



Child Physical Abuse Clinical Pathway Synopsis

Child Physical Abuse Algorithm

Inclusion criteria:

- < 18 years of age
- If ≥ 18 years of age, contact Social Work for guidance

Exclusion criteria:

- Injury due to motor vehicle or bike accident
- Non-abusive injury witnessed by multiple people
- Injury occurring at birth

Findings Concerning for Physical Abuse

- Skin**
- Any bruising on an infant < 6 months of age
 - [Bruising on buttocks, ear, or other suspicious area](#)
 - Burns, particularly if child is < 3 years of age

Bone

- Fracture in an infant < 1 year of age
- [Fracture indicating potential abuse](#)

Internal Injury

- Internal or abdominal injury in child < 4 years of age
- Intracranial bleeding or skull fracture in infant < 1 year of age

Other

- Injuries on a child who is non-verbal or non-mobile
- [Other presentations suggestive of possible abuse without an alternative diagnosis \(e.g., bite marks, isolated vomiting, seizure, apnea\)](#)

Additional Resource with Photos:
[VisualDx / Physical child abuse](#)

When a Report is Needed

- A social worker will complete a PAR to document a psychosocial assessment if concern for potential abuse. A PAR is initiated whenever abuse is under consideration. *A PAR does not mean a child protective services report will be made*
- If a mandated reporter believes in good faith there is a reasonable cause to suspect abuse, a hotline report must be made without unnecessary delay to the appropriate state agency and/or law enforcement.

Abbreviations:

SCAN = Safety, Care, and Nurturing
PAR = Patient At Risk Assessment

Infant, child, or adolescent with a physical injury and/or other indication of abuse presents to any care setting

Initial Evaluation

- Stabilize as needed prior to further evaluation (*if severe injury*)
- Complete a well-documented [history and physical](#)
 - Have parent or caregiver provide a narrative without interruptions
 - Document any skin findings via Multimedia Photo Capture app (*or similar resource, if outside of Children's Mercy*)
- Clearly communicate process with families
 - [Scripts for Communicating with Children and Families](#)
 - [Provider Education Video](#) (available for Children's Mercy providers through the Child Abuse Toolkit)
- **Providers outside of Children's Mercy, contact SCAN Physician OnCall through 1-800-GOMERCY (1-800-466-3729) to discuss process based on resources available**



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Engage Social Work
([Social Work Education Video](#))

- Page social work to discuss concerns and place consult order
- Social Work to complete Patient At Risk (PAR) Assessment
- Consider on-site Safety Plan (1:1 observation and/or visitor restrictions, refer to [Social Work process](#) for details)

A PAR does not mean a child protective services report will be made

Diagnostic Evaluation

- See [Diagnostic Testing for Occult Injury algorithm](#)
- Contact SCAN Physician via [Web OnCall](#) for any questions regarding medical evaluation or diagnostic uncertainty

Ensure closed loop communication with all teams involved

Determine if a report to child protective services and/or law enforcement is needed

Determining Disposition

If questions, contact SCAN Physician regarding disposition

- **Social Work:** If a report was made to a state agency, determine need for discharge safety plan
- **Provider:** If additional diagnostic testing is needed, determine if it will be completed outpatient by SCAN, or if transfer to ED or inpatient is required
- **Trauma Surgery:** If being admitted for acute physical injury, consult Trauma Surgery via [Web OnCall](#)

Discharge Home

- [Communicate findings and follow-up plan with family](#)
- If Safety Plan is needed, finalize **BEFORE** discharge
- Communicate plan with PCP

Transfer to ED and/or Admit

- [Communicate findings and disposition to family](#)
- Contact SCAN Physician, if not already involved
- If patient requires admission, admit to Trauma Surgery (*or other surgical service*), unless otherwise directed by Trauma
- If already admitted to a non-surgical service, consult Trauma Surgery and transfer if needed

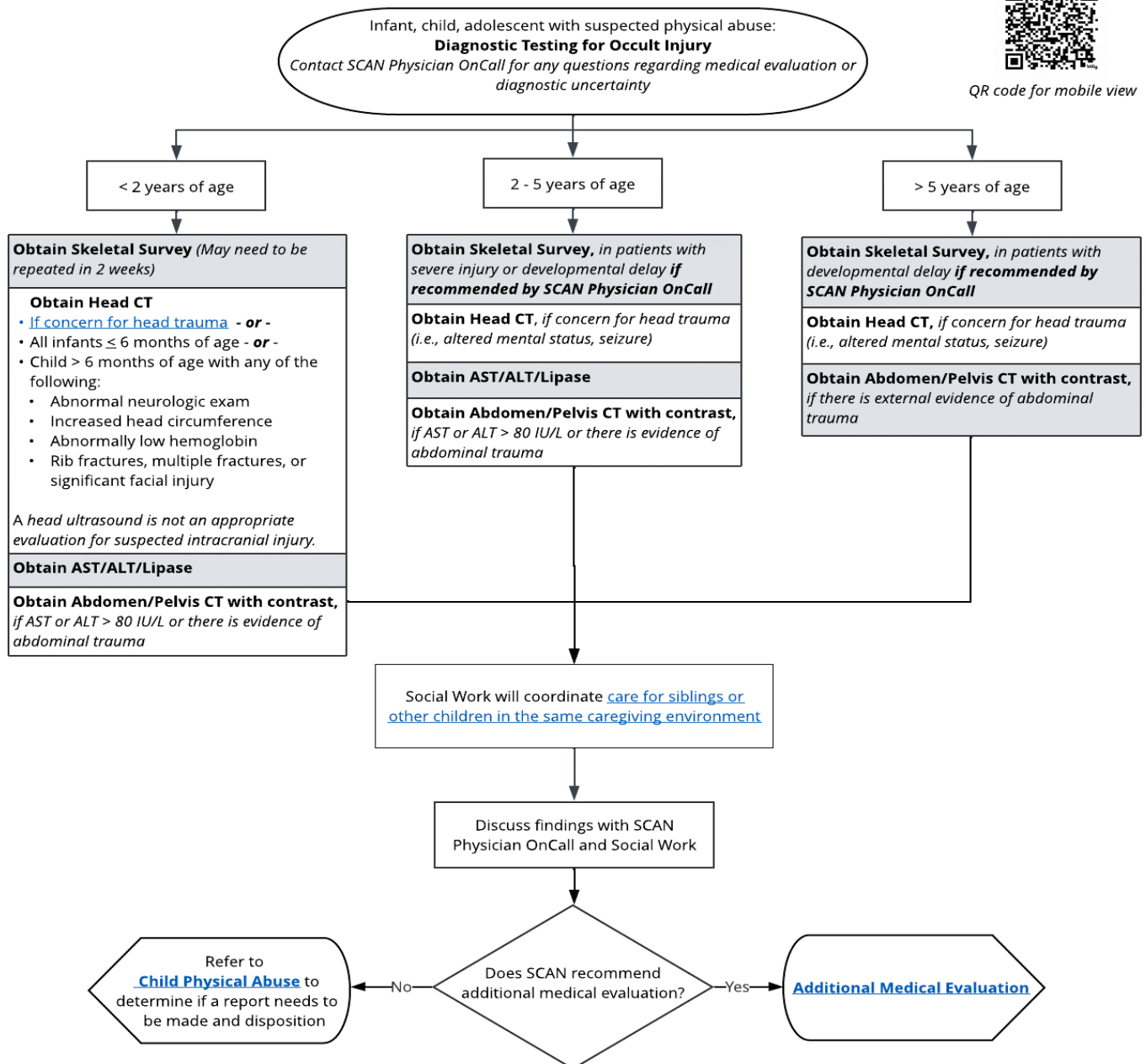
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Child Physical Abuse: Diagnostic Testing for Occult Injury Algorithm



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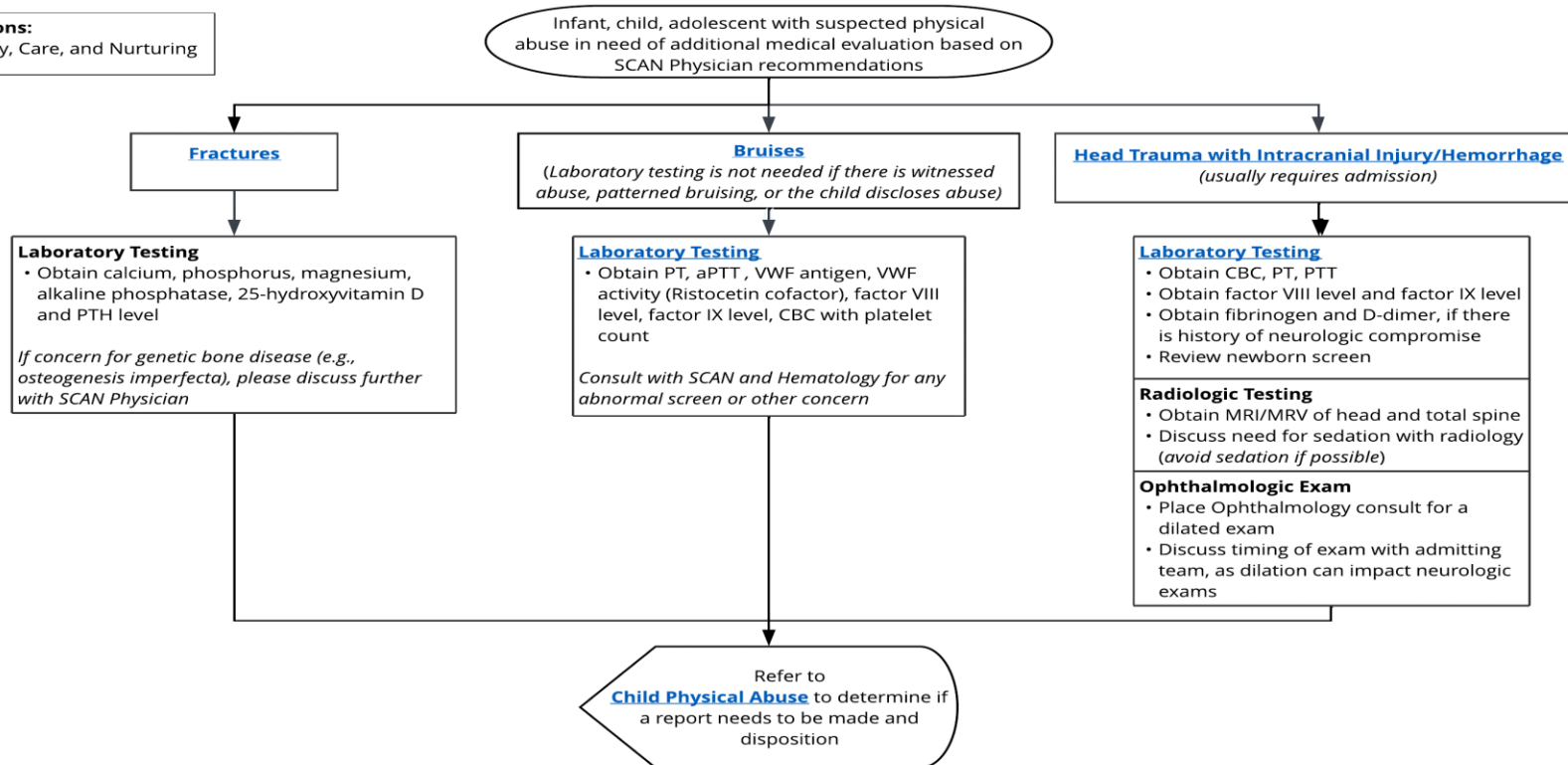


Abbreviations:
SCAN- Safety, Care, and Nurturing

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Child Physical Abuse: Additional Medical Evaluation Algorithm
Abbreviations:

SCAN- Safety, Care, and Nurturing



QR code for mobile view

References

 Anderst, J., Carpenter, S. L., Abshire, T. C., Killough, E., the American Academy of Pediatrics Section on Hematology/Oncology, the American Society of Pediatric Hematology/Oncology, & the American Academy of Pediatrics Council on Child Abuse and Neglect. (2022). Evaluation for bleeding disorders in suspected child abuse. *Pediatrics*, 150(4), e2022059276. <https://doi.org/10.1542/peds.2022-059276>

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Objective of Clinical Pathway

To provide care standards for an infant, child, or adolescent with a physical injury with concern for abuse presenting to any care setting. The Child Physical Abuse Clinical Pathway guides evaluation and the timely engagement of Social Work and the Safety Care and Nurturing (SCAN) Physician OnCall to assist in decision-making or address diagnostic uncertainty.

Background/Epidemiology

While definitions can vary amongst states and organizations, child physical abuse is generally defined as any physical injury to a child or adolescent less than 18 years of age that is incurred using intentional physical force (Centers for Disease Control and Prevention, 2022). Based on the most recent published data, the national rate for child abuse and neglect is 7.7 cases per every 1,000 children, where 17% can be attributed to physical abuse (U.S. Department of Health & Human Services, Administration for Children and Families, Administration on Children, Youth and Families, Children's Bureau, 2024). According to the U.S. Department of Health & Human Services (2024), the number is feared to be an underestimate, as it is believed that many cases go unreported.

Healthcare providers play an essential role in identifying and supporting children and families when physical abuse is suspected (Blangis et al., 2021; Christian et al., 2015; Narang et al., 2020; World Health Organization, 2022). The diagnosis of child physical abuse is complex, as findings can be subtle, and the children may be unable or too frightened to disclose the physical abuse (Anderst et al., 2022; Blangis et al., 2021; Carpenter et al., 2022; Christian et al., 2015; Narang et al., 2020). Findings may also reflect other underlying causes of injury, such as bleeding or bone disorders (Anderst et al., 2022; Blangis et al., 2021; Carpenter et al., 2022; Christian et al., 2015; Narang et al., 2020). Furthermore, provider training encourages information to be sought from the parent or caregiver when evaluating and treating a minor, which can make diagnosing difficult should information be withheld or inaccurate (Christian et al., 2015). The Child Physical Abuse Committee aims to develop a clinical pathway to guide providers and offer resources in the evaluation of occult and sentinel injuries to promote early clinical identification of child physical abuse and intervention and support for children and their families.

Target Users

- Physicians (Emergency Medicine, Urgent Care, Ambulatory Clinics, Hospital Medicine, Fellows, Resident Physicians)
- Nurse Practitioners
- Nurses
- Social Work

Target Population

Inclusion Criteria

- Individuals < 18 years of age
- If ≥ 18 years of age, contact Social Work for guidance

Exclusion Criteria

- Injury due to a motor vehicle or bike accident
- Non-abusive injury witnessed by multiple people
- Injury occurring at birth

AGREE II

Two American Academy of Pediatrics (AAP) national guidelines provided guidance to the Child Physical Abuse Clinical Pathway Committee (Christian et al., 2015; Narang et al., 2020). See Tables 1 and 2 for the AGREE II.

Table 1

AGREE II Summary for The Evaluation of Suspected Child Physical Abuse Clinical Report (Christian et al., 2015)

Domain	Percent Agreement	Percent Justification [^]
Scope and purpose	86%	The aim of the guideline, the clinical questions posed, and target populations were identified.
Stakeholder involvement	82%	The guideline was developed by the appropriate stakeholders and represents the views of its intended users.

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Rigor of development	41%	The guideline developers did not provide how the evidence was gathered and synthesized, how the recommendations were formulated nor how the guidelines will be updated.
Clarity and presentation	94%	The guideline recommendations are clear, unambiguous, and easily identified; in addition, different management options are presented
Applicability	57%	Barriers and facilitators to implementation and strategies to improve utilization were addressed in the guideline. The guideline did not address resource costs associated with implementation.
Editorial independence	71%	The recommendations were not biased with competing interests.
Overall guideline assessment	72%	
See Practice Recommendations		

Note: Four EBP Scholars completed the AGREE II on this guideline.

^Percentage justification is an interpretation based on the Children's Mercy EBP Department standards.

Table 2

AGREE II Summary for the Abusive Head Trauma in Infants and Children Policy Statement (Narang et al., 2020)

Domain	Percent Agreement	Percent Justification [^]
Scope and purpose	82%	The aim of the guideline, the clinical questions posed, and target populations were identified.
Stakeholder involvement	79%	The guideline was developed by the appropriate stakeholders. and represents the views of its intended users.
Rigor of development	34%	The guideline developers did not provide how the evidence was gathered and synthesized, how the recommendations were formulated nor how the guidelines will be updated.
Clarity and presentation	82%	The guideline recommendations are clear, unambiguous, and easily identified. In addition, different management options are presented.
Applicability	21%	The guideline did not address implementation barriers and facilitators, utilization strategies, nor resource costs associated with implementation.
Editorial independence	92%	The recommendations were not biased with competing interests.
Overall guideline assessment	65%	
See Practice Recommendations		

Note: Four EBP Scholars completed the AGREE II on this guideline.

^Percentage justification is an interpretation based on the Children's Mercy EBP Department standards.

Practice Recommendations

Please refer to the American Academy of Pediatrics (Christian et al., 2015; Narang et al., 2020) Clinical Practice Guidelines for evaluation and intervention recommendations.

Additional Questions Posed by the Clinical Pathway Committee

No additional clinical questions beyond those addressed in the AAP Guidelines were posed for formal literature review.

Updates from Previous Versions of the Clinical Pathway

- The Child Physical Abuse Clinical Pathway is a newly developed evidence-based pathway with no previous version for comparison.

Recommendation Specific for Children's Mercy

There were no deviations from the AAP Guidelines regarding practice recommendations, but logistical processes specific to Children's Mercy Kansas City were added.

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- Timing regarding when to engage social work and contact the SCAN Physician OnCall
- Processes for determining discharge disposition

Measures

- Use of the Child Physical Abuse Clinical Pathway

Value Implications

- Decreased risk of missed diagnosis of child physical abuse
- Improved standardization of diagnostic work-up based on patient age and presentation
- Improved safety following a concern for child physical abuse (i.e., disposition; safety plan)
- Increased equity by decreasing unwarranted variation in care

Organizational Barriers and Facilitators

Potential Barriers

- Challenges of identifying warning signs of child physical abuse in some cases
- Challenges with closing the communication loop among providers, nursing staff, social work, and patient's families.

Potential Facilitators

- Collaborative engagement across the continuum of care settings during clinical pathway development
- Multidisciplinary contribution to pathway development
- Collaboration with Human Factors to improve pathway usability
- Anticipated high rate of use of the clinical pathway
- Standardized order set for Emergency Department and inpatient settings

Diversity/Equity/Inclusion

Our aim is to provide equitable care. These issues were discussed with the Committee, reviewed in the literature, and discussed prior to making any practice recommendations.

Power Plans

- EDP Physical Abuse
- Inpatient Physical Abuse

Associated Policies

- Abuse and Neglect

Education Materials

- Provider Education for Suspected Child Physical Abuse ([video](#))
 - Intended to be an audiovisual resource for providers to explain clinical findings and the evaluation process to children and families when child abuse is suspected
 - Available for Children's Mercy providers through the Child Abuse Toolkit
- Social Work Education for Suspected Child Physical Abuse ([video](#))
 - Intended to be an audiovisual resource for social workers explaining the evaluation process when child abuse is suspected and how to communicate with children and families
 - Available for Children's Mercy social workers and providers through the Child Abuse Toolkit
- [Scripts for Communicating with Families and Children When There are Abuse Concerns](#)
 - A communication guide available for Children's Mercy providers through the Child Abuse Toolkit

Clinical Pathway Preparation

This pathway was prepared by the Evidence Based Practice (EBP) Department in collaboration with the Child Physical Abuse Clinical Pathway Committee composed of content experts at Children's Mercy Kansas City. If a conflict of interest is identified, the conflict will be disclosed next to the committee member's name.

Child Physical Abuse Clinical Pathway Committee Members and Representation

- Emily Killough, MD | SCAN Clinic, Division of Child Adversity and Resilience | Committee Chair

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- Danielle Horton, MD | SCAN Clinic, Division of Child Adversity and Resilience | Committee Member
- Erin Scott, DO | Pediatric Emergency Medicine | Committee Member
- Holly Austin, MD, FAAP | Urgent Care Center | Committee Member
- David Juang, MD | Surgery | Committee Member
- Hank Puls, MD | Hospital Medicine | Committee Member
- Ryan Northup, MD | General Academic Pediatrics | Committee Member
- Danny Dooling, MD | Medicine-Pediatrics Resident | Committee Member
- Michelle Camerer, LCSW, LCSW | Clinical Social Work | Committee Member
- Danica Harris, LCSW, LCSW | Clinical Social Work | Committee Member
- Roneika Moore, DNP, RN | Emergency Department | Committee Member
- Sarah Fouquet, PhD | Quality, Safety with Human Factors | Committee Member
- Kerri Kuntz, MSN, CPPS, CPHQ, RNC-OB, C-EFM | Quality and Safety | Committee Member
- DeeJo Miller, BA | Patient and Family Engagement | Committee Member
- Kaylee Hurt, BS | Patient and Family Engagement | Committee Member
- Angie Williams, BSN, RN-BC, CPN | Clinical Practice and Quality | Committee Member
- Sarah Dierking, MSN, RN, CPHQ | Clinical Practice and Quality | Committee Member

Patient/Family Committee Member

- Melanie Traynham | Committee Member

EBP Committee Members

- Kathleen Berg, MD, FAAP | Hospitalist, Evidence Based Practice
- Kelli Ott, OTD, OTR/L | Evidence Based Practice

Clinical Pathway Development Funding

The development of this clinical pathway was underwritten by the following departments/divisions: SCAN Clinic, Pediatric Emergency Medicine, Urgent Care Center, Surgery, Hospital Medicine, General Academic Pediatrics, Clinical Social Work, Emergency Department, Quality and Safety, Patient and Family Engagement, Clinical Practice and Quality, and Evidence Based Practice

Conflict of Interest

The contributors to the Child Physical Abuse Clinical Pathway have no conflicts of interest to disclose related to the subject matter or materials discussed.

Approval Process

- This pathway was reviewed and approved by the Child Physical Abuse Clinical Pathway Committee, Content Expert Departments/Divisions, and the EBP Department, after which it was approved by the Medical Executive Committee.
- Pathways are reviewed and updated as necessary every three years within the EBP Department at CMKC. Content expert teams are involved with every review and update.

Review Requested

Department/Unit	Date Obtained
Safety Care and Nurturing Clinic	August 2024
Pediatric Emergency Medicine	August 2024
Urgent Care Center	August 2024
Surgery	August 2024
Hospital Medicine	August 2024
General Academic Pediatrics	August 2024
Clinical Social Work	August 2024
Clinical Practice and Quality	August 2024
Quality and Safety	August 2024
Patient and Family Engagement	August 2024
Evidence Based Practice	June 2024

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Version History

Date	Comments
September 2024	Version one – (<i>developed Child Physical Abuse Clinical Pathway and synopsis; revised associated powerplans, created provider educational materials</i>)
December 2024	Linked <i>Head Trauma with Intracranial Injury/Hemorrhage</i> information on the Child Physical Abuse: Additional Medical Evaluation algorithm to the Suspected Abusive Head Trauma Clinical Pathway
January 2025	Adjusted age parameters for finding concerning for physical abuse regarding burns
March 2025	Modified Child Physical Abuse: Diagnostic Testing for Occult Injury algorithm regarding abdominal/pelvic CT

Date for Next Review

- September 2027

Implementation & Follow-Up

- Once approved, the pathway was presented to appropriate care teams and implemented. Care measurements will be assessed and shared with appropriate care teams to determine if changes need to occur.
- Order sets/power plans consistent with recommendations were created or updated for the emergency department and inpatient settings.
- The policies were reviewed. The policies detail the institutional processes for handling cases of possible child abuse or neglect and the obligations of a Mandated Reporter for reporting reasonable suspicions of abuse or neglect. The policies were not amended during the development of the Child Physical Abuse Clinical Pathway.
- Education was provided to all stakeholders:
 - Nursing units where the Child Physical Abuse Clinical Pathway is used
 - Department of Child Adversity and Resilience, Clinical Social Work, and Pediatric Surgery
 - Providers from Emergency Medicine, Urgent Care Center, Ambulatory Clinics, and Hospital Medicine
- Additional institution-wide announcements were made via email, the hospital website, and relevant huddles.
- Metrics will be assessed and shared with appropriate care teams to determine if changes need to occur.

Disclaimer

When evidence is lacking or inconclusive, options in care are provided in the supporting documents and the power plan(s) that accompany the clinical pathway.

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