

Every Child, Every Time: Universal Child Abuse Screening Increases Awareness and State Reporting.

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BACKGROUND

A review of our child abuse evaluation system demonstrated a lack of standardization leading to a reporting level below national averages. The purpose of this quality improvement initiative was to develop a standard child abuse screening tool; establish an education program increasing awareness to child abuse; and to measure the impact of the screening tool in child abuse reporting.

METHODS

- Standardized, objective screening tool developed for use in all trauma patients under fifteen years old
- Screening utilization monitored through pediatric trauma coordinator during pediatric trauma QI meetings
- Established a child protection team
- Generalized screening to all pediatric patients September 2014
- Data evaluated from January 2014-September 2015

Figure 1. Child Abuse Screening Tool. The initially used paper version is depicted here. The same format was incorporated into the electronic charts. Compared to what had previously been used at the institution, there is less element of subjectivity with simple yes or no questions. There is still an "other" option to allow for clinical suspicion not based on other criteria. Additionally, the form is not complete without documenting who filed the CY-47 for all positive screens.

RESULTS

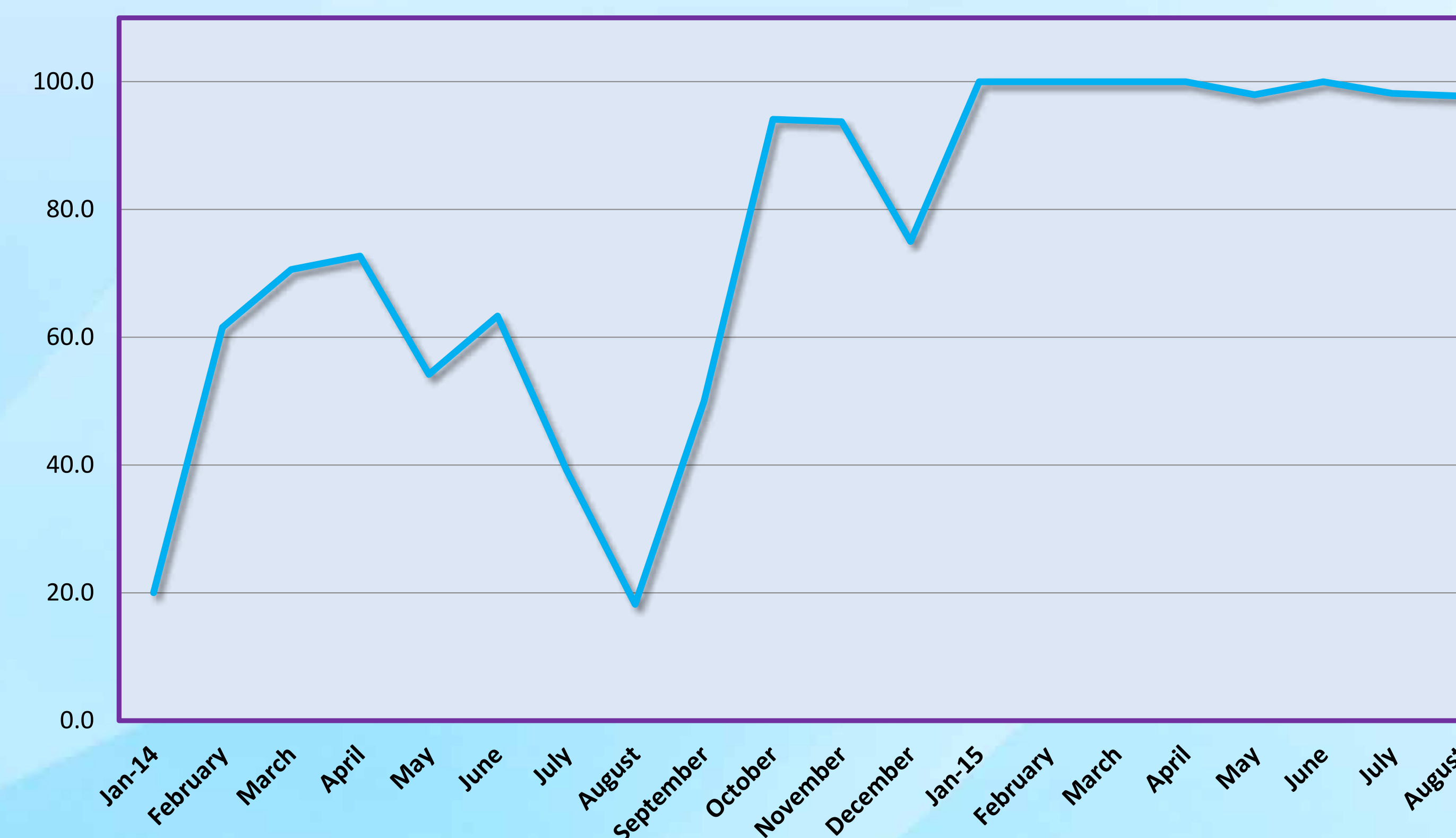


Figure 2. Child abuse screening compliance rates. Education began in January, 2014. Reminder emails and nursing huddles emphasized screening in May, 2014. Screening compliance decreased with new staff hires in the summer months. Child abuse awareness seminars began in August, 2014. Screening was made mandatory for all pediatric trauma patients in September 2014. Screening was maintained at greater than ninety-five percent for the last seven months of monitoring.

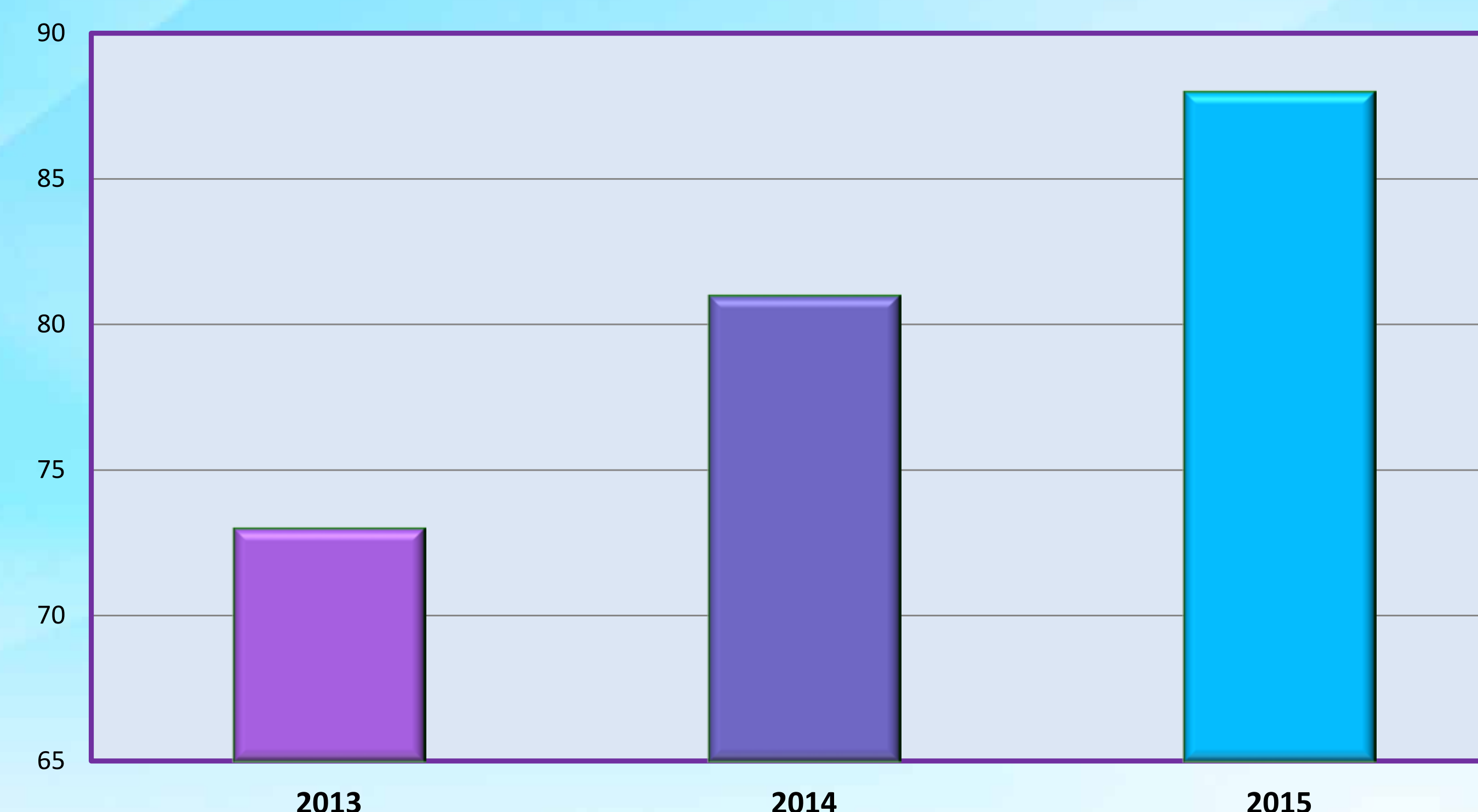


Figure 3. Summary of annual child abuse reporting volumes. Over the study period, reporting volumes increased by twenty percent.

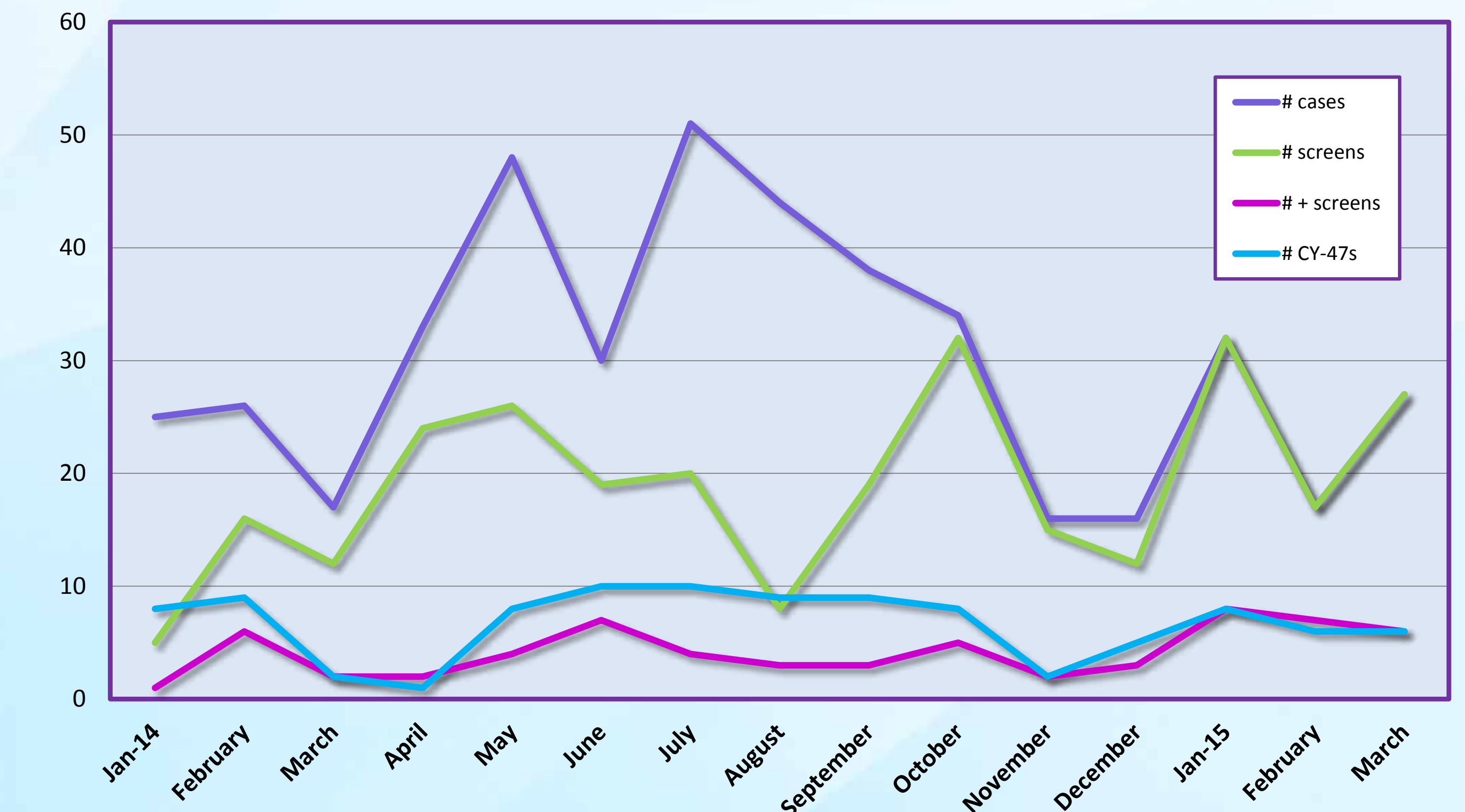


Figure 4. Compilation of data. During months of low compliance, a large gap is evident between the number of trauma patients evaluated and the number of screens performed. Additionally, the relationship between positive screens and number of CY-47s filed fluctuated. When screening compliance was consistent toward the end of the study period, the number of screens is equal to the number of pediatric trauma patients; the number of positive screens is equal to the number of CY-47s.

CONCLUSIONS

- An objective screening tool led to improved screening practices
- Compliance decreased between reeducation sessions
 - Frequent, mandatory education is necessary
 - Child protection team presence led to increased awareness
 - Regular monitoring of compliance allowed for timely discovery of unfavorable trends
- Global screening throughout the entire children's hospital improved compliance

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