting his leg on exposed concrete. In that case, the story fits together," says Altieri. "On the other hand, they may say he fell off the couch. In that case, you can tell them that we don't usually see broken legs with that type of injury."

In other cases, the child may be old enough to be verbal and says something different, Altieri says. "Or you may look at the child and pull the record and [see that he or she] had three other broken bones, or this kid looks not well kept—he is dirty and looks like hasn't had a bath in a week or [has] signs of other old injuries or bruises. So even though explanation is feasible, it throws up other red flags," he explains.

Know the link between domestic violence and

COMING IN FUTURE MONTHS

- Risk management: Policies and procedures
- Manage repeat visitors
- Which headaches are life-threatening?
- Delivering a child safely in the ED

child abuse. "When we find one kind of abuse, there is a 50% cross incidence rate on average for the other kind of abuse," says Cantlon. "If you find one, there should be a screening tool for the other, to see if the family needs help with that."

Recognize injuries indicative of physical abuse. "Physical findings highly suggestive of abuse include adult sized bite marks, cigarette marks, burns, certain types of fractures, multiple healing fractures, and retinal hemorrhages," says Altieri.

Involve EMS. "Listening to what ancillary personnel tell you is key," says Altieri. "If EMS brings in a child who is either injured or sick, the paramedic may tell you something about the home setting, such as that the parents were hitting the kids while EMS was interacting with the family, or that the kids looked neglected."

Don't jump to conclusions. "As health care providers, our job is to report suspicious injury, but we are not the judge and jury," says Altieri. "I have seen nurses decide that a parent is abusing their child, and treat that parent like dirt. Later, it turns out the parent did nothing wrong."

Sometimes a child may appear to be abused, but it is later explained by a medical condition, notes Altieri. "A child came in with unexplained bruising, but we then found that he was a hemophiliac," he recalls. "Likewise, coining and cupping are used to cure different illnesses in Oriental cultures, and they may leave marks, but we wouldn't approach that like abuse."

Remain objective despite your suspicions, advises Altieri. "It is difficult to see a child who has sustained significant injury, suspect parent is cause of it, and still be nice, but you have to remain detached and go the appropriate route," he says. "If the parent is at fault, that has to be dealt with. But we in the ED are not law enforcement. It is not for doctors or nurses to make remarks to [the] parent."

Consider photographing injuries. "Bruising can heal very quickly. What you see today may be practically gone by the following day," notes **Marti Monk, RN, CEN,** interview specialist at the CARES program at St. Luke's. "Some hospital policies require parents to sign a permission form to photograph. If you don't feel comfortable photographing, you may want to suggest that police bring a forensic photographer or proper equipment."

Don't disrupt evidence. "Do not do anything you don't have to do to that could destroy evidence,"

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Objectives of one hospital's children's center

Introduction

The Abused Children's Center at the Fairfax Hospital (ACC) was developed to provide the initial evaluation and crisis intervention in cases where children have been sexually abused or molested. This center combines a specially developed, child friendly center in which to perform the intake exams. It will utilize state of the art technology, the expertise of the SANE nurse program, physician medical backup and the psychosocial expertise of an emergency social worker. This center will be equipped to deal with alleged sexual abuse in children, whether the venue is Fairfax County or any other jurisdiction that wishes to participate in the program.

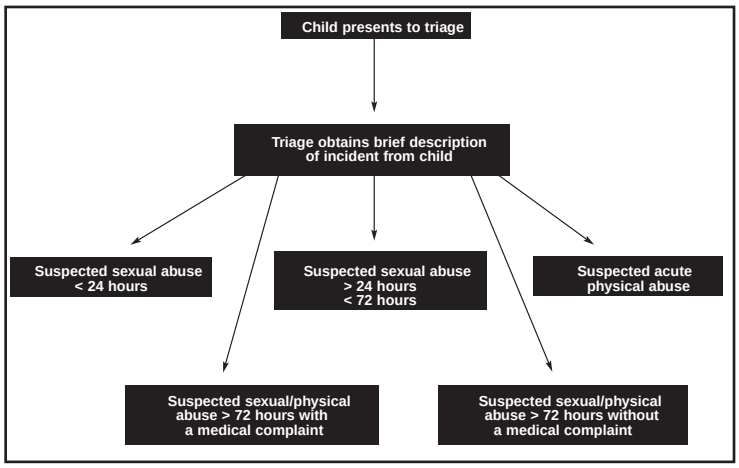
Objectives

The objectives of the ACC are as follows:

1. To provide the child a quiet, private and safe place to be interviewed and examined.
2. To provide the child and family with initial crisis intervention and facilitate other interventions as needed.
3. To conduct a swift initial assessment of the needs and support required to prevent further trauma.
4. To perform the sexual assault examination working from standing orders and protocols, which would include:
   a. the collection and preservation of all forensic evidence
   b. the maintenance of a chain of evidence with the police department, state laboratories, and hospital laboratory.
   c. to provide the expertise for these examinations, by having a small group of trained examiners (SANE nurses and/or Fairfax County Trauma Team Physicians) available 24 hours a day, 7 days a week.
5. To provide the documentation and photographic evidence of injuries including photographs with a colposcope to be available to the court system when needed.
6. To maintain strict patient confidentiality.
7. To facilitate appropriate follow-up in:
   a. the medical treatment of injuries
   b. the medical treatment of sexually transmitted diseases
   c. the psychosocial follow-up through the available government agencies
   d. the legal follow-up through the court system
8. To maintain a complete data base on all patients seen in the center, and maintaining the strict confidentiality of this database.

Source: Fairfax Hospital, Falls Church, VA

Suspected child abuse and neglect



Pediatric Sexual Abuse

The goal of our treatments and interventions are to treat any emergency medical problems and collect and preserve forensic evidence. Legal evidence can only be collected up to 72 hours after an assault. If it is to be of the most benefit, Delfen foam should be inserted as quickly as possible after an assault, once forensic evidence has been collected. The basic guideline to follow with a child (who is anyone up to his or her 18th birthday) is to collect as much of the rape kit as possible. It is with these objectives in mind, that the following protocols were developed.

Pediatric abuse: Suspected sexual abuse more than 24 hours, less than 72 hours:

a. Triage as emergent.
b. Take to a private room as soon as possible.
c. Talk with patient and adult separately.
d. Consult with emergency department physician and charge nurse.
e. Call police in the jurisdiction where abuse occurred *and* Child Protection.
f. Have legal authorities talk with patient and adult.
g. Collect legal evidence using rape kit (in the pediatric bag) and collection protocol if instructed by legal authorities. Discuss with the physician the use of a speculum.
h. Children without their own physician are to be referred to the pediatrician on call for unclaimed patients for follow-up. The pediatricians are to be contacted by the emergency department physician.
i. Disposition of patient to be determined by medical necessity or Child Protection and/or law enforcement.

Pediatric abuse: Suspected acute physical abuse:

a. Take to a room when one is available.
b. Talk with the patient and adult separately.
c. Examine patient and provide medical treatment.
d. Call police in the jurisdiction where the abuse occurred *and* Child Protection.
e. Initiate child abuse task force form.
f. Skeletal survey should be ordered when injury is inconsistent with the history.
g. Children without their own physician are to be referred to the pediatrician on call for unclaimed patients for follow-up. The pediatricians are to be contacted by the emergency department physician.
h. Disposition of patient to be determined by medical necessity or Child Protection and/or law enforcement.

Suspected chronic abuse or suspected sexual abuse more than 72 hours with medical complaint:

a. Obtain information at triage.
b. Register the patient.
c. Physician will examine and treat the patient.
d. Call police in the jurisdiction where the abuse occurred *and* Child Protection.
e. Initiate Child Abuse Task Force form.
f. Skeletal survey should be ordered when the injury is inconsistent with the history.
g. Children without their own physicians are to be referred to the pediatrician on call for unclaimed patients for follow up. The pediatricians are to be contacted by the Emergency Department physician.
h. Disposition of patient is to be determined by medi cal necessity or Child Protection and/or law enforcement.

Suspected chronic physical abuse or suspected sexual abuse more than72 hours without a medical complaint:

a. Obtain basic information at triage.
b. Call police in the jurisdiction where the abuse occurred AND child protection.
c. Have adult talk with Child Protection on the phone.
d. Document on Child Abuse Home Care form at triage.
e. Give top copy of the form to adult and retain copy for chart.
f. If child comes accompanied by PCS or police and they request a physical exam or tests or skeletal survey, they are to be referred instead to the pediatrician on call for unclaimed patients. The pediatrician will follow the case in his office.
g. Complete a nurse's notes and register the patient as usual. This provides documentation. No charge is generated.

Source: St. Luke's Regional Medical Center, Boise, ID.

Suspected child abuse/neglect checklist

Presenting problem(s): _____

_____

_____

_____

Notification:

Yes	No	Discussed with physician
Yes	No	Primary care coordinator (PCC) _____
Yes	No	Child Protective Services (CPS) notified CPS worker _____
Yes	No	Police Department notified Detective _____
Yes	No	Parent Interaction Sheet initiated
Yes	No	Nursing Supervisor
Yes	No	Security notified
Yes	No	Family interviewed by CPS
Yes	No	Consents as needed
Yes	No	If photographs, call Police Dispatch and request CSI (Crime Scene Investigator)
Yes	No	Consults: (circle all that apply) Neuro Ortho Opth CARES x-rays/ultrasound Other:_____
Yes	No	Labs: (circle all that apply) Urine Tox Medtox CBC Coag studies UA CSF Other:_____

Information updates: (names and numbers of involved agencies or professionals):

Appropriate copies of protection order, protective custody, endorsement on summons, imminent danger:

Disposition of Case: _____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

This is not intended to be a part of the medical record. If child is inpatient, attach this form to the front of the hard chart. Please send to PCC. When the child is discharged, send form to Social Services for aggregation of data.

Source: St. Luke's Regional Medical Center, Boise, ID.

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Cantlon stresses. "The clock is ticking because forensic evidence is usually biodegradable. For example, evidence could be lost by throwing a bloody diaper away which may contain the abuser's semen."

Rule out alternate explanations. In addition to documenting injuries, necessary follow-up tests need to be performed. "We've had parents say they lifted their baby out of the bed with a fractured femor and they don't have a clue how it happened," says Nicholson. "That would only occur if the child has osteogenesis imperfecta, and then you would see multiple fractures and other problems suggesting bone diseases."

The sign of bone disorders is slcera of a bright, robin's-egg blue. "So when a parent says 'we have bone disorders in my family,' it's important to note what the family says about that, and also note what color the sclera is," says Nicholson. "If it's white and normal-looking, that needs to be noted."

If a child presents with multiple bruises and the parents say he falls all the time, you need to do coagulation studies that would rule out a bleeding disorder, says Nicholson. "If the child doesn't have a clotting problem, then he shouldn't be covered with bruises," she notes.

Know signs of shaken baby syndrome. "Often, these babies present to the ED with symptoms that mimic other pediatric conditions," Nicholson says. "Some have a history of lethargy, respiratory distress, vomiting, or poor intake." Considering shaken baby syndrome with an infant who presents with those symptoms can be a lifesaving measure on the part of the nurse, she emphasizes.

Don't assume injuries must exhibit external trauma. "It's a myth that a baby has to look battered from a blunt force injury," says Nicholson. "There is often a delay in medical attention in these cases, because the child often presents with no signs of external trauma. If treatment is not begun immediately, the course has already set in, so there is less chance of saving them."

One child presented with a minor bruise in the lower abdomen. "It turned out the child was kicked in the stomach by the father who was wearing a steel toe boot, and later died from the injury," says Nicholson. "There was no major external trauma at all."

Use common sense. A lot of assessment has to do with common sense as opposed to hard facts, says

Portals of entry into one hospital's assult system

A. Child presents to hospital emergency department with alleged sexual assault.

1. The triage nurse will assess the child for the severity of any injuries, obtain a complete set of vital signs including weight, and initiate the registration process.
2. The triage nurse will page the emergency department social worker on-call.
3. The child and family will be sent to the Abused Children's Center interview room where the interview process will begin.
4. If the child presents to another medical facility he/she must first be screened for medical stability and then if so desired be transferred to Fairfax Hospital Emergency Department where he/she can be entered into the system.
5. When the appropriate venue has been determined the police department of that jurisdiction will be notified. The police department and/or child protective services will determine if a forensic exam in the ACC is necessary.
6. If an exam is necessary and the child is within Fairfax County's jurisdiction the Fairfax County protocol will be initiated. If the child is outside of the Fairfax County jurisdiction and is within a jurisdiction that has previously initiated an agreement with the ACC to perform forensic exams. The police department/CPS may initiate a page to the SANE nurse on-call.
7. The SANE nurse will perform the forensic exam.
8. Any injuries or the need for conscious sedation will be addressed by the on-duty pediatric emergency physician. A separate medical record will be generated for the medical exam/treatment.

B. Child presents to police department or protective services.

When a child presents to a police department or to child protective services in a jurisdiction which has previously agreed to utilize the services of the ACC this child will be a candidate for forensic examination in the ACC if such police department or CPS determines that an exam is necessary. When this determination is made, the police or protective services may schedule an exam by contacting the ACC, at which time the SANE nurse coordinator will schedule the exam and contact social work. In an emergent situation the SANE nurse on-call will be paged through the communications center. The SANE nurse will then make arrangements with the requesting jurisdiction and perform the examination. She will also notify the Emergency Department social worker.

Source: Fairfax Hosptial, Falls Church, VA.

Nicholson. "If something is told to you that just doesn't ring true, you should heed it," she advises. "We respond to risk indicators and concerns we have, and a lot of it is not scientifically based."

Work as a team. Intervention is most effective when done by a multidisciplinary team, stresses Nicholson. "That starts with the ED team, but also includes whoever is called in to investigate," she says. "Nobody should shoulder the burden of these cases alone. Yes, as a nurse you are responsible for your patients, but these are complicated, challenging cases that require the involvement of these other systems. Effective intervention requires a team response."

Consider the parent's demeanor. "When a parent blows things out of proportion and the focus is not on the child but on themselves, or a parent's anger is directed at other people, that is something to be concerned about," says Nicholson. "It's critical that nurses make those observations, because at that point social workers or law enforcement will probably not be present to observe it."

Act as a role model for parents. A critical role for nurses with neglected and abused children is that of a role model, advises Nicholson. "These are parents without appropriate coping skills, which has caused them to put their child at risk or injure them. Nurses can role model appropriate interactions with child in a way the parent can learn from, by distracting them, or giving them some attention. It's very important for parents to see nurses physically doing those kinds of things."

Nurses should take the opportunity to teach parents how to care for their children, Nicholson advises. "It's ironic that when a child comes in who is filthy and hasn't been bathed, nurses will race off to clean the child, but we leave the parent out of that whole process," she says. "Instead of going off in a corner to say how horrible the parents are, ask them if they have the resources to bathe the child."

The idea is not to punish families, says Nicholson. "Our job is to ensure families are referred to and engaged in services that make it possible for them to function in an appropriate fashion," she explains. ■

Reporting isn't a choice—Here's how to do it

If you suspect child abuse, then you are obligated by law to report it, says **Michael Altieri, MD, FACEP,** an ED physician at Fairfax Hospital in Falls Church, VA. "The law doesn't give you wiggle room. If you see the injury and the story doesn't fit, you don't have a choice. You have broken the law if you don't report it."

Here are some things to consider about reporting child abuse:

You must report any unexplained injuries. "It's important to know you cannot be sued for libel if you report. If you a file bonafide report, then you are protected by law," says Altieri. "You're still obligated to report if in your heart you feel it's not abuse, but in your head you can't justify an injury."

For example, if a 2-year-old child comes in with a broken leg and the parents don't know what happened, you must report it. "If after an interaction you feel the child must have climbed on the table and hurt himself, but the parents say they have no idea how it happened, you must report it. Sometimes you are wrong and they do the long bone series of x-rays and find more fractures."

If there is a difference of opinion, there is still a requirement to report. Nurses are mandated reporters, even if the physician they're working with does not want them to report, stresses Altieri. "If the nurse suspects abuse, and after the physician examines the child, [he or she] doesn't think it's abuse, the law is clear," he says. "If the nurse still suspects abuse, she is still obligated to report."

Failing to report when abuse is suspected carries legal risks, notes **Elizabeth Nicholson, MS, SW, LISW,** director of Care House, a child advocacy center at the Children's Medical Center in Dayton, OH. "It's a very difficult thing when you are working on a case and suspect abuse and a doctor says, 'I will take care of it, there is no need to report,'" she says. "In the state of Ohio, the law is clear that whoever suspects abuse is responsible, so the nurse is held liable if [he or] she suspects and fails to report."

Err on the side of caution. "You may have known a family for 10 years and think they couldn't possibly abuse their kid, but there are certain stresses that come into play that can cause somebody [to] abuse their

EXECUTIVE SUMMARY

- Nurses are mandated reporters of child abuse and must report any unexplained injuries.
- If a physician does not want to report, the nurse is still required to report if abuse is suspected.
- Inform the parents you will report and explain why.
- Do not attempt to detain caregivers who attempt to leave the ED.

kids," says Altieri.

If a child is being abused and you don't report it, you are putting that child at significant risk to be abused further, says Altieri. "The stakes are high, so when you are not sure, you need to err on the safe side," he notes. "The parents should appreciate that you are doing this, because you are acting as an advocate for their child."

One study showed that a child has a 50% chance of coming back to the ED dead if abuse wasn't recognized and there was no intervention, Altieri says. "It is potentially life threatening if kids fall through the cracks, so it's better to err on the safe side if you're not sure," he stresses.

Don't feel you need to make the decision about abuse. "Calling law enforcement actually lessens the pressure on medical professionals to make a decision," says **Julie Ann Cantlon, BSN,** manager of the Children at Risk Evaluation Services (CARES) at St. Luke's Regional Medical Center in Boise, ID. "Then you can use the team to come to a consensus."

Realize you don't know the entire story, stresses Cantlon. "We need to let go of the notion that medical people have the whole picture," she says. "In fact, we need child protective services (CPS) to know that within this family, there have been arrests related to this issue with other children. That is information we don't have unless we contact CPS."

Don't assume the family will get in trouble. "There is a false perception that children get removed the minute any report is made, but in fact only 5% of children get removed for suspicion of abuse," notes Cantlon. "Typically, what happens is the family receives a service such as counseling. They may have to answer some questions, but that is usually it."

Don't set out to punish the family. "The spirit of the reporting law is of a non-punitive nature. If nurses feel that they will rescue this child from terrible parents and blow the whistle, then we're missing the boat," says Nicholson. "In fact, children don't want to be rescued from their parents."

The goal is to get the family help so children can be safe in their care, says Nicholson. "As Hillary Clinton said, 'it takes a village to raise a child.' Nurses need to see themselves as part of a larger child protection system."

Let parents know you are going to report. "The law says you have the right to remain anonymous as a reporter. But it's important you tell people you are reporting, although a lot of nurses find this very threatening," says Nicholson. "It is setting a bad precedent for a family to see you acting caring and concerned, then go to the nurses station and call children's services without telling them. That sets up a pattern of distrust."

This should be done as a team, Nicholson recommends. "Do it in conjunction with physician or social worker you are working with," she says. "I think it's very important to let parents know that you are concerned and want what is best for their children. Explain that you are going to involve some folks at this point who are going to try and help their family."

Families may ask you not to report. "You can expect families to be scared and ask you not to do this, saying, 'we just came here for health care,'" says Nicholson. "Your message back should be, 'I care what is happening to you. I'll do everything I can to make sure they understand what the concerns are, so there is an appropriate response.'"

Be empathetic when appropriate. "When I inform a parent that I am going to make a report to protective services, sometimes I'll say, I don't think you did anything wrong, but our job is to advocate for the child, and that is why the law makes us report it," says Altieri. "Ninety-nine times out of 100, the parent understands that."

If the parent becomes upset, do not attempt to keep them. "Every once in awhile you'll get somebody who is either afraid or guilty, who wants to leave before you make the report," says Altieri. "In that case, the best thing to do is let the police or protective services know, and not start an altercation. I have seen nurses physically hurt trying to stop people from leaving, and that is not our job. You can get yourself killed that way if [you are] trying to detain the wrong person." ■

Know how to interview abused children

When you suspect abuse, it's imperative that you interview the child without making the situation worse, says **Marti Monk, RN, CEN,** a forensic interview specialist/emergency nurse at Children at Risk Evaluation Services (CARES) at St. Luke's Regional Medical Center in Boise, ID. Here are some things to consider when interviewing children:

Be a nurse, not an investigator. "You are looking for answers to help them make a medical diagnosis, so ask appropriate questions, such as 'What happened to your arm?'" says Monk. "You need to know the

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Guidelines for questioning pediatric abuse victims, if needed

Question the adult separately; be child friendly; get lower than the child.

Why did you come to the ER today?

A. Discloses:
- Tell me about that.
- What happened?
- Who did that?
- What did _____ touch (hurt, tickle, owie—use child's own words) you with?
- What do you call that part of your body?
- Where were your clothes when this happened?
- When did this happen? (Time frames are difficult for children.)
- Did anything get on you from their body?
- When was your last bath/shower?
- When did you urinate/pee, have BM/poop last?
- When did you last eat or drink something?
- What method of birth control, if sexually active?
- Date of last menstrual period—if pubescent.

B. Doesn't Disclose:
- Would it be okay for you to tell me how come you are here?
- What would happen if you did/didn't tell me why you are here?
- Would someone be in trouble if you told me why you are here?
- I need to know why you are here so I can take care of you.

Guidelines for questioning acute/chronic physical abuse victims

Questions:
- What happened?
- Where did this happen?
- Who was there?
- Have you ever been to an emergency room or minor center before?
- Have you ever broken a bone, had stitches, taken medication you shouldn't have, etc., before?

Considerations:
- Is injury consistent with history?
- Assessment of caretaker (uncooperative, angry)
- Caretaker's interaction with the child or other children (impatient, angry with child, excessive or inappropriate affection).

Source: St. Luke's Regional Medical Center, Boise, ID

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mechanism of injury to know how to fix it. It's the same with rape, in that it's not up to the nurse to get a description of the rapist. It's up to the nurse to figure out what he did to her, so we know how to treat it."

Nurses should not take on the role of investigator. "If you do that, you may get some misleading answers, which will throw everything off," says Monk. "Or the child may talk about it so much that by the time they get around to talking to the police, they won't want to talk about it any more."

Stick to questions that pertain to medical care. "The purpose of asking questions is for the provision of medical care, but what you ask also has ramifications for an investigation, so you have to keep that in mind," says Cantlon.

Take the focus away from the child. "Instead of asking 'how did you hurt your arm?' ask the child 'how did your arm get hurt?'" Monk advises. "It's much better to take the onus away from the child. That way, you are making the child completely innocent, instead of it sounding like it was their fault."

Start with simple questions. "Begin with the simplest and easiest questions for a child to answer," says Monk. "If they tell you that their daddy hit their arm with a bat, that opens the door for you to ask more detailed questions, such as 'where were you when it happened?' based on the information the child has already given you."

Talk to children alone. "This goes against everything we teach nurses, but it's the one situation where it's a good idea to separate the caregiver from the child," says Monk. "Otherwise, there is a tendency to talk to the caregiver over the child, but kids can talk very well about what happened, and most of time they want to."

Abused children separate very easily from caregivers, Monk notes. "Just tell them that mommy is going to go talk to my friend, and you and I get to go in this room and talk," she says. "If the parent balks at that and says, 'Don't you take my daughter away,' you don't want to put yourself or child at risk so you stop at that point. But that should put some suspicions in your mind."

If the parent refuses to allow you to interview the child, don't push the issue. "If it's the only way you will be allowed to treat the child, then back off and don't interview them," says Monk. "However, in my opinion, that would be sufficient enough to make the call to report suspicion of abuse."

Talk at child's level. "Talk to them at a level they can understand," says Monk. "If you mention a CAT scan, the child may assume a big cat is going to be down there."

Consider ages of children when asking about abuse. "Children younger than [age] 4 will have a real difficult time telling you about abuse, so be very careful with the language you use," says Cantlon.

Don't sound as if you are accusing the parent. "'Who hurt you?' is a pretty scary question. Instead, ask, 'How did your arm get hurt?'" says Monk. "Most children really love their abusers and will protect them, so you have to be careful of that."

Document the child's responses. "You should quote the child word for word. You don't have the luxury of video or audio tape, so you have to get it down on paper so you can defend it on the stand if called to court," says Monk.

Describe the child's body language and demeanor with details. "Document if a child yelled something with tears running down their face. Or if the child refused to go to the parent and says, 'No, no, no!' when the parent reaches for them. It is vitally important to include those things," says Monk. "Some states have the 'excited utterance hearsay' law, which allows a statement to be admitted in court when it normally would not be."

Describe details of injuries. "Instead of just writing 'bruise,' say 'there is a 2 cm circular bruised area on the left thigh'," says Monk. "You're not saying what happened, just what it looks like. You should also draw where the injuries are on a picture of a child."

Don't question children repeatedly. "If a child presents to the triage nurse and the parent comes out and says that the father may have sexually abused them, you know there are mandated investigators that will come in. So limit your history taking to get whatever information you need to make sure the patient is stable, because the wheels are already in motion," says Nicholson. "Other people will have to come after you, and questions will have to be asked again. It complicates things if you have asked them already."

Be aware of what you say in front of the child. "Sometimes if we are talking to a parent, we assume a 3-year old is playing with their toys. But in reality, they are listening to every word spoken," says Nicholson. "Don't

EXECUTIVE SUMMARY

- Nurses must interview children without compromising an investigation.
- Ask questions related to the child's medical condition.
- Interview children without caregivers present; don't discuss family history with caregivers in front of the child.
- If a child presents at triage with chief complaint of suspected abuse, medically treat the child and allow investigators to interview.

Categories of child maltreatment

Physical abuse: Any act committed by an adult or person in authority over a child that results in intentional physical injury to the child

Sexual abuse: Any sexual contact or exposure to sexual stimuli rendered to a child by an adult or older person.

Emotional or Psychologic Abuse: Patterns of behaviors manifested by a person of authority over a child which result in degradation, humiliation, rejection, or terror to the child.

Neglect: Failure to provide a child with the basic necessities of life, such as food, clothing, shelter, medical care, and a safe environment.

Source: Marianne Gausche, MD, FACEP, FAAP

obtain a family history in front of the child. The whole case can be sabotaged at that point, if the child winds up repeating what they heard their parent say to a nurse." ■

Has a child been sexually abused?

Pediatric sexual abuse cases are severely underreported, says **Marianne Gausche, MD, FACEP, FAAP,** director of emergency medical services at Harbor-UCLA Medical Center in Torrance, CA. "The CDC recorded 126,000 cases in 1996, and they estimate there are over 300,000 potential cases," she reports. "Sexual abuse is criminal and a social taboo. People are extremely uncomfortable with this situation, so there may be a tendency to want to minimize that feeling."

Nurses are key to increasing detection of sexual abuse, Gausche says. "Awareness by nurses is extremely important, because they are the initial contact and spend a lot of time with patients," she notes.

Here are some ways to detect sexual abuse in your emergency department (ED):

Get a thorough history. "Any child who comes in with urinary symptoms or abdominal pain should be evaluated for sexual abuse," says Gausche. "Ask them, 'Has anybody touched you in a way you didn't like?' The child should be examined for obvious signs of sexual abuse."

Allow experts to conduct interviews, gather evidence. "We work with local law enforcement to provide forensic evidence," says **Michael Altieri, MD, FACEP,** an ED physician at Fairfax Hospital in Falls Church, VA. "If a child is suspected of being abused sexually, we leave the questioning to the police department. We don't want non-professional interviewers to contaminate the process, which has occurred in several big cases at day care centers."

At Fairfax, if a child presents to the ED and sexual abuse is alleged or suspected, the triage nurse notifies a social worker and the patient is seen by SANEs. "Law enforcement comes to the ED and does a preliminary interview. They determine if they want a forensic exam done, which is a high-tech evidence gathering exam. The ED physicians and nurses are not involved at all," Altieri explains.

At Fairfax, 20-30 alleged pediatric sexual assaults are seen per month. "Our system is based on the use of a protocol, to ensure that evidence is collected properly by individuals who have special expertise," says Altieri. *(See protocol in this issue.)* "An ED physician may not know what a 2-year-old vagina looks like, let

EXECUTIVE SUMMARY

- Pediatric sexual abuse cases are underreported, according to the Centers for Disease Control and Prevention (CDC).
- Work with local law enforcement to provide forensic evidence.
- Red flags include sexualized behavior, urinary symptoms, abdominal pain, and excessive clinging.

Behavioral/Physical complaints which may be associated with sexual abuse

Behavioral	Physical
aggressive behavior	abdominal pain
clinging behavior	anorexia
insomnia	constipation
excessive masturbation	painful defecation
sudden change of behavior	encopresis
phobias, fears	pregnancy
sexualization of play	rectal bleeding
attempted suicide	sexually transmitted disease
	urethral discharge
	urinary symptoms
	vaginal symptoms

Source: Marianne Gausche, MD, FACEP, FAAP

alone one that has been sexually assaulted."

Make the child comfortable. "Ask some nonthreatening questions first, and move into the more threatening realm," says Gausche. "This helps develop the child's ability to be truthful."

Ask simple and direct questions. Complaints that can seem unrelated may turn out to be the tip of the iceberg, says Altieri. "A 6-year-old girl came in complaining of pain when she voided, but it turned out to be vaginal pain," he recalls. "We asked a simple question, 'Did somebody touch you where it hurts? She told us, yes, that happened two days ago, it was [her] uncle. The mother was trying to tell her not to say anything, but it turned out the uncle who lived in the house had been abusing the child sexually for months."

Collaborate with physicians. If you have any concerns about abuse, communicate that with the physician caring for patient, stresses Gausche. "The nurse may notice something the physician hasn't even thought of," she says. "Good communication is important because patients sometimes say more to the nurse than the doctor, or vice versa."

Suspect abuse when children display sexual behavior. "When a child is beginning to be examined, they may exhibit behaviors with a sexual connotation," says Gausche. "One toddler took off her diaper, lay down and spread her legs open, which is not typical behavior for a toddler. Children may look at these behaviors as playful, because their defense mechanisms do not like to say they are doing something wrong, especially if the abuser is someone they love."

On another occasion, a male resident went in to examine a child, who sat on his lap and stroked his face. "It struck us as clearly crossing the line as inappropriate behavior, and was very concerning," says Gausche. "It's important to realize that a lot of children who are sexually abused don't exhibit any of these behaviors. In fact, that is generally the rule."

Watch for excessive clinging. "Excessive clinging, especially to a female caregiver, can be cause for concern, especially with older children," says Gausche. "However, we see that a lot in children, so you need to put it in the context of the history and chief complaint."

Don't ignore gut feelings. "Don't hesitate to mention a gut level feeling. People in medicine understand that," says Gausche. "Even if you can't quantify it, don't hesitate to bring it up as another piece of information to put into the clinical picture."

Know signs and symptoms *(See chart on behavioral and physical complaints associated with abuse.)* Nurses must be familiar with all signs and symptoms of sexual abuse, ranging from subtle to obvious, Gausche stresses. "There is a huge range of things to look for, which should increase your level of concern," she says.

"Subtle signs and symptoms would include abdominal pain, dysuria, scratching, and vaginal irritation," says Gausche. "They may not want to use the restroom if they have been sodomized, or they may have nightmares, school phobias or constipation." ■

SOURCES

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Bring point-of-care testing to your ED

Many progressive emergency departments (EDs) are using point-of-care testing to get test results in seconds at the patient's bedside, reports **Beverly Giles, RN,** an emergency nurse at Methodist Hospital in Indianapolis. "We've seen this expand in recent years, and it will continue to evolve," she says. "However, you need to examine all the pros and cons before deciding to do point-of-care testing in your ED."

Here are some pros and cons of point-of-care testing to consider:

PROS:

Fast results. At Central Peninsula, point-of-care testing has speeded results for several lab tests. "Before, we could wait up to two hours to get STAT results, now we can get a turnaround of 90 seconds for glucose, hematocrit, hemoglobin, and electrolytes, and 120 seconds for blood gas analysis," reports Johnson.

A small amount of the patient's blood is drawn and injected into a thin cartridge. The cartridge is then inserted into the hand-held analyzer. "You put it into the machine, and by the time you are finished entering your operator number and the data into the medical record, it's about ready to give you the results," says Johnson.

Methodist's ED compared lab times before and after point-of-care testing was implemented. "Before we decided to implement i-STAT housewide, our lab did a study and figured the average turnaround time for a Chem 7 was 20 minutes. With i-STAT, it went down to 5 minutes, including all the steps of drawing the blood," Giles reports.

However, waiting for results are only one component of patient delays, notes Giles. "It may not have a big effect on quicker dispositions, because in the ED usually lab work is not the only thing you are waiting for. If the patient is going to be admitted, there is also the issue of a bed, consults, or a CAT scan."

Patients can be treated more quickly. "It's a benefit to make medical decisions more quickly right there at the bedside. Rather than waiting for the lab to run the test and notify you of the results, it's right there in front of you," says Giles. "Patients with arrhythmia, on ventilators, or multiple trauma patients who need blood, can be treated more quickly."

Delays in treatment are reduced. "Any time you have a change in chloride, potassium, or sodium you can certainly start to treat a lot faster if you know those results," says Johnson. "If some fine tuning is pending on results of those electrolytes, it's easier to monitor a patient who may be losing blood such as a GI bleed, because you can measure that hematocrit. It's also a lot easier to get small sticks at bedside versus having the lab come over and draw it all the time."

EXECUTIVE SUMMARY

- Point-of-care testing is increasingly being used in the ED.
- Results are given within two minutes for glucose, electrolytes, hematocrit, and blood gases.
- If ambulances use point of care testing, treatment can begin immediately.

The local EMS system worked with the vendor to put the system into ambulances. "This way, they can roll in and give us the results as they come through, which certainly speeds things up," says Johnson. "If the ambulance is five minutes away from your facility it won't help you that much, but in rural Alaska it sometimes takes over one hour for them to reach the hospital, so it makes a big difference."

Prehospital providers can get a better sense of internal injuries of trauma patients *(See sidebar on prehospital use of point-of-care testing.)* LifeGuard Alaska, a medevac team from Anchorage, AK also uses i-STAT. "In Alaska, some medevacs are over four hours away, so these results certainly help treatment plans. They can keep an eye on the hematocrit to determine if the patient is losing blood, which will help us be better prepared," Johnson explains. "We can have surgery on standby if needed. This way, we know when they hit the door where our focus should be."

Testing is facilitated for some patients. "It only takes two drops of blood to do all this testing. It's so great when have limited venous access with a patient," says Giles.

CONS:

Potential for decreased accuracy. When ED nurses at Central Peninsula General Hospital in Soldotna, AK, became dissatisfied with accuracy of the point-of-care testing system being used, a more accurate system was requested. "We had been using the One Touch glucose monitor, and people weren't very good throughout the facility about doing controls on it. We were finding that they weren't as accurate as we needed them to be consistently," says **Jan Johnson, RN.**

The One Touch system was dependent on operator technique to yield accurate results, says Johnson. "Small variations in sample volume led to large variation of results," she explains. "In addition, the liquid controls were not being run as required, and matching the calibration value to the specific lot of reagent strips was often overlooked."

Several point-of-care products were evaluated based on the following criteria, says Johnson: accuracy, precision, portability, ability to identify patient and operator ID for each test result, streamlined QC, reduced dependency on operator technique, range of tests available, centralized management of data, ability to integrate with laboratory and nursing routines, and expectation of future support and expansion of available tests. A point-of-care testing device from i-STAT corporation was selected.

One study found looking at point-of-care testing in the ED found that hematocrit results were falsely high.[1] "They retrained staff, but still had falsely high

results," notes Giles.

At Methodist, some quality assurance issues had to be resolved. "At one point, a cardiologists went to check the hematocrit lab results of one of his patients, and noticed discrepancies between ED i-STAT and the central labs," Giles recalls. "We started to investigate why this was happening, and it became a training issue. Our staff was generally not mixing samples well, and using samples which were longer than 10 minutes old rather than sticking the patient again."

Additional training was done, and only nurses were allowed to do the i-STAT testing. "We did retesting to confirm that results were accurate, and each person had to do several tests that were verified by the lab," says Giles. "Also, if we have to do a fresh specimen, we mix it thoroughly, and do it right at the patient's bedside."

Also, a decision was made to use i-STAT on a limited basis. "We only use it if we have a physician's order, instead of anticipating the need," says Giles. "Only certain conditions need lab work immediately, such as diabetics or multiple traumas, not the average run-of-the-mill patient who needs a Chem 7."

Staff need additional training. At Central Peninsula, initial training takes about two hours, using a checklist guide cooperatively developed by nursing services and the laboratory. "Points covered run the range from mechanics of the system to sampling to clinical use of results, and hands-on practice with blood samples," says Johnson. "Annual training is included within the skills update program of nursing services."

Regulations must be adhered to. "The i-STAT system is regulated under CLIA [Clinical Laboratory Improvement Act] as a moderately complex testing system, says Johnson. "As this was the first system installed in Alaska, state compliance inspectors worked with the company to be sure the system was acceptable," she notes.

Patient turnaround times may be decreased. "We started it on a trial basis and found it was the greatest thing to come along," says Giles. "At first we thought it would take up a lot of extra time, but we saw that patients got out faster."

For two months, an audit of turnaround times was done. "We decreased turnaround times by 11 and 15 minutes as compared to previous months," Giles reports. "Multiply that by the 250 patients we see a day, [and it] adds up to a significant savings in personnel time. It's also good for patient satisfaction."

Treat patients in transport

Point-of-care testing can be used to assess patient status in flight, allowing the crew to intervene immediately. "Our goal is to try and treat the patient before we arrive at the ED [emergency deparrtment] , to get them there in the best shape we can," says **Diana Herr, RN,** a Mayo One flight nurse at the Mayo Medical Center in Rochester, Minnesota. Point-of-care testing is used on approximately 50% of patients transported, she reports.

It enables flight nurses to give more accurate care. "For example, our protocol says to start giving 2 liters of ringer's lactate, and then start to give blood," says Herr. "But if we know a patient has a hemoglobin level of 5, we can go directly to treating that patient and give blood right away, since we do carry blood in the helicopter."

A baseline is established, which can be compared with tests done in the ED. "If another lab is done, and the hemoglobin was 10 and is now 8, we know the patient is bleeding faster," says Herr.

The point of care testing has saved patient's lives, Herr reports. "When you are dealing with the golden hour for trauma, we may have only 15 minutes left. Patients may have a ruptured aneurysm, or are in the process of rupturing, or be involved in a motor vehicle accident and have a liver laceration," she notes. "Even with a simple asthma patient, the lab values may help us decide whether a patient needs to be intubated."

The ED staff is forewarned about the patient's condition. "We often call report with the results of blood gases over the air, which gives the doctors an idea of how fast they have to work," says Herr. "If hemoglobin is low, another test can be done in the ED when the patient arrives to get a comparative set of labs to see how things have changed."

One patient who was in a car accident and had a pelvic fracture was receiving blood in route. "The initial hemoglobin was found to be 8, and over a half hour it was the same," says Herr. "This helped us to determine loss of blood and realize that we needed to increase the infusion of blood, so patient care was improved."

Sometimes the crew's i-STAT device is used in the ED. "Many times, small hospitals around here don't have lab facilities for a fast response, so we can get a lab in their ED for the patient," says Herr.

Accuracy is ensured. "If we do an i-STAT and it shows a hematocrit greater than 6, and it just doesn't fit, we have to repeat it so we are not just treating on one erroneous result," says Herr. "If it still doesn't fit, we get on the phone with the medical consultant and rule out other possibilities. We also check every patient that has an i-STAT done to make sure the next lab done correlates somewhat. For example, if we treat the patient aggressively, the hemoglobin should be better." ■

Staff may view it as extra work. "When we first implemented this, staff felt 'we are already doing more with less, and now you want us to do the lab work too?'" Giles recalls. "That was the perception, but now it's second nature."

It may create controversy. The lab department may have strong feelings against point-of-care testing done in the ED. "Often, there is controversy about whether this is needed. A lot of that resistance is due to lab technicians being afraid it will impact their jobs," says Giles.

At Central Peninsula, the lab was involved in the process. "For this to be a successful venture, we needed the lab's buy-in," says Johnson. "Initially, there was a little bit of hesitancy because this does take work away from them. We compromised with the ED, getting the revenue for the blood draw fee and the lab getting paid for the actual test, which created a win-win situation."

The lab manager wanted reassurance that studies would be accurate. "We ran concurrent tests for the first few months to assure test-result accuracy," says Johnson."

A correlation study was completed comparing i-STAT results to laboratory results for each analyte before the system was accepted for use. "Continued concurrent testing has been done on a random basis by performing equivalent lab tests on an i-STAT patient and comparing results," Johnson explains. "These comparisons demonstrate that the i-STAT results continue to meet the original correlation standards."

It may be difficult to do the necessary quality control in the ED. "Labs are concerned about accuracy, and run quality controls on instruments a couple of times each shift, and nurses aren't used to that. That is the mindset of the lab, and nurses are more interested in benefits to patient care," says Giles. "It is a big learning curve for nursing staff to suddenly take this role."

i-STAT is no longer used for glucose testing, which eliminates quality control procedures. "Now we do venous sticks, so patients aren't as happy with that, but we were able to do away with quality control procedures with the glucometer every day," says Giles. "We have a very large ED, so it was a big issue for us to do the simulator testing every six hours, with the number of i-STATs we had in the department."

It may or may not be cost effective. i-STAT units cost approximately $4500. Whether or not point-of-care testing is cost effective depends on your ED, says Giles. "It depends on how you are set up. The cartridges are fairly expensive, but we saved money because we were able to close the stat labs, so the lab was able to shave a lot off their budget." ■

SOURCES

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Reference

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Use blood IV tubing for trauma patients

An important piece of equipment to include in the care of the multiply injured patient is intravenous blood tubing, says **Renee Holleran, RN, PhD,** chief flight nurse and clinical nurse specialist at Cincinnati (OH) Medical Center. "Today, there are multiple types of tubing available, particularly when infusion pumps are being used," she notes. "The patient who has been injured or who has lost blood, for example, a GI bleeder, may require blood or blood products."

Blood tubing has two ports: one for the blood, and one for normal saline. "Many types of tubing also come with a pump, which can be used to increase the rate of fluid administration during resuscitation," says Holleran. "Two ports also allow for the administration of other medications, such as antibiotics." However, you cannot administer medication in a port that blood or blood products have been given through, she notes.

Placing blood tubing on patients who will need to be transferred assists in saving time preparing the patient for transport because tubing will not have to be changed, she notes. "Blood tubing is better for the multiply injured because it has two ports (two solutions may be given if needed), a filter, a pump (for rapid fluid resuscitation), and saves time if blood or blood products are immediately required," says Holleran. "Even though there may be an additional cost involved with the use of this tubing, its use may far outweigh its cost in the injured patient." ■

Correction

For the September 1998 issue of *ED Nursing*, a CE objective was omitted. Here is the is the correct CE Objective.

4. Explain current thinking on pain medication with abdominal patients.

CE Objectives

After reading this issue of *ED Nursing*, the CE participant should be able to:

1. List three signs or symptoms of child abuse.
2. Describe three techniques of interviewing abused children.
3. Discuss benefits of point of care testing.
4. Explain benefits of blood tubing.