

CHILD ABUSE AND NEGLECT POLICY & PROCEDURE GUIDELINES/TOOLKIT

Illinois Emergency Medical Services for Children

Second Edition, 2013



Illinois Emergency Medical Services for Children
is a collaborative program between the
Illinois Department of Public Health and Ann &
Robert H. Lurie Children's Hospital of Chicago
www.luriechildrens.org/emsc



Table of Contents

	PAGE
I. Acknowledgements.....	2
II. Introduction	3
III. Child Abuse and Neglect Policy and Procedure Template	5
Forms	9
1. Guidelines for Calling the Child Abuse Hotline.....	9
2. Written Confirmation of Suspected Child Abuse/Neglect Report: Medical Professionals.....	11
3. Acknowledgement of Mandated Reporter Status	13
IV. Federal and State Regulations Related to Child Abuse and Neglect	15
V. Resources	17
1. Suspected Child Abuse/Neglect Algorithm.....	19
2. Pediatric Suspected Sexual Assault Overview	21
3. Pediatric Suspected Sexual Assault Medical Evaluation and Management Guideline.....	23
4. Guidelines for Sexually Transmitted Infections (STI) Testing and Treatment	24
5. Table A. Behavioral and Physical Indicators of Potential Abuse/Neglect	25
6. Table B. Indicators of Potential Child Physical Abuse	26
7. Table C. Differential Diagnosis of Child Abuse: Conditions That May Be Mistaken for Child Abuse	27
8. Table D. Differential Diagnosis of Sexual Abuse: Conditions That May Be Mistaken for Sexual Abuse	28
9. Table E. Indicators of Potential Child Neglect	29
10. Table F. Child Abuse Mnemonic.....	30
11. Table G. ICD Coding for Child Abuse/Neglect and Suspected Child Abuse/Neglect	31
12. Table H. Identifying Children Who Live with Violence	33
13. Table I. Recognizing and Aiding Human Trafficking Victims	35
14. Sample Emergency Department Quality Improvement Monitoring Tool	37
15. Sample Treatment Guideline: ED Systematic Screening and Detection of Abuse.....	41
16. Sample Checklist for Potential Child Abuse	43
17. Sample Child Abuse and Neglect Screening.....	45
18. Developmental Milestones: Birth Through 5 Years	47
■ Your Baby at 2 Months	49
■ Your Baby at 4 Months	50
■ Your Baby at 6 Months	51
■ Your Baby at 9 Months	52
■ Your Baby at 1 Year	53
■ Your Baby at 18 Months.....	54
■ Your Baby at 2 Years	55
■ Your Baby at 3 Years	56
■ Your Baby at 4 Years	57
■ Your Baby at 5 Years	58
VI. References.....	59
VII. Child Maltreatment Weblinks	61

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Illinois Emergency Medical Services for Children has exercised extreme caution in assuring that all information presented is accurate and consistent with current practice as of the date of publication. The information does not serve as a substitute for an existing child abuse and neglect policy and procedure at your hospital. These guidelines may be modified at the discretion of the healthcare provider.

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INTRODUCTION

Child abuse and neglect are common sources of morbidity and mortality in childhood with devastating consequences.

- One out of every fifty-eight children in the United States (US) is a victim of child abuse or neglect affecting over one million children each year, resulting in irreversible and pervasive damage to our society.¹
- Child maltreatment is the leading cause of trauma-related death in children under four years of age accounting for 80% of all child abuse fatalities.^{2,3}
- In Federal Fiscal Year 2011, 3.4 million referrals were made to Child Protection agencies nationally. Neglect cases represented over 78% of these referrals.⁴
- Annually, the Illinois Department of Children and Family Services (DCFS) Child Abuse Hotline receives over 200,000 calls.⁵
- Unfortunately, the discovery of abuse is often made too late, with over 1,700 deaths, 18,000 permanent injuries, and 150,000 serious injuries³ occurring each year at an annual estimated direct and indirect cost of over \$220 billion in the US.⁶

Whereas child abuse is perceived as more prevalent, neglect is actually the leading form of child maltreatment. More children die from neglect than from other physical abuse. Although neglect is the most common, it is the least understood with regard to identification and intervention.

Morbidity and mortality results from failure to recognize early signs of child abuse and neglect. Up to 75% of abuse may be missed in acute care settings because signs are not recognized.⁷ When abuse is missed, repeat injury occurs in up to 80% of victims with mortality rates as high as 30%.^{3,8-12} Recent research indicates that many fatal or near-fatal abusive events could have been prevented had early signs of abuse been recognized and action taken.^{8,13,14}

Typically, children do not present with a chief complaint of “child abuse,” hence the diagnosis can be very elusive. The emergency department (ED) has a formidable role in identifying and treating children with signs and symptoms of child abuse and neglect. As a 24-hour acute care medical system, the ED is often the first site where an injured, neglected or sexually abused child presents or receives referrals from multiple sources (e.g., parents/caregivers, community physicians, child welfare and law enforcement). Hospitals hold a unique position in their community to promote best practices and appropriately identify, intervene, document, diagnose, and ensure the child’s safety.

Illinois Emergency Medical Services for Children (EMSC) created this 2nd edition to assist organizations develop and enhance their child abuse and neglect policies and procedures as mandated by the Illinois Abused and Neglected Child Reporting Act (325 ILCS 5/et seq.).

The resources in this document have been formatted to allow for copying and posting in clinical areas for easy reference. This document is available online at <http://www.luhs.org/emsc>.

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CHILD ABUSE AND NEGLECT POLICY/PROCEDURE TEMPLATE¹⁵

Every hospital should have policies/procedures addressing child abuse and neglect to assure consistency and accountability. These policies must undergo review on a regular basis to ensure compliance with current state and local regulations. This template provides guidance and outlines key elements that need to be addressed.

I. Child Abuse and Neglect Policy Statement

To identify the responsibilities of healthcare professionals in recognizing, treating and reporting suspected cases of child abuse and neglect as outlined in the (325 ILCS 5/) Illinois Abused and Neglected Child Reporting Act (ANCRA).

II. Child Abuse and Neglect Policy/Procedure Purpose

The policy exists to protect our patients and to ensure compliance with the provisions of the ANCRA.

III. Definitions

Legal definitions of terms related to the maltreatment of children may vary from state to state. This section includes selected text from Section 3 of ANCRA, as well as specific examples from the Illinois DCFS Manual for Mandated Reporters.

Child means any person under the age of 18 years, unless legally emancipated by reason of marriage or entry into a branch of the United States armed services.

Abused child means a child whose parent or immediate family member or any person responsible for the child's welfare or any individual residing in the same home as the child, or a paramour of the child's parent:

- a. inflicts, causes or allows to be inflicted physical injury, by other than accidental means, which causes death, disfigurement, impairment of physical or emotional health, or loss or impairment of any bodily function. Examples include: bruises, human bites, bone fractures and burns.
- b. creates a substantial risk of physical injury. Examples include: choking or smothering a child, shaking or throwing a small child, and violently pushing or shoving a child into fixed objects.
- c. commits or allows to be committed an act or acts of torture upon such child. Examples include: deliberately and/or systematically inflicting cruel or unusual treatment which results in physical or mental suffering.
- d. inflicts excessive corporal punishment. An example includes bruises inflicted on a child, especially a young child.

Neglect occurs when a person responsible for the child:

- a. deprives or fails to provide the child with adequate food, clothing, shelter or needed medical treatment.
- b. provides inadequate supervision of a child. This can occur when children are left either unsupervised or in the care of someone unable to supervise due to his/her condition. Children can suffer injuries that are the result of blatant disregard and are considered neglect. Blatant disregard is a situation in which the risk of harm to a child is so imminent and apparent that it is unlikely that any parent or caretaker would expose the child to such without taking precautionary measures to protect the child.
- c. The child's environment creates a likelihood of harm to the child's health. An example includes a newborn infant whose blood, urine or meconium contains any amount of a controlled substance, with the exception of a controlled substance whose presence is the result of medical treatment administered to the mother or newborn.

Sexual abuse occurs when a person responsible for the child's welfare commits any of the following acts:

- a. sexually transmitted diseases which were acquired originally as a result of sexual penetration or conduct with an individual who was afflicted.
- b. sexual penetration includes any contact between the sex organ of one person and the sex organ, mouth or anus of another person. Typical acts include: vaginal, oral and anal sex.
- c. sexual exploitation is defined as sexual use of a child for sexual arousal, gratification, advantage or profit. This includes such acts as explicit verbal enticements, child pornography, self masturbation in the child's presence, and forcing a child to watch sex acts.
- d. sexual molestation is defined as sexual conduct with a child when such a contact, touching or interaction is used for arousal or gratification of sexual needs or desires. Examples include: fondling a child or having the child touch the perpetrator sexually.

Protective custody is intended for the immediate protection of the child and does not supercede parental rights. Parental consent for treatment of non-emergent conditions must still be obtained. A law enforcement agent, designated employee of the Illinois DCFS, or a physician treating a child may retain temporary protective custody of the child without consent of the person responsible for the child's welfare, if:

- a. there is reason to believe that the child cannot be cared for at home or in the custody of the person responsible for the child's welfare without endangering the child's health or safety;
- b. there is not time to apply for a court order for temporary custody of the child.

The person taking protective custody of the child shall immediately:

- a. notify the person responsible for the child's welfare
- b. notify Illinois DCFS
- c. notify the person in charge of the institution or his designated agent.

Mandated Reporters are required to report suspected child abuse or neglect immediately. They are professionals who may work with children in the course of their professional duties. There are seven groups of mandated reporters as defined by ANCRA: medical personnel (including EMS), school personnel, social service/mental health personnel, law enforcement personnel, coroner/medical examiner personnel, child care personnel and members of the clergy.

Mandated reporters are provided immunity from civil and criminal liability as a result of making a required or authorized report of known or suspected child abuse.

In considering whether there is “reasonable cause” to make a report, there are some issues that are important for mandated reporters to consider in deciding whether to report an incident as suspected abuse or neglect. Definitions in ANCRA are not perfect in helping distinguish between inappropriate/undesirable parenting and those acts which constitute abuse and neglect. Some questions to consider in determining “reasonable cause” include:

- Did you observe evidence that some damage was done to child?
- What information and/or communication has the child provided?
- Is the information consistent and plausible with what you have observed?
- Have there been past incidents which, in retrospect, may have been suspicious?

IV. Policy Standards

- A. Each suspected case of child abuse or neglect shall be immediately reported to Illinois DCFS (1-800-25-ABUSE or 1-800-252-2873) by the mandated healthcare professional.
- B. If an oral report is made to Illinois DCFS, it must be followed by a written report to the local investigation unit within 48 hours of the Hotline call. See Written Confirmation of Suspected Child Abuse/Neglect Report: Medical Professionals, CANTS 4 Form.
- C. Only a single report is required for the hospital/emergency department to meet the reporting requirements. *However, multiple reports of the same incident contribute additional information important for a more thorough investigation by Illinois DCFS.*
- D. The identity of the reporting person and the report shall be confidential subject to disclosure only with the consent of that person or by judicial process.
- E. A person who knowingly and maliciously makes a false report of child abuse or neglect commits the offense of disorderly conduct, a Class A misdemeanor.
- F. When the offender is in a non-caretaker role this abuse or neglect is under the jurisdiction of law enforcement where the incident occurred.

V. Procedure Actions for Medical Personnel

Responsibility of mandated reporter:

- Has reasonable cause to suspect child abuse and/or neglect
- Is required to report suspected child abuse or neglect.

Actions:

1. Inform ED physician or supervisor of suspicions.
2. Conduct and document a complete medical and psychosocial evaluation of the child.
3. Report immediately to Illinois DCFS 1-800-25-ABUSE or 1-800-252-2873
 - 3.1 Document the call and hotline worker's name.
 - 3.2 Notify local law enforcement.
 - 3.3 If the Hotline worker does not accept your call as a report, you will be informed of that fact and given the reason. Most often the explanation will relate to Illinois DCFS' legal jurisdiction or to the evaluation of risk of harm to the child.
 - 3.4 If you disagree with the conclusions of the Hotline worker, you may ask to speak with a Hotline supervisor. Explain the details of the case situation, the reasons you were given for the report being refused, and why you think the Hotline worker's assessment was inaccurate.
 - 3.5 If a report is taken by the Hotline worker, an investigation is commenced within 24 hours. As a mandated reporter, you will be asked to supply a written confirmation of your verbal report within 48 hours (See CANTS 4 form). This written report may be used as evidence in any judicial proceeding that results from the incident.
 - 3.6 Mail the original completed CANTS 4 form to the nearest office of Illinois DCFS (See DCFS website at <http://www.state.il.us/dcfs/contactUs.shtml>).
 - 3.7 Document the completion of the CANTS 4 form in the patient medical record.
4. Activate your hospital protocol and notify appropriate personnel (including Child Advocacy Team, if available) that a suspected case of abuse or neglect has been reported. Request consultation and follow-up.
5. Consider need for debriefing intervention(s) for all involved personnel (including prehospital personnel).

Illinois Department of Children and Family Services Resources:

www.state.il.us/dcfs/index.shtml

Recognizing and Reporting Child Abuse: Training for Mandated Reporters is available online at <https://mr.dcfstraining.org/>.

Child Protection web page www.state.il.us/dcfs/child

- [The Manual for Mandated Reporters](#)
- [Written Confirmation of Suspected Abuse/Neglect report: Medical Professionals \(CANTS 4\) forms](#)
- [What You Need to Know about a Child Abuse or Neglect Investigation](#). This brochure is also available in Spanish
- Other forms and resources

Guidelines for Calling the Child Abuse Hotline

Mandated reporters and other persons should call the Hotline when they have reasonable cause to suspect that a child has been abused or neglected. The Hotline worker will determine if the information given by the reporter meets the legal requirements to initiate an investigation.

Criteria needed for a child abuse or neglect investigation

- The alleged victim is a child under the age of 18.
- The alleged perpetrator is a parent, guardian, foster parent, relative caregiver, paramour, any individual residing in the same home, any person responsible for the child's welfare at the time of the alleged abuse or neglect, or any person who came to know the child through an official capacity or position of trust (for example: health care professionals, educational personnel, recreational supervisors, members of the clergy, volunteers or support personnel) in settings where children may be subject to abuse and neglect.
- There is a specific incident of abuse or neglect or a specific set of circumstances involving suspected abuse or neglect.
- There is demonstrated harm to the child or a substantial risk of physical or sexual injury to the child.

Information the reporter should have ready to give to the Hotline

- Names, birth dates (or approximate ages), races, genders, etc. for all adult and child subjects.
- Addresses for all victims and perpetrators, including current location.
- Information about the siblings or other family members, if available.
- Specific information about the abusive incident or the circumstances contributing to risk of harm—for example, when the incident occurred, the extent of the injuries, how the child says it happened, and any other pertinent information.

If this information is not readily available, the reporter should not delay a call to the hotline.

Illinois Child Abuse Hotline
1-800-25-ABUSE or 1-800-252-2873
1-800-358-5117 (TTY)
217-524-2606 if calling from outside Illinois

The Hotline operates 24 hours per day, 365 days a year. Reporters should be prepared to provide phone numbers where they may be reached throughout the day in case the Hotline must call back for more information.

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CANTS 4
Rev. 10/00

State of Illinois
Department of Children and Family Services

**WRITTEN CONFIRMATION OF SUSPECTED CHILD ABUSE/NEGLECT REPORT:
MEDICAL PROFESSIONALS**

NOTE: Hospitals and medical personnel engaged in examination, care, and treatment of persons are required by the Abused and Neglected Child Reporting Act to report to the Illinois Department of Children and Family Services all suspected cases of child abuse or neglect. The Act provides that anyone participating in this report shall be presumed to be acting in good faith and in so doing shall be immune from liability, civil or criminal, that otherwise might be incurred or imposed.

Child's Name _____

Sex _____ Age _____

Address _____
(Street) (City) (Zip) (County)

Parent's/Custodian's Name _____

Address _____
(Street) (City) (Zip) (County)

Where first seen _____ Date _____

Brought In by _____ Relationship _____

Nature of child's condition:

Evidence of previous suspected abuse(s)/neglect:

Reporter's immediate plan for child including whereabouts:

Remarks:

Person presumed to have abused/neglected child:	
<input type="checkbox"/> Father <input type="checkbox"/> Mother <input type="checkbox"/> Stepfather <input type="checkbox"/> Stepmother <input type="checkbox"/> Sibling <input type="checkbox"/> Other _____	
PERSON MAKING REPORT	PERSON MAKING REPORT (Check Appropriate Box)
_____ Name (Please Print)	<input type="checkbox"/> Attending Physician <input type="checkbox"/> Podiatrist <input type="checkbox"/> Surgeon <input type="checkbox"/> Chiropractor <input type="checkbox"/> Hospital Administrator <input type="checkbox"/> Christian Science Practitioner <input type="checkbox"/> Medical Examiner <input type="checkbox"/> Social Worker <input type="checkbox"/> Coroner <input type="checkbox"/> Social Services Administrator <input type="checkbox"/> Registered Nurse <input type="checkbox"/> Registered Psychologist <input type="checkbox"/> Licensed Practical Nurse <input type="checkbox"/> Psychiatrist <input type="checkbox"/> Dentist <input type="checkbox"/> Advanced Practice Nurse <input type="checkbox"/> Osteopath <input type="checkbox"/> Other _____
_____ Medical Facility	
_____ Address	
_____ Date	_____ Signature

(MAILING INSTRUCTIONS ON REVERSE SIDE)

INSTRUCTIONS

The Abused and Neglected Child Reporting Act states that any hospital, clinic or private facility to which a child comes or is brought suffering from injury, physical abuse or neglect apparently inflicted upon him, other than by accidental means, shall promptly report or cause reports to be made in accordance with provisions of the Act.

The report should be made immediately by telephone to the IDCFS Child Abuse Hotline (800-252-2873) and confirmed in writing via the U.S. Mail, postage prepaid, within 48 hours of the initial report.

This form is provided for the convenience of the hospital, clinic or private facility in making the written report. A form must be completed for each child.

Enter the full name of the child, sex, age and address. Give the first and last names of the parents or persons having custody of the child. If the address is the same as that of the child, indicate by "same."

Where first seen: Give the date the child was first seen; indicate if in-patient, clinic, emergency room, doctor's office or another specified place within the hospital, and by whom the child was brought in.

Nature of the child's condition and evidence of previous suspected abuse(s)/neglect: Self-explanatory.

Reporter's plan for child: Indicate whether child is to remain in the hospital and for how long, or be released and, if so, to whom. State any other pertinent information as to the plan.

Remarks: If a report was also made to a local law enforcement agency, state to which agency report was made. Include any additional information deemed appropriate to the case.

Give the name of the Attending Physician, name and address of the hospital, if report is from the hospital.

Signature: The report is to be signed by the person making the report.

MAILING INSTRUCTIONS

Mail the original to the nearest office of the Illinois Department of Children and Family Services, Attention: Child Protective Services

DCFS is an equal opportunity employer, and prohibits unlawful discrimination in all of its programs and/or services.



Illinois Department of Children & Family Services

ACKNOWLEDGEMENT OF MANDATED REPORTER STATUS

I, _____, understand that when I am employed as a
(Employee Name)

_____, I will become a mandated reporter under the
(Type of Employment)

Abused and Neglected Child Reporting Act [325 ILCS 5/4]. This means that I am required to report or cause a report to be made to the child abuse Hotline number at 1-800-25-ABUSE (1-800-252-2873) whenever I have reasonable cause to believe that a child known to me in my professional or official capacity may be abused or neglected. I understand that there is no charge when calling the Hotline number and that the Hotline operates 24-hours per day, 7 days per week, 365 days per year.

I further understand that the privileged quality of communication between me and my patient or client is not grounds for failure to report suspected child abuse or neglect, I know that if I willfully fail to report suspected child abuse or neglect, I may be found guilty of a Class A misdemeanor. This does not apply to physicians who will be referred to the Illinois State Medical Disciplinary Board for action.

I also understand that if I am subject to licensing under but not limited to the following acts: the Illinois Nursing Act of 1987, the Medical Practice Act of 1987, the Illinois Dental Practice Act, the School Code, the Acupuncture Practice Act, the Illinois Optometric Practice Act of 1987, the Illinois Physical Therapy Act, the Physician Assistants Practice Act of 1987, the Podiatric Medical Practice Act of 1987, the Clinical Psychologist Licensing Act, the Clinical Social Work and Social Work Practice Act, the Illinois Athletic Trainers Practice Act, the Dietetic and Nutrition Services Practice Act, the Marriage and Family Therapy Act, the Naprapathic Practice Act, the Respiratory Care Practice Act, the Professional Counselor and Clinical Professional Counselor Licensing Act, the Illinois Speech-Language Pathology and Audiology Practice Act, I may be subject to license suspension or revocation if I willfully fail to report suspected child abuse or neglect.

I affirm that I have read this statement and have knowledge and understanding of the reporting requirements, which apply to me under the Abused and Neglected Child Reporting Act.

Signature of Applicant/Employee

Date

CANTS 22
Rev. 11/2012

**Office of the Director
406 E. Monroe Street • Springfield, Illinois 62701**

 ACCREDITED • COUNCIL ON ACCREDITATION FOR CHILDREN AND FAMILY SERVICES

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FEDERAL AND STATE REGULATIONS RELATED TO CHILD ABUSE AND NEGLECT

In addition to Mandated Reporter Laws, there are federal and state requirements for hospitals related to abuse recognition, reporting, treatment and referral. These requirements are very briefly outlined below.

CENTERS FOR MEDICARE AND MEDICAID SERVICES CONDITIONS OF PARTICIPATION

At the federal level, the minimum expectations for meeting the management of abuse and neglect practices for patients are outlined in the Centers for Medicare and Medicaid Services Conditions of Participation.¹⁶ Note that accreditation organizations, such as The Joint Commission, Det Norske Veritas Healthcare, and Healthcare Facilities Accreditation Program, incorporate these standards into their patient care standards and use them in surveying hospitals in the US.

- Written guidelines to identify abuse and neglect
- Processes to assure reporting of abuse and neglect as required by local regulation
- Processes to screen employees for past history as an abuse perpetrator
- Processes to educate staff about abuse and neglect assessment and intervention
- Processes to refer the victim for follow up services
- Collect data on suspected and reported cases of abuse and neglect

ILLINOIS JOINT COMMITTEE ON ADMINISTRATIVE RULES (JCAR) ADMINISTRATIVE CODE

The JCAR Administrative Code includes requirements for Illinois hospitals, pediatric facility recognized hospitals, and EMS services.

Illinois Hospital Licensing Requirements

All Illinois hospitals providing emergency services shall:¹⁷

- Render care to victims of sexual assault according to 77 Ill. Adm. Code 545.60, Treatment of Sexual Assault Victims
- Participate in an area wide plan for emergency services according to 77 Ill. Adm. Code 545.50, Treatment of Sexual Assault Victims

Illinois hospital licensing requires that hospitals have processes in place to protect patients from abuse.¹⁸ Each hospital shall:

- Train employees to detect abuse, encourage employees to report abuse, and retrain employees at specified intervals
- Create procedures about reporting an allegation of abuse to the designated hospital administrator, and the appropriate authorities, i.e., law enforcement, Department of Children and Family Services AND the Illinois Department of Public Health (IDPH)
- Conduct a thorough internal review when abuse is suspected and make the findings of this internal review available to IDPH

Illinois EMSC Pediatric Facility Recognition Requirements

Emergency Department Approved for Pediatrics (EDAP) and Standby Emergency Department Approved for Pediatrics (SEDP) requirements:^{19,20}

- Have policies and procedures addressing the child with suspected abuse and neglect that include identification, evaluation, treatment and referral of victims
- Conduct quality monitors of all child abuse and neglect cases

Pediatric Critical Care Center (PCCC) Facility Recognition Criteria include the EDAP requirements, and additionally require that a multidisciplinary pediatric quality improvement committee or alternate hospital committee review all child abuse and neglect cases.²¹

Illinois Emergency Medical Services Requirements

EMS providers are accountable to their EMS System Standing Medical Orders related to Suspected Child Abuse/Neglect.²² The standing orders need to include:

- Documentation of physical findings, discrepancy between history of injury and physical findings, interaction between child and parent/caregiver, characteristics of the environment and reporting suspicions to the emergency room staff
- Description of the prehospital provider's responsibility as a mandated reporter and directions for responding to parent/caregiver refusal to allow transport

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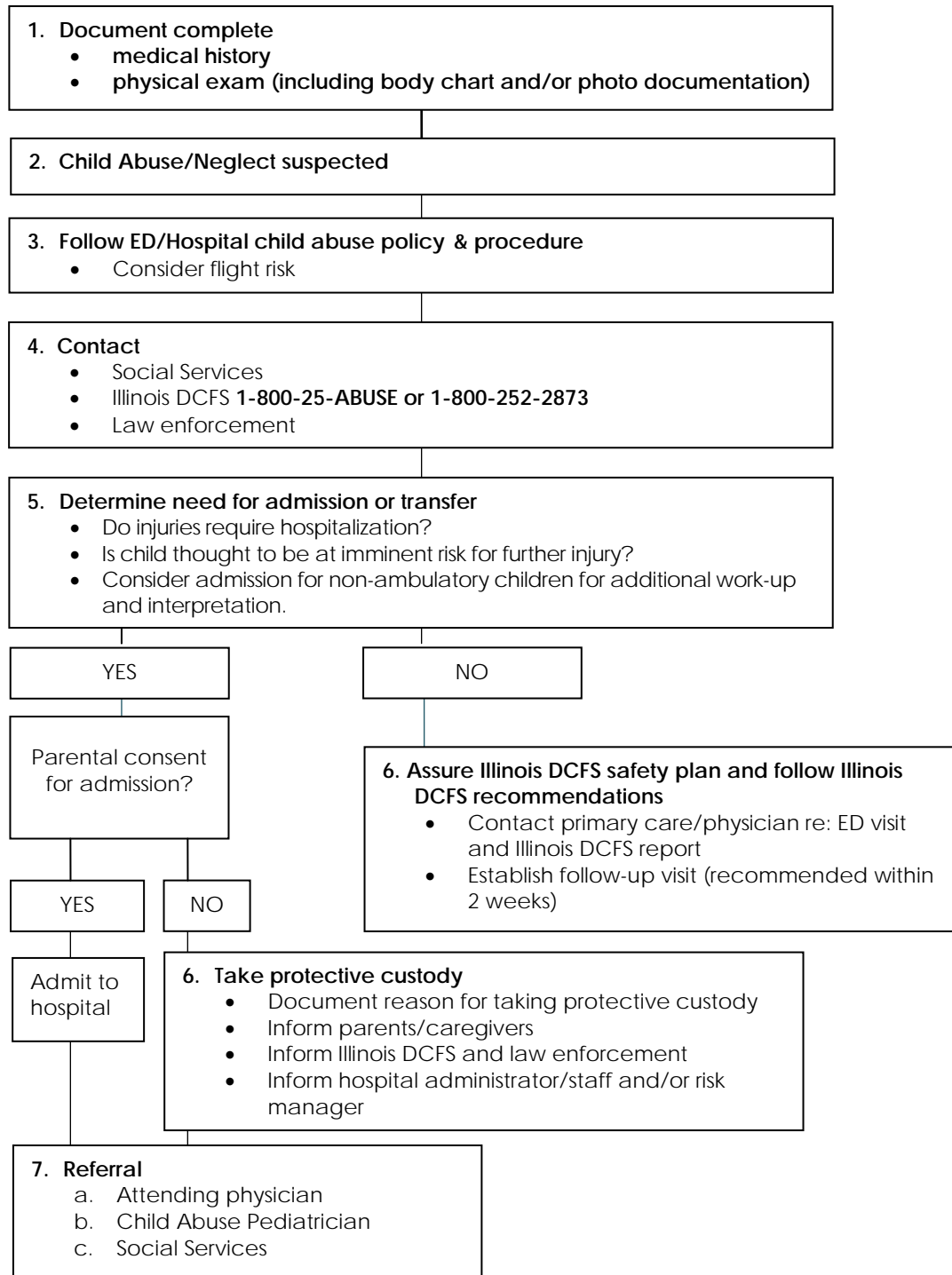
Resources

	Page
▪ Suspected Child Abuse/Neglect Algorithm	19
▪ Pediatric Suspected Sexual Assault Overview	21
▪ Pediatric Suspected Sexual Assault Medical Evaluation and Management Guideline	23
▪ Guidelines for Sexually Transmitted Infections (STI) Testing and Treatment	24
▪ Table A. Behavioral and Physical Indicators of Potential Abuse/Neglect	25
▪ Table B. Indicators of Potential Child Physical Abuse.....	26
▪ Table C. Differential Diagnosis of Child Abuse: Conditions That May be Mistaken for Child Abuse	27
▪ Table D. Differential Diagnosis of Sexual Abuse: Conditions That May be Mistaken for Sexual Abuse	28
▪ Table E. Indicators of Potential Child Neglect	29
▪ Table F. Child Abuse Mnemonic	30
▪ Table G. ICD Coding for Child Abuse and Suspected Child Abuse/Neglect	31
▪ Table H. Identifying Children Who Live with Violence.....	33
▪ Table I. Recognizing and Aiding Human Trafficking Victims	35
▪ Sample Emergency Department Quality Improvement Monitoring Tool	37
▪ Sample Treatment Guidelines: ED Systematic Screening and Detection of Abuse	41
▪ Sample Checklist for Potential Child Abuse.....	43
▪ Sample Child Abuse and Neglect Screening.....	45
▪ Developmental Milestones	47

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SUSPECTED CHILD ABUSE/NEGLECT ALGORITHM

CHILD ABUSE AND NEGLECT POLICY & PROCEDURE GUIDELINES/TOOLKIT



Tips:

- If the child is admitted, review the ICD codes in Table G.
- Consider transfer to a facility with a medically directed child protection team.
- Taking protective custody requires that the physician inform Illinois DCFS that they are taking protective custody.
- Hospital should update Illinois DCFS and law enforcement on admission status.
- Consider involving others who are trained in abuse/neglect (e.g., child life specialists, pastoral care.)

SUSPECTED CHILD ABUSE/NEGLECT ALGORITHM

Complete History and Physical Exam

History obtained in nonthreatening, nonjudgmental fashion.

- Document chief complaint.
- Note who brought the child to the hospital and the mode of transportation.
 - If EMS transport, obtain history and observations from EMS as to condition of scene and location of child.
- Who was present at time of injury?
- When, where, how injury occurred?
- What is the relationship of the historian to patient?
- Develop a timeline of events from when the child was last well (approximately 72 hours). Include the geographic location, clinical condition of child and the transition of caretakers during this time.
- What are parent's/caregiver's responses, both verbally and nonverbally?
 - Document observed behavior.
- What are the child's responses?
 - Minimize the number of times the child repeats the story.
 - Document specific disclosure responses in quotations.
 - The child should be interviewed separately from each parent/caregiver.
- What is the past medical history and care? Does the child have a history or evidence of medical neglect or repeated injuries? Does the child have a history of repeated ED visits?
- Is the history consistent with the injury that is present? Is there current or past history of abuse or neglect?
- What is the condition of any siblings and who is currently caring for them?

Physical exam including:

- Head to toe exam with patient completely unclothed.
- Height, weight and head circumference (as age appropriate) and plot on standard growth charts.
- Body chart and/or photographs (follow hospital labeling policies) of all suspicious lesions and physical findings. Document size, shape and locations of any injury(ies) in detail.

Diagnostic testing should be guided by clinical findings, and/or child's age and may include, but is not limited to:

- Radiologic imaging
 - Complete skeletal survey (19 view skeletal survey recommended in all children under age of 2)
 - CT scan(s) of the head, chest and abdomen
- Complete blood count
- Platelet count and coagulation studies (PT, PTT)
- Liver enzymes, amylase, lipase
- Urinalysis and urine toxicology screen
- Sexually transmitted infection testing (gonorrhea, chlamydia, syphilis, hepatitis, HIV) as appropriate in cases of suspected sexual abuse (See Pediatric Suspected Sexual Assault Algorithm).

Tips:

- Evaluate and investigate any bruising, especially in the non-ambulatory child.
- Always interview child and each parent/caregiver separately.
- Document any delay in seeking care.
- Refer all suspected child abuse or neglect children for social worker assessment.

PEDIATRIC SUSPECTED SEXUAL ASSAULT OVERVIEW

In most cases of child sexual abuse, the disclosure occurs weeks to months after the episode. **Therefore, the forensic medical evaluation of the child sexual abuse patient is rarely an emergency.** Always complete a medical history and physical examination to assess for any urgent healthcare issues. Contact DCFS and law enforcement, as appropriate, and refer the child to a child abuse pediatrician or medical provider with expertise in child sexual abuse so a comprehensive medical evaluation can be scheduled in coordination with the investigative process.

1. Obtain history from child and/or guardian separately

- Document statements made by the child, and parent/caregivers in their own words, ideally in quotations.
(NOTE: Steps 1 and 2 may be completed simultaneously)

2. Perform a complete physical examination including:

- The child's general state of health including signs of physical abuse, neglect, as well as injuries such as bites and bruises and self-injurious behaviors
- Sexual maturity stage
- In female children, the examination should include inspection of the medial aspects of the thighs, labia majora and minora, clitoris, urethra, peri-urethral tissue, hymen, fossa navicularis, posterior fourchette, perineum, and peri-anal tissues.
- In males, assess the thighs, penis, scrotum, perineum, and peri-anal tissues for bruises, scars, bite marks, and discharge.

3. Document

- Written description of physical findings with a detailed diagram and/or photographs
- Describe and address medical conditions unrelated to abuse

4. Based on history and physical examination, are any of the following present?

- History of sexual contact in the past 72 hours, but may extend to 7 days depending on the circumstances**
- Possibility of pregnancy and the need for emergency contraception in a child or adolescent
- Vaginal or penile discharge or the possibility of a sexually transmitted infection and need for post exposure prophylaxis of sexually transmitted infection(s) including HIV
- Evidence or complaint of acute ano-genital injury, pain or bleeding
- Evidence or complaint of extra-genital trauma

YES

NO

Go to step 7, next page

5. Does your ED have a child abuse pediatrician or medical provider with expertise in child sexual abuse?

YES

NO

Consult and determine the need for transfer to a tertiary pediatric facility for further forensic evaluation

6. Complete physical exam and the forensic evaluation for suspected sexual abuse

- Speculum or digital examinations should **never** be performed on the prepubertal child unless there is clinical suspicion of intra-vaginal or rectal trauma. Similarly, digital examinations of the rectum should **never** be performed.
- **To be in compliance with Sexual Assault Survivors Emergency Treatment Act (SASETA), offer evidence collection to children/families up to 7 days following the last abuse/assault with knowledge that it is unlikely to find anything outside the 72-hour timeframe; medical guidelines recommend a 72-hour evidence collection timeframe.²³
- Follow hospital policies to securely store the SAECK kit and follow chain of custody procedures with law enforcement.

Go to step 7, next page

PEDIATRIC SUSPECTED SEXUAL ASSAULT OVERVIEW (CONTINUED)

7. Address medical and emotional conditions including, but not limited to, sexually transmitted infections (STI) and pregnancy

- Approximately 5% of sexually abused children acquire an STI from their victimization.
- Although universal screening of post-pubertal patients is recommended, more selective criteria are often used for testing prepubertal patients.
- Written description of physical findings with a detailed diagram and/or photographs

8. Determine if STI Testing and treatment is needed: The following factors should be considered in deciding which STIs to test for, when to test, which anatomic sites to test and when to treat.

- Age of the child
- Type(s) of sexual contact
- Time lapse from last sexual contact
- Signs or symptoms suggestive of a STI
- Family member or sibling with a STI
- Abuser with risk factors for a STI
- Request/concerns of child or family
- Prevalence of STIs in the community
- Presence of other examination findings suggestive of trauma.

NOTE: Always perform STI testing before administering any antibiotic treatment.

Vaginal, rather than cervical, samples are adequate for STI testing in prepubertal children.

Refer to “Pediatric Suspected Sexual Assault Medical Evaluation and Management Guideline” for more detail

Clinical consideration: Urine Nucleic Acid Amplification Testing (NAAT) is gaining increasing acceptance as a non-invasive, non-traumatic manner of testing for Gonorrhea and Chlamydia in boys of all ages as well as pre and post pubertal girls.

9. Disposition

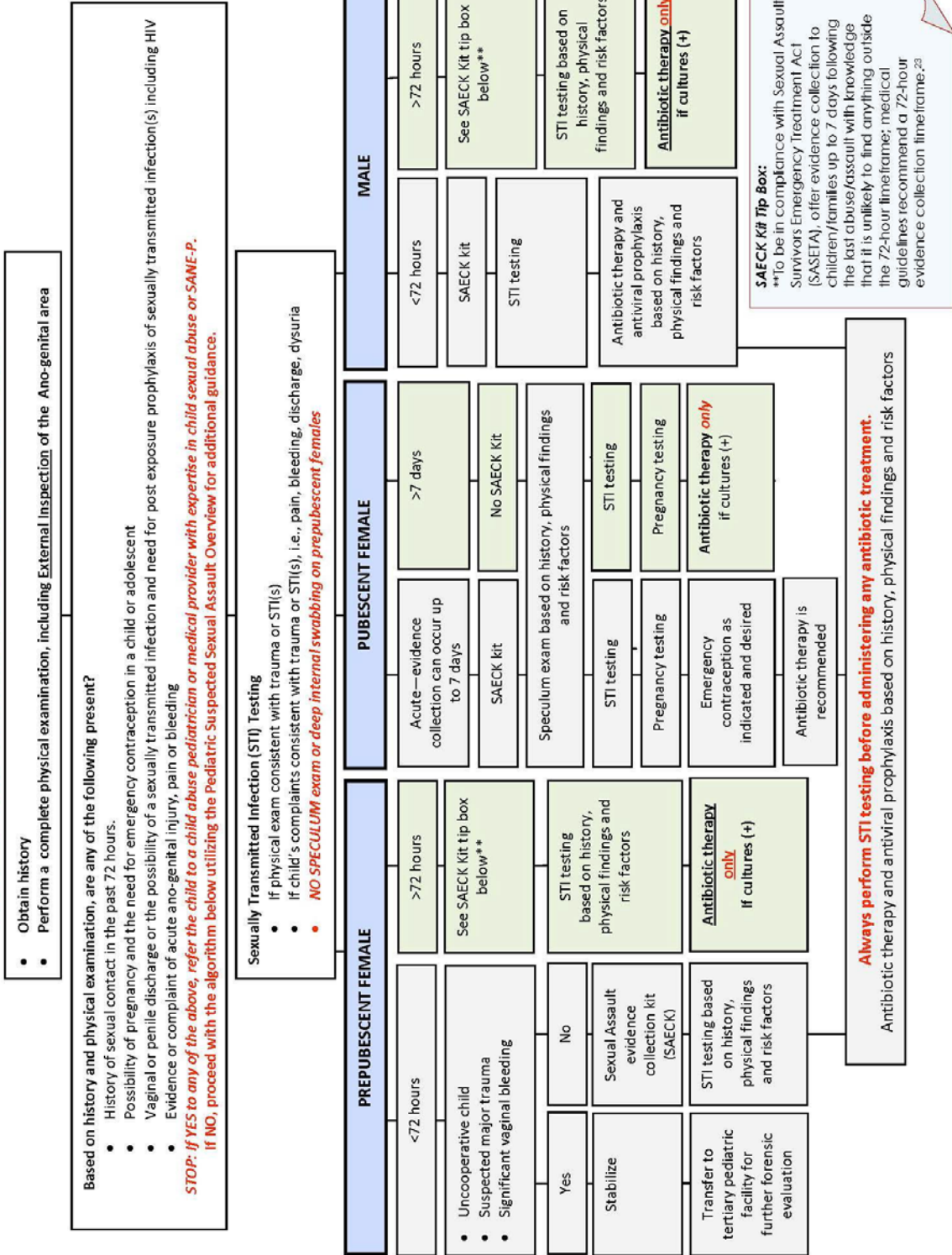
- Refer to DCFS and/or law enforcement, social services and children’s advocacy services (when applicable)
- Release to safe environment (i.e., perpetrator has no contact with the child)
- Consider admission and/or protective custody when there is concern about child safety
- Reassure/educate the child and parent/caregiver
- Refer for further evaluation and treatment including STI follow up in 2 weeks, making referrals as necessary (e.g., primary care/physician)

Medical Exam Tips

- Be aware of local provider(s) with expertise in child sexual abuse.
- The diagnosis of child sexual abuse often can be made on the basis of a child’s history.
- Sexual abuse is rarely diagnosed only on the basis of physical examination or laboratory findings. Physical findings are often absent even when the perpetrator admits to penetration of the child’s genitalia.
- Many types of abuse leave no physical evidence, and mucosal injuries often heal rapidly and completely.
- Children who receive a physical examination, and are reassured they are “normal,” typically have fewer post-event physical complaints/sequelae. A physical examination should occur for reassurance.
- REMEMBER - in the pediatric patient there is rarely injury. Therefore, it is “normal to be normal.” An unremarkable exam does not preclude that the event happened.

PEDIATRIC SUSPECTED SEXUAL ASSAULT MEDICAL EVALUATION AND MANAGEMENT GUIDELINE

Note: Use with Pediatric Suspected Sexual Assault Overview



GUIDELINES FOR SEXUALLY TRANSMITTED INFECTIONS (STI) TESTING AND TREATMENT

The following factors should be considered in deciding which STIs to test for, when to test, which anatomic sites to test and when to treat.

- | | | |
|---|--|---|
| <ul style="list-style-type: none"> ▪ Age of child ▪ Type(s) of sexual contact, time lapse from last sexual contact ▪ Signs or symptoms suggestive of a STI | <ul style="list-style-type: none"> ▪ Family member or sibling with a STI ▪ Abuser with risk factors for a STI ▪ Request/concerns of child or family | <ul style="list-style-type: none"> ▪ Prevalence of STIs in the community ▪ Presence of other examination findings suggestive of trauma. |
|---|--|---|

STI TESTING

BLOOD DRAW

- HIV
- RPR
- HBsAG
- Anti-HBs
- Anti-HCV

ORAL SWABS

- Gonorrhea culture

RECTAL SWABS

- Gonorrhea culture
- Chlamydia culture

URINE

- Gonorrhea culture
- Chlamydia culture

PENILE SWABS

- Gonorrhea culture
- Chlamydia culture

VAGINAL SWABS

- Gonorrhea culture
- Chlamydia culture
- Agar plated Gonorrhea culture for prepubescent child
- Wet prep
- Bacteria gram stain + culture

ANTIBIOTIC PROPHYLAXIS/TREATMENT

- Ceftriaxone AND either of the following:
 - Azithromycin OR Erythromycin
- Metronidazole (only if wet prep positive for trichomoniasis)
NOTE: not to be used in the first trimester of pregnancy

ANTIVIRAL PROPHYLAXIS

HB

- Hepatitis B vaccine
- Hepatitis B Immune Globulin

HIV

- Follow hospital protocol or consult with the hospital infectious disease physician
 - Other resources include the local health department or Illinois Department of Public Health (IDPH)
- If HIV prophylaxis is started, ensure compliance and follow-up in 72 hours

PREGNANCY PROPHYLAXIS

- Levonorgestrel
- Consider ondansetron for nausea

Medical Exam for Suspected Sexual Assault:

- Children who receive a physical examination, and are reassured they are “normal,” typically have fewer post-event physical complaints/sequelae. A physical examination should occur for reassurance.
- REMEMBER—in the pediatric patient there is rarely injury. Therefore, it is “normal to be normal.” An unremarkable exam does not preclude that the event happened.
- If HIV prophylaxis is started, ensure compliance and follow-up in 72 hours.

TABLE A. The indicators listed below are clustered for easier recall and recognition.

BEHAVIORAL AND PHYSICAL INDICATORS OF POTENTIAL ABUSE/NEGLECT	
BEHAVIOR OF CAREGIVER	<ul style="list-style-type: none"> ▪ Aggressive, hostile or evasive ▪ Apathetic, indifferent or unresponsive ▪ Overly concerned about child ▪ Overwhelmed by problems of life
BEHAVIOR OF CHILD	<ul style="list-style-type: none"> ▪ Shy, withdrawn or provocative ▪ Fearful ▪ Indiscriminant attachment ▪ Speech, sleep, eating disorders
HEAD INJURY	<ul style="list-style-type: none"> ▪ Evidence of abusive head trauma <ul style="list-style-type: none"> ▪ altered level of consciousness ▪ closed head injury ▪ CNS hemorrhage ▪ retinal hemorrhages ▪ Cerebral edema
SKELETAL INJURIES	<ul style="list-style-type: none"> ▪ Posterior rib fracture ▪ Metaphyseal fracture ▪ Two or more fractures, different stages of healing ▪ Multiple skull fractures ▪ Long bone fracture in non-ambulating child
WOUNDS/TRAUMA	<ul style="list-style-type: none"> ▪ Blunt trauma to chest/abdomen ▪ Intrauterine abuse ▪ Drug-dependent newborn ▪ Gun shot wounds ▪ Stab wounds ▪ Bites ▪ Lacerations
BRUISES	<ul style="list-style-type: none"> ▪ Periorbital ecchymosis ▪ Skin bruises/lacerations in shapes ▪ Bruises to the face, head, ears, neck, and torso or other non-bony prominence(s) ▪ Bruises, inaccessible, varying stages healing ▪ Circumferential injuries of extremities, neck ▪ An injury resulting from discipline
THERMAL BURNS	<ul style="list-style-type: none"> ▪ Cigarette burns ▪ Glove/sock patterned liquid burn ▪ Iron burns ▪ Diaper area, doughnut-shaped burns ▪ Burns to back of hand/sole of foot ▪ Bilateral burns or injuries to hands
NEGLECT	<ul style="list-style-type: none"> ▪ Delay in seeking medical care ▪ Long periods without supervision ▪ Abandonment ▪ Failure to immunize

TABLE B. INDICATORS OF POTENTIAL CHILD PHYSICAL ABUSE

All children, especially all those less than 36 months, who present with the following conditions should be assessed for potential physical abuse.

INJURIES

- | | | |
|---|---|---|
| <ul style="list-style-type: none"> <input type="checkbox"/> Cutaneous injury <ul style="list-style-type: none"> ▪ Bruises in a non-ambulatory infant ▪ Bruising in a non-ambulating child ▪ Bruises to the face, head, ears, neck, and torso, or other non-bony prominence(s) ▪ Patterned bruising or marks ▪ Bruising/lesions to multiple body surfaces ▪ Bites ▪ Lacerations ▪ Penetrating injury <input type="checkbox"/> Burns <ul style="list-style-type: none"> ▪ Immersion pattern ▪ Patterned contact burns <input type="checkbox"/> Oral/Facial injuries <ul style="list-style-type: none"> ▪ Mouth <ul style="list-style-type: none"> ▪ Dental injuries ▪ Frenulum tears ▪ Ear ▪ Eye ▪ Nose | <ul style="list-style-type: none"> <input type="checkbox"/> Head trauma* <ul style="list-style-type: none"> ▪ Intracranial hemorrhages ▪ Skull fracture ▪ Cerebral edema ▪ Retinal hemorrhages ▪ Loss of gray/white differentiation ▪ Subgaleal hematoma ▪ Alopecia <p>*Infants may appear to have a normal GCS in the presence of severe head injury</p> | <ul style="list-style-type: none"> <input type="checkbox"/> Visceral trauma** <input type="checkbox"/> Genital/Anal trauma <input type="checkbox"/> Poison ingestion <input type="checkbox"/> Failure to thrive <p>**Please note that children can have significant intra-abdominal injury without the presence of abdominal bruising</p> |
| | <ul style="list-style-type: none"> <input type="checkbox"/> Musculoskeletal injury <ul style="list-style-type: none"> ▪ Any fractures in a non-ambulatory child ▪ Any fracture in any age group that is poorly explained | |

HISTORY OF INJURY AND RISK FACTORS

History of injury:

- | | |
|---|--|
| <input type="checkbox"/> Inconsistent with physical findings | <input type="checkbox"/> No history of trauma |
| <input type="checkbox"/> Inconsistent with age of child | <input type="checkbox"/> No history provided |
| <input type="checkbox"/> Inconsistent with developmental abilities of child | <input type="checkbox"/> Delay in seeking medical care |
| <input type="checkbox"/> Multiple histories provided | <input type="checkbox"/> Child discloses abuse |

CHILD AND FAMILY RISK FACTORS:

Child

- No prenatal care
- History of intrauterine drug exposure (IUDE)
- Prematurity
- Developmental/behavioral disability
- Chronic illness
- History of mental illness
- Previous trauma history in child/sibling(s)
- Prior history of Illinois DCFS involvement
- Social isolation
- Child feels unsafe at home
- Child reports family/household/domestic interpersonal violence (past-present-current)

Family

- Young parent
- Single parent
- Multiple caretakers
- Presence of paramour, boyfriend, girlfriend
- Parent feels unsafe at home
- Family/household/domestic interpersonal violence (past-present-current)
- Unstable, chaotic or changing social environment
- Parental behavior indicative of drug or alcohol use
- History of mental illness
- Social isolation
- Death of a child
- Criminal history in family

Tip:

Check with the Department of Children and Family Services or call 1-800-25-ABUSE to track prior history. Give all caretaker's names as well as child's name.

TABLE C. These conditions should be considered in the differential diagnosis of abuse. However, they do not exclude the potential for abuse.

DIFFERENTIAL DIAGNOSIS OF CHILD ABUSE: CONDITIONS THAT MAY BE MISTAKEN FOR CHILD ABUSE

CUTANEOUS LESIONS/BURNS	<ul style="list-style-type: none"> ▪ Mongolian spots ▪ Dermatitis ▪ Ehlers-Danlos ▪ Staph scalded skin syndrome ▪ Chickenpox ▪ Impetigo
SELF-INFLICTED INJURIES	<ul style="list-style-type: none"> ▪ Lesch-Nyhan ▪ Familial dysautonomia ▪ Toddler's fracture
SKELETAL ABNORMALITIES	<ul style="list-style-type: none"> ▪ Congenital syphilis ▪ Stress fracture ▪ Vitamin C or D deficiency ▪ Chromosomal disorders ▪ Copper deficiency
BRUISABILITY	<ul style="list-style-type: none"> ▪ Vitamin K deficiency ▪ Ehlers-Danlos ▪ Salicylate toxicity ▪ Osteogenesis imperfecta ▪ Coining and Cupping (from folk medicine) ▪ Bleeding disorders ▪ Henoch-Schonlein Purpura ▪ Chemical burns ▪ Meningococemia ▪ Erythema multiforme
CENTRAL NERVOUS SYSTEM HEMORRHAGES	<ul style="list-style-type: none"> ▪ Aneurysm ▪ Brain tumor ▪ Hemorrhagic disease of newborn

TABLE D. These conditions should be considered in the differential diagnosis of sexual abuse. However, they do not exclude the potential for sexual abuse.

DIFFERENTIAL DIAGNOSIS OF SEXUAL ABUSE: CONDITIONS THAT MAY BE MISTAKEN FOR SEXUAL ABUSE

- Lichen sclerosis et atrophicus
- Labial adhesions
- Diaper dermatitis
- Straddle injuries
- Impalement injuries
- Lower extremity girdle paralysis (as in myelomenigocele)
- Nonspecific vulvovaginitis and proctitis
- Foreign bodies
- Chronic constipation, Hirschsprung disease
- Chronic gastrointestinal disease, Crohn's disease
- Perirectal streptococcal infection
- Urethral prolapse
- Anal fissures

TABLE E. INDICATORS OF POTENTIAL CHILD NEGLECT

Neglect is the leading form of child maltreatment. More children die from neglect than from other physical abuse. Neglect is the most common, but least understood with regard to identification and intervention.

Neglect investigations are the most challenging because there are many issues that are open to individual interpretation. Illinois law focuses on the minimum parenting standard required to provide for the basic physical needs of a child. The focus is on harm or potential harm to the child.

INJURIES

- Untreated
- Delay in seeking treatment
- Inappropriately treated
- Blatant disregard: lack of seat belt usage
lack of medication safety

MEDICAL NEGLECT

- Lack of medical care
- Lack of providing medications or treatments as needed by child
Examples:
 - Low antiepileptic drug levels
 - Unable to describe medication or treatment routines
 - Diabetics with elevated HbA1C
 - Lack of care supplies i.e., wheelchair, G-Tube supplies
 - Skin breakdown in bedridden child
- Lack of care for developmental or psychiatric conditions
Examples:
 - Developmental delay without intervention
 - Child with mood or thought disorders untreated
 - Child with self injury behavior without intervention
- Failure to thrive
- Lack of hygiene and attention to basic needs
Examples:
 - Long standing poor hygiene e.g., skin breakdown, excessive eczema
 - Lack of corrective eye wear or hearing aids
 - Dental carries
- Medical child abuse/Pediatric condition falsification
 - Treatment that doesn't fit history
 - Concern that caretaker is contributing to or causing the child's condition

MALNOURISHMENT

- Less than 3 years old with weight less than the 5th percentile ("Failure to thrive")
- Child with known growth parameters with a drop of 2 or more percentiles
- Malnourished child more than 2 years old with BMI less than the 5th percentile

CHILD AND FAMILY RISKS

- Poverty
- Young parent
- Child with chronic disease requiring daily medication
- Maternal drug use
- Developmentally delayed parent
- Medically complex child with multiple needs
- Social isolation
- Chaotic environment
- Limited access to health care
- Limited health insurance

TABLE F. This CHILD ABUSE mnemonic is a resource that promotes thorough interviewing and documentation.

CHILD ABUSE MNEMONIC	
C ONSISTENCY OF INJURY WITH DEVELOPMENTAL STAGE	<ul style="list-style-type: none"> Is the incident as described plausible for age and development of the child? Refer to normal developmental milestones. “Non-cruisers are non-bruisers!”
H ISTORY INCONSISTENT WITH IN JURY	<ul style="list-style-type: none"> Does the medical history of the child, or the incident history change from person to person? Is there a previous history of fractures, ingestions or injuries? Is the injury consistent with the presenting history?
I NAPPROPRIATE PARENTAL CONCERNS	<p>Do parents/caregivers:</p> <ul style="list-style-type: none"> Ask pertinent questions? Seem concerned about outcomes? Offer comfort measures to the child?
L LACK OF SUPERVISION	<p>Question family member/caregiver as to:</p> <ul style="list-style-type: none"> Who was present? What happened? When did it happen? Where did it happen? Why did it happen?
D ELAY IN SEEKING CARE	Is the time frame between when the injury occurred and when medical care was sought reasonable? Note unusual delays.
A FFECT/ATTRIBUTIONS	
	<ul style="list-style-type: none"> Document negative attributions. Document reaction of child to all family members/caregivers present. Document response and behavior of family members/caregivers present.
B RUISES	
	<p>Document findings/absence of findings of head to toe exam with patient unclothed. In documenting bruises note:</p> <ul style="list-style-type: none"> Location Size Number Pattern Color Non-cruising or non-ambulatory Presence over bony or non-bony prominence(s)
U NUSUAL INJURY PATTERNS	
	Describe injury characteristics and diagnostic testing performed. Differentiate between non-intentional versus inflicted patterns, e.g., belt loops, bites, iron burns, hand imprints.
S USPICIONS	
	Remember that a report to Illinois DCFS is for “suspicion” of abuse or neglect. YOU do NOT have to prove it. You are a mandated reporter for reasonable suspicion of abuse and neglect. Complete physical exam including body chart and/or photo documentation. Document location, size, color and shape of abnormalities.
E NVIRONMENTAL CUES	
	If a run report from EMS is present, does it contain any contributing information about the environment in which the injury occurred? Gather information from EMS prior to their departure from the ED.

TABLE G. Listed below is ICD coding applicable to child abuse and neglect.

ICD CODING FOR CHILD ABUSE/NEGLECT AND SUSPECTED CHILD ABUSE/NEGLECT²⁴

ICD 9

- V71.6C Physical child abuse, suspected
- V71.6D Sexual child abuse, suspected
- V71.6M Suspected child physical abuse
- V71.6N Suspected child sexual assault
- V71.81 Observation for suspected abuse and neglect
- V71.81A Alleged child sexual assault
- V71.81B Alleged emotional abuse
- V71.81D Alleged sexual abuse
- V71.81E Physical abuse, alleged
- V71.81F Parent concerned about child sexual assault
- V71.81G Parent concerned about child abuse
- V71.81H Observation for alleged abuse and neglect
- V71.81K Sexual Abuse alleged

ICD 10-CM

If abuse or neglect is stated in the record, it should be coded as confirmed. Remember to also assign appropriate codes if physical injuries are present (assault) and/or if the perpetrator is known (Y07).

- T74.02 Child neglect or abandonment, confirmed
- T74.12 Child physical abuse, confirmed
- T74.22 Child sexual abuse, confirmed
- T74.32 Child psychological abuse, confirmed
- T74.4 Shaken infant syndrome
- T74.92 Unspecified child maltreatment, confirmed

If abuse or neglect is suspected, use the suspected coding below. Remember, external cause and perpetrator **are not** recorded in suspected cases.

- T76.02 Child neglect or abandonment, suspected
- T76.12 Child physical abuse, suspected
- T76.22 Child sexual abuse, suspected
- T76.32 Child psychological abuse, suspected
- T76.92 Unspecified child maltreatment, suspected

NOTE: Failure to Thrive should trigger further investigation to rule out child abuse and neglect.

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TABLE H. IDENTIFYING CHILDREN WHO LIVE WITH VIOLENCE

As domestic violence escalates in our society, the role of healthcare providers in enhancing awareness, identification and referral is a critical component in the process of assisting children who are victims of violence. This document can assist in identifying children who are involved in and at risk for domestic violence. *Developed by the 12th Judicial Court Family Violence Coordinating Council and Illinois EMSC, updated 2013.*

CHARACTERISTICS/BEHAVIORS OF CHILDREN LIVING WITH VIOLENCE

INFANTS & TODDLERS (0-2½ years):

- Developmental delay
- Failure to thrive
- Emotional withdrawal
- Physical problems (frequent illness)

PRE-SCHOOLERS (3-6 years):

- Developmental delay (especially in language)
- Low tolerance, easily frustrated
- Acting out, aggressive towards peers/adults
- Low self-esteem
- Abnormal startle response

SCHOOL-AGE CHILDREN (7-11 years):

- Poor school performance, delay
- Behavior problems with peers/adults
- Aggressive acting out, purposeful and severe
- Fearful, nightmares, night terrors
- Abnormal startle responses
- Withdrawn, depressed, despondent
- Chronic physical complaints
- Chronic low self-esteem
- Beginning to mimic adult roles

ADOLESCENTS (12-17 years):

- Depressed
- Signs of physical injuries including scars
- Aggressive
- Delinquent behavior, including running away
- Poor school adjustment
- Alcohol/drug experimenting or use
- Possessive/jealous of girlfriends/boyfriends
- Sexual activity
- Violence expanded to the community
- Proficient at mimicking adult behavior
- Death by suicide or murder

INDICATORS OF EMOTIONAL ABUSE:

- Acting out behaviorally
- Taking responsibility for the abuse
- Low self-esteem
- Constant fear of another beating/abuse
- Fear of abandonment
- Feelings of guilt over inability to stop the abuse

INDICATORS OF SEXUAL ABUSE:

- Child reports abuse
- Overly compliant
- Can't make friends
- Extreme fear of males
- Lack of trust
- No participation in school or social activities
- Can't concentrate
- Sudden drop in grades
- Very withdrawn or depressed
- Delinquent behavior
- Self-destructive or suicidal
- Sexually aggressive
- Seductive behavior
- Inappropriate sexual play with peers, toys and themselves
- Age-inappropriate understanding of sexual behavior
- Sleep disturbances including bed wetting and nightmares
- Secretive behavior
- Hints about sexual behavior
- Arriving early/staying late at school

PHYSICAL INDICATORS OF SEXUAL ABUSE:

- Torn or bloody underclothes
- Pain, swelling or itching of genitals
- Pain when urinating
- Discharge from vagina or penis

NON-AGE SPECIFIC BEHAVIORS INCLUDE:

- | | | |
|-----------------------------------|---|-----------------------------|
| ■ Little or no empathy for others | ■ Sleeping in class regularly | ■ Absence of emotions |
| ■ Loses control easily | ■ Blames others for own action | ■ Boys may be undisciplined |
| ■ Girls may be overly compliant | ■ Uses force/violence to solve problems | |

IDENTIFYING CHILDREN WHO LIVE WITH VIOLENCE (CONTINUED)

IN CASE OF DISCLOSURE:

- How you react is important! Remain calm.
- Provide verbal reassurance to:
 - a) assure the child it is correct to disclose
 - b) assure the child he/she is not responsible
 - c) assure the child he/she is believed
 - d) assure the child he/she is not alone
- Avoid projecting your reaction onto the child
- Do not assume the child knows that the abuse is a problem.
- Remain relaxed.
- Be empathetic.
- Do not be judgmental.
- Explain the need to contact others who can protect the child and help resolve the problem.
- Contact the Illinois DCFS hotline at: 1-800-25-ABUSE (252-2873).

HOW TO REPORT TO ILLINOIS DCFS:

- Call the Illinois DCFS hotline at: 1-800-25-ABUSE (252-2873).
- Information needed:
 - a) name
 - b) date of birth
 - c) address
 - d) phone
 - e) information on siblings
 - f) parent/caregiver name
- State you are a mandated reporter.
- State if you think it is an emergency.
- State why you think the child is abused/neglected (report factual information, not conclusions). Document name of hotline worker and date/time called.
- Ask the local investigative worker to call you back if needed.
- Complete the Illinois DCFS CANTS 4 report form. Download directly from www.state.il.us/dcf or maintain extra blank report forms. Completed forms must be sent to the local Illinois DCFS Investigative Unit. Assure a copy of your CANTS 4 is retained at your institution.
- Your report will be investigated within 24 hours. Your name is not given to those being investigated. Confidentiality of a mandated reporter's identity is protected by law.

RESOURCES

ILLINOIS DCFS HOTLINE..... 1-800-25-ABUSE (252-2873)
NATIONAL DOMESTIC VIOLENCE HOTLINE..... 1-800-799-SAFE (7233)
CRIME VICTIM ASSISTANCE PROGRAM..... 1-800-228-3368

OTHER LOCAL RESOURCES

TABLE I. RECOGNIZING AND AIDING HUMAN TRAFFICKING VICTIMS^{25,26}

Another category of child victims who may present are those who have been exploited for sex and forced labor. Family members, acquaintances and strangers traffic children. Both boys and girls can be victimized. They are often homeless or living with non-family members.

DEFINITIONS:²⁵

Sex trafficking: *Recruiting, harboring, transporting, providing, or obtaining a person for a commercial sex act that is induced by force, fraud, or coercion. When a person is induced to perform such an act is under 18 years of age, no force, fraud or coercion is necessary.*

Labor trafficking: *Recruiting, harboring, transporting, providing, or obtaining a person for labor or services, through the use of force, fraud, or coercion for the purpose of subjection to involuntary servitude, peonage, debt bondage, or slavery.*

BEHAVIOR

- Is under 18 years of age, and is providing sex acts for money or goods
- May exhibit unusually fearful, anxious, hyper-vigilant, depressed, submissive, tense, or nervous/paranoid behavior
- May react with unusually fearful or anxious behavior at any reference to “law enforcement”
- May avoid eye contact
- May exhibit a flat affect
- Has expensive possessions without an income source
- Is in a relationship with a dominating, older adult who may be identified as father/boyfriend/partner/sister/friend
 - Is not allowed to speak alone without this adult present
 - Demonstrates excessive concern for displeasing the dominating older adult
 - Is not free to leave or come and go as he/she wishes
- Provides inconsistent information about personal history
 - Has no identification (e.g., ID card, driver’s license, passport)
 - Unable to provide valid address
 - Lies about his or her age

PHYSICAL INJURIES

- Exhibits unexplained injuries
 - Bruises, cuts, welts, fracture, pelvic pain, rectal trauma, urinary difficulties, STI or pregnancy
- Shows signs of physical and/or sexual abuse, physical restraint, confinement, or torture
 - Injuries do not match history provided
 - Has an unusually high number of sexual partners for his/her age
- Exhibits signs of prolonged/untreated illness or disease
- Branded with a tattoo of the adult/trafficker’s name on neck, chest, or arm
- Appears malnourished

INTERVENTIONS

- Address the medical needs of the child
- Contact social services to discuss concerns and determine need to contact Illinois DCFS and law enforcement
- Additional considerations to keep in mind:
 - Is the trafficker present (i.e., in the waiting room/outside)?
 - What will happen if the child does/does not return to the trafficker?
 - Does the child believe he/she or a family member is in danger?
 - Is the child an emancipated minor?

RECOGNIZING AND AIDING HUMAN TRAFFICKING VICTIMS^{25,26} (CONTINUED)

Human Trafficking Legislation Impact²⁷

- In August 2010, the Illinois Safe Children's Act was signed into law. This legislation provides police and prosecutors with the tools to aggressively tackle this crime. The Illinois Safe Children's Act made the following changes in the criminal code:
 - Provides for the transfer of jurisdiction over children who are arrested for prostitution from the criminal system to the child protection system, with special provisions to facilitate their placement in temporary protective custody if necessary.
 - Makes crimes that penalize the commercial sexual exploitation of children applicable to all minors under 18 as child victims, in conformity with Illinois' human trafficking law and federal law.
 - Removes references to "juvenile prostitutes" in the criminal code. This is in recognition of the fact that children have no capacity to consent to their own commercial sexual exploitation and, thus, are not prostitutes, but rather are victims of a serious sexual offense.
 - Protects minors by limiting the affirmative defense that pimps or traffickers "believed" that the prostituted child was at least 18 years old to only those pimps and traffickers who had no reasonable opportunity actually to see the victim (in accordance with federal law and constitutional requirements of due process).
- **Allegation #40/90 Human Trafficking of Children has been added to the Abused and Neglected Child Reporting Act (ANCRA) and incorporated into the Illinois DCFS Allegations system.**
- The National Human Trafficking Resource Center (NHTRC) has a Hotline at 1-888-373-7888 that operates 24/7 with access to 170 languages. The Hotline provides assistance with assessment questions.

INFORMATION ON THIS FORM IS CONFIDENTIAL AND INTENDED FOR QUALITY IMPROVEMENT PURPOSES ONLY

Illinois EMSC
CHILD ABUSE AND/OR NEGLECT
EMERGENCY DEPARTMENT QUALITY IMPROVEMENT MONITOR TOOL
Injury Screening in Children ≤ 5 Years

<i>Medical Record #:</i>	<i>Age:</i>	<i>Diagnosis:</i>
<i>Date of service:</i>	<i>Date of medical record review:</i>	

	Yes	No	NA	N/D	Reviewer's Comments
1. Head-to-toe physical exam completed?					
2. History consistent with documented injuries (per developmental stage of child)?					
3. History consistent with diagnostic findings?					
4. Histories consistent within ED (Triage, RN, MD)? (N/A can be entered if child seen by only one healthcare provider during ED visit (e.g., NP))					
5. Has there been a delay between injury and seeking medical care? (If Yes, please explain)					
6. Previous history of injuries? (e.g., documented in medical record and/or per retrospective visit review by medical record auditor)					
7. Is there evidence of bruising on non-bony prominence(s), face, head, and characteristic bruising of torso, ear or neck (per TEN-4 clinical decision rule)? ²⁸					
8. Did the injuries sustained require hospitalization or transfer of child?					
9. Was child screened for abuse and/or neglect?					
10. If screening was positive for suspicion of child abuse and/or neglect, was Illinois DCFS notified?					

Monitor follow-up/loop closure steps

- Was follow-up action needed? Yes_____ No_____

If YES, complete the following:

- Date/Action taken _____
- Date/Follow-up _____

INFORMATION ON THIS FORM IS CONFIDENTIAL AND INTENDED FOR QUALITY IMPROVEMENT PURPOSES ONLY

EMERGENCY DEPARTMENT QUALITY IMPROVEMENT MONITOR TOOL (CONTINUED)

Inclusion Criteria

- A. This retrospective medical record review may assist in identifying potential opportunities for improvement with pediatric management of suspected cases of child abuse and/or neglect in an emergency department (ED) setting.
- B. Review the patient's entire ED medical record to collect the necessary data (e.g., MD and RN notes)
- C. N = Maximum of 10 records of diagnosis/presenting complaint, per quarter.
- D. Sample population includes:
 - 1. Age: 1 day through less than or equal to 5 years of age
 - 2. Children who present with the following conditions should be assessed for potential abuse or neglect
 - a. Cutaneous injuries (e.g., patterned bruises or marks; bruises to face, head, ears, neck, torso, or other non-bony prominence(s); bruises on non-ambulatory child; bruises/lesions on multiple body parts; bites; lacerations; penetrating injuries)
 - b. Burns
 - c. Oral/facial injuries
 - d. Head trauma (e.g., intracranial hemorrhage; skull fracture; cerebral edema; retinal hemorrhage; loss of gray/white differentiation; subgaleal hematoma)
 - e. Musculoskeletal injury (any fracture in non-ambulatory child; any fracture poorly explained)
 - f. Visceral trauma
 - g. Genital/anal trauma
 - h. Poison ingestion
 - i. Failure to thrive
 - j. Old untreated or inappropriately treated injuries that the average non-medical person would have sought care for (e.g., burns, fractures, or wounds)
 - k. Lack of appropriate medical care based upon the need of the child
 - l. Malnourishment or concerns with growth/development

Answer the questions using the following acronyms (unless otherwise directed):

- a. Y = Yes/Present
- b. N = No/Not Present
- c. N/A = Not Applicable
- d. N/D = Not Documented/Unknown

EMERGENCY DEPARTMENT QUALITY IMPROVEMENT MONITOR TOOL (CONTINUED)

1. Head-to-toe physical exam completed to determine issues other than presenting injuries?
2. History consistent with documented injuries (per development stage of child)?
 - a. Yes is entered if medical record auditor determines that history is consistent or if ED MD/ED RN documents in medical record that history is consistent.
 - b. No is entered if history is not consistent with documented injuries
 - c. N/A is entered if undetermined
 - d. N/D is entered if medical record lacks documentation
3. History consistent with diagnostic findings?
 - a. Yes is entered if films, CT, or MRI results confirm consistent history
 - b. No is entered if history *not* consistent with diagnostic findings
 - c. N/A is entered if diagnostic tests are not ordered or patient transferred for CT
 - d. N/D is entered if medical record lacks documentation
4. Histories consistent within ED (e.g., Triage, RN, MD)?
 - a. Yes is entered if medical record auditor determines that history is consistent within the medical record or documentation found in the medical record stating that history is consistent
 - b. No is entered if medical record auditor determines that history is not consistent within the medical record or documentation found in the medical record stating that history is inconsistent
 - c. N/A is entered if child is only seen by one health care provider during ED visit (e.g., NP).
 - d. N/D is entered if medical record lacks documentation
5. Has there been a delay between injury and seeking medical care?
 - a. Yes is entered if a delay was documented in the medical record. Please comment further in the reviewer's section the cause of delay if known.
 - b. No is entered if the medical record auditor determines that there was not a delay
 - c. N/A is entered if undetermined
 - d. N/D is entered if medical record lacks documentation
6. Previous history of injuries?
 - a. Yes is entered if documented in medical record and/or per retrospective visit review by medical record auditor
 - b. No is entered if medical record auditor determines there was no previous history of injuries (either by documentation in medical record or per retrospective visit review)
 - c. N/A is entered if undetermined
 - d. N/D is entered if medical record lacks documentation

EMERGENCY DEPARTMENT QUALITY IMPROVEMENT MONITOR TOOL (CONTINUED)

7. Is there evidence of bruising on non-bony prominence(s), face, head and characteristic bruising of torso, ear or neck (per TEN-4** clinical decision rule)?
 - a. Yes is entered if documentation in medical record notes bruising on non-bony prominence(s), face, head, and characteristic bruising of torso, ear or neck per TEN-4** clinical decision rule.²⁸
 - b. No is entered if medical record auditor determines no evidence of bruising
 - c. N/A is entered if undetermined
 - d. N/D is entered if medical record lacks documentation

8. Did the injuries sustained require hospitalization or transfer?
 - a. Yes is entered if child was hospitalized or transferred
 - b. No is entered if child was dispositioned to home
 - c. N/A is entered if child was not discharged to home, transferred, or hospitalized
 - d. N/D is entered if medical record lacks documentation

9. Was the child screened for child abuse and/or neglect as documented in the medical record?
 - a. Yes is entered if documented in medical record (or if charting by exception is acceptable per hospital policy)
 - b. No is entered if medical record auditor determines child was not screened appropriately
 - c. N/A is entered if undetermined
 - d. N/D is entered if medical record lacks documentation

10. If screening was positive for suspicion of child abuse and/or neglect (from Q.9), was Illinois DCFS notified as documented in the medical record?
 - a. Yes is entered if documented in medical record
 - b. No is entered if medical record auditor determines DCFS was not notified appropriately
 - c. N/A is entered if undetermined
 - d. N/D is entered if medical record lacks documentation

**Characteristics predictive of abuse are bruising on the torso, ear, or neck for children less than or equal to 4 years of age, and bruising in any region for an infant less than 4 months of age.²⁸

**EMERGENCY DEPARTMENT**

09/12

Treatment Guideline: ED**Systematic Screening and Detection of Abuse-- Pediatric Patient**

Population: Pediatric patients age 0-15 years presenting to ED

Purpose: Systematically screening for child abuse in the ED increases the detection of suspected child abuse.

Population: Pediatrics age 0-15 years**Acute:**

Children who present with the following should be assessed for potential abuse or neglect

- Injury caused by a person the child is dependent on
- Injury resulting from neglect by caregivers
- Psychological harm resulting from actions of the person the child is dependent on
- Psychological harm resulting from failure of the person the child is dependent on
- Medical care being withheld
- Child that was witness of domestic violence
- Child that was witness of sexual acts
- Child that was victim of sexual acts

Children who present with the following conditions should be assessed for potential abuse or neglect

- Cutaneous injuries (e.g., patterned bruises/marks; bruises to face, head, ears/neck, torso, or other non-bony prominence(s); bruises on non-ambulatory child; bruises/lesions on multiple body parts; bites; lacerations; penetrating injuries)
- Burns
- Oral/facial injuries
- Head trauma (e.g., intracranial hemorrhage; skull fracture; cerebral edema; retinal hemorrhage; loss of gray/white differentiation; subgaleal hematoma)
- Musculoskeletal injury (any fracture in non-ambulatory child; any fracture poorly explained)
- Visceral trauma
- Genital/anal trauma
- Poison ingestion
- Failure to thrive
- Old untreated or inappropriately treated injuries that the average non-medical person would have sought care for (e.g., burns, fractures, or wounds)
- Lack of appropriate medical care based upon the need of the child
- Malnourishment or concerns for growth

Initial Assessment:

- Complete primary assessment and notify Primary Care RN of patient placement
- Complete secondary assessment including medications, allergies, pre-injury development level, and focused history for system of presenting complaint
- Identify mechanism of injury, structures involved, and/or physiology of illness

TREATMENT GUIDELINE: ED (CONTINUED)

Intervention:

- Ensure patent airway—suction and provide oxygen appropriate for patient age, condition, and history
- Control cervical spine as indicated by history
- Ensure safe normothermic environment-remove safety equipment as needed
- Access physician orders to complete appropriate treatment for complaint
- Obtain blood for additional lab studies
- Access medication orders from physician
- Monitor response to interventions and document changes
- Reorientation/reassurance appropriate for age of patient
- Complete **Checklist for Potential Child Abuse** (Appendix A)

Medical Director Signature: _____ **Date:** _____

REVIEWED: _____

DATE: _____

REVIEWED: _____

DATE: _____

REVIEWED: _____

DATE: _____

Used with permission and adapted from Passavant Area Hospital, Jacksonville, IL, March 2013

Hornor G. Medical evaluation for child physical abuse: what the PNP needs to know. *J Pediatr Health Care*. 2012;26(3):163-70.

Letson MM, Tscholl JJ. Bruises, burns, and other blemishes: diagnostic considerations of physical abuse. *Clinical Pediatric Emergency Medicine*. 2012;13(3):155-165.

Louwers EC, Korfage IJ, Affourtit MJ, et al. Effects of systematic screening and detection of child abuse in emergency departments. *Pediatrics*. 2012;130(3):457-64.

Pierce MC, Kaczor K, Aldridge S, O'Flynn J, Lorenz DJ. Bruising characteristics discriminating physical child abuse from accidental trauma. *Pediatrics*. 2010;125(1):67-74.

Pierce MC, Kaczor K, Lohr D, Richter K, Starling SP. A practical guide to differentiating abusive from accidental fractures: an injury plausibility approach. *Clinical Pediatric Emergency Medicine*. 2012;13(3):166-177.

Appendix A



DATE _____ TIME _____

CHECKLIST FOR POTENTIAL CHILD ABUSE

1. Is the history consistent with the injury or illness?
Yes _____ No _____
2. Was there unnecessary delay in seeking medical help?
Yes _____ No _____
3. Does the onset of the injury fit the developmental level of the child?
Yes _____ No _____
4. Is the behavior of the child/the caregivers and the interaction appropriate?
Yes _____ No _____
5. Are the findings of the head-to-toe examination in accordance with the history?
Yes _____ No _____
6. Are there any other signals* that make you doubt the safety of the child or the other family members?
Yes _____ No _____

*If "Yes," describe the signals in the "Other Comments" box below.

Other Comments: _____

Referral made _____ Law Enforcement _____ DCFS _____

RN Signature _____

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SAMPLE CHILD ABUSE AND NEGLECT SCREENING

The following are examples of screening questions and other prompts that may assist with early identification of suspected abuse or neglect, and could be incorporated into the electronic or paper medical record. They may also help when developing quality improvement monitors related to the child abuse and neglect process.

SCREENING QUESTIONS

- Do you feel safe at home and in your relationships?
- What happens at home (at school, at daycare) when people get angry?
- Has anyone ever touched you in a way you didn't like or threatened to hurt you?
- Have you ever been bullied or talked to in a way you didn't like?
- Does anyone try to keep you from having contact/seeing friends?

ASSESSMENT

- Delayed or failed recognition of need for medical care present?
- Injury does not fit history?
- Other unexplained injuries?
- Patient assessed for abuse, neglect and exploitation?
- Staff has reviewed electronic medical record for history of visits?
- Illinois DCFS/law enforcement and/or physician notified of suspicions?
- Social Worker contacted?

EXAMINATION

- Child has unexplained bruises/welts/burns/fractures/lacerations or scars?
 - Child was examined unclothed?
 - Child appears frightened or wary of parent/caregiver?
 - Exhibits very aggressive or withdrawn behavior?
 - Malnutrition/Failure to Thrive (FTT)?
 - Evidence of domestic violence?
 - Displays inappropriate sexual behavior for age?
 - Bruises/bleeding of perineum/genitalia/perianal area?
-

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DEVELOPMENTAL MILESTONES: BIRTH THROUGH 5 YEARS

Appreciating that all children grow and develop at different rates, there are common characteristics that most children share with identified milestones to help chart a child's progress. Understanding pediatric developmental milestones is particularly important in the prehospital and emergency settings. Recognizing suspicious findings, and children at risk, allows healthcare professionals to intervene promptly and appropriately. Additionally, the increased risk for abuse and/or neglect to a child with a developmental disability or delay may be overlooked without this fundamental understanding of child development.

When abuse or neglect is suspected, initiate the mandated reporting process according to your facility's Child Abuse and Neglect Policy and Procedure. For a child with a developmental delay who may be at higher risk of abuse/neglect, refer the parent/caregiver to the facility social worker (when applicable). A social worker has expert knowledge of services to help mitigate potential for abuse and/or neglect such as, parent education programs, parent support groups and other community resources.

The forms that follow on the next several pages review milestones by age as well as developmental concerns for children aged five and younger. They are useful tools for both healthcare professionals and parents/caregivers. The forms are available online at <http://www.cdc.gov/ncbddd/actearly/milestones/index.html>.

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Your Baby at 2 Months

Child's Name _____

Child's Age _____

Today's Date _____

How your child plays, learns, speaks, and acts offers important clues about your child's development. Developmental milestones are things most children can do by a certain age.

Check the milestones your child has reached by the end of 2 months. Take this with you and talk with your child's doctor at every visit about the milestones your child has reached and what to expect next.

What most babies do at this age:

Social/Emotional

- Begins to smile at people
- Can briefly calm himself
(may bring hands to mouth and suck on hand)
- Tries to look at parent

Language/Communication

- Coos, makes gurgling sounds
- Turns head toward sounds

Cognitive (learning, thinking, problem-solving)

- Pays attention to faces
- Begins to follow things with eyes and recognize people at a distance
- Begins to act bored (cries, fussy) if activity doesn't change

Movement/Physical Development

- Can hold head up and begins to push up when lying on tummy
- Makes smoother movements with arms and legs

Act early by talking to your child's doctor if your child:

- Doesn't respond to loud sounds
- Doesn't watch things as they move
- Doesn't smile at people
- Doesn't bring hands to mouth
- Can't hold head up when pushing up when on tummy

Tell your child's doctor or nurse if you notice any of these signs of possible developmental delay for this age, and talk with someone in your community who is familiar with services for young children in your area, such as your state's public early intervention program. For more information, go to www.cdc.gov/concerned or call 1-800-CDC-INFO.

Adapted from CARING FOR YOUR BABY AND YOUNG CHILD: BIRTH TO AGE 5, Fifth Edition, edited by Steven Shelov and Tanya Remer Altmann © 1991, 1993, 1998, 2004, 2009 by the American Academy of Pediatrics and BRIGHT FUTURES: GUIDELINES FOR HEALTH SUPERVISION OF INFANTS, CHILDREN, AND ADOLESCENTS, Third Edition, edited by Joseph Hagan, Jr., Judith S. Shaw, and Paula M. Duncan, 2008, Elk Grove Village, IL: American Academy of Pediatrics.

www.cdc.gov/actearly | 1-800-CDC-INFO



Learn the Signs. Act Early.

Your Baby at 4 Months

Child's Name _____

Child's Age _____

Today's Date _____

How your child plays, learns, speaks, and acts offers important clues about your child's development. Developmental milestones are things most children can do by a certain age.

Check the milestones your child has reached by the end of 4 months. Take this with you and talk with your child's doctor at every visit about the milestones your child has reached and what to expect next.

What most babies do at this age:

Social/Emotional

- Smiles spontaneously, especially at people
- Likes to play with people and might cry when playing stops
- Copies some movements and facial expressions, like smiling or frowning

Language/Communication

- Begins to babble
- Babbles with expression and copies sounds he hears
- Cries in different ways to show hunger, pain, or being tired

Cognitive (learning, thinking, problem-solving)

- Lets you know if she is happy or sad
- Responds to affection
- Reaches for toy with one hand
- Uses hands and eyes together, such as seeing a toy and reaching for it
- Follows moving things with eyes from side to side
- Watches faces closely
- Recognizes familiar people and things at a distance

Movement/Physical Development

- Holds head steady, unsupported
- Pushes down on legs when feet are on a hard surface
- May be able to roll over from tummy to back
- Can hold a toy and shake it and swing at dangling toys
- Brings hands to mouth
- When lying on stomach, pushes up to elbows

Act early by talking to your child's doctor if your child:

- Doesn't watch things as they move
- Doesn't smile at people
- Can't hold head steady
- Doesn't coo or make sounds
- Doesn't bring things to mouth
- Doesn't push down with legs when feet are placed on a hard surface
- Has trouble moving one or both eyes in all directions

Tell your child's doctor or nurse if you notice any of these signs of possible developmental delay for this age, and talk with someone in your community who is familiar with services for young children in your area, such as your state's public early intervention program. For more information, go to www.cdc.gov/concerned or call **1-800-CDC-INFO**.

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www.cdc.gov/actearly | 1-800-CDC-INFO



Learn the Signs. Act Early.

Your Baby at 6 Months

Child's Name _____

Child's Age _____

Today's Date _____

How your child plays, learns, speaks, and acts offers important clues about your child's development. Developmental milestones are things most children can do by a certain age.

Check the milestones your child has reached by the end of 6 months. Take this with you and talk with your child's doctor at every visit about the milestones your child has reached and what to expect next.

What most babies do at this age:

Social/Emotional

- Knows familiar faces and begins to know if someone is a stranger
- Likes to play with others, especially parents
- Responds to other people's emotions and often seems happy
- Likes to look at self in a mirror

Language/Communication

- Responds to sounds by making sounds
- Strings vowels together when babbling ("ah," "eh," "oh") and likes taking turns with parent while making sounds
- Responds to own name
- Makes sounds to show joy and displeasure
- Begins to say consonant sounds (jabbering with "m," "b")

Cognitive (learning, thinking, problem-solving)

- Looks around at things nearby
- Brings things to mouth
- Shows curiosity about things and tries to get things that are out of reach
- Begins to pass things from one hand to the other

Movement/Physical Development

- Rolls over in both directions (front to back, back to front)
- Begins to sit without support
- When standing, supports weight on legs and might bounce
- Rocks back and forth, sometimes crawling backward before moving forward

Act early by talking to your child's doctor if your child:

- Doesn't try to get things that are in reach
- Shows no affection for caregivers
- Doesn't respond to sounds around him
- Has difficulty getting things to mouth
- Doesn't make vowel sounds ("ah," "eh," "oh")
- Doesn't roll over in either direction
- Doesn't laugh or make squealing sounds
- Seems very stiff, with tight muscles
- Seems very floppy, like a rag doll

Tell your child's doctor or nurse if you notice any of these signs of possible developmental delay for this age, and talk with someone in your community who is familiar with services for young children in your area, such as your state's public early intervention program. For more information, go to www.cdc.gov/concerned or call 1-800-CDC-INFO.

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www.cdc.gov/actearly | 1-800-CDC-INFO



Learn the Signs. Act Early.

Your Baby at 9 Months

Child's Name _____

Child's Age _____

Today's Date _____

How your child plays, learns, speaks, and acts offers important clues about your child's development. Developmental milestones are things most children can do by a certain age.

Check the milestones your child has reached by the end of 9 months. Take this with you and talk with your child's doctor at every visit about the milestones your child has reached and what to expect next.

What most babies do at this age:

Social/Emotional

- May be afraid of strangers
- May be clingy with familiar adults
- Has favorite toys

Language/Communication

- Understands "no"
- Makes a lot of different sounds like "mamamama" and "bababababa"
- Copies sounds and gestures of others
- Uses fingers to point at things

Cognitive (learning, thinking, problem-solving)

- Watches the path of something as it falls
- Looks for things he sees you hide
- Plays peek-a-boo
- Puts things in her mouth
- Moves things smoothly from one hand to the other
- Picks up things like cereal o's between thumb and index finger

Movement/Physical Development

- Stands, holding on
- Can get into sitting position
- Sits without support
- Pulls to stand
- Crawls

Act early by talking to your child's doctor if your child:

- Doesn't bear weight on legs with support
- Doesn't sit with help
- Doesn't babble ("mama", "baba", "dada")
- Doesn't play any games involving back-and-forth play
- Doesn't respond to own name
- Doesn't seem to recognize familiar people
- Doesn't look where you point
- Doesn't transfer toys from one hand to the other

Tell your child's doctor or nurse if you notice any of these signs of possible developmental delay for this age, and talk with someone in your community who is familiar with services for young children in your area, such as your state's public early intervention program. For more information, go to www.cdc.gov/concerned or call 1-800-CDC-INFO.

The American Academy of Pediatrics recommends that children be screened for general development at the 9-month visit. Ask your child's doctor about your child's developmental screening.

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www.cdc.gov/actearly | 1-800-CDC-INFO



Learn the Signs. Act Early.

Your Child at 1 Year

Child's Name _____

Child's Age _____

Today's Date _____

How your child plays, learns, speaks, and acts offers important clues about your child's development. Developmental milestones are things most children can do by a certain age.

Check the milestones your child has reached by his or her 1st birthday. Take this with you and talk with your child's doctor at every visit about the milestones your child has reached and what to expect next.

What most children do at this age:

Social/Emotional

- Is shy or nervous with strangers
- Cries when mom or dad leaves
- Has favorite things and people
- Shows fear in some situations
- Hands you a book when he wants to hear a story
- Repeats sounds or actions to get attention
- Puts out arm or leg to help with dressing
- Plays games such as "peek-a-boo" and "pat-a-cake"

Language/Communication

- Responds to simple spoken requests
- Uses simple gestures, like shaking head "no" or waving "bye-bye"
- Makes sounds with changes in tone (sounds more like speech)
- Says "mama" and "dada" and exclamations like "uh-oh!"
- Tries to say words you say

Cognitive (learning, thinking, problem-solving)

- Explores things in different ways, like shaking, banging, throwing
- Finds hidden things easily
- Looks at the right picture or thing when it's named
- Copies gestures
- Starts to use things correctly; for example, drinks from a cup, brushes hair
- Bangs two things together
- Puts things in a container, takes things out of a container
- Lets things go without help
- Pokes with index (pointer) finger
- Follows simple directions like "pick up the toy"

Movement/Physical Development

- Gets to a sitting position without help
- Pulls up to stand, walks holding on to furniture ("cruising")
- May take a few steps without holding on
- May stand alone

Act early by talking to your child's doctor if your child:

- Doesn't crawl
- Can't stand when supported
- Doesn't search for things that she sees you hide.
- Doesn't say single words like "mama" or "dada"
- Doesn't learn gestures like waving or shaking head
- Doesn't point to things
- Loses skills he once had

Tell your child's doctor or nurse if you notice any of these signs of possible developmental delay for this age, and talk with someone in your community who is familiar with services for young children in your area, such as your state's public early intervention program. For more information, go to www.cdc.gov/concerned or call 1-800-CDC-INFO.

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www.cdc.gov/actearly | 1-800-CDC-INFO



Learn the Signs. Act Early.

Your Child at 18 Months (1½ Years)

Child's Name _____

Child's Age _____

Today's Date _____

How your child plays, learns, speaks, and acts offers important clues about your child's development. Developmental milestones are things most children can do by a certain age.

Check the milestones your child has reached by the end of 18 months. Take this with you and talk with your child's doctor at every visit about the milestones your child has reached and what to expect next.

What most children do at this age:

Social/Emotional

- Likes to hand things to others as play
- May have temper tantrums
- May be afraid of strangers
- Shows affection to familiar people
- Plays simple pretend, such as feeding a doll
- May cling to caregivers in new situations
- Points to show others something interesting
- Explores alone but with parent close by

Language/Communication

- Says several single words
- Says and shakes head "no"
- Points to show someone what he wants

Cognitive (learning, thinking, problem-solving)

- Knows what ordinary things are for; for example, telephone, brush, spoon
- Points to get the attention of others
- Shows interest in a doll or stuffed animal by pretending to feed
- Points to one body part
- Scribbles on his own
- Can follow 1-step verbal commands without any gestures; for example, sits when you say "sit down"

Movement/Physical Development

- Walks alone
- May walk up steps and run
- Pulls toys while walking

- Can help undress herself
- Drinks from a cup
- Eats with a spoon

Act early by talking to your child's doctor if your child:

- Doesn't point to show things to others
- Can't walk
- Doesn't know what familiar things are for
- Doesn't copy others
- Doesn't gain new words
- Doesn't have at least 6 words
- Doesn't notice or mind when a caregiver leaves or returns
- Loses skills he once had

Tell your child's doctor or nurse if you notice any of these signs of possible developmental delay for this age, and talk with someone in your community who is familiar with services for young children in your area, such as your state's public early intervention program. For more information, go to www.cdc.gov/concerned or call 1-800-CDC-INFO.

The American Academy of Pediatrics recommends that children be screened for general development and autism at the 18-month visit. Ask your child's doctor about your child's developmental screening.

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www.cdc.gov/actearly | 1-800-CDC-INFO



Learn the Signs. Act Early.

Your Child at 2 Years

Child's Name _____

Child's Age _____

Today's Date _____

How your child plays, learns, speaks, and acts offers important clues about your child's development. Developmental milestones are things most children can do by a certain age.

Check the milestones your child has reached by his or her 2nd birthday. Take this with you and talk with your child's doctor at every visit about the milestones your child has reached and what to expect next.

What most children do at this age:

Social/Emotional

- Copies others, especially adults and older children
- Gets excited when with other children
- Shows more and more independence
- Shows defiant behavior (doing what he has been told not to)
- Plays mainly beside other children, but is beginning to include other children, such as in chase games

Language/Communication

- Points to things or pictures when they are named
- Knows names of familiar people and body parts
- Says sentences with 2 to 4 words
- Follows simple instructions
- Repeats words overheard in conversation
- Points to things in a book

Cognitive (learning, thinking, problem-solving)

- Finds things even when hidden under two or three covers
- Begins to sort shapes and colors
- Completes sentences and rhymes in familiar books
- Plays simple make-believe games
- Builds towers of 4 or more blocks
- Might use one hand more than the other
- Follows two-step instructions such as "Pick up your shoes and put them in the closet."
- Names items in a picture book such as a cat, bird, or dog

Movement/Physical Development

- Stands on tiptoe
- Kicks a ball

- Begins to run
- Climbs onto and down from furniture without help
- Walks up and down stairs holding on
- Throws ball overhand
- Makes or copies straight lines and circles

Act early by talking to your child's doctor if your child:

- Doesn't use 2-word phrases (for example, "drink milk")
- Doesn't know what to do with common things, like a brush, phone, fork, spoon
- Doesn't copy actions and words
- Doesn't follow simple instructions
- Doesn't walk steadily
- Loses skills she once had

Tell your child's doctor or nurse if you notice any of these signs of possible developmental delay for this age, and talk with someone in your community who is familiar with services for young children in your area, such as your state's public early intervention program. For more information, go to www.cdc.gov/concerned or call 1-800-CDC-INFO.

The American Academy of Pediatrics recommends that children be screened for general development and autism at the 24-month visit. Ask your child's doctor about your child's developmental screening.

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www.cdc.gov/actearly | 1-800-CDC-INFO



Learn the Signs. Act Early.

Your Child at 3 Years

Child's Name _____

Child's Age _____

Today's Date _____

How your child plays, learns, speaks, and acts offers important clues about your child's development. Developmental milestones are things most children can do by a certain age.

Check the milestones your child has reached by his or her 3rd birthday. Take this with you and talk with your child's doctor at every visit about the milestones your child has reached and what to expect next.

What most children do at this age:

Social/Emotional

- Copies adults and friends
- Shows affection for friends without prompting
- Takes turns in games
- Shows concern for a crying friend
- Understands the idea of "mine" and "his" or "hers"
- Shows a wide range of emotions
- Separates easily from mom and dad
- May get upset with major changes in routine
- Dresses and undresses self

Language/Communication

- Follows instructions with 2 or 3 steps
- Can name most familiar things
- Understands words like "in," "on," and "under"
- Says first name, age, and sex
- Names a friend
- Says words like "I," "me," "we," and "you" and some plurals (cars, dogs, cats)
- Talks well enough for strangers to understand most of the time
- Carries on a conversation using 2 to 3 sentences

Cognitive (learning, thinking, problem-solving)

- Can work toys with buttons, levers, and moving parts
- Plays make-believe with dolls, animals, and people
- Does puzzles with 3 or 4 pieces
- Understands what "two" means
- Copies a circle with pencil or crayon
- Turns book pages one at a time
- Builds towers of more than 6 blocks
- Screws and unscrews jar lids or turns door handle

Movement/Physical Development

- Climbs well
- Runs easily
- Pedals a tricycle (3-wheel bike)
- Walks up and down stairs, one foot on each step

Act early by talking to your child's doctor if your child:

- Falls down a lot or has trouble with stairs
- Drools or has very unclear speech
- Can't work simple toys (such as peg boards, simple puzzles, turning handle)
- Doesn't speak in sentences
- Doesn't understand simple instructions
- Doesn't play pretend or make-believe
- Doesn't want to play with other children or with toys
- Doesn't make eye contact
- Loses skills he once had

Tell your child's doctor or nurse if you notice any of these signs of possible developmental delay for this age, and talk with someone in your community who is familiar with services for young children in your area, such as your local public school. For more information, go to www.cdc.gov/concerned or call **1-800-CDC-INFO**.

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www.cdc.gov/actearly | 1-800-CDC-INFO



Learn the Signs. Act Early.

Your Child at 4 Years

Child's Name _____

Child's Age _____

Today's Date _____

How your child plays, learns, speaks, and acts offers important clues about your child's development. Developmental milestones are things most children can do by a certain age.

Check the milestones your child has reached by his or her 4th birthday. Take this with you and talk with your child's doctor at every visit about the milestones your child has reached and what to expect next.

What most children do at this age:

Social/Emotional

- Enjoys doing new things
- Plays "Mom" and "Dad"
- Is more and more creative with make-believe play
- Would rather play with other children than by himself
- Cooperates with other children
- Often can't tell what's real and what's make-believe
- Talks about what she likes and what she is interested in

Language/Communication

- Knows some basic rules of grammar, such as correctly using "he" and "she"
- Sings a song or says a poem from memory such as the "Itsy Bitsy Spider" or the "Wheels on the Bus"
- Tells stories
- Can say first and last name

Cognitive (learning, thinking, problem-solving)

- Names some colors and some numbers
- Understands the idea of counting
- Starts to understand time
- Remembers parts of a story
- Understands the idea of "same" and "different"
- Draws a person with 2 to 4 body parts
- Uses scissors
- Starts to copy some capital letters
- Names four colors
- Plays board or card games
- Tells you what he thinks is going to happen next in a book

Movement/Physical Development

- Hops and stands on one foot up to 2 seconds
- Catches a bounced ball most of the time
- Pours, cuts with supervision, and mashes own food

Act early by talking to your child's doctor if your child:

- Can't jump in place
- Has trouble scribbling
- Shows no interest in interactive games or make-believe
- Ignores other children or doesn't respond to people outside the family
- Resists dressing, sleeping, and using the toilet
- Can't retell a favorite story
- Doesn't follow 3-part commands
- Doesn't understand "same" and "different"
- Doesn't use "me" and "you" correctly
- Speaks unclearly
- Loses skills he once had

Tell your child's doctor or nurse if you notice any of these signs of possible developmental delay for this age, and talk with someone in your community who is familiar with services for young children in your area, such as your local public school. For more information, go to www.cdc.gov/concerned or call 1-800-CDC-INFO.

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www.cdc.gov/actearly | 1-800-CDC-INFO



Learn the Signs. Act Early.

Your Child at 5 Years

Child's Name _____

Child's Age _____

Today's Date _____

How your child plays, learns, speaks, and acts offers important clues about your child's development. Developmental milestones are things most children can do by a certain age.

Check the milestones your child has reached by his or her 5th birthday. Take this with you and talk with your child's doctor at every visit about the milestones your child has reached and what to expect next.

What most children do at this age:

Social/Emotional

- Wants to please friends
- Wants to be like friends
- More likely to agree with rules
- Likes to sing, dance, and act
- Is aware of gender
- Can tell what's real and what's make-believe
- Shows more independence (for example, may visit a next-door neighbor by himself [adult supervision is still needed])
- Is sometimes demanding and sometimes very cooperative

Language/Communication

- Speaks very clearly
- Tells a simple story using full sentences
- Uses future tense; for example, "Grandma will be here."
- Says name and address

Cognitive (learning, thinking, problem-solving)

- Counts 10 or more things
- Can draw a person with at least 6 body parts
- Can print some letters or numbers
- Copies a triangle and other geometric shapes
- Knows about things used every day, like money and food

Movement/Physical Development

- Stands on one foot for 10 seconds or longer
- Hops; may be able to skip
- Can do a somersault
- Uses a fork and spoon and sometimes a table knife
- Can use the toilet on her own
- Swings and climbs

Act early by talking to your child's doctor if your child:

- Doesn't show a wide range of emotions
- Shows extreme behavior (unusually fearful, aggressive, shy or sad)
- Unusually withdrawn and not active
- Is easily distracted, has trouble focusing on one activity for more than 5 minutes
- Doesn't respond to people, or responds only superficially
- Can't tell what's real and what's make-believe
- Doesn't play a variety of games and activities
- Can't give first and last name
- Doesn't use plurals or past tense properly
- Doesn't talk about daily activities or experiences
- Doesn't draw pictures
- Can't brush teeth, wash and dry hands, or get undressed without help
- Loses skills he once had

Tell your child's doctor or nurse if you notice any of these signs of possible developmental delay for this age, and talk with someone in your community who is familiar with services for young children in your area, such as your local public school. For more information, go to www.cdc.gov/concerned or call 1-800-CDC-INFO.

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Learn the Signs. Act Early.

References

1. Sedlak A, Mettenburg J, Basena M, et al. Fourth National Incidence Study of Child Abuse and Neglect (NIS-4): Report to Congress. Washington, DC: U.S. Department of Health and Human Services, Administration for Children and Families. (2010). Available at: http://www.acf.hhs.gov/programs/opre/abuse_neglect/natl_incid/index.html Accessed June 25, 2010.
2. U.S. Department of Health and Human Services, Administration for Children and Families, Administration on Children, Youth and Families, Children's Bureau. Child Maltreatment 2008. (2010). Available at: http://www.acf.hhs.gov/programs/cb/stats_research/index.htm#can Accessed June 25, 2010.
3. A nation's shame. Fatal child abuse and neglect in the United States. Fifth Report, U.S. Advisory Board on Child Abuse and Neglect. April 1995;XXIII-XXXVI:7-18.
4. U.S. Department of Health and Human Services, Administration for Children and Families, Administration on Children, Youth and Families, Children's Bureau. (2012). Child Maltreatment 2011. Available at <http://www.acf.hhs.gov/programs/cb/research-data-technology/statistics-research/child-maltreatment> Accessed February 1, 2013.
5. Illinois Department of Children and Family Services. Child abuse and neglect statistics fiscal year 2011 . Available at <http://www.state.il.us/DCFS/docs/CANTS2011.pdf> Accessed February 1, 2013.
6. Gelles, Richard J., & Perlman, Staci (2012). Estimated Annual Cost of Child Abuse and Neglect. Chicago IL: Prevent Child Abuse America. Available at [www.preventchildabusenc.org/assets/preventchildabusenc/files/\\$cms\\$/100/1299.pdf](http://www.preventchildabusenc.org/assets/preventchildabusenc/files/cms/100/1299.pdf) Accessed April 26, 2013.
7. Kunen S, Hume P, et al. Underdiagnosis of child abuse in emergency departments. *Acad Emerg Med*. 2003;10(5):546-a.
8. Jenny C, Hymel KP, Ritzen A, et al. Analysis of missed cases of abusive head trauma. *JAMA*. 1999;281:621-626.
9. Worlock P, Stower M, Barbor P. Patterns of fractures in accidental and nonaccidental injury in children: a comparative study. *Br Med J*. 1986;293:100-102.
10. O'Neill Jr JA, Meacham WF, Griffin PP, et al. Patterns of injury in the battered child syndrome. *J Trauma*. 1973;13:332.
11. King J, Kiefendorf D, Apthorp J, et al. Analysis of 429 fractures in 1289 battered children. *J Pediatr Orthop*. 1988;8:585-589.
12. Rivara FP, Kamitsuka MD, Quan L. Injuries to children younger than 1 year of age. *Pediatrics*. 1988;81:93-97.
13. King WK, Kiesel EL, Simon HK. Child abuse fatalities: are we missing opportunities for intervention? *Pediatr Emerg Care*. 2006;22(4):211-214.
14. Saade DN, Simon HK, et al. Abused children: missed opportunities for recognition in the ED. *Acad Emerg Med*. 2002;9(5):524.
15. Manual for Mandated Reporters. DCFS Children's Justice Task Force, September, 2012 Revised Edition. Available at: <http://www.state.il.us/DCFS/docs/CFS%201050-21%20Mandated%20Reporter%20Manual.pdf> Accessed December 21, 2012.
16. State Operations Manual. Appendix A 482.13(c)(3). Available at: http://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/downloads/som107ap_a_hospitals.pdf Accessed January 10, 2013.

17. Joint Committee on Administrative Rules Administrative Code Section 250.750. Available at: <http://ilga.gov/commission/jcar/admincode/077/077002500G07500R.html> Accessed March 5, 2013.
18. Joint Committee on Administrative Rules Administrative Code Section 250.260. Available at: <http://ilga.gov/commission/jcar/admincode/077/077002500B02600R.html> Accessed March 5, 2013.
19. Joint Committee on Administrative Rules Administrative Code Section 515.4000. Available at: <http://www.ilga.gov/commission/jcar/admincode/077/077005150J40000R.html> Accessed January 11, 2013.
20. Joint Committee on Administrative Rules Administrative Code Section 515.4010. Available at: <http://www.ilga.gov/commission/jcar/admincode/077/077005150J40100R.html> Accessed January 11, 2013.
21. Joint Committee on Administrative Rules Administrative Code Section 515.4020. Available at: <http://www.ilga.gov/commission/jcar/admincode/077/077005150J40200R.html> Accessed January 11, 2013.
22. Joint Committee on Administrative Rules Administrative Code Section 515.Appendix D. Available at: <http://ilga.gov/commission/jcar/admincode/077/07700515ZZ9996dR.html> Accessed March 5, 2013.
23. Joint Committee on Administrative Rules Administrative Code Section 545.60. Available at: <http://www.ilga.gov/commission/jcar/admincode/077/077005450000600R.html> Accessed March 20, 2013.
24. ICD10 Data.com Available at: <http://www.icd10data.com/> Accessed April 26, 2013.
25. National Human Trafficking Resource Center. Polaris Project Assessment Tools. Available at <http://www.polarisproject.org/resources/tools-for-service-providers-and-law-enforcement> Accessed January 4, 2013.
26. Victims of Trafficking and Violence Protection Act of 2000. U.S. Department of State. Available at: <http://www.state.gov/j/tip/laws/61124.htm> Accessed January 4, 2013.
27. Cook County State's Attorney Office. Available at: http://www.statesattorney.org/index2/press_safechildrensact01.html Accessed December 21, 2012.
28. Pierce M, Kaczor K, Aldridge S, O'Flynn J, Lorenz D. Bruising characteristics discriminating physical child abuse from accidental trauma. *Pediatrics*. 2010;125(1):65-74.

Child Maltreatment Weblinks

Child Abuse Evaluation & Treatment for Medical Providers

Author: Ann S. Botash, MD, Professor of Pediatrics at the State University of New York Upstate Medical University

Child Abuse Evaluation & Treatment for Medical Providers provides a single, comprehensive source of child abuse information that offers tools and resources with which to diagnose and manage child and adolescent abuse victims. It is a resource for medical providers who do not have a background or expertise in child abuse pediatrics and are striving to develop best practice standards for their patient care setting.

Link: <http://www.childabusemd.com/index.shtml>

Author: Children's Advocacy Centers of Illinois

This website describes the services available and supported by Children's Advocacy Centers of Illinois (CACI). CACI is dedicated to the multidisciplinary, child advocacy approach and a coordinated, comprehensive response to child abuse. These centers are located throughout the state.

Link: <http://www.childrensadvocacycentersofillinois.org/website/>

Author: Stanford Medical Sites

This website is intended to assist affiliated healthcare personnel of Stanford University Medical Center with questions about recognition and management of suspected child abuse.

Link 1: <http://childabuse.stanford.edu> (home page)

Link 2: <http://childabuse.stanford.edu/screening/signs.html> (signs & symptoms)

Child Maltreatment Presentations

Author: University of New Mexico, Department of Emergency Medicine.

This is an on-line Child Abuse Shaken Baby Syndrome Module for EMS and ED providers which is part of the EMS Pediatric CE course directory.

Link: <http://hsc.unm.edu/emersed/ped/emsc/training/course.shtml>

Evaluation of Suspected Child Abuse and Neglect AAP Committee on Child Abuse and Neglect

Author: Various

This site links to the AAP Committee on Child Abuse and Neglect articles from 2000 to the present. This includes articles on child abuse recognition, evaluation and treatment. Maltreatment prevention is also reviewed.

Link: <http://pediatrics.aappublications.org/site/aappolicy/index.xhtml>

Recognizing and Reporting Child Abuse: Training for Mandated Reporters

Author: Child Welfare Information Gateway

This Web site connects child welfare and related professionals to comprehensive information and training resources to help protect children and strengthen families. It features the latest on topics from prevention to permanency, including child abuse and neglect.

Link: <https://www.childwelfare.gov/>

Authors: [Illinois DCFS](#), [Chicago Children's Advocacy Center](#), [Cook County State's Attorney's Office](#), [Chicago Board of Education](#)

Everyone who suspects child abuse or neglect should call the Illinois Department of Children and Family Services Child Abuse Hotline to make a report, but Mandated Reporters are required by law to do so. The purpose of this online course is to help all Illinois Mandated Reporters understand their critical role in protecting children by recognizing and reporting child abuse.

Link: <https://www.dcfstraining.org/manrep/index.jsp>