Southern Minnesota Regional Trauma Advisory Committee (SMRTAC)

Regional Practice Management Guideline

Initial Management of Suspected Non-accidental Trauma

Pediatric **Practice Management Guideline**	**Effective: 6/2015**
Contact: SMRTAC Coordinator	**Last Reviewed:**

Purpose

To provide a consistent approach to the care of injured children caused by suspected non-accidental trauma.

Definitions

Pediatric Trauma Patient: Defined as a child less than or equal to 14 years of age evaluated or admitted for an injury.

Non-accidental Trauma (NAT): Any injury that is purposefully inflicted upon a child.

Policy Statements

1. Children are vulnerable to many forms of maltreatment.
2. Providers that care for children need to have a high index of suspicion for NAT as presentation can vary.
3. Appropriate evaluation and care of NAT patients requires a multi-disciplinary approach.
4. Children who present with suspected NAT injuries are considered pediatric trauma patients.
5. When abuse is considered, provider is encouraged to contact the Mayo Child and Family Advocacy Provider (MCFAP) on call to discuss immediate care and potential need for follow-up MCFAP consult visit. Contact number is 507-284-2511. This resource is available for all hospital, clinic, and EMS providers throughout the entire SMRTAC region regardless of affiliation.

Procedure Statements

1. Physical/history findings suggestive of child abuse/suspected NAT include:

A. Discrepancy in the reported history and physical findings.
B. Bruising in infants /children not cruising (development skill)
C. Intra-cranial bleeding without history of trauma
D. Perioral injuries
E. Trauma to genital or perianal area
F. Suspicious bruising patterns
G. Sharply demarcated burns in unusual areas
H. A normal exam does NOT mean that "nothing happened!"

2. Physical exam and documentation
   A. PHYSICAL ABUSE, injuries include:
      1) BRUISES:
         a) One cannot date a bruise on exam; do not commit an age to your bruise description
         b) Describe and photograph (according to the policy of the institution involved) the bruise: location, size, color, over bone, tender, swelling, shape
         c) History to include risks of bleeding or genetic disorder or other contributing medical (dermatitis)

      2) BURNS:
         a) Describe burn: location, shape, size; agent causing burn; take multiple photographs
         b) Examine for other injuries

      3) FRACTURES:
         a) History of injury.
         b) History of child's developmental ability
         c) One cannot rule out fractures, in child <2 year old, without skeletal survey

      4) HEAD TRAUMA:
         a) Immediate labs: PT, PTT, CBC with platelet count
         b) CT of head (non-contrast) considered for acute injury; without head soft tissue injury and with neurological exam (only valid in infant/child over 9 months of age) CT may not be indicated acutely. Clinical decision for CT overrides recommendations.
         c) Consider skeletal survey

      5) SKELETAL SURVEY CONSIDERATIONS:
         a) All physical abuse victims under age 2
         b) A skeletal survey cannot be used to RULE OUT physical abuse
         c) Repeat skeletal survey in 2-3 weeks must be obtained
         d) Age 2-5 do physical exam; consider skeletal survey or isolated x-rays of abnormal areas
         e) Over age 5; isolated films of abnormal areas of bony exam

6) ABDOMINAL INJURY:
   a) Consider potential injury (in spite of no obvious injury and normal bowel sounds) for physical abuse victims or those with burns, bruises, fractures or head trauma.
   b) Consider labs: AST, ALT (if > than 80 CT of the abdomen should be considered), Amylase, Lipase, and UA

B. Reporting suspected NAT
   1) All medical care providers are mandated reporters.
   2) Child abuse/neglect reporting to the county in which the patient resides is to be done verbally within 24 hours and written within 72 hours.
   3) NO child/teen leaves your location until a safety plan is in place (law enforcement or CPS must determine plan)

C. Transfer to a Designated Pediatric Trauma Center if the child's injuries or social situation exceed your capabilities. (See Pediatric Trauma Management Guideline for transfer criteria for all injuries including suspected NAT.

Prepared by: SMRTAC Pediatric SubCommittee; SMRTAC leadership
Approvals: SMRTAC membership 6/11/2015

Disclaimer: This is a general guideline and is not intended as a substitute for clinical judgment or as a protocol for the management of all trauma patients.