

Patient Safety Programs for Child Maltreatment: Does One Size Fit All?

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In this issue of *Pediatrics*, Hansen et al¹ present a hospital-based patient safety program to identify children for whom there is a concern for or suspicion of child maltreatment. Rationale for such a safety program is supported by the high prevalence of child maltreatment,² likelihood of recurrence without recognition and reporting,³ subtlety of clinical presentations, and physician reluctance and lack of confidence in assessing and diagnosing child maltreatment.⁴

Although recognition of clinical presentations that may indicate maltreatment can be facilitated through hospital policies and various trainings, clinician uptake may be variable and inconsistent. In addition, managing suspected abuse or neglect involves a report to Child Protective Services and the possibility of separating the child from the family. This is the antithesis of pediatric practice for many clinicians, so this decision to report is understandably difficult. Yet the stakes are significant and include not reporting suspected abuse in a child who returns with another injury (or worse), as well as reporting suspected abuse in a child who is later determined to have a medical condition that explains their clinical findings. Even when maltreatment is suspected, medical errors can occur if diagnostic testing is incomplete or critical information from investigators or caregivers is not solicited. A system-wide safety program removes some of the uncertainties and angst by

implementing an intermediate measure that allows for additional information to be gathered and analyzed to determine the best next steps.

In their study, Hansen et al¹ detail a system-wide program in a large pediatric health care system encompassing both inpatient and outpatient settings. The intermediate measure is expensive in terms of resources and time: 24/7 availability of a social worker who conducts an in-person assessment and completion of a patient at risk (PAR) form and availability of a child abuse team to review every PAR form within 24 hours. But the outcomes appear to be worth the expense: nearly 27% of the 7698 PARs required further interventions by the child abuse team, and of these, 53 required immediate interventions because of potential diagnostic errors and concerns about child safety. This safety intervention appears to be an effective bridge between the clinician (who is concerned but may not pursue all the tests, information, and follow-up to complete the assessment) and the child abuse team, which is willing to ensure that assessments are complete and safety needs are addressed. Optimizing safety and minimizing diagnostic errors are of particular concern for suspected physical abuse, the most common maltreatment type to generate a PAR. This system primarily addresses type II errors.

In this study, the patient safety intervention was implemented in a

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large pediatric health care system composed of 2 free-standing children's hospitals, each with dedicated pediatric emergency department and inpatient units, a pediatric ICU, 3 urgent care sites, 2 primary care offices, and >30 specialty clinics. This is an ideal system for children because pediatric specialists are likely more adept at recognizing and responding to suspected child maltreatment. Other systems of care, especially in rural communities, may face greater challenges in detection, assessment, and management of child maltreatment, such that both type I and type II errors are likely.⁵ In these latter settings, resources may not include comprehensive support from social workers experienced in child maltreatment assessments or child abuse pediatricians or expertise. In addition, clinician uptake of a patient safety program for child maltreatment may vary as demands for screening and documentation have increased across all areas of medical practice. Alternative interventions are needed because one size does not fit all. Accessibility to child abuse

pediatricians, even remotely by telephone or other secure communication channels, may be a simple first step. To facilitate this, clinicians should understand that child abuse pediatricians not only assist in assessing possible maltreatment but also can be just as helpful in determining that an injury is accidental.

Safety programs for child maltreatment have potential to optimize detection and minimize medical errors. Effective implementation relies on several factors, including clinician uptake, resources, strategic planning and design, and capacity for follow-up testing and assessment. Health care providers are challenged to examine ways to improve screening for maltreatment in their own practice, including simple measures such as documenting all bruises in precruising infants or requesting additional information when a concern is not yet a suspicion. As the authors aptly stated, "we do not know what we are missing if we do not look."

ABBREVIATION

PAR: patient at risk

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