Manitoba
Health, Seniors and Active Living

Patient Safety Learning Advisory

Lap Belt Strangulation

Summary: Client slid down partially out of wheelchair and found deceased with lap belt around neck.

Keywords: lap belt, positioning belt, restraint, strangulation

This review is based on a single event.

Findings of the Review:

Client utilized a specialized wheelchair with a side release positioning belt, designed to prevent the client from sliding out of the chair.

Staff secured the lap belt at a level on the client higher than the belt is designed for.

A formal process for educating staff regarding the use and application of positioning belts and restraints had not been implemented.

Development of regional restraint policy and procedure underway.

System Learning:

Formalize a delivery method of education related to the use of positioning belts and restraints used on the unit, to reduce the risk of incorrect application.

For example:

a. Provide pictures at point of use that illustrate securing of positioning belts or restraints.
b. Include the information for correct use of positioning belts or restraints in the individual care plans.

Facilitate completion of education for clinical staff of the regional restraint policy following approval.

Incorporate visual references that demonstrate the application of positioning belts or restraints in the regional policy. Discuss audit process specific to regional restraint use at committee level.

Discontinue use of the unit-specific restraint policy upon implementation of regional policy.

Date of Posting: February 2019