

	Policies and Procedures Title: ENTANGLEMENT, STRANGULATION, ENTRAPMENT AND FALLS PREVENTION PEDIATRICS I.D Number: 1063
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DEFINITIONS

Entanglement: The state of body or limb, being wrapped or twisted in any tubing, cords, cables and wires.

Strangulation: Constriction of a body part so as to cut off the flow of blood, fluid or air.

Entrapment: The state of body or limb being caught, trapped or entangled such as in the space in or about the bed rail, mattress or bed frame.

Fall: "an event that results in a person coming to rest inadvertently on the ground or floor or other lower level, with or without injury. This includes un-witnessed falls where the person is unable to explain the events and there is evidence to support that a fall has occurred; and near falls where the person is eased to the floor by staff or family members.

ROLES:

Nurse: A Registered nurse (RN), Registered Psychiatric Nurse (RPN), or Licensed Practical Nurse (LPN)

Unregulated Care Providers (UCP): Continuing Care Assistant (CCA), Home Health aide (HHA), Home Care Aide (HCA), Daily Living Attendant, Special Care Aide (SCA), or Care Partner

Acute Care: A pattern of healthcare in which a client is treated for a brief but severe episode of illness. Acute care is usually given in a hospital by specialized personnel and it may involve intensive or emergency care.

- Ambulatory Care: Health services or acute care services that are provided on an outpatient basis
- Diagnostic Services: Diagnostic care that includes the clinical services of Laboratory Medicine, Radiology, and Nuclear Medicine.

1. PURPOSE

- 1.1 To promote safety and prevent injury to children in acute care facilities.
- 1.2 To provide a standardized process to identify which children are at increased risk for entanglement, strangulation and entrapment that may stem from the use of products and equipment used in diagnosis, prevention and treatment.
- 1.3 To provide a standardized process to identify which children are at risk of falls and to implement the SHR Universal Falls Prevention strategies for all children.

- 1.4 To provide prevention strategies to avoid adverse events for pediatric patients who have been identified at increased risk for entanglement, strangulation, entrapment and falls.

2. POLICY

2.1 Assessment

2.1.1 All clients will be assessed for risk of entanglement, strangulation, entrapment and falls by the nurse in collaboration with other Health Care Providers (HCP), using the Pediatric Entanglement, Strangulation, Entrapment, Fall Risk Assessment and Intervention Flowsheet (Appendix A)

2.1.1.1 At admission/transfer

2.1.1.2 Shift change

2.1.1.3 Change in client's status where the level of risk changes.

NOTE: Acute Care – Ambulatory Care/Diagnostic Service Departments (e.g. diagnostic imaging) receiving inpatients will be informed by the child's nurse prior to transportation that the child has been identified as a "high risk for entanglement, strangulation, entrapment & falls" and the prevention strategies that have been implemented.

2.2 Prevention Strategies

2.2.1 Clients scored to be at risk will have prevention interventions identified on the flowsheet (Appendix A). These interventions will be implemented and a plan of action documented in the client care plan and nursing record.

NOTE: Acute Care – Ambulatory Care/Diagnostic Service Departments (e.g. diagnostic imaging). Clients will be transported either by support staff or nursing staff. Ward staff will be responsible to supervise the child while in the diagnostic service area and then transport the child safely back to the unit.

2.3 Safety Incidents

2.3.1 The child's status will be assessed and the staff will respond to the immediate needs of the child.

2.3.2 All safety events will be reported as soon as possible to the most responsible physician (MRP) or designate and charge nurse/ward nurse caring for the child.

2.3.3 The physician or designate will be contacted to assess the child if the event resulted in any change in the child's clinical status.

2.3.4 All events will be documented on the appropriate documentation record. Complete the SHR Fall Record form (#101853) for fall events.

2.3.5 Ensure the safety incident is reported in the facility reporting system (306)655-1600/on line adverse event management system (AEMS).

2.3.6 The safety event will be disclosed to the family.

2.3.7 Following an event a new risk assessment will be done and a review of the risk interventions in place. Any changes to the action plan must be documented in the client's care plan.

2.4 **Parental Involvement and Participation**

- 2.4.1 Parents/caregivers will have an active role in the prevention strategies through:
- 2.4.2 Education
- 2.4.3 Discussion about child's usual behavior when alone, ill or distressed
- 2.4.4 Negotiation about what prevention strategies to adopt when parents are present and when they are asleep or not present.
- 2.4.5 A plan will be developed for parents/caregivers who refuse to comply with the suggested preventive strategies for their child. This plan will be documented in the client's care plan and nursing record.

3. **PROCEDURE**

3.1 **Risk Assessment**

- 3.1.1 Assess the client using the criteria provided in the risk assessments/intervention flowsheet (Appendix A).
- 3.1.2 Circle the number in the ESE and Falls criteria column if you have identified a risk.
- 3.1.3 Total the risk assessment scores for ESE and Falls at the end of each column.
- 3.1.4 If the score indicates that prevention interventions need to be implemented refer to page 2 of the risk assessment/intervention flowsheet.
- 3.1.5 Check off the interventions that apply to the client.

3.2 **Prevention Strategies**

- 3.2.1 Apply appropriate interventions for the child if the score indicates the child is at risk.

3.3 **Documentation**

- 3.3.1 Document the risk assessment score and the action plan in the client care plan and nursing record

3.4 **Safety Events**

- 3.4.1 Assess child's clinical status and respond to the immediate needs of the child.
- 3.4.2 Report the event as soon as possible to the most responsible physician (MRP) or designate and charge nurse.
- 3.4.3 Contact the physician or designate to assess the child if the event resulted in any change in the child's status.
- 3.4.4 Document the event and outcome on the appropriate documentation record. For falls complete SHR Fall Record form (#101853).
- 3.4.5 Report the safety event to the facility reporting system.

3.4.6 Disclose the event to the family and document discussion in the nursing record

3.4.7 Review the risk assessment and intervention flow sheet and make changes as needed. Document in the care plan and nursing record if changes are made to the action plan.

3.5 Family/Patient Education and Participation

3.5.1 Educate the family/patient about the risks involved and why the interventions were put in place.

3.5.2 Parents/ caregivers who refuse to comply with the suggested preventive strategies to minimize the risk for their child:

3.5.3 Explain the risks and how preventive strategies reduce the risk. Involve other health care providers e.g. Clinical Coordinator, Manager of Nursing, Physician or alternate in further discussion.

3.5.4 Consider increasing level of observation including use of sitters.

3.5.5 Share and discuss this information with other members of the healthcare team.

3.5.6 Report the situation in the facility reporting system to indicate the potential risk.

3.5.7 Document, in the patient's progress notes, the caregiver's refusal to implement the suggested preventative strategies.

4. RELATED POLICIES

SHR Region-Wide Policies & Procedures Manual- #7311-60-012 Least Restraint

5. REFERENCES

Entanglement, Strangulation:

Alberta Health Services. Child Health Manual Patient Care Policy, Entanglement Prevention (February 2011).

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Hospital for Sick Children. (July 2011). Prevention of Entanglement, Strangulation, Entrapment (ESE) and Falls. Toronto, Ontario.

Pediatric Medical Line Safety (March 2015): The Prevalence and Severity of Medical Line Entanglements

Rynne, A. Algorithm on the prevention of entanglement and entrapment related to medical and non-medical equipment. Our Lady's Children's Hospital, Crumlin. 2016. <http://www.olchc.ie/Healthcare-Professionals/Nursing-Practice-Guidelines/Entanglement-and-Entrapment-Algorithm-2017.pdf>

Stollery Children's Hospital, Capital Health. (February 2003). Staff Response to Pediatric Patient Risk of Entanglement. Edmonton, Alberta.

The risk of harm from children and neonates entangled in lines: signals. NHS. 2011. <http://www.nrls.npsa.nhs.uk/resources/?entryid45=94851>

Entrapment and Falls:

Hospital for Sick Children. (July 2011). Prevention of Entanglement, Strangulation, Entrapment (ESE) and Falls. Toronto, Ontario.

Safer Health Care Now! (2012) – Reducing Falls and Injuries from Falls Getting Started Kit

Saskatoon Health Region (January 2012). Policy #60-01-001. Falls Reduction and Injury Prevention Saskatoon, S.

London Health Sciences Centre (May 2016) Paediatric Falls Risk Assessment and Prevention Strategy



RUH SCH SPH Other _____

NAME: _____

HSN: _____

D.O.B.: _____

PEDIATRICS

ENTANGLEMENT, STRANGULATION, ENTRAPMENT (ESE) AND FALLS RISK ASSESSMENT/INTERVENTION FLOW SHEET

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Complete this form for every client:

- On admission/transfer of care
- Shift change
- Change in client status where the level of risk changes

Instructions:

1. Circle the number in both "ESE" and "Falls" column if you have identified a risk for your client.
2. Total scores at the end of each column to establish an ESE and Falls score.
3. Determine interventions based on the score. See prevention strategies on page 2. Check off the interventions that apply.
4. If score indicates client is at risk, document score and interventions on the client care plan and nursing record.

SCORE	ESE	Falls	ESE	Falls	ESE	Falls	ESE	Falls
Date								
Time								
Nurse Initials								

CRITERIA

Mobility Impairment (gait disturbance)								
Ambulates or transfers with assistance or assistive device.	N/A	1	N/A	1	N/A	1	N/A	1
Ambulates with unsteady gait (no assistive device).	N/A	1	N/A	1	N/A	1	N/A	1
Aged 4 years and under (toddlers)	N/A	1	N/A	1	N/A	1	N/A	1
History of ESE or Illness-Related Falls								
Before or after admission	1	1	1	1	1	1	1	1
Medications which increase risk								
Current medications include one or more of the following: Anticonvulsants, opioids Benzodiazepines Sedatives/hypnotics	1	1	1	1	1	1	1	1
Procedural Sedation								
Surgery or Procedural Sedation within last 48 hours	1	1	1	1	1	1	1	1
Cognition/Development								
Developmentally and/or cognitively delayed/impaired /impulsive/disoriented	1	1	1	1	1	1	1	1
Very active, restless, combative	1	1	1	1	1	1	1	1
Aged 4 months to 4 years	1	N/A	1	N/A	1	N/A	1	N/A
Clinical Judgement								
Clinical diagnosis or condition warrants ESE strategies or falls prevention program	1	2	1	2	1	2	1	2
AND								
MANDATORY ESE Field: Score as 2 Exposure to medical and non-medical tubing/cords/cables (e.g. IV/oxygen tubing, feeding tubes, monitor cables, lighting cords) and equipment that poses risk (bed/crib/stretchers/wheelchair/stroller)	2	N/A	2	N/A	2	N/A	2	N/A
TOTAL SCORE:								

Legend:
 Implement ESE Prevention Interventions for a score equal to or greater than 3 (include mandatory score of 2).
 Implement Universal Fall Preventions for a score less than 2
 Implement High Risk Falls Prevention Interventions for a score equal to or greater than 2

NAME: _____

HSN: _____

D.O.B.: _____

**ENTANGLEMENT, STRANGULATION,
ENTRAPMENT (ESE) AND FALLS RISK
ASSESSMENT/INTERVENTION FLOW SHEET**

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PREVENTION STRATEGIES										
CHECK OFF THE INTERVENTIONS THAT APPLY TO THE CLIENT										
Date										
Time										
Nurse Initials										
ENTANGLEMENT, STRANGULATION, AND ENTRAPMENT PREVENTION INTERVENTIONS (score equal to or greater than 3)										
Assess q shift need for continued use of tubing/cables and remove if necessary										
Saline lock IV lines for intermittent medications or fluids										
Avoid extension sets to the IV line/oxygen tubing										
Tape medical lines together										
Medical stabilizer: Corrugated oxygen tubing modified to amalgamate all multiple tubings/cords										
Reposition necessary tubings/cables/cords (i.e. secure through clothing, use burn netting vest, coil excess tubing, move SpO ₂ sat probe to toes)										
Increase monitoring (i.e. move closer to nursing station/observation unit/sitter)										
Continuous SpO ₂ monitoring if unable to continually observe										
Clear unnecessary items from crib/bed										
Adjust crib/bed /bedside table to prevent access to light and telephone cords										
Appropriate crib/bed. Properly fitted mattresses										
Caregiver present										
Caregiver education provided about risk and prevention interventions in place										
HIGH RISK FALLS PREVENTION INTERVENTIONS (score equal to or greater than 2)										
Climber crib										
Continuous supervision with toileting										
Accompany with ambulation										
Increase monitoring (i.e. move closer to nursing station/observation unit/sitter)										
Consult Physical Therapy or Occupational Therapy										
Provide lift transfer										
Caregiver present										
Client/caregiver education provided about risk and prevention interventions in place										
UNIVERSAL FALLS PREVENTION (score less than 2)										
Orientate to surroundings, bathroom, call bell	Applies to ALL clients. Follow SHR FALL STRATEGIES Universal Falls Precautions (SAFE).add link here									
Appropriate crib/bed										
Crib/bed in lowest position unless client directly attended; brakes on										
Crib/bed side rails up where appropriate										
Non-skid footwear										
Assess elimination needs; supervise as needed										
Place call bell/personal items/walking aids within reach										
Clear pathways of clutter										
Secure in wheelchair/stroller/highchair/car seat/other seating equipment with age and developmentally appropriate and approved restraints										
Adequate lighting in client's room										
Transport infant/young child off the unit for a test in a stroller or crib. Do not carry.										