

Industry Feedback Alert

Coronial Inquest: Lap belts on wheelchairs

From the Office of Aged Care Quality and Compliance (Aged Care Complaints Scheme)

26 November 2013

Who is this alert for?	All Australian Government subsidised residential aged care providers.
What is an Industry Feedback Alert?	Industry Feedback Alerts outline an issue we have identified through an analysis of our complaints data and other sources. They provide suggestions of areas that aged care providers may wish to review within their service. Alerts are not directions.
Issue	In July 2011, a resident of an aged care facility died after she slipped off her wheelchair and was caught in the wheelchair restraint strap (also called a lap belt).
	On 5 September 2013, following an inquest into the resident's death, the South Australian Coroner (the Coroner) found that she had died as a result of a neck compression by the wheelchair lap belt.
	The Coroner recommended that the department issue a warning to all aged care services on the risks involved in the use of lap belts on wheelchairs.
Observation	The Coroner's recommendation included an opinion that the use of lap belts should be discouraged. The Coroner stated that "there are other, better methods for securing people in wheelshairs and those should be drawn to the attention of

for securing people in wheelchairs and these should be drawn to the attention of aged care facilities".

Aged care facilities are encouraged to read the full text of the Coroner's Finding of Inquest that can be found at

http://www.courts.sa.gov.au/CoronersFindings/Lists/Coroners%20Findings/Attach ments/567/DICKER%20Ruth%20Ann.pdf

In addition, the department has developed a resource titled *Decision-Making* Tool: Supporting a Restraint-Free Environment. This document can assist staff and management working in both residential and community aged care settings to make informed decisions in relation to restraint. Some of the topics covered in this decision making tool include:

- the risks of using restraint and what needs to be done to minimise risk (e.g., ensuring the correct use of a particular restraint if it is required)
- selection of the restraint option with the lowest risk to the care recipient
- consideration of using alternatives to the use of constraint such as using seating and position support that does not restrict free movement.

Details on how to access this document are on the next page.

Suggestions for consideration

That:

- key personnel are made aware of this information, including the Coroner's findings and recommendations
- aged care providers provide training to staff in restraint management
- facilities establish appropriate restraint guidelines for their service
- facilities also consider other alternatives to lap belts available in the resource *Decision-Making Tool: Supporting a Restraint-Free Environment.* This resource can be found at

http://www.health.gov.au/internet/main/publishing.nsf/Content/ageing-decision-restraint.htm

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Responsibility for administration of the Aged Care Act transferred to the Minister for Social Services on 18 September 2013. Services for older people, including their carers, are now dealt with by the Department of Social Services. Aged Care Program staff dealing with aged care matters before these changes continue to do so in the newly created Department of Social Services.