

The Identification of Psychosocial Risk Factors Associated With Child Neglect Using the WE-CARE Screening Tool in a High-Risk Population

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ABSTRACT

Introduction: Neglect accounts for over 70% of child maltreatment and carries significant sequelae. Identification of psychosocial determinants of health may allow pediatric providers to ameliorate precursors of child neglect. **Methods:** Data were collected 1 month before and after implementation of the Well-Child Care Visit, Evaluation,

Community Resources, Advocacy, Referral, Education (i.e., WE-CARE) screen at all well-child visits. Social workers recorded number and types of referrals, and providers completed surveys.

Results: Analysis of 602 completed screens (75% capture rate) showed 377 families (63%) with at least one need and 198 (33% overall, 53% of those with positive results) indicating a desire to discuss. Of families requesting assistance, 122 (62%) connected with a social worker, and total referrals increased after implementation. Provider surveys supported an increased frequency of and comfort with assessing families for certain risk factors, and screening was not perceived to interrupt clinic flow.

Conclusion: Standardized screening identifies families at risk for neglect, improves provider comfort, and minimally affects flow. Identification of psychosocial needs should be part of routine preventive care. *J Pediatr Health Care.* (2017) ■, ■-■.

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KEY WORDS

Child neglect, determinants of health, pediatrics, psychosocial screening

INTRODUCTION

In 2013, nearly 700,000 children in the United States were victims of child maltreatment ([Centers for Disease Control and Prevention \[CDC\], 2016a](#)). More than 70% of these were victims of child neglect

(CDC, 2016a). Child maltreatment can result in lifelong physical, psychological, medical, and emotional sequelae at a lifelong cost of nearly \$210,000 per victim (Fang, Brown, Florence, & Mercy, 2010). Child neglect is defined as an act of omission, which is “the failure to provide for a child’s basic physical, emotional, or educational needs or to protect a child from harm or potential harm” (CDC, 2016a, Definition section, Acts of Omission (Child Neglect), para. 1). Because the actual incidence of child neglect is likely much higher than reported because of inconsistent reporting, the identification of children at risk for neglect is vital to their current and future wellbeing (Dubowitz, 2009).

Key to the identification of and intervention in child neglect are awareness and knowledge of those caring for children on a daily basis, including health care providers (Berkowitz, 2008; Carter, 2012; Fraser, Mathews, Walsh, Chen & Dunne, 2010; Garg & Dworkin, 2016; Raman, Holdgate, & Torrens, 2012; Schickedanz & Coker, 2016). The ability of medical personnel to identify and adequately report child neglect is vital to being able to successfully intervene when a risk for neglect is present (Berkowitz, 2008; Fraser et al., 2010; Raman et al., 2012; Schickedanz & Coker, 2016). Education and increasing the ability and confidence of medical personnel to identify and report child neglect when suspicion is present are significant factors in reducing the incidence of child neglect (Berkowitz, 2008; Fraser et al., 2010; Raman et al., 2012).

The Well-Child Care Visit, Evaluation, Community Resources, Advocacy, Referral, Education (WE-CARE) screen, developed by Garg and colleagues (2007), was first implemented in an urban, hospital-based pediatric primary care clinic. This 10-item survey assesses parental need for education, employment, child care, and housing, in addition to screening for food insecurity, tobacco use, substance (drug or alcohol) abuse, domestic violence, and depression. The researchers found that intervention families reported a significantly higher number of psychosocial topics discussed at the well-child visit, fewer unmet parent needs, and increased referrals for resources compared with parents in the control group. At the 1-month follow-up, parents in the intervention group were 10 times more likely than the control group to report contacting a referred community agency; pediatric providers reported minimal disruption to workflow. Garg et al. (2007) found that implementing the WE-CARE screen was not only feasible but also effective in addressing family psychosocial problems during well-child examinations for low-income children.

We hypothesized that implementation of routine psychosocial screening using the previously validated WE-CARE tool would result in an increased detection rate of family psychosocial needs and resultant social work referrals. Thus, our objectives were to evaluate the feasibility and acceptability of integration of the WE-CARE screen into all well-child visits by measuring (a) identified psychosocial needs, (b) change in social work referrals, (c) provider comfort with screening, and (d) characteristics associated with in-office social work consultation after universal implementation of the WE-CARE screen within a high-risk primary care pediatrics population.

METHODS

Setting

This study involved the primary care pediatric practice at the University of Rochester Medical Center in Rochester, NY. This large university-based practice provides care to more than 12,000 children and employs attending pediatricians, resident physicians, and pediatric nurse practitioners in a team-based setting. In addition, the practice employs two full-time social workers in addition to traditional support staff. More than 70% of patients have public insurance, and are African American.

WE-CARE Screen

Based on the high-risk population of families served within the clinic, we implemented systematic screening for psychosocial needs using the WE-CARE tool at all well-child visits beginning November 2014. This 10-item screener was used in its original form, and was given to each family being placed in a room for well-child care. The parent or caretaker completed the form for review by the provider, and positive results triggered a social work referral at the time of the visit per the current standard of care. All completed screens were collected by 1 month after implementation.

Data Collection

WE-CARE screen results collected during the month after implementation were entered into a study spreadsheet by the study’s principal investigator. This included whether a need was identified, what the need(s) were, and whether the parent indicated a desire for resources. This information was correlated with social work records from an existing central hospital database.

Social work data were provided by the hospital’s central social work office, which houses the database of encounters used by all hospital social workers. Output provided included all consultations documented by the clinic social workers within the period of interest. This included patient demographics

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