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Trauma-Informed Education Toolkit for Screening Pediatric Victims of Sexual Abuse and Maltreatment

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This is to certify that the doctoral study by

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has been found to be complete and satisfactory in all respects,
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Walden University
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Abstract

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by

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MSN, Walden University, 2013

BSN, The Catholic University of America, 2003

Project Submitted in Fulfillment

of the Requirements for the Degree of

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Abstract

The complex challenges facing the sexual assault nurse examiners program in a midwest state are underreporting, late reporting, and poor coordination of care for pediatric victims of child maltreatment with sexual abuse. The main objective of this quality improvement project was the identification of necessary practice-related approaches to care to decrease barriers associated with reporting suspicions of abuse or neglect. An evidence-based, multidisciplinary assessment clinical toolkit that followed clinical components of trauma-sensitive, child-centered screenings triggering a coordinated response to conduct a forensic medical exam within 96 hours of the alleged incident was evaluated. During 3 rounds of surveys following the Delphi technique, 10 members of an expert panel agreed upon critical success indicators were used for the review and final decision for adoption of the toolkit. The final consensus obtained, with an intraclass correlation of 0.924 with a 95% confidence interval, supported implementation of this trauma-informed toolkit which would ensure that medical care and throughput through the system of care addressed the physical and mental needs of the patient and caregivers as well as improvement in the forensic investigative data collection. A child-centered, trauma-sensitive approach to screening and evaluation by healthcare professionals will help decrease the delay to evaluation and to curtail long-term adverse impacts on survivors. This family-based primary prevention effort is a framework for healthcare practitioners to use and includes strategies (i.e., health history, mental health evaluation, family dynamics evaluation) that are child and family centered contributing significantly to positive social change.

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Dedication

The loss of a child is perhaps one of the most unforgettable and devastating moments for anyone. As healthcare professionals, we are trained to heal and save lives. When we fail to be thorough or miss clues, it could make the difference between life or death. It is important to have the tools to see past the obvious and peel back the layers in order to discover the answers. I dedicate this project to every child who deserves a voice, an advocate, and a champion.

"Be the change you want to see in the world." Mahatma Gandhi

Acknowledgments

Upon reflecting on how I have made it to this point in both my academic career and personal life, I cannot find a scholarly way to convey my deepest thanks to every person and patient who has made me who I am today. I have been fortunate to work with amazing professionals in the arena of forensic nursing who inspire me to continue pursuing avenues to improve our trauma-informed approach to care for those who are wounded and lost. Thank you to the exceptional team of sexual assault nurse examiners who truly exemplify professionalism, compassion, and empathy with every caring touch. Your guidance, faith, and support aided in developing a tool which will make a difference in our current practice.

Thank you to all my mentors that I had the privilege of working with in the arenas of nursing and academia. Jayne E. Raymond, RN, MBA, thank you for showing me the importance of "peeling back the onion layers" in order to understand the complexities of everything to lead me towards making meaningful and evidence-based decisions. My eyes are wide open thanks to you. Associate Professor, Lucy Meyer, RN, MSN, thank you for pushing me to continue this journey, believing that I could manage both school and homework. Your understanding and positive reinforcements helped me daily and provided me greater insights to becoming a better educator and student.

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feel blessed as I complete this project in hopes of being a true catalyst for change that makes a difference for all. A nurse who becomes a SANE chooses this calling because we want to be part of something bigger than ourselves and to serve a greater purpose.

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Section 1: Nature of the Project

Introduction

Identifying pediatric patients who may be victims of maltreatment and sexual assault requires health professionals with skills to use trauma-informed practice principles that help establish a trusting relationship and mitigate further retraumatization (Kraus & Thomas, 2011). A developmentally appropriate, patient-specific evaluation and treatment of suspected pediatric maltreatment/abuse, which takes into consideration acute and long-term consequences of sexual violence victimization creates a safe and trusting environment for the child minimizing trauma (Campbell, Greeson, & Fehler-Cabral, 2013). Pediatric patients require support from healthcare professionals to manage the physical effects of trauma and introduce coping skills to effectively handle its emotional impact and achieve positive long-term recovery (Fallot & Harris, 2009; Felitti, 2013). The latest science on the prevention, identification, and treatment of various forms of child maltreatment (CM) with sexual abuse (SA)are critical tools that every healthcare professional caring for pediatric patients should possess to provide optimal care to children and families.

Problem Statement

Data reported by an internal report from the organization under study in 2015 identified approximately 6,437 children who were victims of abuse or neglect in a Midwest state; of that number, 1,760 children were deemed as being in high-risk situations that required immediate services. Since 2010, this Midwest state has experienced a 9% annual increase in the number of children being referred to specialty

services as a result of neglect or abuse. For every 1,000 children in this Midwest state, 10 children were maltreated, which puts the state above the national average of 9.4% per 1,000 in 2014 (Annie E. Casey Foundation, 2016). The United States Department of Health and Human Services (USDHHS) estimated 3.6 million referrals involved alleged maltreatment of approximately 6.6 million children; the national rate of screened-in reports was 28.9 per 1,000 children (USDHHS, 2016).

The complex challenges facing the sexual assault nurse examiner (SANE) program in a Midwest state are underreporting, late reporting (which results in retraumatization), and poor coordination of care. One objective of the SANE program was to identify necessary practice-related approaches to care to decrease barriers associated with reporting suspicions of abuse or neglect within 96 hours of the alleged incident. Despite mandatory national reporting laws, the knowledge and experience to identify behaviors, signs, and symptoms of maltreatment during assessments are not always skillsets providers possess (Jenny, Crawford-Jakubiak, & Committee on Child Abuse and Neglect, 2013). The Emergency Nurses Association (ENA) and the International Association of Forensic Nurses (IAFN) joint position statement (2017) recommended that emergency care facilities develop policies, procedures, assessment protocols, and education to provide developmentally appropriate care to pediatric sexual abuse patients. Furthermore, both entities mandate that nurses who care for pediatric patients have specialized forensic training. Implementing screening tools to assess acute and nonacute suspicions or disclosures are recommended for proper mandated reports, referrals, and support to occur ensuring timely exams and follow up (ENA & IAFN,

2017). The level of care that is provided to the pediatric population requires specialized medical evaluations and interpretation of medical findings and reports (Adams et al., 2016; Adams et al., 2012; Flaherty & Stirling, 2010). Healthcare professionals need to recognize the negative health consequences of sexual violence, including increased health risks, depression, and premature death (Dube et al., 2005; Felitti, 2013).

The challenge the project site was experiencing was that although there was a pediatric SANE program in place, there had not been a standardized coordinated response or guideline identifying questionable acute cases of maltreatment/abuse that present for evaluation within 96 hours of a reported assault. In the central part of the Midwest state that was my focus in this DNP project, all pediatric patients age 0 to 14 years who present to the emergency department (ED) are medically cleared by providers and referred to the Child Advocacy Center (CAC) for follow-up forensic evaluations and joint interviews instead of activating pediatric SANEs and patient advocates, which immediately respond to the ED for patient screening and coordinating CAC and law enforcement response during the process. There is a gap in practice as not every healthcare provider understands how to address immediate safety needs, gather basic information about abuse to assess the time frame and medical needs, and assist with the apprehension of the perpetrator. In addition, specialized training is necessary for healthcare professionals to screen pediatric patients for abuse if there is no disclosure at the time of the exam and a regular medical evaluation is conducted (Fraser, Mathews, Walsh, Chen, & Dunne, 2010; Frasier, Thraen, Kaplan, & Goede, 2012; Jenny, Crawford-Jakubiak, & Committee on Child Abuse and Neglect, 2013). Since the nature

of physical abuse is sometimes atraumatic and less than 5% of those abused typically have visible injuries following a sexually assault, if the right questions are not asked, then referrals are not made and the child suffers (Adams et al., 2012). Consequently, when a child is discharged and directed to the CAC for further care, many patients may be delayed or may not follow up due to the great distances many must travel for the joint interview or forensic evaluation. This results in revictimization because of having to recount events which can be distressing for both the patient and family or caregiver (Bunting, 2014; Hornor & Fischer, 2016; Jackson & Deye, 2015).

Routine medical treatment does not always involve a child-centered, trauma-sensitive approach that encompasses an assessment and intervention pathway for children who may have been sexually abused since routine medical practices do not take into consideration developmental, cognitive, and socio-emotional factors (Bartlett et al., 2016; Brown, Fang, & Florence, 2011; Campbell, Olson, & Keenan, 2015; Czincz & Romano, 2013; Fang, Brown, Florence, & Mercy, 2012). As outlined in the National Protocol for Sexual Abuse Medical Forensic Examinations-Pediatric, not all sexually abused children exhibit symptoms and disclosure does not always occur since they often do not understand what sexual abuse is, are fearful to communicate it to anyone, and/or do not have a way to access help (U.S. Department of Justice Office on Violence Against Women, 2016). The 2016 guidelines presented in the protocol recommended that exams be trauma sensitive and child centered as healthcare professionals evaluate the child paying close attention to verbal, physical, and behavioral cues that could alert them to the possibility of maltreatment, including sexual abuse. Healthcare professionals

must gather child and family specific information as well as obtain a thorough medical history, which includes a complete medical evaluation and examination of the anogenital area (Adams et al., 2016; Adams et al., 2012; Clements, Burgess, Fay-Hillier, Giardino, & Giardino, 2015; Jordan & Steelman, 2015; Kellog, 2005). In the central Midwest state, the lack of standardized pediatric screening tools for healthcare professionals has led to significant gaps in care including, but not limited to: (a) underreporting, (b) retraumatization for children and families, and (c) poor coordination of after care services.

Purpose

Campbell, Olson, and Keenan (2015) explained that in the acute setting, clinicians might experience difficulty making diagnoses or identifying abuse in pediatric patients, especially in the absence of eyewitness reports, a confession from the assailant, or as a result of no obvious sign of injury noted during the exam. The evaluation needs to be comprised of critical elements focused on detailed psychological and standardized trauma sensitive principles, to include directly obtaining a history from the child (Campbell et al., 2015; Louwers, Affourtit, Moll, deKoning, & Korfage, 2010; Middlebrooks & Audage, 2008). Challenging questions need to be asked, keeping in mind that when proposing a differential diagnosis that points to possible sexual abuse or violence with the pediatric population, physical evidence is quite rare (Frasier, Thraen, Kaplan, & Goede, 2012). A patient presenting for care after a sexual assault needs to feel they can trust those caring for them, feel safe, and have confidence that their needs are met (Jordan & Moore-Nadler, 2014; Koc, Oral, & Butteris, 2014; Santaularia et al.,

2014; Thackeray, Hibbard, Dowd, Committee on Child Abuse and Neglect, & Committee on Injury, Violence, and Poison Prevention, 2010). Disclosure of abuse is often times not a one-time event; it may be accidental or deliberate, immediate or delayed because the dynamics of sexual abuse are unique for a child given their cognitive, emotional, and self-concept of being (Bunting, 2014; Campbell et al., 2015; Jenny, Crawford-Jakubiak, & Committee on Child Abuse and Neglect, 2013).

The project site works closely with local health agencies and the CAC to coordinate referrals of children who are suspected of being victims of maltreatment, including sexual abuse based on medical evaluation or have disclosed abuse. In 2014, an internal report from the organization under study, received 12,392 reports of suspected child abuse and neglect, of which 8,282 were in Child Protection Services (CPS) jurisdictions; 6,338 were assigned to investigations with 3,809 completed and 2,424 assessments terminated due to new information or jurisdictional issues. Most importantly, a decision for required services was made in 23.9% (n = 911) of the 3,809 full assessments, which identified 1,616 children as victims of child abuse and neglect. The challenge the rural Midwest state faces is the lack of quantitative data to track delayed reporting due to challenges posed by limited staffing, large catchment areas, and weather-related travel hazards. According the CAC and the project site executive director, the Midwest state SANE program plans to track this information for state and national surveillance reporting in the near future. Currently, there are no data available for delays of up to 96 hours from the precipitating event. According to the executive director of the Midwest SANE program participating in this project, the project site has

begun to track and report pediatric cases and began sharing data with the CAC and in 2016 to raise awareness and improve reporting.

The focus of this project was to enhance the current healthcare practices of the healthcare providers and SANE professionals when screening and referring pediatric patients who may be exposed to maltreatment/abuse. The lack of comprehensive protocols providing optimal pediatric screening for patients who disclose an acute assault has caused a gap in identification of these cases. According to the Midwest state's sexual assault evidence collection protocol and the 2016 IAFN National Protocol for Sexual Abuse Medical Forensic Examinations-Pediatric Guidelines, the suspicion of child abuse alone is sufficient to trigger a mandatory report and evaluation based upon disclosure or observations of a pattern of indicators associated with sexual abuse (Adams et al., 2016; U.S. Department of Justice Office on Violence Against Women, 2016).

Although delayed reporting occurs most often in pediatric sexual assault because children often fail to disclose immediately, it is imperative that healthcare professionals have the appropriate skillsets and knowledge to conduct timely health assessments, treatment, and interventions on victims of maltreatment or sexual abuse, regardless of the probability of evidence. One of the strategic goals for 2017 was to follow the Midwest state guidelines for forensic collection which recommend that if a child presents acutely for an evaluation within 96 hours of the reported assault, a prompt medical response and evaluation should immediately occur The project site executive director identified a need to review and enhance current screening and forensic exam

practices postassault within the recommended national and state guidelines, ensuring accessibility for all children regardless of circumstances or geographical location. An educational curriculum was developed to include techniques to improve assessment, screening, and pediatric-specific treatment modalities based on clinical and behavioral characteristics employing the Adverse Childhood Experiences (ACE) screening tool as part of the exam process.

The purpose of this quality improvement (QI) DNP project was to develop an evidence-based, multidisciplinary clinical toolkit with educational materials that followed clinical components of trauma-sensitive, child-centered screenings within the IAFN and Midwest Regional Child Advocacy Center (MRCAC) practice guidelines. The QI project was reviewed by a panel of experts who evaluated the clinical toolkit and education materials making recommendations to endorse implementation, which was outside the scope of this DNP project. This project has the potential to integrate evidence-based strategies into nursing practice that follows trauma-informed approaches and concentrates on gaps in practice related to follow-up care and addressing mental health concerns that will lead to favorable long-term outcomes for the pediatric population.

Nature of the Doctoral Project

The IAFN and MRCAC have published revised forensic guidelines for nurses and healthcare professionals to incorporate into care pathways in order to evaluate and engage in evidence-based trauma care as well as focused mental health treatment (Adams et al., 2016, p. 82). In critically examining the current pediatric SANE care, it is

important to emphasize that SANE nurses are activated by the ED based upon healthcare provider exams, disclosure from the child or caregiver, and/or suspicion of maltreatment or abuse (Czincz & Romano, 2013; Jenny, Crawford-Jakubiak, & Committee on Child Abuse and Neglect, 2013; Jordan & Moore-Nadler, 2014; Moylan, Lindhorst, & Tajima, 2017). The 2016 IAFN National Protocol for Sexual Abuse Medical Forensic Examinations-Pediatric Guidelines recognized the uniqueness of reporting that occurs in communities (U.S. Department of Justice Office on Violence Against Women, 2016). One of the main initiatives since its last update in 2013 was to separate the adult/adolescent medical forensic needs from younger children (U.S. Department of Justice Office on Violence Against Women, 2016). Included in the update was the validation of using developmentally appropriate screening tools to facilitate improved screening, care, and sexual abuse reporting in prepubescent children as well as resources to facilitate specialized education for pediatric examiners and criteria for QI and protocol developments to ensure standardization and prioritization are provided throughout the care continuum (U.S. Department of Justice Office on Violence Against Women, 2016).

The purpose of this project was to identify and implement a screening/assessment tool which was consistent with the updated 2016 protocol. There was a need to improve screening and reporting of child sexual abuse as well as trigger a coordinated SANE response to conduct a forensic medical exam. This evidence-based screening and assessment tool will be used by the referring agency, such as the ED or

clinic, to evaluate pediatric victim needs for individualized supportive treatment plans and referrals to ensure future health and well-being after a sexual assault incident.

Proposed Solution

CM, including SA, is a public health problem in need of specialized health care professionals to address the needs of these victims as well as institute preventative measures for safety and improved health outcomes. My primary objectives of developing a trauma-informed pediatric screening toolkit were to decrease the length of time from acute presentation to actual screening and assessment to 96 hours or less and improve the screenings and early recognition in clinical settings by detecting possible CM with SA before serious complications occur. In this DNP QI project, I used the star model of knowledge transformation, which organizes both old and new concepts for improving care and provides a framework to organize evidence-based practice (EBP) processes and approaches (see Stevens, 2012).

I presented the development of a toolkit based on the 2016 IAFN Pediatric clinical forensic guidelines which included a screening/assessment tool, an algorithm of care, and educational materials to the expert panel of stakeholders from the SANE program and the Sexual Assault Response Team (SART) for review, approval, and implementation. The toolkit was to be implemented at two clinical sites. For practice improvements to be successful, it is important to provide information, education, clarification of questions, and emphasize the benefits of the proposed change in practice, demonstrating trauma sensitive responses and interventions (Green et al., 2016).

Significance

Pediatric patients who have been victims of CM with SA are in a vulnerable state and usually struggling with internal and external issues related to the unwelcomed stress (Briggs et al., 2013). The SANE professional is an advocate for these patients both in the medical and judicial arenas. In addition, coordination and communication among initial responders can enhance documentation and evidence collection during forensic medical care as well as information gathered during forensic interviews (Adams et al., 2012; Campbell et al., 2015). SANE professionals are the navigators providing the victim safety and the necessary resources to support successful short and long-term recovery, facilitating overall health and well-being (Campbell et al., 2013; Clements et al., 2015; De Arellano, Ko, Danielson, & Sprague, 2008; Jackson & Deye, 2015).

In 2014, the U.S. Department of Health and Human Services reported an estimated 3.6 million cases of CM, a 14.6% increase since 2010 (U.S. Department of Health & Human Services, Administration for Children and Families, Administration on Children, Youth and Families, Children's Bureau, 2016). Although healthcare providers are mandatory reporters, their responsibility to report abuse or maltreatment is based on assessment, knowledge, and skills acquired through experience and education (Jordan & Steelman, 2015). Barriers to identifying and reporting abuse are due to the lack of knowledge regarding the characteristics of child abuse and neglect, pediatric specific training, and exposure to the judicial system which delay the determinations of whether care is urgently needed (Bartlett et al., 2016; Bunting, 2014; Fraser et al., 2010; Jordan & Steelman, 2015). A clinical toolkit that has an educational component illustrating the

flow of how to identify abuse and prioritize screening and care will improve clinical performance.

A standardized, developmentally appropriate exam as well as coordination of care across the disciplines and judicial system provides a solid infrastructure that delivers collaboratively-disciplined responses, prevents further revictimization, addresses safety, and promotes healing for the child and caregiver. In a multivariate analysis conducted by Fraser, Mathews, Walsh, Chen, and Dunne (2010), nurses who received specialized training for assessment and recognition of abuse as well as the judicial process were more likely to report suspected cases [$\chi_2(df = 2, n = 792) = 54.93$, $p < .001$], demonstrating a strong correlation that education improves clinical performance and reporting since they are more confident in their skillset. This project will improve the healthcare professionals' knowledge and clinical expertise as well as expand their ability to manage these patients in an environment that is therapeutic and nonjudgmental (see Richmond & Aitken, 2011).

Summary

The nurse-patient interaction involves the whole person, focusing on body, mind, and spirit, and this comprehensive holistic approach to care has a profound effect on the healing process for pediatric patients (Green et al., 2016; Jenny, Crawford-Jakubiak, & Committee on Child Abuse and Neglect, 2013; Kraus & Thomas, 2011). The trauma of violence can compromise the quality of life and affect functional, psychological, and spiritual status of the individual, which in turn impacts how well these patients do in the long term (Dube et al., 2005; Felitti et al., 1988; Hornor & Fischer, 2016; Middlebrooks

& Audage, 2008; National Research Council, 2014; Senn & Carey, 2010). Healthcare professionals who care for pediatric patients of maltreatment or sexual abuse must practice the principle that every act must have a healing intention (Czincz & Romano, 2013).

Merrick and Latzman (2014) discussed the importance of healthcare professionals being vigilant during assessments of pediatric patients and integrating clinical expertise, patient preferences and values, as well as research evidence into the decision-making process to better enhance clinical outcomes and positively impact the quality of life of pediatric patients and their families. Healthcare providers who obtain a health history and provide comprehensive medical evaluations when concerns about abuse arise play a critical role in eliminating victimization and provide crucial links to specialized medical, social, and mental health interventions for prepubescent and adolescent patients that will reduce long-term negative disparity (Fallot & Harris, 2009; Jordan & Steelman, 2015; Kraus & Thomas, 2011; Stoltenborgh, van Ijzendoorn, Euser, & Bakermans-Kranenburg, 2011; U.S. Preventative Services Task Force, 2014). Healthcare professionals have a responsibility to understand the types of maltreatment and abuse in order to be the best advocates and clinicians possible. Their knowledge must include proper screening, identification, and documentation of abuse to reveal underlying causes, initiate appropriate interventions, and improve prevention efforts for this vulnerable population. The approach to care must be trauma sensitive and comprehensive, identifying risk factors early since children who are exposed to repeated

violence or who are victims are more likely to have significant negative outcomes later in life (Brown et al., 2011).

Section 2 will discuss the concepts of CM with SA and the importance of understanding the physical and psychological complications that may arise if not identified early. In order to facilitate a practice change, a theoretical framework will be considered as a foundation for developing a toolkit to improve screening, care, and reporting. The research appraised for developing a QI process for the organization under study will be outlined and explained.

Section 2: Background and Context

Introduction

CM and SA have become a global health issue because they can lead to a sequela of adverse long-term health and economic burdens on survivors, well into their adult years (Briggs et al., 2013; Felitti, 2013; Felitti et al., 1988; Finkelhor & Browne, 1985). It is important that healthcare professionals have a common definition and understanding of CM with SA. Empirical evidence suggests that CM with SA influences developmental progress and can cause the development of maladaptive behaviors, such as smoking, oppositional behavior, and substance abuse, which allow individuals to deal with their anxiety, depression, and aggression (Senn & Carey, 2010; Stoltenborgh et al., 2011). In this literature review, I addressed practice questions and included key sources of evidence from sources such as the: (a) National Association of Pediatric Nurse Practitioners (2011), (b) U.S. Department of Justice Office on Violence Against Women (2016), (c) North American Society for Pediatric and Adolescent Gynecology (2016), (d) International Association of Forensic Nurses (2016), and (e) National Children's Alliance (2016). These data sources were evaluated using the Grade of Recommendation, Assessment, Development, and Evaluation approach (see Appendix B) which helps determine if the proposed guidelines for practice change are clearly defined, applicable, and systematically evaluated to be evidence-based (see Brozek et al., 2009).

Concepts of Childhood Maltreatment with Sexual Abuse

Defining how child abuse and neglect appear poses challenges in healthcare settings because signs of abuse are often invisible. Along with skills for identifying children at risk during wellness evaluations or medical visits, a common language for defining abuse and neglect is key to continued surveillance, appropriate interventions and treatment, and establishing strong prevention awareness programs for this vulnerable population (Child Welfare Information Gateway, 2016b). For this project, the definition of child abuse and neglect for children (ages newborn to 17 years) is defined by the Centers for Disease Control and Prevention (CDC) and by federal law under Section 3 of the Child Abuse Prevention and Treatment Act (42 U.S.C. § 5101) which states:

> any action or series of actions that pose threats of harm or potential harm (physical abuse, sexual abuse, psychological abuse), failure to provide for a child's basic physical, emotional, or educational needs or failure to protect a child from harm or imminent risk of harm (CDC, 2016b; Leeb et al., 2008; U.S. Department of Health and Human Services, 2003).

It is important to note that a necessary item for developing an effective response to child abuse and neglect is reasonable agreement on the definition of the problem and its scope by stakeholders and law enforcement.

Campbell, Greeson, and Fehler-Cabral (2013) presented evidence from a qualitative study in which they evaluated forensic nurses practice of two pediatric SANE programs using a prospective sampling strategy. In their study, interviews with

adolescent sexual assault victims 14–17 years old who received full medical forensic examinations and follow-up care were evaluated, along with their experiences and interactions with the SANE program, SART, and law enforcement. Open coding techniques and data analyses revealed that SANE care received positive responses for healing based on the actions and behaviors of SANE professionals who were sensitive to victims' needs, provided compassionate care, and offered unbiased support and validation empowering patients to regain autonomy and independence postassault (Campbell et al., 2013). Findings from their study suggested compassionate care is developmentally informed and patient-centered during the evaluation and forensic exams, which improves the perception of care. Their results also suggested that specific practice differences between adults and adolescents may address barriers to reporting and improve long-term healthcare outcomes for this population.

It is important to understand CM with SA and the early identification of acute cases leads to reductions in the need for expensive services if untreated (Senn & Carey, 2010). Monitoring and surveillance of data drives changes in the development of new prevention and intervention programs as well as evaluation of current processes. In a mixed method study of 414 female participants (*M* age = 28 years) from a publicly-funded sexually transmitted disease (STD) clinic, Senn and Carey (2010) found that early childhood SA was associated with a greater likelihood of adult sexual risk behavior. Participants willingly responded to survey questions outlining adult sexual behaviors and childhood experiences or exposure to abuse from the Comprehensive Child Maltreatment Scale, which assesses childhood physical abuse, psychological

abuse, and neglect (Senn & Carey, 2010). Their results showed that only CM accompanied with SA was uniquely associated with risky adult sexual behavior (i.e., percentage of episodes of unprotected sex in the past 3 months and number of lifetime partners). Thus, CM with SA was the best predictor of risky adult sexual behavior. Most women in their study (80%; $n = 330$) reported at least one type of CM, with 56% ($n = 232$) reporting multiple types of CM and few participants (4%; $n = 18$) who reported SA without another type of abuse. Those who reported they had experienced SA at an early age were more likely to disclose than those who did not report physical abuse, $\chi^2(n = 414) = 11.78$, $p < .001$, $OR = 2.12$ (CI = 1.37-3.26); neglect, $\chi^2(n = 414) = 14.96$, $p < .001$, $OR = 2.29$ (CI = 1.50-3.51); and psychological abuse, $\chi^2(n = 414) = 16.96$, $p < .001$, $OR = 2.58$ (CI = 1.63-4.08; Senn & Carey, 2010, p. 329).

The multivariate analysis Senn and Carey (2010) performed in their study displayed a significant statistical relationship of the likelihood that participants who experienced one type of CM also experienced another form of maltreatment and/or abuse leading to further SA and/or risky sexual behavior. The results of their study provided clinicians evidence that suggested childhood SA could have enduring effects on risky sexual risk behavior. Their findings showed not only that exposure to abuse, regardless of the severity and amount, proves to be traumatic, so the need to address it early is crucial. The implications for clinicians is that a need exists to develop improved screenings and history collection from children during regular visits to identify children at risk and decrease the likelihood of negative health and behavioral complications extending into adulthood.

Assuring physical and emotional safety with appropriate assessment instruments reduces retraumatization. Children who experience violence or abuse have been linked to an increased risk for sexual victimization, including complex behavioral and physical manifestations that compromise cognitive development (Bartlett et al., 2016; Felitti et al., 1998; Hornor, 2011; Hornor & Fischer, 2016; Sedlak et al., 2010). Educating healthcare professionals to provide patient-and family-centered care that is trauma sensitive facilitates appropriate care and evaluations creating a mutually beneficial partnership among the pediatric patients, families, and between the health care professionals (Campbell et al., 2013; De Arellano et al., 2008; Fallot & Harris, 2009; Green et al., 2016).

In a 1-year retrospective study by Hornor and Fischer (2016), children under the age of 18 (n = 198) presented to the CAC for SA assessments were divided into two groups (Group A: no identified previous concern for SA after first SA assessment and Group B: seen for a SA assessment and identified for a SA concern/victimization). The researchers compared demographics; familial psychosocial factors; and SA characteristics (i.e., disclosure, parent/caregiver belief and support, duration of abuse, relationship of perpetrator to child) between the groups to identify those at greater risk for revictimization and negative health concerns. Their findings indicated children in the revictimization group were younger (M = 5.98 years, SD = 3.5 years); 22% had developmental delays/disabilities; and 25% had a mental health disorder diagnosis (i.e., bipolar, oppositional defiant disorder, depression, anxiety). In addition, their results showed statistical significance in the number of assessments and disclosing SA. From

Group A, 46.4% disclosed abuse during the forensic interview compared to 13.4% from Group B ($\chi^2 = 14.5$, $df = 1$, $p = 0.0$) because of parent/caregiver belief and support. The lack of support from the parent or caregiver can have negative outcomes leading to nondisclosure and contribute to developmental delays, further SA, revictimization, and other health and mental complications (Hornor & Fischer, 2016). The results of their study substantiate that vulnerability to revictimization corresponds to familial psychosocial characteristics like involvement with drug and alcohol, exposure to domestic violence, and parental mental health and/or history of SA.

The practice implications from the Hornor and Fischer study suggest a need to conduct thorough psychosocial assessments and multiple forensic interviews when SA is suspected to provide appropriate interventions. Identifying abuse and obtaining a good family history drives treatment and proper referrals to meet the needs of the child and caregiver as well as possibly preventing SA revictimization (Bartlett et al., 2016; Briggs et al., 2013). The age at which children are first traumatized, the frequency of these traumatic experiences, and the degree to which caregivers contribute to the event all have a profound impact on the extent of psychological damage and physical well-being (CDC, 2016b; Felitti, 2013; Felitti et al., 1988, Finkelhor & Browne, 1985).

Theoretical Frameworks

Nursing theories serve as a framework for guiding practice, emphasizing the importance of EBP and translating research into practice (Alligood, 2013, p. 6). Incorporating strong foundational care principles are important to understand circumstances faced by pediatric victims. In addition, during evaluation and assessment,

it important to include looking at obvious facts such as developmental levels, the nature of experienced SA and reactions to it, and long-term recovery (Bartlett et al., 2016; Campbell et al., 2015).

The theoretical frameworks I identified for this project served as the foundation for program planning, development following evidence-based interventions to investigate methods for fostering change, and offering a basis for program evaluation (see Mitchell, 2013). In this subsection, I will examine Duffy's guiding principles of care and Finkelhor and Browne's traumagenic dynamics model. The clinical applicability of these models of care were considered when analyzing the dynamics of how child abuse and neglect come into a family system and how the strategic integration of multifaceted approaches to care aid in mitigating long-term negative health and behavioral consequences (see Moulding, Silagy, & Weller, 1999; Senn & Carey, 2010; Thackeray et al., 2010).

First and foremost, it was important to educate nurse examiners on the guiding principles of care based on Duffy's quality caring model as defined by the updated Pediatric SAFE protocol, aimed at supporting child-focused, victim-centered, trauma-informed care for children who disclose or are suspected of being sexually abused (U. S. Department of Justice Office on Violence Against Women, 2016). The guiding principles of care are based on the following seven principles:

1. Provide children with timely access to examinations, trained examiners, and quality care;
2. Secure the physical and emotional safety of children;

3. Recognize each child has unique capacities and strengths to heal;
4. Offer comfort, encouragement, and support;
5. Provide information about the exam process and links to resources to further address needs;
6. Involve children in decision making, to the extent possible; and
7. Ensure appropriate confidentiality (U.S. Department of Justice Office on Violence Against Women, 2016, p. 24).

In practice, this midlevel theory acknowledges clinicians' approach to care as one that cultivates a caring relationship with patients and families, as well as other health professionals, leading to the feeling of being cared for, to include caring for self, patients, caregivers, and the community (Duffy & Hoskins, 2003). The clinical applicability of this care model describes the importance of considering a multifaceted approach to care that creates and sustains collaborative relationships of care that are child and family centered (see Figure 1). The feeling of being cared for is appropriate when delivering trauma-specific care because it emphasizes interaction across all levels, assisting patients and caregivers in improving short- and long-term outcomes; hopefully increasing referrals for follow up, and decreasing posttraumatic symptoms and behaviors (Adams et al., 2016; U. S. Department of Justice Office on Violence Against Women, 2016).

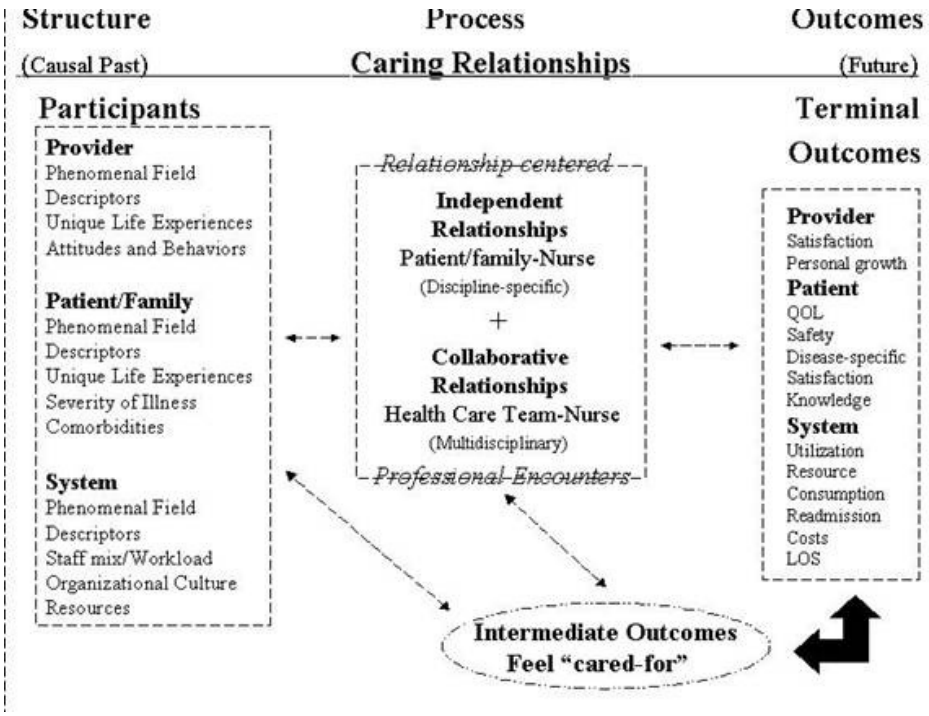

Figure 1. From "The Quality-Caring Model: Blending Dual Paradigms," by J. Duffy and L. Hoskins, 2003, *Advances in Nursing Science, 26*(1), p. 81. Copyright 2003 by Wolters Kluwer Health, Inc. Reprinted with permission.

Finkelhor and Browne (1985) developed the traumagenic dynamics model to describe how four trauma dynamics (traumatic sexualization, betrayal, powerlessness, and stigmatization) that a child experience when they are sexually abused, which alters their cognitive and emotional orientation to the world, evolving into distortions of self-concept, world view, and affective capacities (p. 1). The trauma caused by SA is unique. The psychological trauma compounded by the betrayal of being harmed by someone who cared for them while being disempowered manifests behaviors of shame, guilt, and/or feelings of being defective (Finkelhor & Browne, 1985). Thus, understanding how to assess these victims for each of these dynamics will help healthcare professionals anticipate potential problems providing appropriate interventions to address both the

emotional and physical development of survivors. The model of traumagenic dynamics can be the basis for developing instruments specifically designed to assess the impact of SA (National Research Council, 2014; Clements et al., 2015).

Theory and Clinical Fit

Change is essential to produce optimal outcomes; for the change process to work, change agents must employ evidence-based frameworks to guide the implementation process (Mitchell, 2013). Early detection and intervention may help prevent child abuse and limit damage to the cognitive and physical development. Medical providers have the primary responsibility of recognition, reporting, and proper postreporting management of suspected CM with SA cases. The care practice problem of interest was how to improve care delivery to pediatric victims of maltreatment and abuse by providing trauma-informed, patient-centered approaches towards care.

For the implementation of this DNP project within the SANE program, the Kotter and Cohen's model of change was considered as a guiding principle for transitioning towards a practice change (see Figure 2). Kotter’s 8-step change model comprises eight overlapping steps that illustrate the process of creating a climate of engagement following steps to sustain the organization’s infrastructure to collaborate and embrace the change (Webster, 2016). Successful change occurs when there is commitment, a sense of urgency or momentum, stakeholder engagement, openness, clear vision, good and clear communication, strong leadership, and a well-executed plan.

Kotter’s 8-step change model recognizes each of these characteristics. This theory was chosen due to the appeal to the stakeholder's emotional side to identify with

the ‘why’ of the change. Given that people within the organization are given facts behind the necessity of change, they will be more prone to implementing said change (Appelbaum, Habashy, Malo, & Shafiq, 2012). Creating a culture of change that is sustainable will be important even if the organization experiences a turnover in leadership even if there is a change in the leadership team (Melnyk & Fineout-Overholt, 2015). This step requires a continuing re-evaluation of the effectiveness of the implementation strategies and ways to reenergize the members of the organization to continue to fuel the change. It will be necessary to perform continuous reevaluation of the proposed practice change from those that are implementing the change properties in order to create a belief and vested interest among the organizational members allowing them to be change agents in the revision and standardization of the pediatric SANE program.

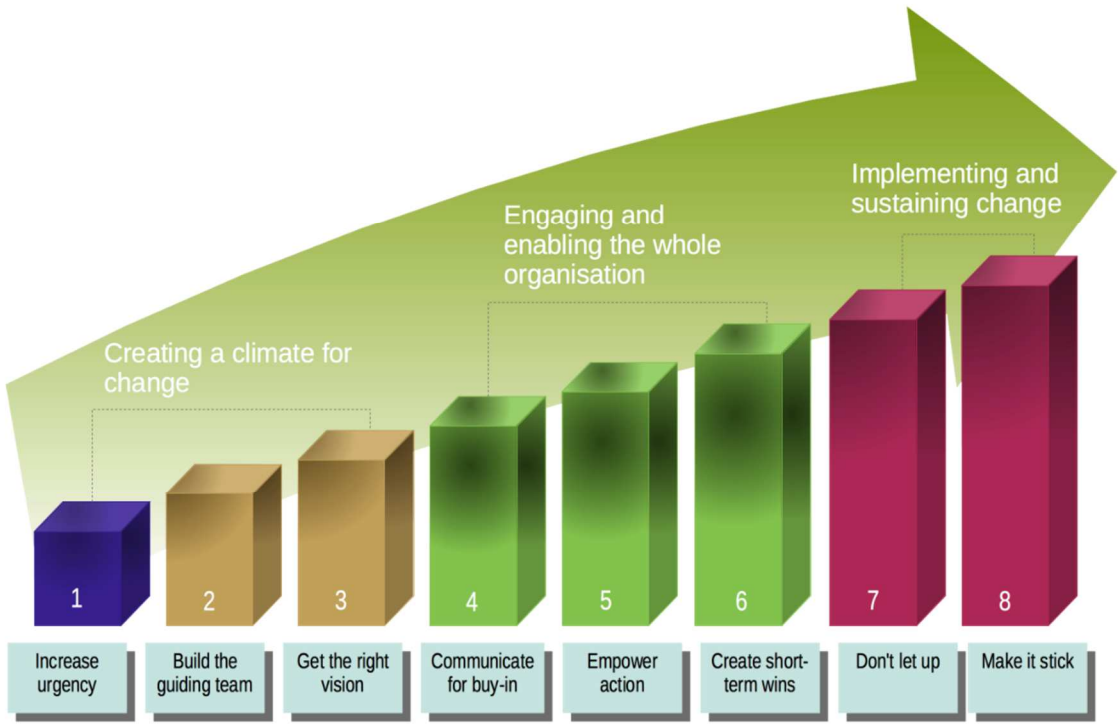

Figure 2. Kotter's 8 Step Change Model. Adapted from "Successful Change Management-Kotter's 8 Step Change Model," by S. Appelbaum, S. Habashy, J.L. Malo and H. Shafiq, 2012, *Journal of Management Development, 31,* p. 766. Copyright 2012 by Emerald Group Publishing Limited. Reprinted with permission.

The IAFN and MRCAC have published revised practice guidelines for forensic nurses and healthcare professionals to effectively incorporate care pathways which evaluate and engage in evidence-based trauma care focused mental health therapy to improve screenings (Adams et al., 2016, p. 82). A seamless continuum of trauma sensitive care understands that achieving long term recovery goals requires care planning which includes social, economic, cultural, and physical needs (Richmond & Aiken, 2011). Many of these patients pose multiple challenges in the acute, intermediate, and rehabilitative phases. Forensic trained nurses are always thinking about care beyond the specific situation in a systematic manner because the goal is to deal with acute issues

that potentially become complicated if provided services are not holistic and preventative.

Without considering or understanding the impact of trauma, healthcare services can be retraumatizing, may be ineffective and patients may engage with the healthcare professional (Green et al., 2016; De Arellano et al., 2008). Trauma-informed approaches to care address the human response to trauma providing a safe environment for the victim. The holistic approach to care also facilitates a collaborative response towards decreasing emotions and trauma, while promoting positive recovery.

Cost of Care

The economic burden of CM with SA, as reported by the CDC estimated 1 year of confirmed cases of child maltreatment (physical abuse, SA, psychological abuse and neglect) resulted in 1,740 fatal and 579,000 nonfatal events, costing approximately $124 billion (CDC, 2012). Brown, Fang, and Florence (2011) presented aggregated data using an incidence-based approach from literature reviews and budget calculation from 2010 to forecast the lifetime cost per victim of nonfatal child maltreatment at $210,012 in 2010 dollars, including $32,648 in childhood health care costs; $10,530 in adult medical costs; $144,360 in productivity losses; $7,728 in child welfare costs; $6,747 in criminal justice costs; and $7,999 in special education costs.

CM with SA can lead to cognitive impairment and delays, increasing risks of negative behavior problems, premature aging, and increased risk of disease. Using an incidence-based approach, Fang, Brown, Florence, and Mercy (2012) calculated the cost of managing both the short and long-term care of CM with SA to be substantial and the

lack of nationally representative data on CM with SA cases, as well as a standardized current range of inpatient and outpatient costs for care, makes it difficult to provide strong economic evaluation. One of the main limitations of current medical cost estimates for the at risk pediatric populations as cited by Brown et al. (2011), reported all costs are inpatient episode–specific. Outpatient expenditures for medical costs were not as specific as those with adult studies. Defining CM with SA nationally with the CDC's Uniform Definitions and the Behavioral Risk Factor Surveillance System data could help correlate economic analysis and medical estimates across the board to advance understanding of CM with SA (Brown et al., 2011; CDC, 2012; Leeb et al., 2008).

Relevance to Nursing Practice

In recent years, the healthcare community has begun to acknowledge widespread prevalence of psychological trauma in human experiences, as well as its pervasive impact on individuals, families, and society (Briggs et al., 2013). According to the U.S. Department of Health and Human Services *Child Maltreatment 2014*, of the 702,000 victims of maltreatment, 75.0% of victims were neglected, 17.0% were physically abused, and 8.3% were sexually abused (U.S. Department of Health & Human Services, Administration for Children and Families, Administration on Children, Youth and Families, Children Bureau, 2016). Empirical data has shown that research and knowledge about traumas occurrence, its negative biological, psychological, and social effects has increased because exposure to violence has shown significant disturbances in children and adolescent functioning and development (Flaherty & Stirling, 2010; Sedlak

et al., 2010). Despite this growth of knowledge and the fact that psychological trauma profoundly impacts development, there is a lack of training showing how to assess a child who does not disclose abuse using a trauma focused informed approach to care. Trauma-informed interventions begin with early screening and assessment; culturally and developmentally appropriate care and services; a trauma-informed and responsive workforce; evidence-based and emerging best practices; creation of safe environments; community outreach and partnership building; and ongoing performance improvement and evaluation (De Arellano, et al., 2008).

Gaps in Practice: Late Recognition and Delays in Treatment

Early recognition of CM with SA is of utmost importance to prevent morbidity and mortality (Jackson & Deye, 2015). As healthcare professionals conduct risk assessments taking into consideration safety, exposure to violence, and socio-demographics, a portion of the evaluation needs to focus on identifying subtle physical findings and behavioral manifestations which are indicative of possible CM with SA (Jordan & Steelman, 2015). Not every child displays obvious signs of trauma and the differential diagnosis of abuse or maltreatment needs to be considered. Reporting a suspicion of CM with SA should be part of practice which leads to a forensic interview and a second detailed medical examination.

Koc, Oral, and Butteris (2014) presented case studies where two children from one family frequently attended well-child visits and sought medical care for injuries. Review of their medical records never indicated concerns for abuse or maltreatment. The youngest child died at the age of 4 ½ years from cardiopulmonary arrest and his autopsy

showed evidence of multiple traumas to the brain, lungs, and heart. He had been a victim of abuse up until his death. The second child was also a victim of abuse and maltreatment and at the age of 7, after being seen for an angulated fracture, the physician felt this injury warranted further investigation. This child was removed from the home and after further forensic and medical evaluation, it was determined that the child had suffered multiple beatings and was diagnosed with attention deficit hyperactivity disorder (ADHD) and oppositional defiant disorder. As a survivor, this child had profound posttraumatic stress disorder (PTSD) and developmental delays due to the abuse. Once he was placed with another family and into counseling, he began disclosing details of the abuse. These two case studies illustrate delayed diagnoses of child maltreatment because symptoms were nonspecific and/or the history provided was misleading. In both cases, healthcare providers failed to recognize the signs of abuse and could have prevented the sequelae of negative events and the fatal outcome that occurred (Koc et al., 2014).

Various factors influence how and when children decide to disclose and the amount of information pertaining to the abuse itself. In addition, healthcare providers do not always report suspected cases or lack the knowledge, skills, and confidence to definitively identify CM with SA (Clements et al., 2015; Jordan & Steelman, 2015). In a clinical report published by the American Academy of Pediatrics in a 2002-2003 survey regarding the pediatrician's role in the prevention of maltreatment, approximately 70% of pediatricians agreed with primary healthcare providers that their duties include understanding the triggers and signs of CM with SA to provide proper care, as well as

education and guidance to parents and families to help prevent child abuse. Furthermore, 91% also agreed that all pediatricians should screen for parenting problems during health supervision visits (Flaherty & Stirling, 2010). Participating in consistent educational programs and training improves how healthcare providers evaluate pediatric/adolescent patients to include identifying risk factors, childhood development features, and patterns of injury associated with maltreatment. Furthermore, learning to use trauma sensitive language during interviews and medical evaluations is important in reducing the fears and anxiety that providers feel when reporting a suspicion of CM with SA.

In a mixed methods research study, Lincoln, Arford, Prener, Garverich, and Koenen (2013) identified barriers to providing patient-centered approaches to care for some providers, which created a strained provider-patient relationship due to lack of familiarity with trauma-sensitive words that are simple to recall when screening. Through structured qualitative interviews with healthcare providers caring for patients diagnosed with posttraumatic stress disorder, language evaluating the health literacy and mental well-being of a patient with PTSD at times would trigger stressful responses, emotions, and negative psychiatric symptoms related to the trauma their experiences. The impact of retraumatization is possible or could be potentially harmful to children and families negating early identification and intervention. The gaps in medical, social, and education disciplines revealed key aspects of care and the need for improvement in recognition, reporting, and post-reporting follow-up of suspected CM with SA cases to prevent recurrent abuse (Child Welfare Information Gateway, 2016a).

Physical and Psychological Complications of CM with SA

PTSD, anxiety, and depression are detrimental psychological conditions. These circumstances negatively impact victims' quality of life if not treated promptly and appropriately (Santaularia et al., 2014). Felitti et al. (1998) conducted one of the largest ongoing collaborative longitudinal studies with Kaiser Permanente and the CDC, providing quantitative data to support early recognition and intervention for children exposed to adverse experiences.

The adverse childhood experience (ACE) study examined the medical, social, and economic consequences of adverse childhood experiences over their lifespan. ACEs are very common and disturbing. ACEs are mostly unrecognized and are powerful indicators of adult social malfunction, disease, mental illness, disability, substance abuse, poor quality of life, and premature death (CDC, 2016b; Felitti et al., 1998).

The ACE study. In a landmark study Felitti et al. (1998), along with the National Institutes of Health and Kaiser Permanente between conducted a retrospective and prospective longitudinal study between 1995 to 1997 known as the adverse childhood experiences (ACE) study, which followed more than 17,000 adult participants who had received medical evaluations. The ten categories of adverse childhood experiences studied and scores obtained resulted in almost two thirds of participants reporting at least 1 ACE, more than 1in 5 reported three or more ACEs (Felitti, et al., 1998; Middlebrooks & Audage, 2008). The ACE study found a statistically significant relationship between exposure to abuse, neglect, and family/household challenges ranging from a 1.8 to 2.2-fold increased risk of developing chronic diseases. The study

also identified at least more than half of the patients who participated in the ACE study having experienced ≥2 types of childhood exposures demonstrating a strong correlation between the number of categories of childhood exposure and adult health risk behaviors and diseases ($p > .001$). In addition, persons who had experienced four or more categories of childhood exposure, compared to those who had experienced none, had 4 to 12-fold increased health risks for alcoholism, drug abuse, depression, and suicide attempt; a 2- to 4-fold increase in smoking, poor self-rated health, ≥50 sexual intercourse partners, and sexually transmitted disease; and a 1.4- to 1.6-fold increase in physical inactivity and severe obesity (Felitti, et al., 1998; Felitti et. al., 2013). Findings from the ACE study confirmed that prevalence and exposure to child abuse and violence at a young age, if not identified and treated early lead to a sequelae of negative health outcomes (i.e., obesity, addiction, certain cancers, liver disease, chronic obstructive pulmonary disease, high blood pressure, heart disease) to include early death. Thus, the higher the ACE score, the greater likelihood of untoward health outcomes later in life (see Figure 3).

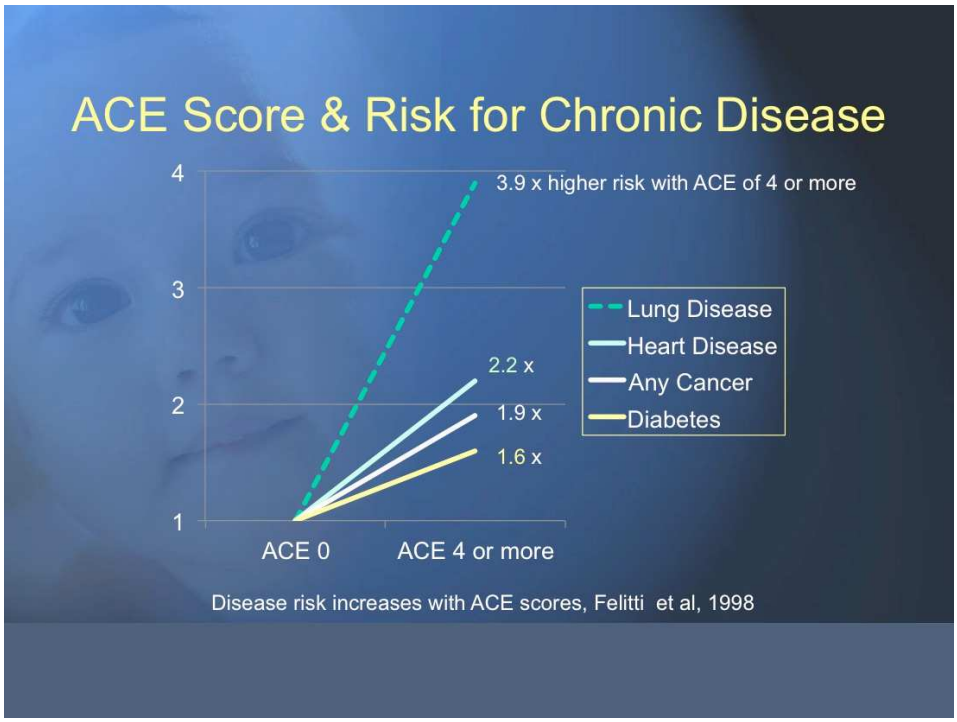

Figure 3. ACE score and risk for chronic disease. From "Traumatic childhood experiences and their relationship to informed decision-making: Turning gold into lead," by V.J. Felitti, 2013, *Pediatric/Adolescent Training Program*. *C*opyright 2016 by International Association of Forensic Nurses. Reprinted with permission.

The ACE: Understanding trauma and implications. Empirical research from the ACE study as seen in the ACE pyramid depicts how ACEs are markers which influence health and well-being throughout the lifespan with negative outcomes if not identified early and untreated (see Figure 4). The ACE study has been a leading source of EBP development recommending the importance of developing a close relationship with the child and family during healthcare visits. A healthcare professional must recognize that trauma is insidious preying on the most vulnerable with the impact being very broad and often deep and life shaping (Briggs et al., 2013; Fallot & Harris, 2009).

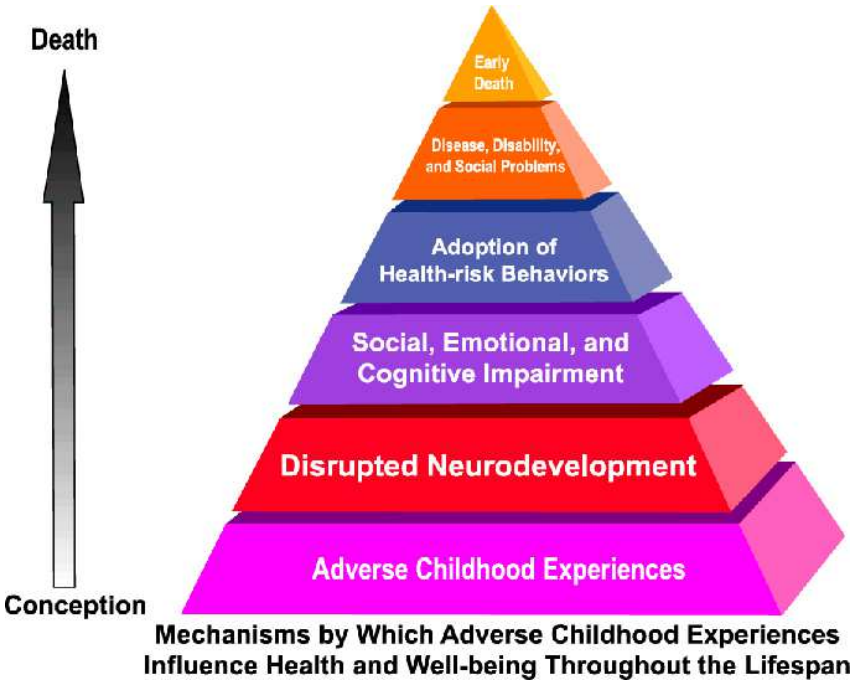

Figure 4. From "Relationship of childhood abuse and household dysfunction to many of the leading causes of death in adults: The Adverse Childhood Experiences (ACE) Study," by V.J. Felitti, R. F. Anda, D. Nordenberg, D. F. Williamson, A.M. Spitz, V. Edwards, M. P. Koss, and J. S. Marks, 1998*, American Journal of Preventive Medicine, 14(4), p. 256.* Copyright 1998 by Elsevier. Reprinted with permission.

A child centered, trauma sensitive approach to screening and evaluation by healthcare professionals may help decrease the incidence of CM with SA and improve prevention efforts to curtail long term adverse impacts on survivors. This family-based primary prevention effort is a framework of thinking and practice for healthcare practitioners to consider when improving assessment strategies (i.e., health history, mental health evaluation, family dynamics evaluation) that are child and family centered. The research of Felitti et al. (1998) supported integration of assessment, trauma oriented questions for screening that were not symptom related. A biopsychological approach to obtaining a full history, including ACE questions which

consider behaviors, thoughts, and feelings in order to acknowledge that problems may exist, recognize possible cases of CM with SA early during medical visits, provide age appropriate interventions, and prevent further revictimization (CDC, 2016b; Finkelhor & Browne, 1985; Kraus & Thomas, 2011).

Improving screening and reporting tools. Identifying pediatric patients who may be victims of maltreatment, sexual assault, and abuse requires health professionals to have the skills to use trauma-informed practice principles which establish a trusting relationship and mitigates further retraumatization (Thackeray et al., 2010). The American Academy of Child and Adolescent Psychiatry published in 2011, *The Practice Parameter for Child and Adolescent Forensic Evaluations,* provides guidance to clinicians by clarifying their role during forensic evaluations stressing the principles of being knowledgeable, competent, and experienced in forensic evaluations to properly obtain accurate diagnostic accounts of physical and psychological standing (Kraus & Thomas, 2011). Pediatric patients require support from healthcare providers who conduct objective evaluations and help manage the physical effects of trauma; introducing coping skills to effectively manage their emotions and long-term recovery.

CM with SA typically necessitates narrative, diagrammatic, and photographic documentation which could create a gap in practice since health care professionals may not be properly trained (Clements et al., 2015, pp. 14-15). Clinicians who care for pediatric/adolescent populations require adequate and continued education to improve knowledge and clinical skills necessary to achieve a level of best practice (Jordan & Steelman, 2015, p. 111). As education programs and integration of CM with SA

screening algorithms are used, the benefits increase reporting, increased levels of awareness, and increases the clinicians' consideration of maltreatment.

Jordan and Moore-Nadler (2014) presented a study in which 31 registered nurses from an ED participated in a comprehensive child maltreatment nursing education program which increased the knowledge and skill set of the pediatric nursing staff. When surveyed, only 16 nurses (52%) reported receiving education on child maltreatment in academic nursing programs. However, 100% of the participating nurses reportedly cared for at least one child with confirmed or suspected child maltreatment in the preceding 6 months. The curriculum consisted of general education on child maltreatment (i.e. incidence, prevalence, signs and symptoms) and screening/assessment tools were introduced to improve documentation and reporting. Upon completion of the 4-week education curriculum, 100% of nurses who participated in the program stated their ability to identify CM improved. During the 4-week period of data collection, a total of 2,309 children were evaluated in the ED and the nursing staff completed 37 child maltreatment screening tools. In a retrospective review, 42 children should have been screened for which represented an interrater reliability of 88%. Of the children screened, a total of 35 children had evidence of child maltreatment that required further intervention, representing 1.5% of the pediatric patient population. All 35 children had interventions initiated while in the ED involving social work, child protective service, and/or law enforcement. Pediatric patients require support from healthcare professionals to help manage the physical effects of trauma and introduce coping skills to effectively

manage their emotions and achieve positive long-term recovery (Kellog, 2005; Louwers et al., 2010).

The value in reviewing and employing principles of a trauma-informed, multidisciplinary approach to pediatric care, allows healthcare professionals to recognize the pervasiveness of trauma intervening with appropriate treatment and referral (Briggs et al., 2013). Burton and Carlyle (2015) observed that clinicians have often felt ill equipped to handle victims of sexual violence. For many clinicians, their interventional approaches do not address the complexity of how trauma has negatively impacted their health and well-being, as well as their vulnerability (p. 227).

Developing a Toolkit: Implications for Practice

Barac, Stein, Bruce, and Barwick (2014) discussed how toolkits helped improve practice by disseminating information to a diverse audience in a wide variety of settings, including healthcare providers, clinicians, and organizations. The authors explored the usefulness and versatility of toolkits as a strategy for knowledge translation in their scoping review of the available toolkits in the literature. In a systematic review, Barac et al. (2014) reviewed 83 toolkits, of which 68 were identified in research journal articles, with 81% of all toolkits categorized as healthcare related, directed mainly towards healthcare professionals and designed for the purpose of facilitating a practice change to improve processes and outcomes. With respect to overall outcome evaluation, the majority (n = 31) of evaluated toolkits reported that a toolkit was satisfactory, useful, or resulted in an intention to change practice. Thus, a properly developed toolkit based on

scientific evidence is an effective method to inform, facilitate, and improve clinical practice (Barac et al., 2014).

The trauma of violence can compromise quality of life, affecting functional and psychological status of the individual which could compromise long term recovery (Richmond & Aitken, 2011). An evidence-based toolkit will help providers use current strategies for assessing a victim of violence, enhancing trauma-informed follow-up care, and addressing mental health concerns. For a practice change to be successful, it is important to provide information, education, clarification of questions, and emphasize the benefits of proposed changes to practice, demonstrating trauma sensitive responses and interventions (Green et al., 2016). For some healthcare professionals, the challenges are providing a safe and empathetic first response, as well as non-threatening trauma sensitive approaches to care.

Local Background and Context

The goals of this DNP project were consistent with the Midwest state SANE program's mission and the values of the nursing profession. According to the executive director of the SANE program participating in this project, the goals of the SANE program include providing a: (a) compassionate and sensitive approach to all patients of sexual assault seeking assistance; (b) timely medical/legal examination to collect forensic evidence according to the IAFN Standards of Practice, SANE program protocol, the local city sexual response protocol, investigative services protocol, and the Department of Health standards and community needs; (c) consistent caregiver throughout the examination with minimal patient exposure; (d) appropriate discharge

instructions and referral for follow-up care and counseling; (e) fact and expert witness testimony; operating as part of the community SART following outlined standards for response under the community's sexual assault response protocol; and lastly (f) 24-hour services as part of the communities' SART.

Community-Based SANE Organizational Structure

The SANE program where this project took place was in a Midwest state which serves 23 counties in its western and central areas. This community-based, nurse driven 501(c)3 tax exempt charitable organization is under the direction of the executive branch, which employs licensed registered nurses who serve victims of sexual assault ages newborn and older in rural and metropolitan areas of the state. The organization has memorandums of understanding (MOU) with law enforcement agencies in the counties served by SANE professionals. In addition, an MOU exists with each medical facility that SANE nurses respond to so that medical evaluation and care can be offered. At the five Emergency Department (ED) locations, where SANE nurses are deployed the program has an MOU with the ED physicians, with one identified as a medical director at each location. The medical director is a board-certified ED physician trained in trauma-informed care. This individual works collaboratively with the program coordinator and nurses. The medical director participates in quality improvement meetings, ensuring proper care and interventions are followed, providing feedback as needed.

The executive director, a statewide SANE coordinator, is a licensed registered nurse certified as a sexual assault nurse examiner for adolescent and adults, with over 17

years of clinical experience. The director manages a staff of 21 managers and SANE nurses and reports monthly to the board of directors all budgetary, administrative, and operational issues. The community-based SANE program has a clearly defined reporting structure, as detailed in the organizational chart listed below (see Figure 5).

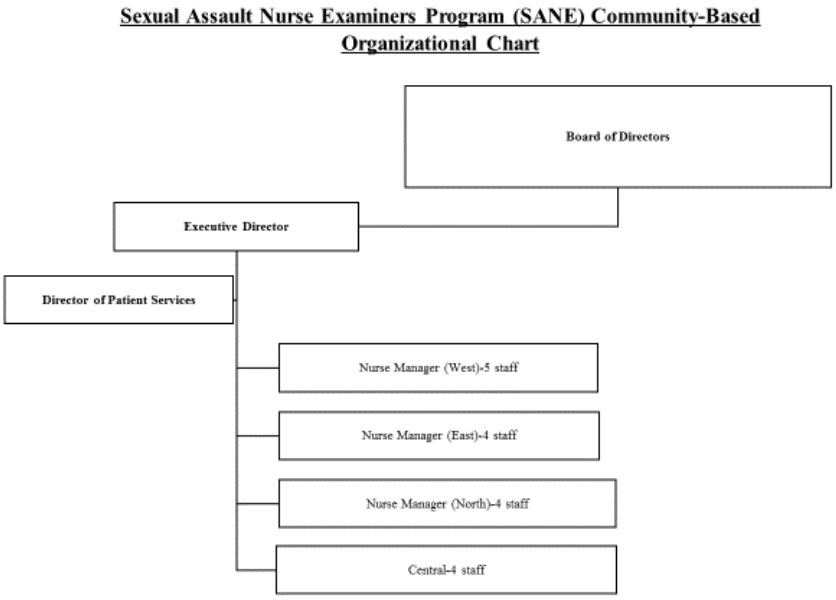

Figure 5. Organizational chart.

Sexual Assault Processes

According to the Midwest state's sexual assault medical care best practice guidelines, all SANE nurses complete a 40-hour didactic and/or web-based training, and clinical hours as outlined by IAFN before operating as a SANE. The primary responsibility of SANE nurses is to perform a forensic-medical examination on alleged perpetrators or victims of a sexual assault for the purpose of evidence collection, documentation, preservation of evidence, and education of the necessary follow-up

planning and referrals to medical facilities, advocacy, mental health, social services, law enforcement, and crime victim compensation services.

The SANE program is accountable to the crime laboratory division of the Midwest state attorney general's office for forensic collection kits, the Midwest state Board of Nursing for nursing scope of practice and licensure, and the state attorney general's office for legal matters and expert witness testimony. The organization follows mandated training guidelines, forensic requirements, and updates published by the IAFN, as well as the CDC medication and treatment guidelines for sexually transmitted diseases, pregnancy prevention, and follow-up care parameters for the pediatric and adult population.

Currently, the ED process for activating a SANE nurse and response team comprised of an advocacy representative and law enforcement is shown on the Sexual Assault Response Chart-Activation process, in Appendix C. The flowchart details how to activate the appropriate providers when a patient presents to the ED reporting abuse. This process has proven successful in ensuring a timely response and improved accountability for all parties involved.

The DNP project took place at two project sites located in a Midwest state that have an existing MOU under the supervision of the executive director of the community-based SANE program. The first site is a 25-bed critical care access hospital with a 16 bed ED located in the western region of rural Midwest state. The ED is staffed by 22 registered nurses, 10 board certified emergency physicians (to include six visiting locums ED physicians, as well as, three board certified nurse practitioners and two

physician assistants) who have worked in critical care and/or emergency medicine. For the hospital, there is only one case manager and a quality director who provide support to all department 24/7. The ED is managed by nurse director who is also SANE trained and has worked in urban Level 1 trauma centers with hospital-based SANE programs for over 10 years. At this site, approximately 2,000 patients are seen annually with approximately 35% pediatric. The second site is a 10-bed public health clinic that provides a broad array of services including well-child check-ups aimed at promoting and protecting the health for residents for eight surrounding counties with 1,200 pediatric patients seen annually. On staff, there are 15 part-time or full-time nurses with an additional 10 contract or on call nurses. They have one board certified family medicine physician who provides consulting on a contractual basis. There are no case managers on staff and they do have five nutritionists/dieticians that also work with the pediatric population.

Per the ED director and clinic nurse manager all staff receive annual training on mandated reporting. However, both disclosed that they believe reporting suspected cases of CM with SA probably does not occur as often as it should because of lack of time, guidance, and skills to recognize CM with SA. ED data from 2015 revealed a total of 6 cases being reported to CPS of suspected cases of CM with SA whereas at the clinic many under the age of 14 that are seen are in foster care because of some form of maltreatment, neglect, or sexual assault. In 2016, they cared for 150 under the age of 14; 100 were suspicious for maltreatment/neglect; 50 disclosed some type of abuse with 10% reporting sexual assault.

The Office of Juvenile Justice and Delinquency Prevention conducted the National Survey of Children's Exposure to Violence in 2011 to investigate how many children experienced abuse, assault, and maltreatment during a one year time-period from representative samples nationwide. The results reported rates of maltreatment (i.e., physical, sexual, emotional abuse; neglect; custodial interference, or family abduction) in the 2010 study year to be 13.8%, confirming that approximately 3 in 5 children (60%) experienced at least one exposure to violence (U.S. Department of Justice Office of Justice Programs, 2015). In addition, the survey identified challenges when estimating how many children had been victimized due to a lack of full disclosure of the abuse or violence and minimization of the event by care providers or healthcare professionals due to inadequate understanding or definition of abuse. Recognizing the prevalence of CM with SA being challenging to measure because it is underreported, working with the ED and clinic nurses at both sites to develop a clinical toolkit that will facilitate rapid screening of pediatric patients will improve detection and increase reporting of suspected cases of CM with SA.

Role of the DNP Student

As the project leader, first and foremost, it was important to understand the culture of the organization and current behavior. Effective communication, stakeholders buy-in, and cohesive teamwork are essential in implementing a successful change project (White, Dudley-Brown, & Terhaar, 2012). For this DNP project of implementing a screening tool to identify pediatric/adolescent victims of maltreatment or abuse, evidence-based literature and processes were explained in a manner that persuaded

health care professionals to understand how this practice change would help improve their assessment. Integration of evidence-based practice strategies will foster a change in practice that follows a trauma-informed approach to follow up care and addresses mental health concerns leading to favorable long-term outcomes for the pediatric/adolescent population.

The pediatric and adolescent population is categorized as vulnerable and for many it is hard to be objective during when providing care. People may become emotional and find it hard to be objective at times. Developing a diverse team representative of the community that can address the varied needs of children and their caregivers will lead to increased support and a united response. In turn, the multidisciplinary team approach to care will facilitate improved coordination of resources and an accurate determination of the spectrum of victim services they can provide to children, caregivers, and families. Planning and implementation of the education program needs to be flexible in order to mitigate barriers. The challenges that may present such as time constraints, possible staff opposition to the idea of using a toolkit, and the inability to attend an education session will be addressed as best as possible. It may be necessary to provide additional education sessions or 1-on-1 teaching to engage participation from the SANE nurses, ED, and clinic personnel. Nursing staff and clinicians needing additional guidance may be required to attend refresher training sessions to review screening, communication techniques, and topics on child maltreatment and sexual abuse. Education will be important for all providers and members of the leadership team. Implementing a change in practice will require

explanation and even hard data to demonstrate the benefits both short and long term for the patient as well as for the organization.

The methods that were used to develop a recommendation for a procedural change included current forensic and screening procedure reviews at the DNP project sites. In addition, this DNP student sought input from the staff and leadership team regarding concerns and recommendations to improve the approach to care for the pediatric population including needs for education and an evidence-based clinical toolkit to improve screening and reporting. This was accomplished at monthly SANE staff meetings, quarterly leadership advisory meetings, and through trainings where discussions and objectives regarding the benefits of the change in practice were provided to staff and stakeholders. In addition, this DNP student shared metrics of how screenings and follow up would provide valuable QI data to evaluate the impact the change process would be on workflow, performance, and outcomes (Weiner, Balijepally, & Tanniru, 2015).

Role of the Project Team

For this DNP project, the objective was to develop and introduce a uniformly appropriate education and clinical toolkit that predicts CM with SA which could be beneficial if screening is effective and if a simultaneous increase of incorrect suspicions of child abuse can be prevented. Individuals who have a vested interest in the outcome of this project primarily and initially included the executive director of the SANE program and SANE nurses currently employed by the program who have been trained in forensic medicine, emergency and critical care with a combined 45 years of experience

as well as the nurse directors from both the ED and clinic. The implementation of an EBP pediatric care pathway that provides appropriate interventions for each maltreatment/abuse case will also need to support the investigative needs for judicial processes (Clements et al., 2015).

The revised protocols and care pathway were evaluated by all members of the Midwest state SANE nurses and SART to ensure that medical care and throughput through the system of care was addressing the physical and mental needs of the patient and caregivers as well as improvement in the forensic investigative data collection. Roundtable discussions with these stakeholders were held to evaluate and identify accessibility to include input on current response protocols and services. The feedback obtained regarding the potential success and involvement of trauma-informed multidisciplinary approaches to pediatric care was a perfect opportunity to also keep stakeholders updated on evidence-based information and practice recommendations. This in turn strengthened the current infrastructure to support a collaborative multidisciplinary approach for response which proved to be a value-added benefit for medical and judicial care/follow-up.

Summary

The desired outcome is to improve screening for acute pediatric sexual assault patients. Growing awareness of the facts of CM with SA and how pervasive trauma can be has led to the need for trauma sensitive and child focused services. Facilitating the appropriate medical and psychological treatments and services in a timely manner requires an understanding how the prevalence and impact abuse, neglect, and trauma can

complicate recovery and healing long-term (Bartlett, et al., 2016; Campbell et al., 2013; Jackson & Deye, 2015).

Information does not replace education. Empirical evidence recommends providing training and opportunities for healthcare providers to advance their knowledge and skills toward the identification and interventions of children who are at risk of CM with SA preventing untoward outcomes. Evidence-based practice that guides healthcare professionals to incorporate interventions aimed at providing psychological, physical and emotional healing for the child into their practice and nonoffending caregivers will promote a proactive approach to care and improve outcomes. The effectiveness of implementing a comprehensive systematic trauma-informed clinical process for screening, identification, and physical evaluation of a child will address the current gap in practice. An evidence-based multidisciplinary clinical toolkit coupled with education pertaining to CM will equip healthcare providers to better assess, screen, identify, and report any child who may be at risk. A screening tool that is child-focused, developmentally appropriate and trauma sensitive will guide the healthcare professional to ask the right questions and investigate further even when the physical signs are not obvious or the child does not disclose.

In section 3, a detailed description of the research conducted will be explained which lead to the development of the trauma-informed toolkit and education. The components of the evaluation process by the expert panel of forensic experts will be presented since they will decide if the toolkit can be incorporated into daily practice. The

method of analysis and synthesis of this EBP tool will serve as a guide for structuring delivery of care for the pediatric population.

Section 3: Collection and Analysis of Evidence

Introduction

Child abuse/maltreatment is the leading cause of morbidity and mortality in children and poses one of the greatest threats to the health, welfare, and social well-being of children (Child Welfare Information Gateway, 2016a). Nationally, on average four children per day die from abuse or neglect (CDC, 2014; Child Welfare Information Gateway, 2016a). Healthcare professionals require continuous training to understand and recognize that children at risk of maltreatment/abuse present differently than adults (Adams et al., 2012). It is important to understand that trauma is pervasive and ACEs like child SA may perpetuate chronic diseases and psychological problems extending into adulthood if not treated early (Felitti, 2013; Felitti et al., 1988; Finkelhor et al., 2015). Using a developmentally appropriate, trauma-informed approach to care facilitates a more coordinated and safer care delivery (Frasier et al., 2012; Green et al., 2016). Children require developmentally appropriate, empathetic, trauma-informed approaches to care when experiencing abuse, neglect, and dysfunction at home (Jackson & Deye, 2015; Jordan & Steelman, 2015; Lincoln et al., 2013). For this DNP project, my objective was to develop and introduce uniformly appropriate education and a clinical toolkit that predicts CM with SA, which could be beneficial when screening is effective and simultaneously prevents incorrect suspicions of child abuse.

Practice-Focused Question

The practice-focused question for this project was: How does the implementation of a trauma-informed education toolkit improve screening and assessment and influence

increased reporting and appropriate care response within 96 hours of assault as compared to the current standard of practice in pediatric victims of sexual abuse and maltreatment? Guiding principles lead to goals. One of the greatest challenges for the SANE program was proper identification to include screening of children who could be victims of abuse or maltreatment. An important and agreed upon QI goal for the project site included a timely forensic exam to decrease the length of time from acute presentation to actual screening and assessment to 96 hours or less and improve recognition and increase reporting of suspected abuse.

My intent with this DNP project was to develop and present to the SART team and SANE advisory leadership (a) a trauma-informed pediatric screening toolkit that follows the practice guidelines from the IAFN and MRCAC, (b) detailed plans for the ED outlining care and how they can access medical and forensic exams if a child discloses abuse or exam findings point to one (see Appendix D), and (c) educational materials on recognizing signs of abuse based on history and physical exam. Consequently, the development and implementation of a trauma-informed pediatric assault toolkit included a screening and assessment tool, uniform approach to conducting the forensic examination, evaluation and care for STDs (see Appendix F), and an algorithm for practice that follows the IAFN 2016 guidelines (see Appendix E). The toolkit was implemented through a revised policy and procedure, which was properly approved through existing processes at the project site. I developed the toolkit within the scope of this DNP project to be deployed to two of the five counties included in this DNP project after receiving approvals from an expert panel. As detailed in Appendix D,

should abuse be suspected in a child, the process flow for acquiring a forensic exam and establishing contact with and follow up services with the CAC is clearly delineated for providers in the ED and clinic.

Community and clinical interventions need to be focused towards education and behavior change which will in turn trigger an intervention and increased reporting in cases of nondisclosure where there are concerns of CM with SA. I developed an evidence-based multidisciplinary clinical toolkit and education materials for health care professionals using current evidence from trauma-informed, child-focused best practices and guidelines for screening, assessment and follow-up care to decrease the risk for retraumatization. The implementation will enhance communication between the pediatric patient, the nonoffending caregiver, and treatment provider leading to decreased risks associated with misunderstanding the patient's reactions and presenting problems or underestimating the need for appropriate referrals for evaluation or trauma specific treatment. Organizational investment in developing or improving trauma-informed services may also translate to cost effectiveness so that services are more appropriately matched from the outset (Bartlett et al., 2016; Green et al., 2016). Communication among the clinical and administrative team along with community partners was key as we worked towards standardization to improve our current care pathway.

Sources of Evidence

I used multiple sources of evidence to support this DNP project. In addition to the evidence supplied through my thorough and comprehensive review of the published

literature, there were also sources of evidence generated for this doctoral project. In the following subsections I have summarized my appraisal of the evidence.

Published Research and Outcomes

I performed a literature search based on the practice focused question. During the evidence search, filters were applied to MEDLINE, CINAHL, Google Scholar, PyscINFO, Academic Search Premiere, and Cochrane Database of Systematic Reviews that included: behavioral studies, publication dates between 2005–2017; and ages compromising of all prepubescent/adolescent ages (0–18 years). In my evidence search of electronic databases, I combined specific terms related to the practice focused question. Keywords for the search included: *child sexual abuse, sexual violence, child maltreatment, psychological health outcomes, child victimization, disclosure, child maltreatment screening, forensic interview, interpretation of findings, adverse childhood experiences, trauma-informed care,* and *competence*, along with a combination of these words. Due to the lack of studies found related to the specific practice focused question, no filters were placed on the types of studies that were included in this review. The articles that I selected for inclusion in the evidence were meta-analysis of randomized control trials, descriptive studies, cross-sectional cohort studies, retrospective cohort studies, longitudinal studies, exploratory retrospective studies, and case study analyses.

Evidence Generated for the Doctoral Project

Participants. I chose the 12-member Advisory Panel located in the Midwest state's community as participants for their expert knowledge and work experience in specialties such as victim advocacy, pediatrics, emergency care, public health, law

enforcement, nursing, and forensic medicine. Participants in the review were: (a) a detective from the county police department, (b) lead victim advocate for a Midwest state regional Rape and Crisis Center (c) director of nursing for a Midwest state health clinic, (d) lead clinic nurse for a government clinic, (e) nurse practitioner for a Midwest state private family practice clinic, (f) ED physician for a Midwest critical access hospital, (g) lead nurse coordinator for a community public health clinic, (h) senior pediatric nurse for a Level 2 trauma center, (i) three pediatric SANE nurses from a Midwest state SANE program, and (j) executive director from a Midwest state SANE adult and pediatric program. At the time of the study, the panel members worked in either a clinic/hospital, government, or community outreach setting providing services to the outlying eight counties in the Midwest state. The selection of these key individuals for this QI project was primarily due to their proficiency in forensics and medicine and their daily interaction with the pediatric community. By virtue of their positions and work experience, these panel members were recognized by the healthcare community at large and me to be experts in the field. They were able to provide insight and feedback in identifying and defining trauma-sensitive, multidisciplinary approaches to care to improve screenings for pediatric victims of CM with SA.

Procedures. In this subsection, I will describe the components of the toolkit. In addition to the ways in which the toolkit will be cascaded throughout the SANE referral centers in the Midwest state's central region. In this section, I will also describe procedures related to collecting data from the expert panel team to achieve consensus in the distribution of these materials and educational processes for the referral sites.

Screening toolkit. The ACE Study questionnaire tool will be used as the rapid screening tool during the forensic child abuse and neglect evaluations (see Appendices L and M). I included guidance on how to use the tool, who should complete the screening instrument, and how to score in the toolkit. This tool will be used by health care providers in assessing adverse and traumatic experiences and traumatic stress in children and adolescents looking for specific behavioral, educational, or health needs. Questions cover categories such as family dysfunction; physical, sexual and emotional abuse and neglect by parents or caregivers; peer violence; witnessing community violence, and exposure to collective violence (Burke Harris & Renschler, 2015; Felitti, 2013; Finkelhor et al., 2015). One point for scoring in each category will be assigned for each affirmative answer (Felitti et al., 1998). Upon completion of the ACE tool, the score will be computed and compared to the published ACE score recommendations for further care, forensic collection, and appropriate interventions by the practitioners at each referral site (Felitti et al., 1998).

Trauma imprints itself and affects the biological development of the brain. From early childhood through adolescence, if a child is experiences traumatic events, their brain function could be altered and reshaped, manifesting in terror or even shutting down in order to deal difficult events or experiences (Briggs et al., 2013; CDC, 2016a; Felitti et al., 1998). The ACE tool has been tested extensively for reliability, validity, and clinical utility to aid in minimizing the chance of misdiagnosis and finding CM with SA when there is none (CDC, 2016b; Dube et al., 2005; Felitti, 2013; Felitti et al., 1988; Finkelhor et al., 2015). The predictive capability of the ACE tool when gathering

information about common childhood adversities, exposures to trauma, and violence provides valuable information identifying patients who are at risk in developing a chronic disease early, engagement in risky behaviors, mental health problems, and/or death (Felitti et al., 1998; Finkelhor, Shattuck, Turner, & Hamby, 2015). Furthermore, the ACE tool provides the healthcare professional a strong foundation to improve evaluation and understand how the exposures could trigger further trauma and impact their patient's well-being (mental, physical, and behavioral health).

Algorithm of care. A critical care pathway will be implemented to provide the clinicians guidance for screening and appropriate care, forensic collection, and referrals following the 2016 IAFN national protocol of sexual abuse medical forensic examination for the pediatric population. As detailed in Appendices C, D, E, and F, the care pathways to be followed for access to medical exams, care, and recommended testing were mapped out for healthcare professionals at the referral sites and SANE to follow when responding to a request for medical and forensic evaluation for the prepubescent child sexual abuse cases (U.S. Department of Justice Office on Violence Against Women, 2016).

Education plan. I developed an education plan for the Midwest state forensic nurse professional that met the American Nurses Credentialing Center's criteria for continuing education. State and national forensic and medical guidelines will be presented along with specific physical examination issues, developmental considerations in interviewing children when CM with SA is suspected and documentation, and differential diagnoses fundamentals when reporting and referring. During the training

sessions, participants will work on worksheet exercises and in groups where they will engage in active discussion and role-playing. This will help participants understand and identify vicarious trauma consequences and help them develop self-care activities, which will in turn provide clinicians with tools and improved skillsets to provide more structured responses to patients of violence. Education will follow on when and how to use the assessment tools during treatment and how to foster empathetic engagement with these victims. The goal is to create a culture of safety, while addressing the immediate physical and emotional needs of children and their families and establishing appropriate follow-up care.

The proposed education plan and training included information regarding confidentiality and informed consent and caring principles regarding child-centered, trauma-informed care practices (see Appendix I). Prior to implementing the training education, statistical information and current protocols will be presented to the participants. State and national statistics of CM with SA will be discussed, along with recommended evidence-based information from the CDC and the Midwest state Department of Health, Division of Injury Prevention and Control regarding trauma-informed care for victims of violence. Materials regarding the educational plan are presented in Appendix I. I presented the full roll-out of the educational plan to the expert panel for feedback and approval in order to proceed. Full implementation of the educational plan was out of scope of this DNP project.

Evaluation plan through the expert panel. The protocols and care pathway developed through this DNP project were evaluated by all members of the expert panel

for the SANE QI project selected by the DNP student and DNP project site executive director. The goal was to review the proposed toolkit and training to ensure medical care and system throughput addresses the physical and mental needs of children and caregivers, as well as improves forensic investigative screening data collection. The Delphi technique was utilized when presenting to the SANE team leadership to obtain feedback and direction to determine appropriate processes and that implementation is aligned with project objectives (Hsu & Sandford, 2007).

There were three rounds of questionnaires sent to the expert panel (see Appendices G and H). During the first round, an open-ended questionnaire was sent to panel of experts to gather baseline feedback and information on the clinical toolkit and training program, with a two-week deadline to return data for compilation. Within 4 weeks, I delivered a second questionnaire comprised of items summarized from the first survey, seeking feedback and asking to rate priorities for review, design change, and/or implementation. This second survey was due back within 2 weeks. A third survey that compiled items and ratings summarized from the second survey, was compiled requesting panel members to re-evaluate their rankings and/or to specify their reasons for not agreeing with the rating of priorities previously submitted. Within two weeks, responses from the third survey were received. I sent a final summative report of the responses received during the process, grouping opinions, concerns, and ratings which was distributed to the panelists at an advisory meeting within three weeks from the date the third submission. The executive director and I convened a meeting with the expert panel, presented the final evaluation, and gained consensus on the validity of the clinical

toolkit and training, as well as how to proceed with the QI project implementation.

Protections. The trauma-informed education toolkit to be approved by a panel of experts for implementation in the Midwest state SANE program was the focus of this project. Data collection did not take place as it is outside the scope of this DNP plan. Upon implementation of project recommendations and data collection of the pre-test and post-test knowledge survey of CM with SA, the participants were assured that their responses and input would be anonymously tabulated. Their summaries based on prior input to identify common results would be reported with the goal of reaching a consensus on implementation of this toolkit. A letter was sent to each panel member explaining the purpose of the project, three round survey process, and consent to participate. The goal of the surveys was to evaluate knowledge and confidence when caring for patients of maltreatment and sexual abuse, as well as additional information on continued education. To facilitate truthful answers, participants were not required to put names on their tests. Once consensus for adoption of the trauma-informed toolkit was obtained, a final summative report was provided to the panel of experts informing them of practice changes, including the use of the ACE screening tool and the algorithm and process flow chart.

Analysis and Synthesis

The objective of this DNP QI project was to evaluate the effectiveness of the implementation of the pathway trauma-informed toolkit (quantitative and qualitative data collection). I collected data using a paper/pen questionnaire that was provided to each panel member as a hard copy and a jump drive which contained the education

toolkit, as well as the questionnaire for review and completion. Reminders were sent to each panel member via e-mail with phone call follow-ups to ensure they completed the surveys within 3 days of the due date for each round. Each panel member was compliant and returned a completed survey via e-mail or copy on their jump drive. Each returned survey was completed in full with no missing information; comments were annotated on the Excel spreadsheet in no particular order.

Questionnaire responses were assigned a unique identifier for tracking purposes, analyzed, and statistical analyses were compiled for each round calculating average response rates for each critical indicator by panel member. The data was analyzed using SPSS Base 7.0 for Windows software and responses were compiled and presented using a Microsoft Excel spreadsheet. During each round, the panel member received a summary of the groups' responses which were aggregated and anonymous, with a percentage ranking for each critical indicator based on importance using Likert scales (see Appendices G and H). Each member was asked to review the educational toolkit and based on the groups' responses, reviewed their rankings and re-prioritized each round of surveys. Upon completion of the three survey rounds, a summative report was prepared to share with the Advisory Panel detailing suggestions and recommendations to include with the implementation of the toolkit and education.

Summary

Implementing an EBP practice change that is sensitive and trauma focused for the pediatric population will support an organized approach to implementation. The healthcare professional needs to understand and identify the risk factors during their

health care visits which are related to the dynamics of how a child's emotional well-being, cognitive ability, and self-concept to receive and give affection are altered when they are victims. The implementation of an EBP pediatric care pathway that provides appropriate interventions for each maltreatment/abuse case will also need to support the investigative needs for judicial processes (Clements et al., 2015). The sequelae of exposure to childhood victimization can lead to a wide array of negative behaviors and poor health outcomes. The U.S. Preventive Services Task Force recognizes CM/SA as a serious health problem recommending instituting early childhood home visitation programs to prevent maltreatment and violence recommending referrals as needed in high risk scenarios (U.S. Preventative Services Task Force, 2014). With the implementation of a revised pediatric SANE clinical practice guideline, creating an awareness of maltreatment/abuse and educating on the signs/symptoms will enhance the program's mission to provide a multidisciplinary approach to pediatric care. Concurrently, SANE professionals will be able to identify and rectify the lack of support, resources, and direction provided to these children and their families.

Section 4 will entail presenting my findings after data analysis collected from the three rounds of surveys. The impact of the doctoral team's participation and contribution to the project will be evaluated. In addition, the expert panel findings and feedback will be assessed to include my interpretation of the implications from the panel's input on the toolkit's suitability for implementation.

Section 4: Findings and Recommendations

Introduction

Routine medical treatment does not always involve a child-centered, trauma-sensitive approach that encompasses assessment and intervention pathways for children who may have been sexually abused and takes into consideration developmental, cognitive, and socio-emotional factors. Gaps in knowledge and experience lead to providers not always possessing the skillsets necessary to identify behaviors, signs, and symptoms of maltreatment during assessments. In order to support aspects of self-care management, monitoring, and maintenance, healthcare providers must be fully equipped to assess, screen, and improve their care delivery using the principles of trauma-informed care to improve their commitment to prevent disability and promote a healthier environment for both child and caregiver (U.S. Department of Health and Human Services, 2013).

Findings and Implications

Overall, there was a high degree of reliability and agreement between all participant responses in both Round 2 and Round 3 of the survey. For Round 2, the average measures intraclass correlation (ICC) was .924 with a 95% CI from .844 to .974 ($F(11,286) = 13.105$, $p < .001$). I also found a high response rate of agreement for Round 3 with the ICC being .906 (CI: .802 to .970; $F(10,260) = 10.595$, $p < .001$).

In order to observe if there was variability between the different members of the panel, I divided respondents into three groups: a community group made up of SANE nurses; a clinic group of nurses, nurse practitioners, and physicians that work at local

clinics and the hospital; and a government group comprised of law enforcement and other governmental agencies. The ICCs were then rerun with the analyses divided between groups.

The community group had a Round 2 ICC of .833 (CI: .450 to .988; $F(3,78) = 5.979$, $p < .001$), while the clinic and government groups had higher ICCs of .918 (CI: .731 to .994; $F(3,78) = 12.241$, $p < .001$) and .947 (CI: .825 to .996; $F(3,78) = 18.788$, $p < .001$), respectively. From Round 2 to Round 3, the community group showed an increase in agreement with an ICC of .926 (CI: .755 to .995; $F(3,78) = 13.438$, $p < .001$). The clinic group evidenced a decrease in reliability with an ICC of .779 (CI: .123 to .994; $F(2,52) = 4.522$, $p < .05$) in Round 3. The government group was the only group to remain relatively stable with a Round 3 ICC of .897 (CI: .667 to .993; $F(3,78) = 9.687$, $p < .001$; see Figure 6).

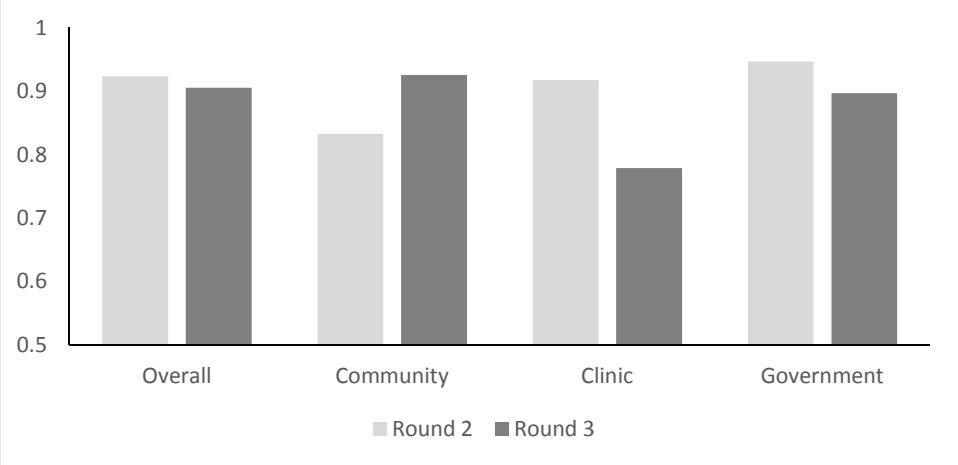

Figure 6. Agreement based on interclass correlations.

The most important implications resulting from the findings in terms of this Midwest state's professional community are that at all three portals of entry where a

child obtains medical care the healthcare professionals agreed to implement the toolkit into their current practice as an evidence-based toolkit to provide structured guidance. Clinicians must incorporate trauma-sensitive principles into their practice when communicating with patients, especially during assessment, screening, reporting, and discharge (Campbell et al., 2013). Much of the feedback obtained during survey review stated the need to improve the clinician-patient communication to support both short-long-term trauma recovery and facilitate appropriate reporting and referrals for follow-up care. Comments from several panel members (i.e., SANE professionals, advocacy, and law enforcement) discussed how: (a) "comprehensive documentation and operational process help prevent someone slipping through the cracks"; (b) "this is a tool that is easy to use which will rapidly screen and guide both patient and professionals"; and (c) this "toolkit will make it much easier to ask the right questions, report to the right people, and help with legal process." The potential implication for positive social change is to provide clinicians support and confidence to look at the patient and diagnosis, while making sense of the problem in context with present and past trauma history, creating a practice environment that is respectful and supportive.

Recommendations

Panel members provided suggestions and recommendations in which they laid out the foundation to standardize the care approach for screening, reporting, and forensic collection. Collectively, members agreed during each round of survey responses that policies and guidelines needed to be developed and implemented that would assess and screen for CM with SA in an environment that was trauma sensitive and safe. Critical

pathways to direct care coupled with standardized, pediatric-focused, forensic examination documentation, discharge/follow-up instructions, and developmentally appropriate rapid assessment ACE screening tools were reviewed and approved by the panel (see Appendices C, D, E, F, J, K, L, M, and N).

The panel also agreed to include an education module to educate and support professionals who encounter pediatric patients. The education would incorporate the seven guiding principles of care following Duffy's quality caring model as well as targeted teaching materials to help identify subtle signs/symptoms of CM with SA and victimization. The main goal of the trauma-informed toolkit is to provide healthcare professionals the flexibility to use a screening tool that helps collect information to support further investigation as well as minimize further retraumatization. Improving communication through verbal and written materials (i.e., evidence-based education and screening toolkit) will aid in applying the appropriate interventions to support the psychological and physical needs of the patient to achieve favorable outcomes and long-term recovery. A practice change will assist clinicians when caring for patients who have experienced trauma and violence.

Contributions of the Doctoral Project Team

The doctoral project team consisted of a group of professionals that encounter the pediatric population in various professions, ranging from law enforcement, emergency medicine, family practice, community health, pediatrics, advocacy, forensics, and academia. The executive director of the Midwest SANE program was actively involved with this project as well as two pediatric-trained SANE nurses from each

SANE office in the Midwest region. The expertise of each individual provided a diverse perspective and valuable information.

Law enforcement and advocacy recommendations included elements from the Pediatric Screening for Electronic Health Record Systems (see Appendix L) as a screening tool during initial interviews or investigations to rapidly triage a suspicious case to trigger an immediate SANE response if the offender is unknown. In addition, clinical experts provided feedback and input to improve documentation, history and physical examinations, and a clearly delineated process to follow when identifying physical and psychosocial symptoms. The main goal was to have a seamless triage and assessment tool that improved upon their current practice of screening and care.

Strengths and Limitations of the Project

I developed this QI project out of necessity, with the desired goal of standardizing pediatric trauma-based critical care pathways for use by clinicians and the forensic SANE when identifying potential abuse and maltreatment at the time of a clinic visit, SANE exam, and in the ED. The support and buy-in from the project team, expert panel, and community made it easy to persuade people to participate in the design and development of a process that would improve reporting of suspicious cases and created a multidisciplined response that would work for the rural Midwest state's SANE program.

One of the strengths of using the Delphi tool was the flexibility to create a customized survey. The panel was able to identify critical indicators in agreement with established measurement statements for each indicator and category to ensure homogeneity. Additionally, recommendations and input allowed for the standardization

of processes and a screening tool supporting an approach to responding and identifying early cases of CM with SA within the primary healthcare setting.

The expertise and diversity of the panel participating in this survey was crucial in identifying the needs and gaps in service and care for the pediatric population. Each member of the panel either worked closely with or cared for pediatric victims and understood the safety and benefits of identifying suspicious cases early on to direct care appropriately. The third round of the survey provided valuable information included in the final screening documentation and generated consensus to create a uniform algorithm of care and trauma-sensitive education.

There were several limitations to this study but one of the primary ones was the small sample size from a rural Midwest state community consisting of 12 panel members. The sample size was small, but I was able to find significance in the results from the survey rounds so the tests can be easily interpreted as valid. The sample size was only 12 participants, so the basic assumption of central limit theorem (i.e., at least 30 participants to assume normality) was violated. Therefore, it was important to interpret the results with caution. Future studies should try to use a larger sample size to confirm my findings from this study.

Although the participants were representative from agencies who encounter the pediatric population, a larger sample size from a nonrural community could have yielded interesting information to include additional testing and/or processes for the development of the trauma-informed toolkit to consider. The Midwest community-based SANE program has only recently initiated its pediatric SANE program and no data for

delays past 96 hours from the precipitating event were available from the Midwest state Department of Human Services of SANE program to track and compare. Reliable surveillance data will be important to determine the effectiveness of the healthcare delivery model and whether the critical indicators are either redundant or need modification.

Section 5: Dissemination

Introduction

Discussions to implement the trauma-informed toolkit and education within the Midwest state SANE program locations as well as in the ED and public health clinics beyond the DNP doctoral project was been agreed upon by the members of the Midwest state SART, executive director, and Advisory Panel. After full implementation, formative evaluations will show how many times clinicians screen patients and implement the trauma-informed toolkit. The organization will also track the extent to which nurses follow the screening protocols, assessment guidelines, and referral processes. The data will be compared to preintervention screening 30 days prior to training and 8 weeks postimplementation of the program. Summative evaluation will contain assessment scores provided by clinicians who completed the toolkit and seek feedback on whether they felt better equipped to assess and establish healthier relationships with their patients. The evaluation will also solicit feedback on recommendations or suggestions for further training or improvements. Dissemination of future findings will be presented in the final data analysis along with feedback from clinicians and patients.

A formal education and rollout to the different entities within the SANE program are planned to take place in the next quarter. At the quarterly SART peer review and follow-up meetings with SANE program stakeholders and healthcare teams, the program director will review the effectiveness of the screening tool and documentation, seeking feedback updates as evidence-based information becomes available from the IAFN and

MRCAC and should other new information become available. The SANE program will track the timing of disclosures and screening process reporting data, sharing best practices at the SART, Midwest state SANE meetings, and to the Midwest state Department of Human Services.

Analysis of Self

This project has shown me that integration of EBP strategies fosters change. As the Midwest state SANE program improves and works to strengthen the multidisciplinary team approach to care, improved coordination of resources will facilitate an accurate determination of the spectrum of victim services that are needed. Planning and implementation of changes in practice need to be flexible to mitigate barriers. Additionally, sharing metrics of improved screenings and follow up will provide valuable QI data, evaluating change process impacts on workflow, performance, and outcomes (Weiner et al., 2015). Furthermore, it was interesting to develop action plans and understand logic modeling which are crucial and strategic instruments to advance the science of nursing and healthcare. These tools can be used to support and coordinate different venues within the decision-making process. By using each tool and resource available, each practice site can appropriately screen and direct care following a standardized approach.

Working with a seasoned panel of experts in pediatrics and forensics has facilitated access to evaluation data, affording me the use of information with which to advocate for the importance of maximizing the impact of a sustainable, trauma-informed screening program for the pediatric population. A trauma-informed delivery approach

ensures implementation of decisions that optimize therapeutic outcomes that minimize adverse effects on the patient (Bartlett et al., 2016; Burton & Carlyle, 2015; De Arellano et al., 2008; Fallot & Harris, 2009). When the system of care is fragmented, patients do not receive appropriate legal, medical, or follow-up care which leads to decreased reporting, unfavorable health outcomes, and/or death (Moylan et al., 2017).

This project experience has taught me the importance of understanding beliefs and attitudes in hopes of acquiring information to create a more informed approach to program development. This project has depended on the collaboration of stakeholders and community members for success. During discussions and brainstorming sessions, consideration of the needs or problems from team members and the community were important. My mentor along with the panel of forensic and child specialists afforded me opportunities to learn how to operationalize the rollout of this project and further strengthen my leadership role.

As the leader of this proposed change, it was necessary to perform continuous reevaluation of the proposed practice. It was essential to create a belief and vested interest among the organizational members, allowing them to be change agents in the revisions and standardization of the pediatric SANE program. It was also essential to be flexible and available with resources and guidance for all key players involved to see the benefits for both the organization and from the community perspective.

As nurses, we may not think we have a place in politics because we have not been trained to be politicians. We think of ourselves as healers and not as policy makers or change agents. However, exposure and participation in the legislative process in an

individual's organization of practice, community, state, and at the national level is now a must and should be part of our job description. Nurses not only have the expertise and experience but also possess the voice and numbers which can sway a vote or consideration in favor of healthcare reform and policy. We are considered one of the most trusted professions in the United States. With this status comes power and support that our profession should take advantage of by shaping policy and healthcare reform to contribute towards providing effective, safe, and high-quality care (Olshansky, 2011).

This practicum experience and DNP program have also afforded me opportunities in the arena of leadership. I have met many influential community leaders, many of whom are highly respected in the arena of forensic medicine, legislation, and community advocacy and who also share in my passion to improve access to specialized services that incorporate trauma-informed principles. The DNP program has provided me with tools to become a more well-rounded practitioner who thinks outside the box and brings research to the forefront of improving care. I now look at things more analytically with a wider lens.

I plan to accept nominations to participate on two advisory boards here in my community as the lead SANE representative for both the health system and forensic nurse examiners program in the Midwest state. In addition, I plan to keep my options open to further my education in forensic science and assist in establishing a nurse-managed, trauma-informed clinic in the new family justice center in this Midwest state. My mentor has taken me under her wing and plans to show me how to write grants and participate in legislative leadership groups related to advocacy, healthcare, domestic

violence, forensic care, and human trafficking. I am very excited to be a part of an elite group of DNPs in my state and hope someday to teach in either a Masters or Doctoral program to share my experience and mold new nurse professionals to be a catalyst for change.

Summary

With vulnerable populations, such as pediatrics, clinically viewing the children across various contexts beginning with the family system and moving progressively outward allows for consideration of trauma interactions to reveal if abuse has occurred and the ability to initiate proper treatment and referrals (Bartlett et al., 2016). The EBP that guides healthcare professionals to incorporate interventions aimed at providing psychological, physical, and emotional healing for the child and nonoffending caregivers into their practice and will promote a proactive approach to care and improve outcomes. It is important to understand monitoring and surveillance of the data drives changes in the development of new prevention and intervention programs as well as evaluation of current processes. As more and more clinicians are trained in trauma-informed care principles and these are incorporated into interventions, the patient-focused concepts will promote awareness and early identification of CM with SA. Further evaluation and feedback from community stakeholders regarding the potential success and involvement of trauma-informed multidisciplinary approaches to pediatric care will be helpful as the pediatric SANE program grows to improve care for children exposed to CM with SA in the Midwest state.

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The ACE-Q and User Guide have been made available to health care professionals for the purpose of information sharing. The ACE Questionnaire ("CYW ACE-Q") is free and is intended to be used solely for informational or educational purposes. The ACE Questionnaire ("CYW ACE-Q") is not a validated diagnostic tool, and is not intended to be used in the diagnosis, cure, mitigation, treatment or prevention of a disease or other condition.

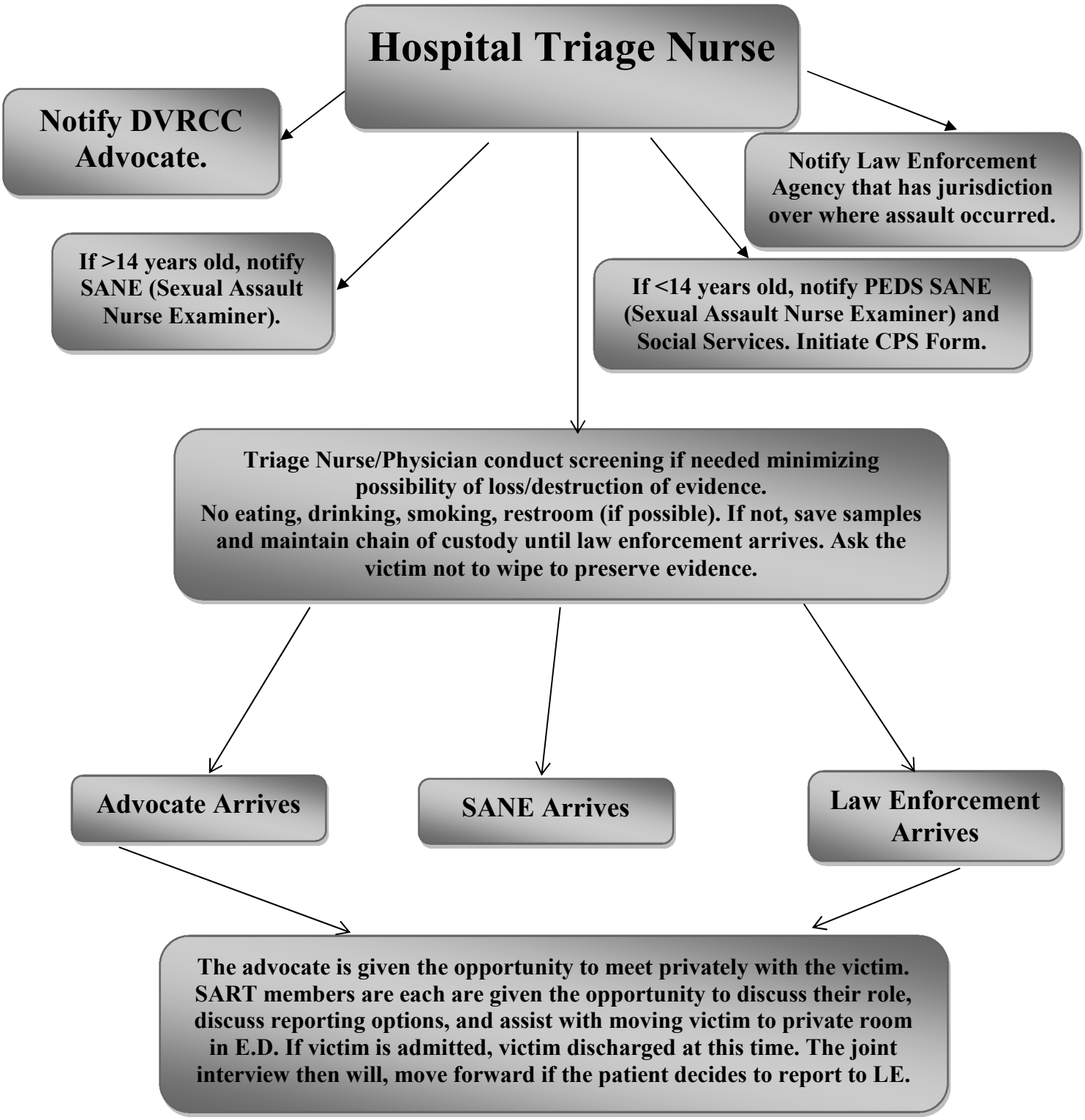
Burke Harris, N. and Renschler, T. *(version 7/2015).* Center for Youth Wellness ACE-Questionnaire *(CYW ACE-Q Child, Teen, Teen SR).* Center for Youth Wellness. San Francisco, CA.

Appendix B: The GRADE Approach Model

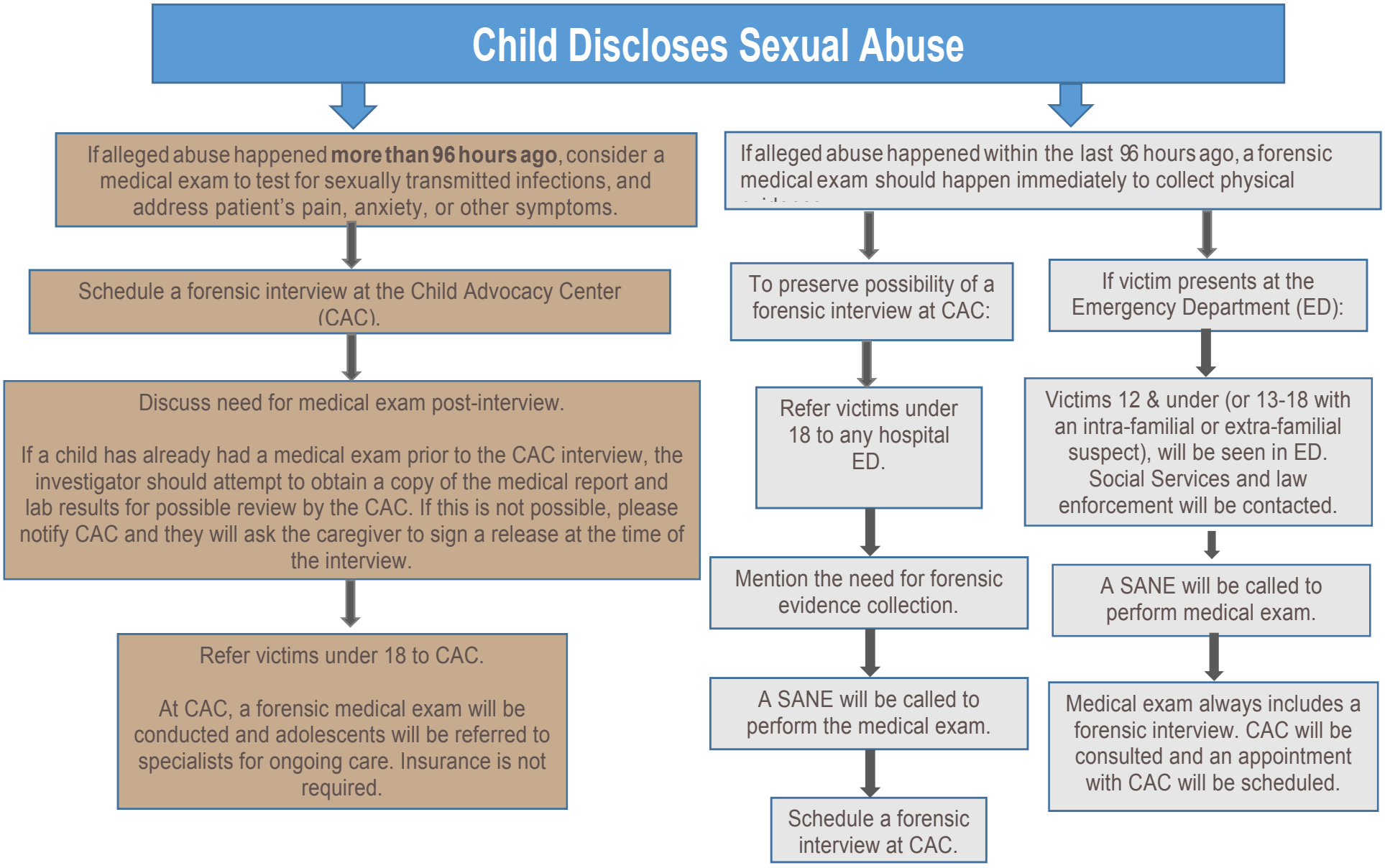
Level of Evidence	Description	Examples
4	Further research is very unlikely to change our confidence in the estimate of effort.	Randomized trials without serious limitations. Well performed observational studies with very large effects (or other qualifying factors).
3	Further research is likely to have an important impact on our confidence in the estimate of effect and may change the estimate.	Randomized trials with serious imitations. Well performed and observational studies yielding large effects.
2	Further research is very likely to have an important impact on our confidence in the estimate of effect and is likely to change the estimate.	Randomized trials with very serious limitations. Observational studies without special strengths or important limitations.
1	Any estimate of effect is very uncertain.	Randomized trials with very serious limitations and inconsistent results. Observational studies with serious limitations. Unsystematic clinical observations (e.g. case series or case reports).

Appendix C: Sexual Assault Response Chart-Activation Process

Sexual Assault Response Chart

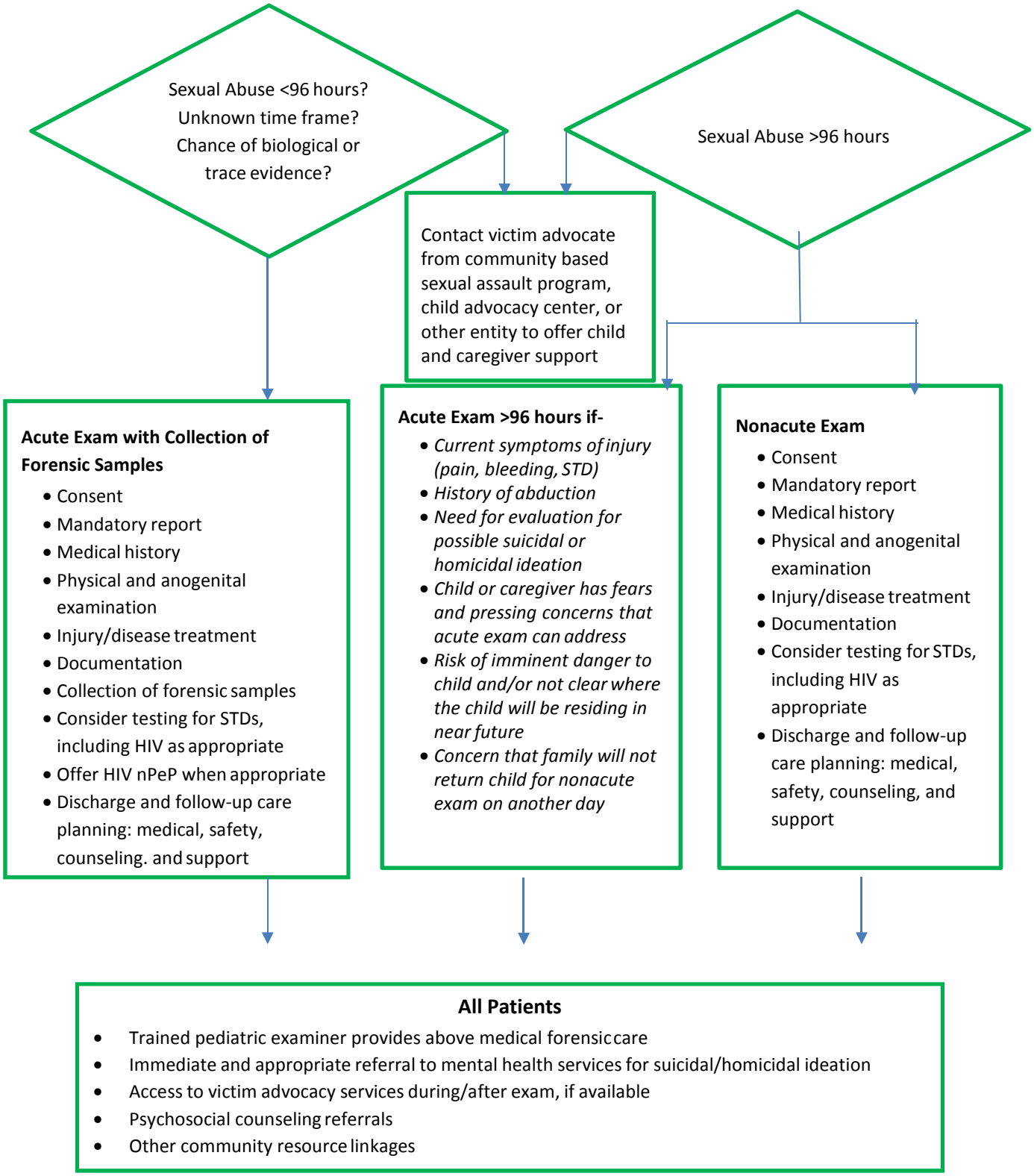


Appendix D: How to Access Medical Exams for Child & Adolescent Victims of Sexual Abuse in Midwest County



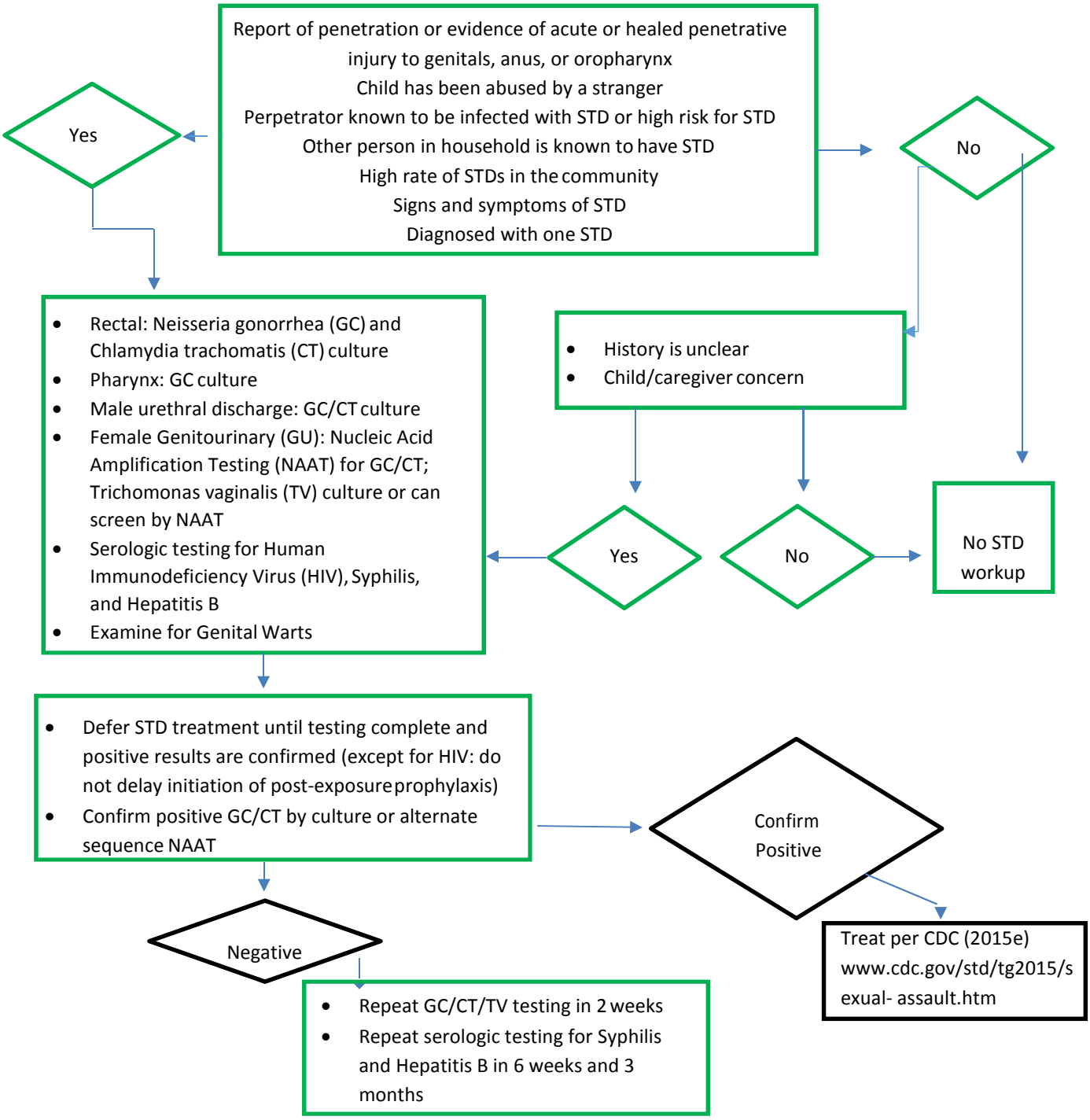
Appendix E: Care Algorithm

The algorithm, adapted in part from Day and Pierce-Weeks (2013), illustrates the general flow of and procedures involved in medical forensic care in prepubescent child sexual abuse cases. Reprinted with permission from the International Association of Forensic Nurses/www.kidsta.org.



Appendix F: Prepubescent STD Testing Algorithm

This algorithm is meant to illustrate the general flow of and procedures involved in STD testing in prepubescent child sexual abuse cases. Reprinted with permission from the International Association of Forensic Nurses/www.kidsta.org.



Appendix G: Baseline Survey Sent to Expert Panel

Trauma-Informed Education Toolkit for Nurses Serving Pediatric Victims of Sexual Abuse and Maltreatment

Round 1: Baseline Context

1. What type of organization do you work for? Circle one:

Hospital Government Health Department Law Enforcement Health Clinic

Other (specify): _____

2. How many pediatric clients do you encounter yearly in your practice? Circle one:

a) <50 b) >75 c) >200 d) >500 e) >1,000

Please place an X in the Column that corresponds with your level of agreement.

Critical Indicators	YES	NO	I DON'T KNOW	N/A
1. Do you currently use an-assessment tool to screen pediatric patients exposed to violence, maltreatment, and/or sexual abuse?				
2. Is a procedure followed for determining services such as SANE, child advocacy, judicial, and appropriate referral services?				
3. Do you feel you are trained and educated to screen and identify a child exposed to violence, maltreatment, and/or sexual abuse?				
4. Do you have a standardized pediatric specific procedure to document and report suspicious cases of maltreatment and/or sexual abuse?				
5. Are there metrics or QI processes in place to monitor how effective your organization handles pediatric cases of maltreatment and/or sexual abuse?				
6. Does your organization have policies and procedures in place to assist providers/professionals caring for pediatric patients (i.e. infrastructure, equipment, resources)?				
7. Do you have the manpower to support the needs of the pediatric population who need a forensic exam, advocacy, law enforcement, and follow-up services?				
8. Would you consider yourself knowledgeable in the field of child maltreatment with sexual abuse; adverse childhood events (ACEs); trauma-sensitive principles?				
9. Do you believe you have support from your organization leaders and the SANE program to assist the child and family in order to do your job well?				

What would you recommend to improve upon your current processes for early screening and identification of suspicious cases for maltreatment with sexual abuse?
Additional Comments:

Appendix H: Round 2 and 3 Survey Sent to Expert Panel

Trauma-Informed Education Toolkit for Nurses Serving Pediatric Victims of Sexual Abuse and Maltreatment

Feedback on Clinical Toolkit and Education

Please circle the number that corresponds with your level of agreement.
Unimportant = 1 Little-important = 2 Mildly-important = 3
Moderately Important = 4
Important = 5 Very-important = 6 Strongly-important = 7

---

1. What type of organization do you work for? Circle one:

Hospital Government Health Department Law Enforcement Health Clinic

Other (specify): _____

2. How many pediatric clients do you encounter yearly in your practice? Circle one:
b) <50 b) >75 c) >200 d) >500 e) >1,000

Critical Success Indicators	**Rating of Importance**						
1. Availability of Manpower:							
• Availability of pediatric forensic trained (SANE) nurses for services 24/7.	1	2	3	4	5	6	7
• Utilizing pediatric SANE trained nurses to provide support and training to sexual assault response team (SART), healthcare professionals, and nursing on recognition, activation of SANE, documentation, and reporting (new personnel training, staff training).	1	2	3	4	5	6	7
2. Availability of Materials (infrastructure, equipment):							
• Adoption of the Adverse Childhood Experience (ACE) assessment screening tool into workflow practice.	1	2	3	4	5	6	7
• Resources being available and accessible to activate forensic exam/law enforcement.	1	2	3	4	5	6	7
• Availability of mechanism to incorporate technology (i.e., electronic health record) for triage or exam visits.	1	2	3	4	5	6	7
3. Pediatric Skills: Assessment and Screening:							
• Availability of the (ACE) tool appropriate for each age group and easy to follow scoring ACE events for further assessment.	1	2	3	4	5	6	7

• Achieve a higher level of clinical insight into performing diagnoses in a setting where it may be difficult to access a pediatric specialist	1	2	3	4	5	6	7
• Guidelines for evaluating findings and standardizing the classification of injuries.	1	2	3	4	5	6	7
• The ability to communicate effectively with pediatric patients, caregivers, and the healthcare team.	1	2	3	4	5	6	7
4. Documentation and Reporting:							
• The ability to obtain an appropriate pediatric history and physical form to include Tanner staging, clear diagrams for noting injury, full medical history, ACE, appropriate medical and advocacy follow-up.	1	2	3	4	5	6	7
• Being provided a clear understanding of how to complete and file the Child Protective Services SFN960 Form.	1	2	3	4	5	6	7
• Being provided a checklist/evaluation tool for obtaining pertinent information and handover procedures.	1	2	3	4	5	6	7
5. Policies and Procedures:							
• Care algorithms providing adequate guidance on accessing SANE care.	1	2	3	4	5	6	7
• Using care algorithms to guide development of internal policies and procedures for early screening and care of pediatric child suspicious for CM with SA.	1	2	3	4	5	6	7
• Recommendations for acute and follow-up care processes following state and national forensic and pediatric care guidelines.	1	2	3	4	5	6	7
6. Presence of Efficient Referral System:							
• Utilizing a toolkit which provides Child Advocacy/SANE Referral information	1	2	3	4	5	6	7
• Being provided a listing of local and national community resources: shelter, hotline information, legal and law enforcement, community clinic information, pediatric physician information.	1	2	3	4	5	6	7
7. Workplace Culture:							
• Education toolkits which enhance awareness of trauma-sensitive comprehensive approaches to care.	1	2	3	4	5	6	7
• Guidance on how to discuss ACEs with families and children (if appropriate).	1	2	3	4	5	6	7
8. Education:							
• Training which adequately addresses issues of child abuse.	1	2	3	4	5	6	7
• Training which adequately addresses issues of child abuse reporting.	1	2	3	4	5	6	7
• Availability of training and professional development opportunities in the workplace.	1	2	3	4	5	6	7

9. Routine Inquiry/Assessment:							
• Improved understanding of the Caring Principles outlined in the training which provide trauma-sensitive care guidelines.	1	2	3	4	5	6	7
• Defined processes for conducting peer and case reviews for QI procedures with SART, Midwest Regional Child Advocacy (MRCAC), and the SANE Medical Director	1	2	3	4	5	6	7
• Strengthening recognition of the signs and symptoms of CM with SA in order to direct specialized services.	1	2	3	4	5	6	7
10. Regular Supportive Supervision:							
• Availability of SANE and pediatric physician/NP: medical and forensic	1	2	3	4	5	6	7
• Availability of CDFNE Pediatric SANE: follow-up and forensic care	1	2	3	4	5	6	7

**Upon review of the education toolkit please provide comments and recommendations below. **

Appendix I: Education Materials

Introduction

The loss of a child is perhaps one of the most unforgettable and devastating moments for anyone. As healthcare professionals, we are trained to heal and save lives. When we fail to be thorough or miss clues, it could make the difference between life or death. It is important to have the tools to see past the obvious and peel back the layers in order to discover the answers. Every child deserves a voice, an advocate, and a champion.

Objectives

- Objectives
  - Understand key terms defining child maltreatment, victimization, and sexual abuse (state and national)
  - Traumagenic Dynamics Model and Trauma-Sensitive Care
  - Improved identification of suspicious cases: screening, assessment, documentation, and reporting
  - Application of Child-Centered Caring Principles for exam and follow-up
- Target Audience
  - Pediatric Sexual Assault Nurse Examiners (SANE)
  - Sexual Assault Response Team (SART) and Providers

Understanding Child Maltreatment
Fact Sheet ***2014***

Child maltreatment includes all types of abuse and neglect of a child under the age of 18 by a parent, caregiver, or another person in a custodial role (e.g., clergy, coach, teacher). There are four common types of abuse.

- **Physical abuse** is the use of intentional physical force, such as hitting, kicking, shaking, burning or other show of force against a child.
- **Sexual abuse** involves engaging a child in sexual acts. It includes fondling, rape, and exposing a child to other sexual activities.
- **Emotional abuse** refers to behaviors that harm a child's self-worth or emotional well-being. Examples include name calling, shaming, rejection, withholding love, and threatening.
- **Neglect** is the failure to meet a child's basic needs. These needs include housing, food, clothing, education, and access to medical care.

For more detailed definitions, see www.cdc.gov/ViolencePrevention/pub/CMP-Surveillance.html.

Why is child maltreatment a public health problem?

The few cases of abuse or neglect we see in the news are only a small part of the problem. Many cases are not reported to police or social services. What we do know is that:

- 1,640 children died in the United States in 2012 from abuse and neglect.[1]
- 686,000 children were found to be victims of maltreatment by child protective services in 2012.[1]
- The total lifetime economic burden resulting from new cases of fatal and nonfatal child maltreatment in the United States is approximately $124 billion.[2]

How does child maltreatment affect health?

Child maltreatment has a negative effect on health. Abused children often suffer physical injuries including cuts, bruises, burns, and broken bones. In addition, maltreatment causes stress that can disrupt early brain development.[3] Extreme stress can harm the development of the nervous and immune systems.[3] As a result, children who are abused or neglected are at higher risk for health problems as adults. These problems include alcoholism, depression, drug abuse, eating disorders, obesity, high-risk sexual behaviors, smoking, suicide, and certain chronic diseases.[4,5]

Who is at risk for child maltreatment?

Some factors can increase the risk for abuse or neglect. The presence of these factors does not always mean that maltreatment will occur. Children are never to blame for the harm others do to them.

Age. Children under 4 years of age are at greatest risk for severe injury and death from abuse.

Family environment. Abuse and neglect can occur in families where there is a great deal of stress. The stress can result from a family history of violence, drug or alcohol abuse, poverty, and chronic health problems. Families that do not have nearby friends, relatives, and other social support are also at risk.

Community. Poverty, on-going community violence, and weak connections between neighbors are related to a higher risk for child abuse and neglect.

Note: This is a partial list of risk factors. For more information, see www.cdc.gov/violenceprevention.

National Center for Injury Prevention and Control
Division of Violence Prevention

CDC

Understanding Child Maltreatment
Fact Sheet *2014*

How can we prevent child maltreatment?

The ultimate goal is to stop child maltreatment before it starts. Strategies that promote safe, stable, and nurturing relationships (SSNRs) and environments for children and families are key to protecting against maltreatment and other harmful childhood experiences. These prevention strategies include improving parent-child relationships by teaching positive parenting skills like good communication, appropriate discipline, and response to children's physical and emotional needs. Programs to prevent child maltreatment also provide parents with social support.

How does CDC approach prevention?

CDC uses a four-step approach to address public health problems like child maltreatment.

Step 1: Define the problem
Before we can prevent child maltreatment, we need to know how big the problem is, where it is, and who it affects. CDC learns about a problem by gathering and studying data. These data are critical because they help us know where prevention is most needed.

Step 2: Identify risk and protective factors
It is not enough to know that child maltreatment is affecting a certain group of children in a certain area. We also need to know why. CDC conducts and supports research to answer this question. We can then develop programs to reduce or get rid of risk factors and increase protective factors.

Step 3: Develop and test prevention strategies
Using information gathered in research, CDC develops and evaluates strategies to prevent child maltreatment.

Step 4: Ensure widespread adoption
In this final step, CDC shares the best prevention strategies. CDC may also provide funding or technical help so communities can adopt these strategies.

For a list of CDC activities, see www.cdc.gov/violenceprevention/pub/PreventingCM.html.

Where can I learn more?

To report abuse or get help, contact the National Child Abuse Hotline at 1-800-4-A-CHILD (1-800-422-4453).

Centers for Disease Control and Prevention
www.cdc.gov/violenceprevention

CDC Facebook Page on Violence Prevention
www.facebook.com/vetoviolence

Children's Bureau, Administration for Children and Families
www.acf.hhs.gov/programs/cb

Child Welfare Information Gateway
www.childwelfare.gov

FRIENDS National Resource Center
www.friendsnrc.org

National Scientific Council on the Developing Child
www.developingchild.net

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2. Fang X, Brown DS, Florence CS, Mercy JA. The economic burden of child maltreatment in the United States and implications for prevention. Child Abuse and Neglect 2012; 36:156-165.
3. National Scientific Council on the Developing Child. Excessive stress disrupts the architecture of the developing brain, Working Paper No. 3 [online]. 2005 [cited 2008 Feb 20]. Available from www.developingchild.net.
4. Felitti V, Anda R, Nordenberg D, Williamson D, Spitz A, Edwards V, et al. Relationship of childhood abuse and household dysfunction to many of the leading causes of death in adults. American Journal of Preventive Medicine 1998;14(4):245-58.
5. Runyan D, Wattam C, Ikeda R, Hassan F, Ramiro L. Child abuse and neglect by parents and caregivers. In: Krug E, Dahlberg LL, Mercy JA, Zwi AB, Lozano R, editors. World Report on Violence and Health. Geneva, Switzerland: World Health Organization; 2002. p. 59-86.

1-800-CDC-INFO (232-4636) • www.cdc.gov/violenceprevention

Toolkit and Care Pathway Education

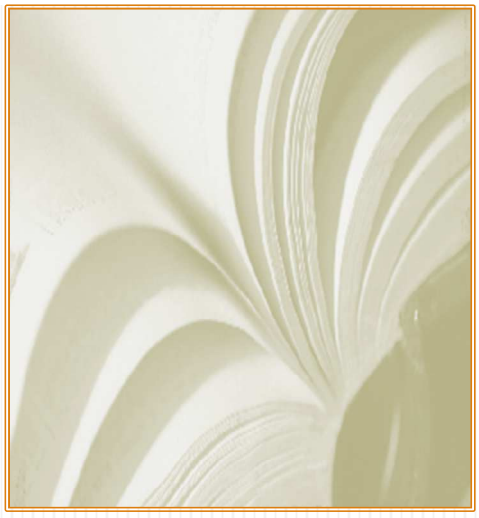
- Education Toolkit
  - Screening tools: Adverse Childhood Experience (ACEs) questionnaire and referral algorithm
  - Mandated reporting and Sexual Assault Response Team (SART) activation
  - Care Algorithm (screening, medical examination, referral, and follow-up)
  - Community Resources: follow-up testing protocol and Child Advocacy support for medical and mental health services

Education Module A

- Learning Module A: (SANE)
  - Complete pre-test prior to lecture
  - PowerPoint and lecture on Child Maltreatment, Caring Principles, ACEs, Forensic Care
  - Introduction to trauma-informed toolkit
  - Case Studies and group discussions: screening and assessment

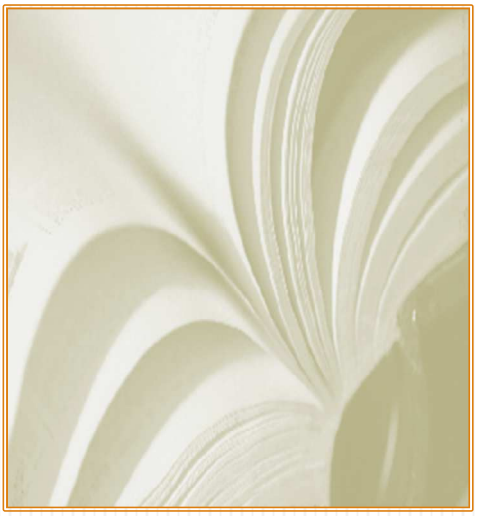
Education Module A (continued)

- Learning Module A: (SANE)-continued
  - Small group simulation on examination techniques
  - PowerPoint lecture and group case studies: interpretation of medical finding physical and laboratory findings
  - Workshop: Documentation and Interpretation
  - Mock Peds case: small group simulation
  - Post-test/ Wrap Up



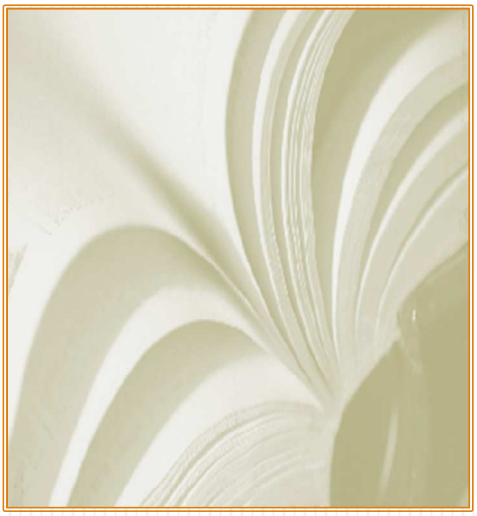
Education Module B

- Learning Module B: SART Team and Providers
  - Complete pre-test prior to lecture
  - PowerPoint and lecture on Child Maltreatment and Forensic Care
  - Trauma-Sensitive Caring Principles introduction



Education Module B (continued)

- Learning Module B: SART Team and Providers- continued
  - Lecture: Mandated reporting and Social Services
  - Introduction to trauma-informed toolkit
  - Case Studies and group discussions: assessment, screening, and documentation (interactive)
  - Post-test/ Wrap Up



Resources and Continuing Education (CEU)

- Screening Algorithm for triage and providers
- SART Team Activation Protocol for triage
- Child Maltreatment and Abuse Education poster
- ACE tool for each age group
- Pediatric documentation for SANE
- Community Resource list
- Follow-up meetings with providers, SART and SANE: peer and case reviews (QA/ QI)
- Refresher course: Online (yearly)
- Online Journal Club: pediatric forensic care best practices/ CEU learning

Learning Outcomes

- Participants will be able to:
  - Define child abuse and neglect
  - Identify who must report child abuse and neglect
  - Follow trauma-informed toolkit for all pediatric visits/ screenings
  - Practice the questions they should ask children before making a report
  - Interpret and document findings
  - Activate early SART based on ACE and physical findings
  - Appreciate that child abuse can be a sensitive and stressful experience for child and caregiver

Appendix J: Pediatric Forensic Examination and Documentation

1 copy each to Evidence Kit, Law Enforcement, CDFNE file

Pediatric Forensic Examination and Documentation

Patient Name:_____ DOB:_____Male € Female €

Forensic exam location: CHI St. Alexius, Dickinson

Time exam began:_____ Time exam ended: _____

Race:_____ Time of assault: _____

Reported Assault Date: _____

Name of Reported Assailant(s):

1. _____ **Age**_____ **DOB**_____**Reported Race of Assailant** _____
2. _____ **Age**_____ **DOB**_____**Reported Race of Assailant** _____
3. _____ **Age**_____ **DOB**_____**Reported Race of Assailant** _____
4. _____ **Age**_____ **DOB**_____**Reported Race of Assailant** _____

Number of Reported Assailants: _____
Place of Reported Assault: _____
City: _____ **County** _____ **State** _____

€ Stranger **€ Non-stranger** **€ Relative** **€ Brief Encounter (known less than 24 hours)**

Joint interview Yes € No €

Reporting

1. Report to police: □Yes □No
   If No, provide patient with options:
   - Anonymous reporting ***Option if 14 years or older***
   - Medical examination and treatment without police report
   - May return within 96 hours from day of assault for evidence collection kit
2. Other children in the home potentially at risk for abuse? □Yes (If Yes, include in child line report) □ No
3. Agencies Contacted:
   - CPS □ Yes □ No _____
   - CAC □ Yes □ No _____
   - Other □ Yes □ No _____

Patient Social History

1. Primary Care Medical Provider: _____
2. Currently receiving counseling: □ Yes □ No
3. Abuse Screen: (Assess dynamics during arguments or discipline)
   Caregiver: □ Yes □ No □ Suspected □ Unable to assess
   Patient: □ Yes □ No □ Suspected □ Unable to assess

If Yes: Concerns and Interventions:

_____
_____
_____
_____

Pediatric Forensic Examination and Documentation

1. Are you sexually active? □ Yes □ No □ Deferred due to age If Yes, what form of birth control is used?

_____

2. Drug, Tobacco, Alcohol use: □ Yes □ No □ Deferred due to age

Type: _____

Last use: _____

3. Personal Hygiene: □ Dependent □

Independent Irritants: □ Use of bubble bath □

Environmental

Concerns: _____

4. Toileting: □ Diaper □ Potty Training □ Independent

Concerns: _____

5. Behavior Concerns: □ Yes □ No

_____

_____

_____

_____

6. Suicidal Ideations: □ Yes □ No □ Deferred due to age

- If Yes, Crisis and Emergency Physician consults done _____

7. Homicidal Ideations: □ Yes □ No □ Deferred due to age

If Yes, Crisis and Emergency Physician consults done _____

Immunizations Up to date: □ Yes □ No □ Unsure HPV Vaccination: □ Yes □ No □ Unsure

Hepatitis B series: □ Yes □ No □ Unsure Last Tetanus: _____

Allergies Denies Medication Allergies • _____ • _____ • _____ Other • _____	**Current Medications:** (Prescription, OTC and herbal) □ None • _____ • _____ • _____ • _____ • _____ • _____ • _____

Past Medical History: □ None

□ Attention Deficit Disorder □ Hyperactivity □Depression/Anxiety

□Trauma: _____

□ Birthmarks/Mongolian Spots □ Diabetes □Bleeding/Clotting Problems □ Eczema/Psoriasis

□ Surgeries/Hospitalizations: _____

Pediatric Forensic Examination and Documentation

□ Heart Disease □ Pulmonary Disease □ Frequent Urinary Tract Infections

□ Headache (migraines) □ Last menstrual period:_____ □ Premenarchal

□ Other:_____

Review Of Systems

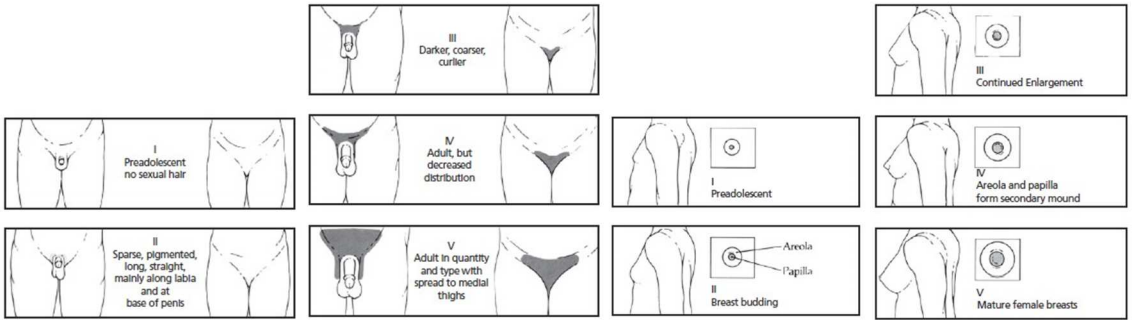
Skin □ Negative □ Rash □ Wound Other: _____	**Cardiovascular** □ Negative □ Regular rate, rhythm □ Chest pain □ Palpitations Other: _____
Hematologic □ Negative □ Easy bruising □ Recent epistaxis (nosebleed) □ Heavy menstrual bleeding □ Prolonged bleeding after surgical procedure Other: _____	**Genitourinary** □ Negative □ Pain with urination □ Hematuria □ Genital pain □ Genital discharge Other: _____
ENT □ Negative □ Ear pain: □ Right □ Left □ Ear discharge □ Sore throat □ Trouble Swallowing □ Nasal congestion □ Dental pain Other: _____	**Eyes** □ Negative □ Discharge □ Recent visual changes Other: _____
Neurological □ Negative □ Headache □ Dizziness □ Numbness/tingling Other: _____	**Musculoskeletal** □ Negative □ Gait problems □ Muscle/Joint pain Other: _____
Pulmonary □ Negative □ Lungs clear to auscultation □ Shortness of breath □ Cough □ Wheezing Other: _____	**Gastrointestinal** □ Negative □ Abdomen soft, non-tender, non-distended □ Nausea/Vomiting □ Constipation/Diarrhea Last bowel movement: _____ Other: _____

Pediatric Forensic Examination and Documentation

Neurological (Infant/Nonverbal Italicized) □ N/A

	1	2	3	4	5	6
Eyes	**Does not open eyes**	**Opens eyes in response to painful stimuli**	**Opens eyes in response to voice**	Opens eyes spontaneously	**N/A**	**N/A**
Verbal	**Makes No Sound**	**Incomprehensible sounds *Inconsolable, agitated***	Utters inappropriate words *Inconsistently inconsolable, moaning*	Confused, disoriented *Cries, but consolable; inappropriate interaction*	Oriented, converses normally *Smiles, orientated to sounds, follows objects, interacts*	**N/A**
Motor	**Makes No movements**	Extension response (decerebrate) to painful stimuli	Abnormal flexion (decorticate) to painful stimuli	Flexion/withdrawal to painful stimuli *Infant withdrawals from pain*	Localizes painful stimuli *Infant withdrawals from touch*	Obeys commands *Infant moves spontaneously or purposefully*

Circle Tanner Stage:
Breast (Female only) Genital (Female □, Male □)



Patient's Description of Events: Record exactly what he or she says. Place quotation marks around the patient's words or phrases:_____

_____

_____

_____

_____

_____

_____

_____

Patient History/ Initial Assessment

Vital Signs Weight:_____□ kg □ lbs □ Deferred Height:_____□ in □ cm □ Deferred
T:_____HR:_____RR:_____BP:_____SPO2:_____Time:_____

Pain Present? □ Yes (Non-verbal signs or symptoms) □ No (Per patient or no non-verbal signs or symptoms)

• Location: _____

• Scale: _____

• Onset: _____

• Quality/Type:_____

Overall Appearance (Torn clothing, disheveled):

_____

_____

Behavioral Observations/Affect/Mood:

_____

_____

_____

Last Contact Known: □ Unknown □ Known Date: _____

Post-Assault Hygiene □ Not applicable if over 96 hours	Yes	No	Unknown
Urinated			
Defecated			
Genital or body wipes			
Oral gargle/oral rinse			
Bath/shower/wash			
Brushed Teeth			
Ate			
Drank			
Changed Clothing			
Vomited After			

Record of Envelopes in Sexual Assault Kit (□ N/A over 96 hours)

Envelope	Collected and sealed	NOT collected and Sealed	Reason
Bra			
Outerwear			
Underwear			
Shirt			
Pants			
Debris Collection			
Fingernail Scrapings			
Head Hair Combings			
Oral Swabs and Flossing			
Pubic Hair Combing			
Vaginal Swabs and smears			
Rectal Swabs			

Known Saliva Sample			
Known Blood Sample			

Patient Description of Clothing Worn During Reported Assault: (check all that apply)/ □ **NA (over 96 hours)**

_____ Clothing collected by the SANE nurse; see clothing list for details

Initial

_____ Clothing collected by law enforcement.

Initial

_____ Clothing not collected Reason_____

Procedure for wet clothing: Items must be dry to preserve evidence. If clothing is wet, lay on a sheet of clean, unused, white paper and cover with another sheet of white paper. Gently fold each article of clothing and place in a paper bag then label and seal the bag. Give to the officer. **Advise law enforcement that the clothing is wet.**

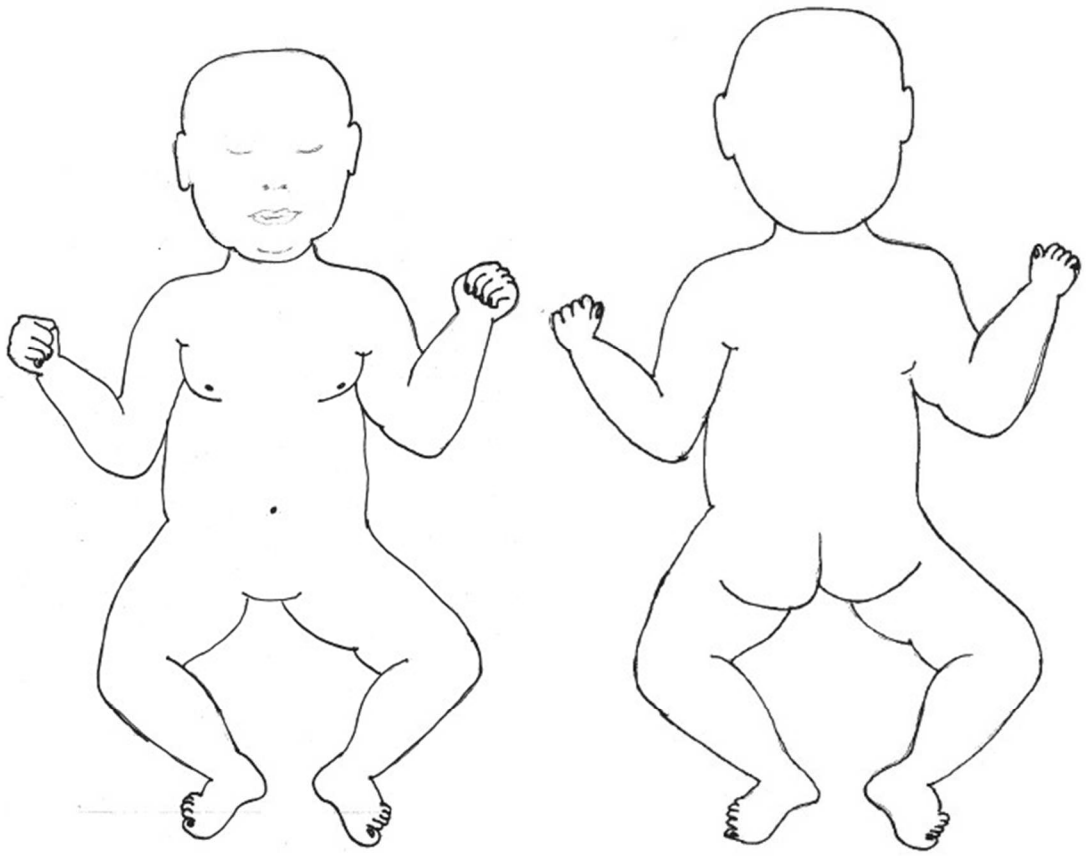
Describe clothing (with minimal handling) carefully noting condition (clean, dirty, rips, tears, stretched out elastic, missing buttons) and visible signs of foreign material (grass, fiber, hair, twigs, soil, splinters, glass, blood, dry or moist secretions).				
	Yes	**No**		
Underwear (Put in kit)				
Shirt				
Undershirt				
Sweater				
Jacket				
Pants				
Bra				
Socks (state if one or two present)				
Shoes (state if one or two present)				
Additional photos				
Other:				

Determine the baseline testing for STD in Children (Test If Yes to any of the Following)

Condition	Yes	No	Unknown
Genital Discharge, itching, odor, ulcers, painful lesions or painful urination?			
If suspect is known, do they have any STDs or have a high risk, including IV drug use, multiple partners, previous STD, ECT.?			
Anyone in the household (all location the patient resides) with an STD?			
Disclosure by a child or caregiver of genital, anal or oral penetration?			
Known or suspected ejaculation?			
Child or caregiver requesting testing?			
Multiple assailants?			

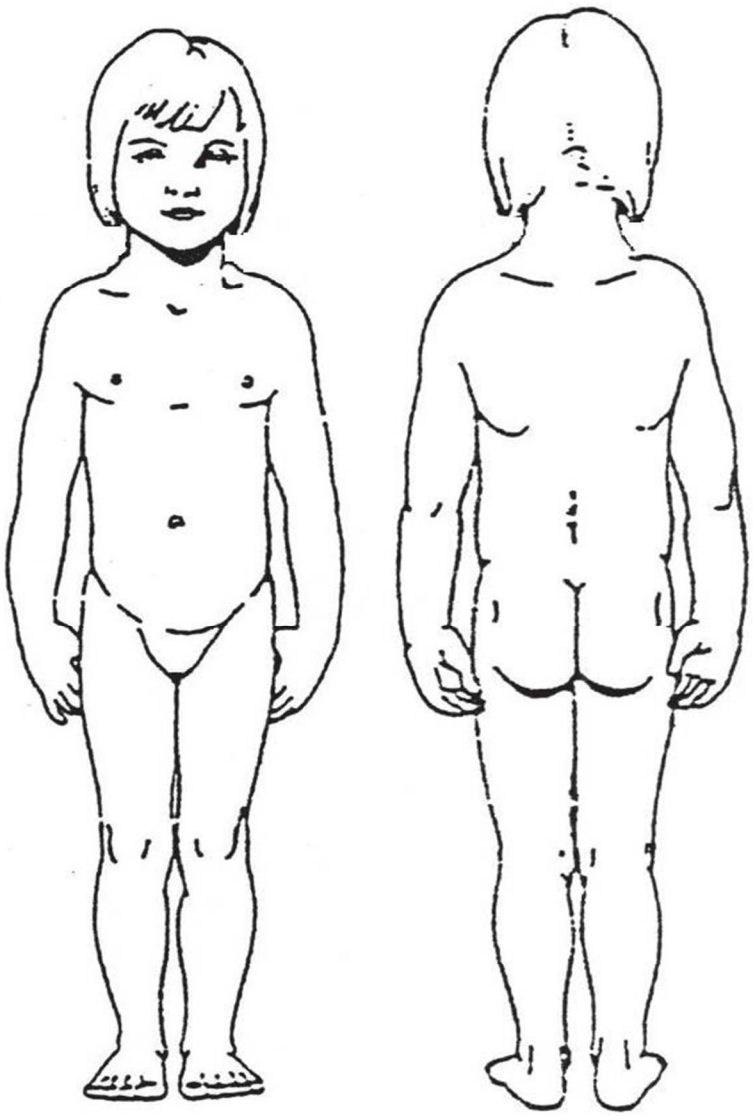
If yes to above please describe:

€N/A €No Injury Noted



B	BR = Bruise BL = Bleeding BI = Bitemark BU = Burn	A	AB = Abrasion AV = Avulsion	S	SW = Swelling ST = Stain (+FL if fluorescent)	E P	ER = Erythema PA = Patterned Injury	P	PE = Penetrating Injury I = Incised S = Stab P = Puncture
		L	LA = Laceration						
		D	DE = Deformity	T	TE = Tenderness TR Trace Evidence		PT = Petechiae		
Draw shape, use initials & size, color, shape (e.g. "BR red oval 3cm H x 2cm W) Carter-Snell, C. (2011) http://mtroyal.ca/forensicresearch. (see "resources" section) May be copied.									

☐ N/A ☐ No Injury Noted



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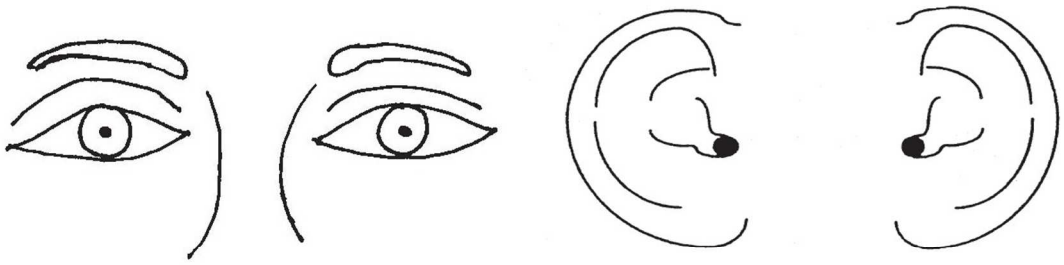
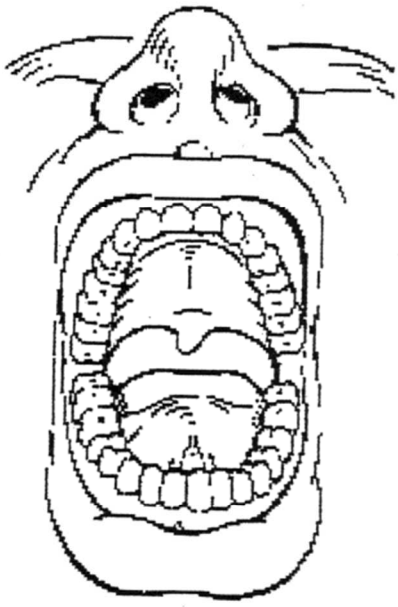
Carter-Snell, C. (2011) http://mtroyal.ca/forensicresearch. (see "resources" section) May be copied.

☐ N/A ☐ No Injury Noted



☐ N/A ☐ No Injury Noted



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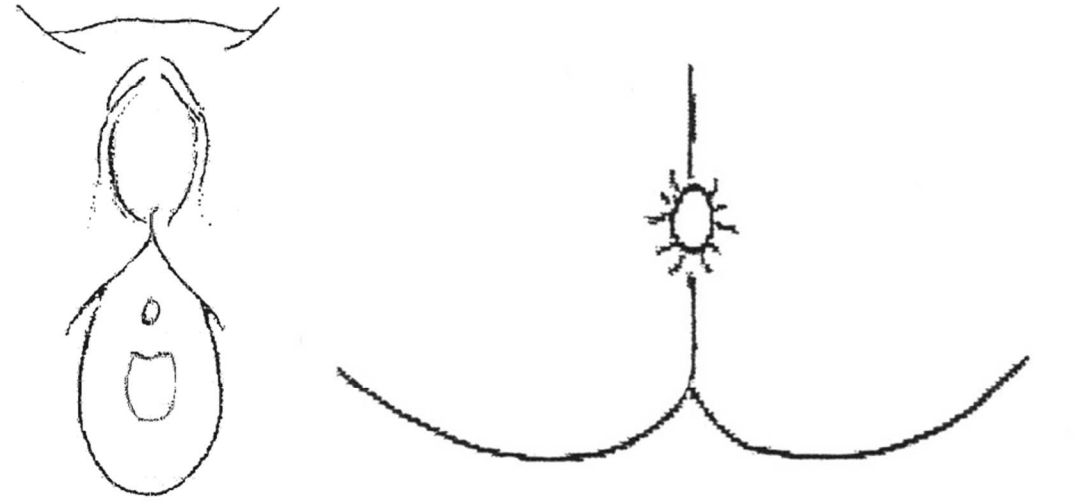
☐ N/A ☐ No Injury Noted

☐ N/A ☐ No Injury Noted



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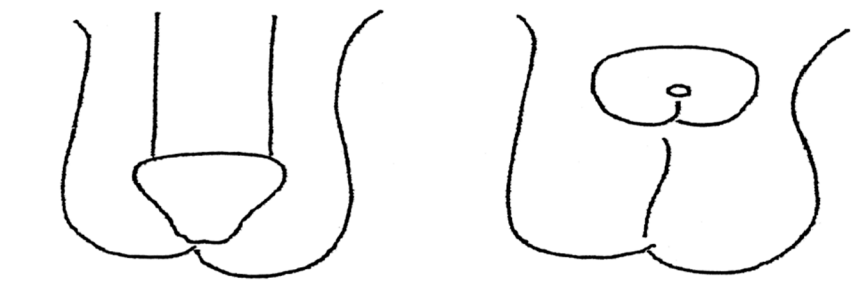
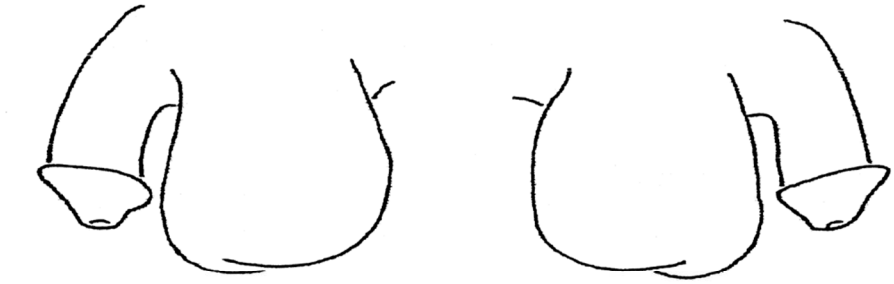
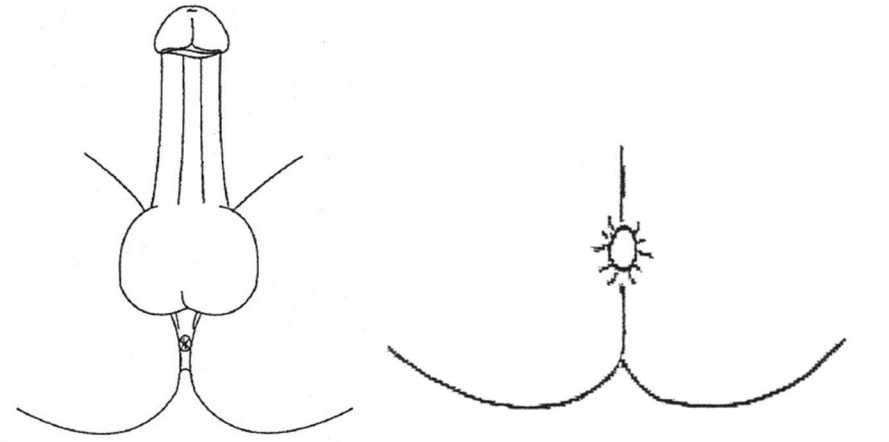
		L	LA = Laceration			P	PA = Patterned Injury				
		D	DE = Deformity	T	TE = Tenderness TR Trace Evidence		PT = Petechiae				
Draw shape, use initials & size, color, shape (e.g. "BR red oval 3cm H x 2cm W) Carter-Snell, C. (2011) http://mtroyal.ca/forensicresearch. (see "resources" section) May be copied.											

☐ N/A ☐ No Injury Noted







B	BR = Bruise BL = Bleeding BI = Bitemark BU = Burn	A L D	AB = Abrasion AV = Avulsion LA = Laceration DE = Deformity	S T	SW = Swelling ST = Stain (+FL if fluorescent) TE = Tenderness TR Trace Evidence	E P	ER = Erythema PA = Patterned Injury PT = Petechiae	P	PE = Penetrating Injury I = Incised S = Stab P = Puncture		
Draw shape, use initials & size, color, shape (e.g. "BR red oval 3cm H x 2cm W) Carter-Snell, C. (2011) http://mtroyal.ca/forensicresearch. (see "resources" section) May be copied.											

Evaluation/Treatment Provided:

- Inpatient Laboratory testing done: □ Yes □ No □ Other:_____
- Outpatient Laboratory slip provided: □ Yes □ No □ Other:_____
- Prescriptions: □ Yes □ No □ Other:_____

Safety Plan Checklist for Discharge (If not done by advocate or child protective services):

□ Safety Plan confirmed with Medical Advocate or Children, Youth, and Family Representative.

□ Yes □ No 1. Will the child be in contact with the person suspected of hurting them?

(If Yes, contact on call child protective case worker)

□ Yes □ No 2. Has a safe place to go upon discharge.

□ Yes □ No 3. Identifies a support person. (May deferred base on age)

□ Yes □ No 4. Information given about counseling options and the benefits of getting counseling.

Narrative:_____

_____

_____

Summary of Forensic Exam:

Summary of Findings

Sexual Abuse/Assault Suspected based on: □ Available history □ Physical Findings

Physical Findings of sexual abuse/assault are:

1. **Anal-Genital Findings**
   - □ normal anal-genital exam
   - □ abnormal anal-genital exam
   - □ Non-specific anal-genital exam
2. **Assessment of Anal-Genital Findings**
   - □ Corroborates history
   - □ Does not corroborate history
   - □ Limited/Insufficient history
3. **Interpretation of Anal-Genital Findings**
   - □ Normal exam: can neither confirm nor negate sexual abuse
   - □ Non-specific: may be caused by sexual abuse or other mechanisms
   - □ Sexual abuse is highly suspected
   - □ Definite evidence of sexual abuse and/or sexual contact
4. **□ Need further consultation /investigation**
5. **□ Lab results or photo review pending (may alter assessment)**
6. **Additional comments:** _____

_____

Signature of Forensic Nurse: _____ **Date:** _____

CDFNE	Law Enforcement	Kit
Full copy of CD with photos	CD with intimate photos	Print copy of report
Copy of Release of Information	Copy of report	Original of Release of Information
Chain of Custody Sheet	Copy of Release of Information	
Reimbursement Forms	Copy of Chain of Custody Sheet	Original Chain of Custody Sheet
	Urine for drug facilitated assault needs to be picked up and frozen as soon as possible!	

Appendix K: Discharge Documentation

Discharge Information:

The professionals who cared for you understand that it took great courage and strength to come in for an examination. Once you leave, you and your child may experience a wide range of emotions as a result of the assault. This information is a guide to your care following an examination for sexual assault and is to be used in conjunction with any additional information provided to you by your examiner and/or primary healthcare provider. Please use this information to assist you in your recovery and call the number provided with any questions/concerns you may have after your discharge.

Testing for sexually transmitted disease was recommended today: □ **Yes** □ **No**
□Swabbing of the genitals □Swabbing of the oral cavity □Swabbing of the anus

We will contact you for the results of any testing completed.

Please bring these Discharge Instructions with you and make an follow-up appointment with your healthcare provider:
□ Within 2 weeks □ As needed

Other:_____

Please call your healthcare provider if you experience:
• Signs of infection such as fever, pain, sores, discharge, etc.
• Urinary symptoms such as frequent, painful or difficult urination
• Unusual vaginal bleeding; a missed menstrual period
• Stomach pain
• Pain and swelling or leakage in anal/rectal region; rectal bleeding, fever of 101.0 degrees F or higher
• Shaking chills
• No bowel movement within 1 week of exam
• Anything unusual or different bothering you

Victims may experience symptoms of rape trauma syndrome at any time following an assault. Symptoms may occur immediately, days, weeks, or months after the assault, and may include:

• Memories, nightmares, or fears about the abuse

• Changes in eating and sleeping patterns

• Avoidance of particular people, activities, or situations

• Withdrawal or depression

• Irritability, crankiness, or short-tempered behavior

• Difficulty concentrating

• Acting out sexually

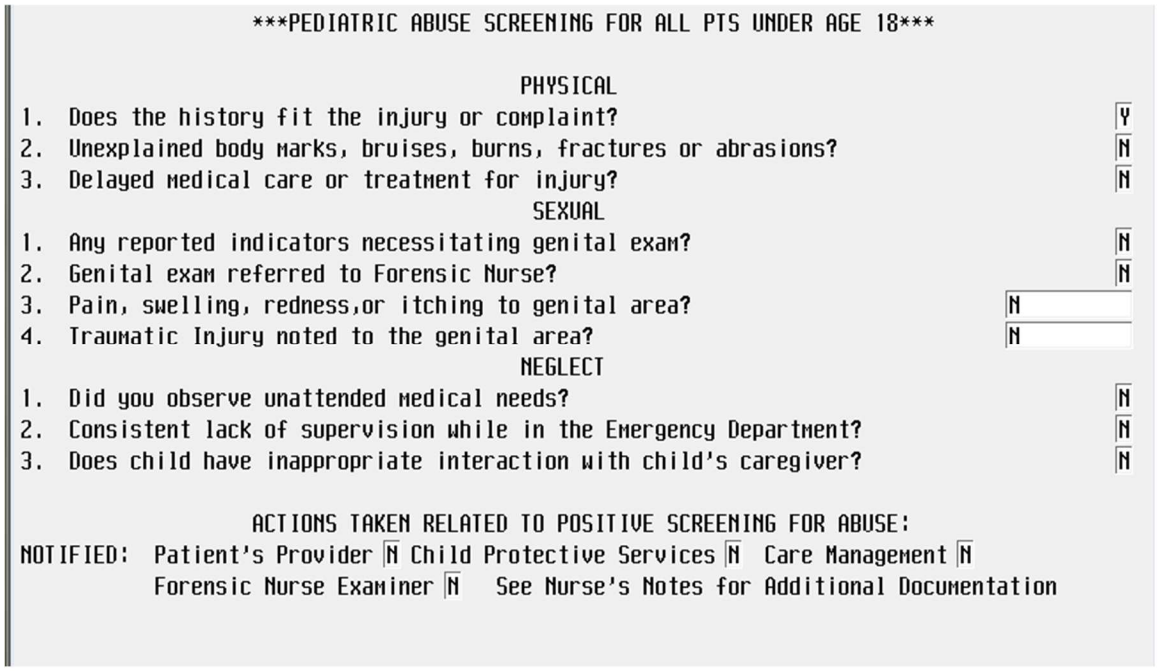
• Flashbacks

If any of these symptoms occur, please contact your healthcare provider, or counseling service provider.
If you have thoughts of Hurting yourself or ending your life, you need to speak to someone immediately: *National Suicide Prevention Lifeline at 1.800.273.8255 or 1.800.273.TALK.*

Discharge Notes/Recommendations:

Signature of Forensic Nurse: **Date:**

Appendix L: Pediatric Screening for Electronic Health Record Systems



PEDIATRIC ABUSE SCREENING FOR ALL PTS UNDER AGE 18

PHYSICAL

1. Does the history fit the injury or complaint? [Y]
2. Unexplained body marks, bruises, burns, fractures or abrasions? [N]
3. Delayed medical care or treatment for injury? [N]

SEXUAL

1. Any reported indicators necessitating genital exam? [N]
2. Genital exam referred to Forensic Nurse? [N]
3. Pain, swelling, redness,or itching to genital area? [N]
4. Traumatic Injury noted to the genital area? [N]

NEGLECT

1. Did you observe unattended medical needs? [N]
2. Consistent lack of supervision while in the Emergency Department? [N]
3. Does child have inappropriate interaction with child's caregiver? [N]

ACTIONS TAKEN RELATED TO POSITIVE SCREENING FOR ABUSE:

NOTIFIED: Patient's Provider [N] Child Protective Services [N] Care Management [N]
Forensic Nurse Examiner [N] See Nurse's Notes for Additional Documentation

Sample Screen Shot which can be adopted in any electronic health system medical records system (i.e. EPIC/MEDITECH).

Please note that answering Yes to any of the 10 questions would automatically generate consult for Forensic Nurse Examiner (SANE) consult. Notifying Child Protective Services, Care Management and Patient's Provider up to the discretion of SANE and attending provider at time of screening.

Appendix M: ACE Screening Tools

CYW Adverse Childhood Experiences Questionnaire (ACE-Q) Teen Self-Report[1]

To be completed by Patient

Today's Date: _____

Your Name: _____ Date of birth: _____

Many children experience stressful life events that can affect their health and development. The results from this questionnaire will assist your doctor in assessing your health and determining guidance. Please read the statements below. Count the number of statements that apply to you and write the total number in the box provided.

Please DO NOT mark or indicate which specific statements apply to you.

1) Of the statements in section 1, HOW MANY apply to you? Write the total number in the box. _____

Section 1. *At any point since you were born...*

- ▪▪ Your parents or guardians were separated or divorced
- ▪▪ You lived with a household member who served time in jail or prison
- ▪▪ You lived with a household member who was depressed, mentally ill or attempted suicide
- ▪▪ You saw or heard household members hurt or threaten to hurt each other
- ▪▪ A household member swore at, insulted, humiliated, or put you down in a way that scared you OR a household member acted in a way that made you afraid that you might be physically hurt
- ▪▪ Someone touched your private parts or asked you to touch their private parts in a sexual way that was unwanted, against your will, or made you feel uncomfortable
- ▪▪ More than once, you went without food, clothing, a place to live, or had no one to protect you
- ▪▪ Someone pushed, grabbed, slapped or threw something at you OR you were hit so hard that you were injured or had marks
- ▪▪ You lived with someone who had a problem with drinking or using drugs
- ▪▪ You often felt unsupported, unloved and/or unprotected

2) Of the statements in section 2, HOW MANY apply to you? Write the total number in the box. _____

Section 2. *At any point since you were born...*

- ▪▪ You have been in foster care
- ▪▪ You have experienced harassment or bullying at school
- ▪▪ You have lived with a parent or guardian who died
- ▪▪ You have been separated from your primary caregiver through deportation or immigration
- ▪▪ You have had a serious medical procedure or life threatening illness
- ▪▪ You have often seen or heard violence in the neighborhood or in your school neighborhood
- ▪▪ You have been detained, arrested or incarcerated
- ▪▪ You have often been treated badly because of race, sexual orientation, place of birth, disability or religion
- ▪▪ You have experienced verbal or physical abuse or threats from a romantic partner (i.e. boyfriend or girlfriend)

[1]CYW ACE-Q Teen SR (13-19 yo) © Center for Youth Wellness 2015 Burke Harris, N. and Renschler, T. (version 7/2015). Center for Youth Wellness ACE-Questionnaire (CYW ACE-Q Child, Teen, Teen SR). Center for Youth Wellness. San Francisco, CA.

CYW Adverse Childhood Experiences Questionnaire (ACE-Q) Child[2]

To be completed by Parent/Caregiver

Today's Date: _____

Child's Name: _____ Date of birth: _____

Your Name: _____ Relationship to Child: _____

Many children experience stressful life events that can affect their health and wellbeing. The results from this questionnaire will assist your child's doctor in assessing their health and determining guidance. Please read the statements below. Count the number of statements that apply to your child and write the total number on the line provided.

Please DO NOT mark or indicate which specific statements apply to your child.

1) Of the statements in Section 1, HOW MANY apply to your child? Write the total number in the box. 1- One i

Section 1. *At any point since your child was born…*

- Your child's parents or guardians were separated or divorced
- Your child lived with a household member who served time in jail or prison
- Your child lived with a household member who was depressed, mentally ill or attempted suicide
- Your child saw or heard household members hurt or threaten to hurt each other
- A household member swore at, insulted, humiliated, or put down your child in a way that scared your child OR a household member acted in a way that made your child afraid that s/he might be physically hurt
- Someone touched your child's private parts or asked your child to touch their private parts in a sexual way
- More than once, your child went without food, clothing, a place to live, or had no one to protect her/him
- Someone pushed, grabbed, slapped or threw something at your child OR your child was hit so hard that your child was injured or had marks
- Your child lived with someone who had a problem with drinking or using drugs
- Your child often felt unsupported, unloved and/or unprotected

2) Of the statements in Section 2, HOW MANY apply to your child? Write the total number in the box. 1- One

Section 2. *At any point since your child was born…*

- Your child was in foster care
- Your child experienced harassment or bullying at school
- Your child lived with a parent or guardian who died
- Your child was separated from her/his primary caregiver through deportation or immigration
- Your child had a serious medical procedure or life threatening illness
- Your child often saw or heard violence in the neighborhood or in her/his school neighborhood
- Your child was often treated badly because of race, sexual orientation, place of birth, disability or religion

CYW Adverse Childhood Experiences Questionnaire Teen (ACE-Q) Teen[3]

To be completed by Parent/Caregiver

Today's Date: _____

Child's Name: _____ Date of birth: _____

Your Name: _____ Relationship to Child: _____

Many children experience stressful life events that can affect their health and wellbeing. The results from this questionnaire will assist your child's doctor in assessing their health and determining guidance. Please read the statements below. Count the number of statements that apply to your child and write the total number on the line provided.

Please DO NOT mark or indicate which specific statements apply to your child.

1) Of the statements in Section 1, HOW MANY apply to your child? Write the total number in the box. 1- One

Section 1. *At any point since your child was born…*

- Your child's parents or guardians were separated or divorced
- Your child lived with a household member who served time in jail or prison
- Your child lived with a household member who was depressed, mentally ill or attempted suicide
- Your child saw or heard household members hurt or threaten to hurt each other
- A household member swore at, insulted, humiliated, or put down your child in a way that scared your child OR a household member acted in a way that made your child afraid that s/he might be physically hurt
- Someone touched your child's private parts or asked them to touch that person's private parts in a sexual way that was unwanted, against your child's will, or made your child feel uncomfortable
- More than once, your child went without food, clothing, a place to live, or had no one to protect her/him
- Someone pushed, grabbed, slapped or threw something at your child OR your child was hit so hard that your child was injured or had marks
- Your child lived with someone who had a problem with drinking or using drugs
- Your child often felt unsupported, unloved and/or unprotected

2) Of the statements in Section 2, HOW MANY apply to your child? Write the total number in the box. 1- One

Section 2. *At any point since your child was born…*

- Your child was in foster care
- Your child experienced harassment or bullying at school
- Your child lived with a parent or guardian who died
- Your child was separated from her/him primary caregiver through deportation or immigration
- Your child had a serious medical procedure or life threatening illness
- Your child often saw or heard violence in the neighborhood or in her/his school neighborhood
- Your child was detained, arrested or incarcerated
- Your child was often treated badly because of race, sexual orientation, place of birth, disability or religion
- Your child experienced verbal or physical abuse or threats from a romantic partner (i.e. boyfriend or girlfriend)

Appendix N: ED Pediatric Sexual Assault OrdersSet

ORDERS MUST BE SIGNED BY LICENSED NURSE PRACTITIONER OR PHYSICIAN

Check box directions: CHECK BOX "€" FOR YES Leave € unchecked FOR NO

Allergies and Reactions: _____

_____

Weight:_____kg Height_____cm/inches

BMI _____

Meds/IVs Only	ORDERS
	LABORATORY
	€Urinalysis Complete with Culture if Indicated
	€GC/Chlamydia RNA
	€GC Culture
	€Rectal/Throat/vaginal
	Plate at bedside; Add comments in computer "Concerned for GC" and "Medical/Forensic Exam;" Call lab at 4472
	€CT Culture
	€Rectal/Throat/vaginal
	Use viral medium (COPAN) Add comments in computer "Concerned for CT"and "Medical/Forensic Exam;" Call lab at 4472
	€GenitalCulture
	€Order "Aerobic Culture" in computer for external female and male genitalia; Add comments "R/O strep," and "Medical Forensic Exam;" Call lab at 4472
	€Order "Genital Culture" in computer when swabbing inside labia; Add comments "R/O strep," and "Medical Forensic Exam;" Call lab at 4472
	€Wet Prep
	€HerpesCulture if lesion present
	€Urine Toxicology if indicated

NP/MD Signature_____Date/Time____-_____-_____/_____

RN Signature _____

Date/Time_____-____-_____/_____

All home, post-operative/procedure, transfer and discharge medication orders must be reconciled and written or verified by NP or MD