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EDUCATIONAL RESOURCES

The Case of Child Abuse and Neglect: Identification of Non-accidental Injuries by Medical Professionals at the Emergency and Trauma Department

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Abstract

It is well established that accidental and non-accidental injuries/child abuse and neglect (CAN) are a major public health problem globally. Not only do they affect individuals, injuries affect families, the community, government and internationally as well. Injuries span throughout childhood and into adulthood. Purpose of this study is to identify what are the difficulties and challenges in identifying and reporting CAN cases at the emergency (ED) department in Malaysian hospitals. Thirty in-depth interviews were conducted at the ED in three major hospitals in the Klang Valley, Malaysia which consists of specialists, medical officers, nurses and medical assistants. The study found that there is a significant gap identified in medical professionals' knowledge and skills related to understanding, identifying and detecting CAN, particularly among medical officers who are in charge of diagnosis and reports in the hospital. Those who had previous experience or encounters in dealing with CAN cases would have higher suspicion index compared to those who haven't. Other medical professionals such as nurses and medical assistants although do not have the mandate to diagnose or report of CAN cases, needed to have the basic knowledge and awareness and play more active role in their respective settings.

Keywords: Child abuse and neglect, non-accidental injuries, childhood injuries, qualitative research

Introduction

According to the World Health Organisation and UNICEF's World Report on Child Injury Prevention (Peden, 2008), while communicable diseases are still the primary killer of infants, injuries contribute significant proportions of deaths for children aged between 5 and 14 years (27%) and adolescents/young adults aged 15-29 years (40%). More specifically, drowning and road traffic injuries were reported to be the top ten causes of death amongst children within the ages of 1 to 14 years old, and for those aged between 15 and 19 years old, road traffic injuries was the number one cause of death in the year 2004. Each year, injury and violence kills up to 950,000 children under 16 years of age and millions more suffer long-term consequences of non-fatal injuries. (Roach, 2001) And about 60% of road traffic injury deaths occur in the South East Asian and Western Pacific Regions. (UNICEF, 2008) Again, to further demonstrate the importance and significance of the burden of injuries to children, everyday over 2,000 children die as a result of an injury worldwide, and many more sustain severe injury outcomes (Peden, 2008).

Specific objectives of this research is to determine the current indicators used by medical staff to identify intent of child injury and the processes that are undertaken once potential child neglect, maltreatment or abuse is identified (i.e. police report, department of social and welfare, etc.).

Methods

Participants were recruited from three major hospitals in the Klang Valley (Selayang Hospital, Serdang Hospital and Sg Buloh Hospital) and included ED specialists, paediatricians, medical officers, nurses and medical assistants using purposive sampling. Participants were invited to participate and recruited specifically if they worked directly with children presenting at the hospital (mainly at the Emergency Department and Paediatric Department).

A total of 30 participants were recruited and interviewed from all three hospitals. Houseman was excluded from the study as they are considered to be trainee and would not have enough experience, knowledge and skills within the area of pediatric injuries (identification of accidental and non-accidental injuries); medical officers, nurses and medical assistants who have less than 3 years of experience working at the Emergency and Trauma Department were also excluded. The number of healthcare professionals interviewed and years of service are shown in Table 1.

Table 1. Frequencies and percentages for demographic characteristics of participants

Variable		N=30	%
Gender			
	Male	12	40.00
	Female	18	60.00
Ethnicity			
	Malay	25	83.30
	Chinese	2	6.70
	Indian	3	10.00
Position			
	Specialist	5	16.67
	Medical Officer	11	36.67
	Nurse	10	33.33
	Medical Assistant	4	13.33
Years in service			
	0 -5 years	12	40.00
	6 – 10 years	12	40.00
	11 – 15 years	5	16.67
	16 – 20 years	1	3.33

A higher proportion of females (60%) compared with males (40%) were interviewed, and a range of experience levels were shown amongst the sample. In general, there was a high level of experience with participants working around 8 years on average. Only two participants had worked for a minimum of two years and one for twenty years.

Result

Based on the I-change model of behaviour and suggested coding for NVivo analysis, several themes

emerged. Under the first major theme on Determinants of Awareness of Healthcare Professionals, four key themes were identified. First main key theme of “Actual action triggers”, several subthemes such as “Signs of child abuse” and “Sources of signs for abuse” emerged. The second key theme of “Knowledge”, several subthemes such as “Defining child abuse”, “Inadequate training and availability” and “Content of training” emerged. Third key theme is “Risk Perception” and the last key theme is “Awareness of detection tools”.

The second major theme is on Determinants of Motivation of Healthcare Professionals, two key themes were identified. The first main key theme of “Attitude”, several subthemes such as “Responsibility” and “Negative aspects” emerged. The second key theme of “Social influences”, several subthemes such as “Internal support system”, “External support system” and “Lack of support” emerged.

The third and final major theme is on Determinants of Action of Healthcare Professionals, three key themes were identified. First main key theme of “Performance Skills” the subtheme of “Lack of commitment” emerged. The second main key theme of “Dealing with child abuse cases”, two subthemes emerged such as “Action plans” and “Barriers” emerged.

Major theme 1: Determinants of awareness of healthcare professional

Key theme 1: Trigger for actions

Participants were asked questions to find out how they go about determining whether a child is suspected of being abused or not when the child presented himself/herself at the ED (whether at first triage, second triage or in the consultation room). Subthemes emerged from these questions are discussed in detailed below.

Subtheme 1: Signs of abuse

Most medical officers, nurses and medical assistants in this study reported that they depend on the physical signs to detect abuse. There is neither detection nor screening tools that is currently being used in any of the hospital to detect child abuse in the emergency settings. Most medical officers claimed that the most reliable signs of abuse that they looked for in a child who came with injuries are the inconsistency between the history and the physical signs. One medical officer noted:

“If it’s a physical abuse, uhhh...well, we’ll talk about history first. History, there will be probably inconsistencies, and then there will be changes in the history as well, delayed in coming to seek treatment.”

This statement was supported by another staff nurse,

“When the baby was brought in, she couldn’t lift her arm. From her hand to her feet, I can’t remember. And then when we did the X-ray, we found a fracture, it shows that it’s broken, it does not corroborate to what the parents had told us.”

In addition, participants indicated that they looked at the presentation of the injuries itself, for example an atypical fracture such as spiral type of fracture, or an atypical place for abrasion such as at the posterior triangle of the neck or the inner thighs which usually happens when a child is being sodomized, or even specific pattern of injuries such as a buckle-mark, a cigarette mark, or a pinch mark were noted as ‘red flags’ for abuse. Signs that showed intracranial bleed were also considered a ‘red flag’ for abuse such as sudden seizures in a previously healthy child and an upper neurological sign such as hypertonia.

In terms of neglect, one nurse mentioned a case that caught her eye,

“But when I looked at the hygiene of the child, she looked really dirty, she was like..maybe had not had a shower for a long time maybe, like dirty, a lot of dirt, like...she had a lot of scabies..I

feel like the child is not being taken care properly.”

The staff nurse focused on the hygiene aspect of a child in order to detect neglect in the child. It should be noted that severe presentation of unhygienic features and severe malnutrition is usually picked up as a sign of neglect. Another medical officer added that immunization record and the state of nutrition of the child can also be used to detect neglect.

In terms of psychological and emotional abuse, a nurse recalled one of the cases that she encountered, *“And when the mother came to pick up the child, the child did not want to go with her. The child only wanted the father. So something is wrong there.”*

The act of refusal that one child showed to his or her perpetrator is considered as an important indicator of child abuse as noted by many of healthcare workers that were interviewed. Only a few participants highlighted the fact that abuse can be psychological, neglect or emotional. In contrast, a high proportion of participants emphasised more on physical type of abuse, which typically can be seen visibly on a child upon presentation at the Emergency and Trauma Department.

Subtheme 2: Sources of signs of abuse

Although most of the healthcare workers did not mention the importance of source of signs of abuse, most of them noted that the people who brought the child to the hospital was an indicator as sources who would bring the child in for an examination due to their suspect that the child had been abused. For example, a teacher, a parent or a police officer who came to the emergency department with a child. One example was taken from the experience of one of the nurses, *“The teacher will make a report. The student didn’t come to school for 3 days, and when the student came, he/she was wearing worn out clothes, slow in learning and with other types of injuries. The teacher suspected the child was abused by his/her parents. The teacher or the police took the child in, the police did.”*

This signified the important role of teachers and authorities in recognizing child abuse in the community. One specialist stated that unless anyone close to the child such as their teachers, their neighbours, or their relatives played their part in reporting child abuse cases, these kinds of cases would continue to be underreported and undetected at the clinical setting.

But sometimes when there is conflict between both parents (such as fighting for child custody), they tend to manipulate the system to accuse the other party as perpetrator in order to take full custody of the child. This complicates the case even more as the parent request for clinical examination to be done by the medical officer so that based on the clinical report they can make a police report. This was mentioned by one of the specialist during the interview, *“There was one case, parents are divorced, the father accuses the mother of neglecting the children. Always leaving the children at the babysitter, and only came back late at night. This is because of child custody battle of the children. This case is currently under DSW, so still under investigation. The mother of the children instead accuses the father of abusing the children. Both are very educated, mother a teacher, father a doctor.”*

Therefore, sources of sign abuse can still be assessed depending on case by case nature to determine the intent of the person bringing the child in for clinical examination.

Key theme 2: Knowledge

Participants were posed several questions regarding their understanding on what can be define as child abuse in their own words as they did not need to provide a full textbook definition of child abuse. Regardless, most of them struggled to provide a full definition of child abuse and resorted to examples of child abuse instead as shown in subthemes discussion below. As such their understanding of child

abuse affect their capability in identifying children who are potentially at risk of being abused which are discussed further in the subthemes below.

Subtheme 1: Defining child abuse

Most healthcare workers were well-informed about the definition of child abuse and some were aware on the different types of child abuse such as physical abuse (bruises, fractures, etc.) mental abuse (change in attitude, verbally abused, etc.), and neglect (malnourished, unhygienic etc.). One doctor mentioned that any harm that came to a child with intention was a form of child abuse, *“For me child abuse...I’d say it can be...it is actually an intentional act of intention to harm the child. That is, including negligence also”*

But most participants would define child abuse more frequently as physical abuse as oppose to other types of abuse that are not visible,

“Child abuse...uhmm...you can divide into two whether the mentally or the physically abused. The physically abused sometimes we can see the signs and symptoms quite clear. If he’s not brought by the one who abused them. If brought by other relatives. But mentally abused is a bit challenging because history taking is a bit difficult.”

However, some of the participants found it hard to separate the physical abuse and neglect completely.

One medical officer exemplified this in one of the interviews,

“There’s a very thin line when talking about is it a true abuse, and a true neglect. Say, a child who sustained, you know some huge bruise on the cheek or on the forehead. Because this child is now 9 months old, knows to roll over and was put on a sofa. Mom just turned her back momentarily and the child fell. It’s a form of neglect too.”

A high proportion of participants claimed to know variety types of abuses other than the physical ones but many decided that they needed more training in order to discover the signs of these abuses when it was time to face these types of cases in the hospital. Some are concerned that they might be misdiagnosing a child as being neglect if based on appearance and malnutrition. As explained by one specialist,

“If the child comes in looking a bit malnourished and not wearing clean clothes while the parent is very presentable, can you simply diagnose the child as being neglect? The parent would become defensive and decided to take the child out without being treatment. How severe the neglect that you can diagnose it as an abuse?”

The difficult decision to diagnose neglect has been an issue even for those who have been dealing with abuse cases for such a long time. It is not surprising that many new junior medical officers are often not able to make the call, hence, would refer to their supervisors for guidance. Child abuse cases were not commonly found in the hospitals where this research was conducted. Some said that in a month maybe around 5% of children came with injuries consistent with abuse. Therefore, even though these healthcare workers knew the text-book signs of child abuse, many did not have enough experience when it comes to recognizing the signs, especially the non-physical signs.

Some of the participants noted that emotional and psychological abuse were often subtle and could be missed easily by the healthcare workers. Therefore, they demanded that more awareness needed to be created so that the probability of missed cases could be lowered. One medical doctor mentioned this in one of the interviews,

“But when it comes to those who don’t have physical signs, such as the emotionally abused, the neglected ones, uhmm I would really want to know more about it. Because, this is that...when we say that the adults are neglecting them, we as clinicians also fail them, because the symptoms and signs are very subtle. Unless you have the awareness, you can pick them up.”

Many healthcare workers also based their action on their own intuition and their own experience in dealing with child abuse cases instead of consistent training. One medical officer noted, *“Even sometimes there’s no signs, no obvious signs of child abuse but based on suspicions we can categorize...or we can already have the....lodge a report towards...I mean, against child abuse, for child abuse.”*

This could be problematic especially to the junior participants and junior nurses who were not experienced enough in recognizing signs of neglect or abuse. This is where the role of training should come into place where the junior workers could be educated on picking up signs of neglect or abuse so that in the future, even the junior medical professionals can report a case to the police.

Subtheme 2: Inadequate training and availability of training

While some training sessions were made available in these hospitals, most of the healthcare workers needed to wait for their turn to participate in such events. The frequency of such training was also inadequate to accommodate the increasing number of healthcare professionals that are new within the department. This problem was highlighted by one of the participants, *“There’s a training, but it’s a rotational basis, that they will pick uhh...during this time, they will pick three people at most first.”*

The reason that this kind of situation occurred was explained by one of the specialist interviewed,

“The Ministry of Health, I would say, honestly, cannot provide enough funding to send everyone for the good courses, you know, so a lot of times, again, if you are selected, if you’re lucky, then you get to go, if not, you have to sacrifice you own money to go for it.”

This would setback participants up to thousands of ringgits as some of the most comprehensive courses/trainings in child protection are only available overseas. Apart from lack of funding, other reasons of not going to training was given such as not having enough human resources in their department to take charge in their absence, and also not having an available place in the training course.

For those who are interested in understanding more about child protection, or recognizing signs of child abuse in the clinical setting, they opt for self-directed learning where they would find their own sources of information either through medical textbooks or online journals. Again, this depends on their own initiative to find the appropriate materials to enhance their knowledge and skills. If not, they will only learn through hands on experience from the clinical setting or through direct teaching and supervision by their superior. This could be an advantage or disadvantage because it depends on how much transfer of knowledge had transpired within the setting, some might gain more while others not so much. Consequently, it creates a knowledge gap amongst healthcare professionals.

Subtheme 3: Content of training

According to the professional healthcare workers interviewed, the content of the current training included basic introduction on child abuse (definition, signs and symptoms), the procedure needed to be done in dealing with child abuse, the policies, and so on.

As stated above, paramedics (staff nurses and medical assistants) are in charge of supporting and assisting medical officers in handling child abuse cases. They are also in charge of collecting evidence for processing and to produce in court and to the police. Hence, most training for these paramedics are only limited to understanding procedures in collecting and processing specimens for the purpose of producing evidence in court, if the child abuse case would proceed to the court.

Key theme 3: Risk perception

There were also issues where the healthcare workers were not sure where to draw the line when it

came to distinguishing between an abuse and an accident. One of the participants mentioned that an intracranial bleeding injury did not necessarily mean that the child had been abused. It could be an accident whereby the caretaker might accidentally shook the baby in order to make him or her to sleep but instead, due to lack of experience and knowledge of a proper childcare, causes the baby to suffer intracranial bleeding from the shaking.

These findings suggest there is a real lack of awareness within hospitals as to what defines neglect and abuse, and confirms there is a definite grey area that needs to be addressed so that all findings of child neglect and abuse can be defined, standardized and identified.

Another issue that was discovered was the appropriate time when to act when it comes to abuses other than the physical ones, especially neglect. One medical officer noted, *“There are a few cases like [clears throat] where we take a full history is actually immunization is not complete? Because parents don’t believe in those things? Which I think it should be as neglected as other cases as well? So those are the cases that I think some of the MOs don’t think that they need to pursue.”*

One doctor took this matter into light where she said that Malaysia is a country where multiple cultures and beliefs are allowed to be practiced freely. However, some of the cultures involved not believing in immunization by which it denies the right of the child to access healthcare services (such as treatment) and this lead to the medical officers not knowing how to act since the act of reporting it would interfere with the basis of human rights while the act of not reporting it would mean they had become an accessory to neglect.

Again, all of these are the effect of not having a high suspicious index in order to pick up children coming in with presentation that raises certain “red flags” due to lack of knowledge in understanding in depth what is child abuse.

Key theme 4: Awareness of detection tools

When being asked about the presence of child abuse detection tools in the hospital, most of the healthcare workers interviewed were not aware that such tools are in existence.

This is confirmed by one of the medical officer, *“To tell the truth, in Emergency, there is no fast and hard guideline for certain areas, especially...areas, including children.”*

While there were no tools used to identify or detect child neglect or abuse, participants indicated that checklists were in use in the participating hospitals. Most of the checklists that are currently present are those that provide guidelines regarding the procedure (Standard Operating Procedure for One Stop Crisis Centre) of dealing with child abuse such as taking samples, making a report, and a clerking sheet which is used mainly by medical officers and specialists whereas case report is used by nurses. Again, this Standard Operating Procedure (SOP) will only come into play when the child has already been suspected of being abused by the attending medical officer before full examination to determine the suspicion is being carried out in the One Stop Crisis Centre (OSCC).

When asked to comment on the benefits of screening tools, the majority of participants gave a lot of positive attitude and agreement with the development of a screening tool for child abuse as it can be used to standardize the screening for all children attending the department regardless of their presenting symptoms. They will be screened in or out based on the checklist/screening tools. As such healthcare professionals would benefit a lot from having such a tool, especially for new staff in the frontline such as medical assistant, as the assessment is based on the tool rather than their own perception or high index suspicion.

This idea was fully supported by one medical assistant during the interview, *“I can look for, more objective lah meaning you have all the documentation and everything*

lah based on the criteria then push lah (for case refer to OSCC). I believe eh the first person to see the patient can affect the final outcome..”

This is of great importance as it will potentially save a life of a child. However, one medical officer argued that although a screening tool can be beneficial, it could also be a problematic, *“Sometimes, the way the assessor understands or perceives from the screening tool would probably make the case...it’s probably just a normal kid and sometimes uhmm it turns out to be the suspected abuse because the way they perceive.”*

In this statement, the medical officer emphasized that a screening tool might also lead to an over-estimation of a case. This could lead to a lot of false positive situations where more children are screened for being potentially at risk of abuse and the children and their family would have to face unnecessary conflict and pressure in the future. Not to mention the amount of added work needed to be done by the staff of the department, which would include thorough examination, collection of samples for tests and consultation with members of the SCAN team. Therefore, the content of the tools must be properly tailored.

In regards to what should be the content of a checklist for a detection tool, most healthcare workers mentioned the importance of looking at physical signs such as bruises, atypical fractures, foreign cutaneous marks, body weight and also radiological images that could suggest a possible atypical injury. The inconsistency of the history and the child’s injury was also suggested as one of the most important component of the detection tool. Some of the healthcare workers also recommended including the family history because certain family situations could lead to child abuse.

One medical officer gave an example of the family history needed, *“For example, the...definitely the income...of the family members. And then the errr...involvement of the family members with certain...drugs.”*

Other examples of family history that should be taken into consideration were added by another medical officer, *“Sometimes we tend not to ask about the father...urmm, about the father, the father is alcoholic, any...pernah masuk penjara ke? Has been jailed before?”*

In order to detect neglect, some healthcare workers recommended putting immunization history into the screening tool as well as a closed-ended question regarding being called ‘stupid’ or any degrading terms by someone else. One of the recommendations was also to customize the screening tool according to ages.

Other recommendations included the number of presentations to the hospital, any recurrent infections, status of the person who bring the child in, and also the amount of the similar complaints whenever a child is presented to the hospital.

Discussion

Medical healthcare professionals, being the first point of contact and front liners in the medical setting, provides an opportunity for children potentially at risk of being abused and neglect to be identified. During the course of the interviews, the researcher found that a two tiered system exist within the healthcare setting, with medical practitioners on one end and paramedics (such as nurses and medical assistants) on the other (see Fig 1).

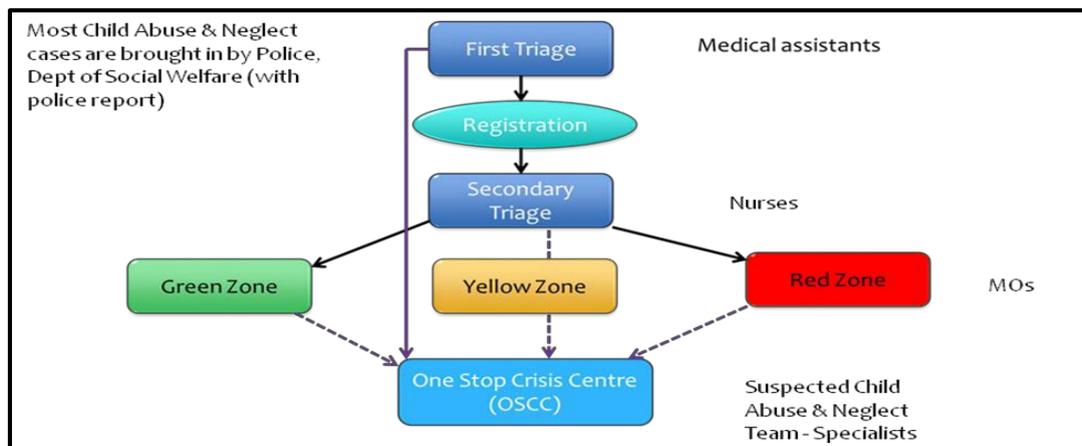


Figure 1. Flowchart of patient coming into the ED.

Often enough, paramedics were reluctant to raise any warning signs to the attending medical officer if he/ she found that a child coming into the ED could be potentially at risk of being abused/ neglect. There were contradicting statements coming from both ends whereby medical practitioners said to have encouraged paramedics to bring up warning signs of abuse to them but observed that most of the time none of the nurses or medical assistants would do so. But when nurses and medical assistants were prompted on whether they would bring it up if these warning signs occur, most of the time they said that they would say yes but in practice they would not do so. It could be because they felt that they might be overstepping their boundaries as their role is mainly to assist and provide support to attending medical officers or could be because they don't have the authority to diagnose, hence, may not have adequate knowledge to do so. The same sentiment was reported in the study done by Lazenbatt and Freeman, where they found that nurses may also feel some discomfort and anxiety from dealing with CAN cases and they might have fears from the consequences of their actions (Lazenbatt & Freeman, 2006).

It could also be the fact that being paramedics in the ED, they are usually extremely busy carrying out their respective duties and tasks that are at hand, any other additional tasks would be an added burden and overwhelming for them. It should also be noted that because the standard operating procedure in the ED clearly stated what their roles and responsibilities are, any other instruction given verbally usually does not carry much weight. Anything that is not stated in the SOP, protocols or guidelines might also incur repercussions, which also added to the lack of motivation for paramedics to take on the initiative to raise the alarm in the first place. There should not be any issue or concern about raising false alarm because if all children are being screened in the first place, there is less chances of children who may fall under the radar.

In other countries such as Australia, nurses' duties to report CAN are expressed in legislation, or in occupational policy documents. (Fraser, Mathews, Walsh, Chen, & Dunne, 2010) The Australian Nursing & Midwifery Federation (ANMF) also had issued a policy statement in 2007 which clearly stated "It is essential for anyone working with children or young people to recognise their vulnerable status and the special protection they may require if they appear to be at risk" (The Australian Nursing & Midwifery Federation, 2007).

Similar legislation and systems are being implemented in Taiwan where the nurses have their own position in the healthcare settings and have their own voice in reporting CAN cases within their respective setting. Therefore, it is important that paramedics are also held accountable to provide more

than just assistance and support in terms of services to patients (screening in the first triage and taking vital signs in the second triage). Being frontliners as the initial first contact in the first and second triage, they play a very important role but are currently heavily underutilized. This should be done at all hospitals and if possible to be included in an addendum within the current SOP. So that it can be formalized in such a way that identifying child who are potentially at risk of neglect abuse, and bring it to the attention of the person in charge are also part of their duty and not just those who are assigned in the SCAN team.

Likewise, attending medical officers carry the responsibility to identify children who are suspected of neglect or abuse, but they also need support, encouragement and empowerment on their vital role in identifying children who are at risk of neglect or abuse. This would encourage them to spend extra time on children whom they have high suspicions of potentially being abused and neglect.

Knowledge Gap

There is a gap in terms of understanding early warning signs of abuse among the healthcare professionals. Some of the points highlighted during the interview were:

1. Inadequate training on CAN/ child protection;
2. No standardized training across all hospitals on CAN/ child protection;
3. Different level of training provided for medical officers and paramedics;
4. Uncertainties in identifying in the level of severity of neglect for diagnosis;
5. Inability to ascertain emotional and psychological abuse masked by other presenting signs and symptoms;

Even for those who are at a senior/ specialist level were still unable to confirm that throughout their career they had never missed a sign of abuse. The same medical healthcare professionals reiterate again that more specialized training is needed focusing only on CAN or child injury prevention or protection. Paramedics (nurses and medical assistants) should be included in all levels of training and emphasized on their role in identifying and reporting to their superior of any children who are potentially at risk of being abuse in their respective setting. This would enable them to receive the support, encouragement and empowerment to undertake their duties in promoting awareness on CAN in the clinical setting. This is of utmost important because nurses and MAs are at the front liners who will be the first person to be in contact with the patient, hence have the opportunity to screen children who are potentially at risk of abuse and direct them straight to OSCC for further investigation.

Therefore, if several warning signs have been raised in the first and second triage there is enough evidence for the attending medical officer (MO) to do further examination on the child away from the suspected perpetrator(s) (eg. parents, caregivers or any other family members). This would set precedent to inculcate the culture of screening in all children presented at the ED as oppose to screening out.

Current training available for medical healthcare professionals is based on the two-tiered level. These trainings can be either part of their continuing medical education (CME) or more specific to One Stop Crisis Centre (OSCC) training whereby topics related to domestic abuse and child abuse are taught together in the training. Or in some training child abuse and neglect is being focused on, and this depends on who leads the training. These trainings are usually organized internally by certain departments or being organized by other hospitals whereby certain MOs, nurses and MAs are identified to attend those trainings.

Therefore it is important that paramedics, MOs and HOs are able to attend a more specialized training looking at more in depth information of child abuse and neglect detection regardless of their position. For example in the United Kingdom (UK), each hospital has the responsibility to provide adequate safeguarding children training. For example in King's College Hospital, they are responsible in providing all clinical staff with child protection awareness training. They also ensure that all staffs are given information about the importance of child safeguarding and how they can support the needs of

vulnerable children and young people. They also provide dedicated help through their specialist Safeguarding Children team to identify, protect and care for those at risk. And they also work with General practitioners (GPs), social services and other professionals to ensure the needs of vulnerable children and young people are met (King's College Hospital, 2017).

Providing adequate to specialize training is important but providing regular training is also critical to the development of a skilled medical healthcare professional and to achieving outcomes of safety, permanency, and well-being for children entrusted to the public health system. Having these knowledge not just assist the technical aspect of identifying children potentially at risk of abuse, but it also increases the level of awareness of such case but also increases one's level of suspicion if they do come across cases that may potentially be a CAN case hence increase the sense or obligation and responsibility of officers in the ED. And this cuts across all level let it be paramedics or medical officers or specialists and consultants.

Community and work culture

Organisational culture in the healthcare setting has been long discussed in the Western world, but not so much in the ASEAN region. According to the Organizational Culture Profile (OCP) instrument, performance orientation culture is shaped by the following characteristics: enthusiasm for the job, results orientation, highly organized employees and high performance expectations. (Zachariadou, Zannetos, & Pavlakis, 2013) Supportiveness and constructive organizational culture are also needed to generate a sense of collectively and emotional attachment that develops a community focused on organizational goals. Working as a team encourages more exchange of information and because of the frequent contacts, members are aware of who possesses the knowledge to resolve specific problems (Zachariadou et al., 2013).

But what was found and observed during this study was that nurses were less enthusiastic with their work and more dependent on the senior staff nurse when encountered with complex cases such as child abuse and neglect cases. This was noted visibly among junior nurses, who were highly dependent on community nurses who manage the OSCC when it comes to SOPs and guidelines in handling CAN cases. Because the fact that they are on rotational basis, they would not have the opportunity to undergo any OSCC training hence did not feel the need to undertake additional initiative to understand more on CAN.

Community culture also acts as a barrier for nurses to respond towards CAN cases. Several researchers found that nurses considered addressing the phenomenon of child abuse to be an ethical obligation and they adopted the role of patient advocacy to support victims. (Bannon & Carter, 2003; Carter, Bannon, Limbert, Docherty, & Barlow, 2006) This is particularly true especially when they have more experience working with children and had dealt with a lot of CAN cases as it was found in this research. While other nurses considered CAN to be a personal and family issue in which they had no role or say hence the reluctance to highlight the matter and bring it to the attention of MOs or attending physician. (Alrimawi, Saifan, & AbuRuz, 2014) This is especially true within the Malaysian cultural context, which is quite similar with other Arab and eastern culture where child rearing can be it is considered socially acceptable for parents to practice physical punishments and yelling to their children as a normal part of child-rearing (Chavis et al., 2013; Elbedour, Abu-Bader, Onwuegbuzie, Abu-Rabia, & El-Aassam, 2006).

Screening tools for child abuse

This study managed to establish that there are no screening/ detection tools being used at the ED or any other clinical department in the public hospital as of current. What is currently available is Form 9, which is used by MOs once a child is being diagnosed as CAN case and is brought into OSCC for further examination and investigation. Prior to that, there are no checklist or screening tools being used at the first triage or second triage at the ED.

This study found that most healthcare professionals interviewed were not aware that screening or detection tools for child abuse are available and being used worldwide. Only specialists in the ED and paediatrics were aware of such tools but were not sure whether they were being used in the ED or any other clinical departments in the hospital. Currently there are several screening/ detection tools being used in the US, Europe and Australia. Some of the most well-known tools are the SPUTOVAMO, SPUTOVAMO-R and the most recent one SPUTOVAMO- R2 (it does not only look at the injury, but also at the interaction with parents and child) and being used widely in the ED, the ESCAPE Instrument which is also widely used in the ED. There are other tools/ instrument that can be used such as the ISPCAN Child Abuse Screening Tools (ICAST), but this instrument is not being used at the ED, but more in the community and homes.

For healthcare professionals, having a standardized screening/ detection tool would assist them greatly in identifying children who are potentially at risk of abuse in the ED especially at the first and second triage, where paramedics are stationed as shown by Louwers et al. in the study they conducted in 2014 (Louwers et al., 2014).

Conclusion

The significant gap identified in healthcare professionals' knowledge and skills related to understanding what does CAN entails and how it is being identified and detected, particularly among medical officers who are in charge of diagnosis and making police reports of any CAN cases in the hospital. Those who had previous experience or encounters in dealing with CAN cases would have higher suspicion index compared to those who haven't.

Other medical healthcare professionals such as nurses and medical assistants or also known as paramedics although do not have the mandate to diagnose or report of CAN cases, needed to have the basic knowledge and awareness on CAN. They should also be encouraged and empowered to take an active role in identifying or raising the 'red flag' with high index of suspicions so that these children can be brought in for further examination by medical officers. Likewise, those who had been in the force for the longest would have more experience in dealing with CAN cases, they are more skilful, aware and empowered to bring the matter to the attention of the attending medical officer compared to those who are quite new in the department. Consequently, the process of conducting qualitative study amongst medical healthcare professional has some impact in creating awareness on CAN in the clinical setting.

Specialised and intensive standardized training in child protection and awareness on CAN are needed and should be made available for all healthcare professionals to attend and improve their knowledge and understanding on the differentiation between accidental and non-accidental injuries as it present at the ED. And these training should be on-going with reviews and updates on the latest information on detection of CAN cases.

Parents should be made aware of the importance and severity of CAN, hence the need for them to lodge a police report if they suspect that their child is being abused. Fear of making false report even with evidence (diagnosis) by attending medical officer should be sufficient to encourage the parent to make a report. The same goes with the medical officer attending such case, not having enough confident to diagnose a case due to lack of knowledge and experience should not hinder them from consulting their superior and remove that barrier of reporting.

Medical healthcare professionals, being the front liners and the first point of contact has the responsibility as "protector" being mandated by the highest authority to help these children by identifying them at the outset and take them out from a potentially hostile and harmful environment.

The healthcare system itself needed to be enhanced and strengthened to ensure that strategies are in place such as screening tools, checklist are available to assist healthcare professionals in making the diagnosis and speed up the process of identification and reporting more efficiently. Early diagnosis of

CAN is important, as without early identification and intervention, about one in three children will suffer subsequent abuse. Based on finding of this study there is a need to implement such tools in the ED. Because these tools are standardized, it can be used cutting across all hospitals. There are several tools that can be used for pilot implementation (eg. ESCAPE form, SPUTOVAMO-R), therefore it is envisaged that these can be done as a post-doc research study in one of the hospitals.

The current available electronic database can be enhance to assist medical professionals by linking up services with the Child Registry under the DSW and communicate with other agencies to enhance cooperation at the inter- agency level to ensure smooth and efficiency reporting and transition of the child from the clinical setting to a safer home/ environment under the protection of the DSW officers.

Medical healthcare professionals, being at the forefront has to play their vital role in ensuring that every children that passes through the ED everyday would be dealt with in mind that they are all potentially at risk of being abuse and neglect in order to potentially save one life. We as part of society and community also has our role to play by creating awareness towards CAN and ensuring that every child in our community is safe and protected at all times, then maybe we would see reduction in number of CAN cases in future.

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