

Barriers to recognition and reporting of Non-Accidental Injury in children in peripheral Emergency Departments.

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Aim: Child abuse causes structural and chemical changes in the developing brains of children, and is a potential cause of a life threatening event. The aim of this study is to highlight suspicious injuries and behaviours associated with non-accidental injury (NAI), and the barriers to detection and reporting of suspicious injuries in children, presenting to peripheral emergency departments within Western Australia (WA).

Method: Database search using CHINAL, PubMed, ScienceDirect, UpToDate on patterns of injury including fractures, bruising, burns, and abusive head trauma that are developmentally inappropriate and are associated with NAI. Database search of parental behaviours, utilisation, value and effectiveness of screening tools, barriers to detection, and barriers to reporting was also undertaken.

Results: What is known is that there is significant underreporting of suspicious injury. In WA, there has been a 24% increase in the notifications to Department of Child Protection (DCP) within the last 4 years, however these statistics must be interpreted with caution as underreporting is a widely recognised phenomenon. There is a failure to recognise suspicious patterns of injury and parental behaviours, and a failure to report due to cultural, legal, personal, or professional risk.

Emergency Departments see 80% of all injuries, and often is the only place parents with injured children will present. Developed in the 1980's, screening tools increase the rate of detection of NAI. However there is poor compliance and resistance to their completion and its often viewed as just another form to fill in. Excessive workloads, large turnover of medical staff in ED, and children and adults being treated within the same ED have been identified as barriers to completion.

Screening tools from Europe, USA and UK that are available in current literature were studied for sensitivity, specificity and usability. The "ESCAPE tool" developed in Sweden was simple in its design, demonstrating high specificity and sensitivity. A positive result to any one of the six questions automatically mandates a thorough injury assessment be done by a senior medical officer or Consultant. There is overwhelming evidence for the active participation of nurses in assessing children for NAI, and the ESCAPE tool could easily be modified for use by ED nurses at triage.

Conclusion: Emergency Department nurses are in a unique position to assess and advocate for the protection of children, and investment into training and increasing the scope of ED nurses is crucial to improving screening, detection and reporting of NAI in children. Triage nurses are in a unique position to observe for behavioural indicators of abuse, and research is required into whether performing a simple assessment using a modified "ESCAPE tool" as part of the triage process would increase detection and reporting of NAI. Also highlighted is the need for more research on the effects of cultural diversity, cohorting paediatric and adult patients within the same ED, organisational resistance, and inadequate training on detection and reporting of NAI and suspicious injury.