



SPOTLIGHT ON **PREVENTION**

Partnering to protect people
with special needs

WHEELCHAIR SECUREMENT

The Justice Center created this toolkit to provide information and resources for individuals receiving services, service provider agencies, staff, and family members to support the safety of people who require the use of a wheelchair during transportation.



**Justice Center for the
Protection of People
with Special Needs**

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The Issue

In 2018, there was an increase in the number of cases reported to the Justice Center that involved people in care who were not properly secured in their wheelchairs while riding in agency vehicles. Issues with incorrect placement of lap and shoulder belts, improper application of wheelchair tiedowns, and staff and people in care standing on platform lifts resulted in injuries to people in care. A systemic review of wheelchair securement led by the Justice Center also found that staff were not always trained on wheelchair securement practices and did not know the individual safeguards of people in care related to wheelchair securement and transportation.

A [2016 report](#) submitted to the National Highway Traffic Safety Administration (NHTSA) stated that, in accidents involving people in care who use wheelchairs, one of the main reasons people in wheelchairs are injured is improper or incomplete use of lap/shoulder-belt restraints. If improperly secured, people may be thrown from the wheelchair or may slide under the lap belt. If the wheelchair is not properly secured, the wheelchair itself may tip over.

To safely transport a person in care who uses a wheelchair for transportation, staff, caregivers and/or

family members must be trained and understand:

- the wheelchair securement process
- individual transportation related safeguards
- agency policies and procedures for transportation and wheelchair securement

Staff, caregivers, and/or family members must also know how to:

- safely use a platform lift
- secure a wheelchair using a floor, four-point restraint system
- secure the person in their wheelchair using lap and shoulder belts
- secure any loose objects or equipment in the vehicle

With an increased understanding of the steps involved in the wheelchair securement process, interactive training for staff, and comprehensive guidance provided in agency policy, staff, family/caregivers and agencies can work together to reduce accidents and injuries to people in care.

Could This Happen in Your Program?

These case studies are offered for use in staff training and are loosely based on real Justice Center cases. The names of the people, settings, and other information have been changed.

Case #1

Jenny lives in an individualized residential alternative (IRA). Although Jenny uses a walker in her home, she requires the use of a wheelchair when traveling. Her Staff Action Plan directs staff to ensure that she wears a seatbelt while in the vehicle. Jenny was going to the grocery store to help buy groceries for the week, so staff helped Jenny get into the wheelchair van.

First, staff secured her wheelchair on the platform lift. Then staff wheeled her into the van and secured her wheelchair with the floor four-point restraint system using two floor restraints for the back of the wheelchair and two floor restraints for the front of the wheelchair.

The staff knew that Jenny didn't like the shoulder belt so staff draped it behind her back. Jenny held her walker in front of her wheelchair during the drive to the store.

Jenny's van was only a few blocks from the IRA when a dog ran into the street in front of the van, causing the driver to slam on the brakes. While Jenny's chair stayed in place, she fell out of it and hit her face and head on her walker and on the van floor because she was not wearing a shoulder harness.

Case Concerns:

- ▶ Staff did not secure Jenny using the vehicle's lap or shoulder seatbelt.
- ▶ Staff did not secure Jenny's walker to prevent it from injuring Jenny or the staff during the accident.
- ▶ Jenny's individual safeguards did not direct staff to use wheelchair occupant and restraint systems, only to ensure she wore her seatbelt.

Case #2

Sheila had new protocols in her service plan regarding her mobility while she was recovering from hip replacement surgery. She used a wheeled walker to ambulate and a self-propelling manual wheelchair for transportation, and was able to stand by herself from a seated position and transfer with the use of a walker to stand or pivot. Sheila went shopping with a staff member, who told her to take her walker and not her wheelchair. Staff made her use the steps to get on and off the van, which was hard for Sheila. When she exited the van using the stairs, she had to come down backwards and it hurt. After staff saw Sheila struggling,

they let her stand on the platform lift with her walker to get on and off the van.

As Sheila was getting off the lift, the walker got caught on the platform and she fell over. A staff member stated that this was the first time he had taken Sheila out since her hip replacement and the new protocols for transportation “slipped his mind.” All staff at the agency were required to read and sign changes to service plans but did not receive interactive training about changes. The agency policy did not prohibit the use of the platform lift by people who are not in wheelchairs.

Case Concerns:

- ▶ Staff was not familiar with the new protocols in Sheila’s service plan.
- ▶ Staff training relied on a “read and sign” method of training rather than interactive training.
- ▶ Agency policy did not address the use of the platform lift by people who receive services who were ambulatory.

Case #3

Vicki and one of her housemates were getting dropped off by their residential provider for a hair appointment. Both Vicki and her housemate used wheelchairs in their homes and for transportation. The driver took Vicki’s housemate off the van first and left the platform lift lowered to the ground. He re-entered the van using the stairs, then proceeded to unhook Vicki’s safety

straps and wheel Vicki out of the van, pushing her backwards using the arms of her wheelchair. The driver did not see that the platform lift was still lowered to the ground. Vicki fell out of the van and landed on her back while still strapped into her wheelchair. Staff from the salon came out to assist, and Vicki was evaluated for possible injuries after someone called 911.

Case Concerns:

- ▶ The driver did not ensure the platform lift was raised after Vicki’s housemate exited the van.
- ▶ The driver did not have Vicki facing forward as she was exiting the van so his view of the lift was blocked.

Case #4

Ken reported that he was in the van on the way home from a medical appointment when his wheelchair tipped over while the van was in motion. Ken reported that this happened when the driver was going fast and made a sharp turn. He also stated that his wheelchair was not correctly secured and that when he fell, he cut his right palm. Ken said the staff person pulled over and helped him up and put a gauze pad on his cut and

then drove him directly home without calling a medical professional or reporting the incident to anyone. Ken said that the staff had secured both floor ties in the back but only secured one in the front. It was later discovered that the staff, a contracted transportation provider, was never trained on the safeguards related to transportation in Ken’s service plans.

Case Concerns:

- ▶ Ken and his wheelchair were not properly secured.
- ▶ The transportation provider did not report the incident to anyone.
- ▶ Ken did not receive any medical attention after his fall.
- ▶ The transportation provider was not familiar with the safeguards for transportation in Ken’s service plans.

Case #5

Matt attends a day program and is transported to and from the program by the staff who work at the day program. When Matt got to the day program in the morning, the platform lift of the van got stuck and the front roll stop of the lift did not stay in place. The staff member who drove Matt to the day program commented to another staff that the lift was “acting up.” He did not report it to anyone else.

That afternoon, the driver used the same van to bring Matt home from his day program. When the wheelchair van pulled up in front of his home, the driver opened the van door, lowered the platform lift and released Matt’s chair from the floor restraint system that had secured it in place. He rolled Matt out on to the lift

then turned around to get something from inside of the van. As the driver turned around, Matt’s chair rolled forward off the lift and Matt fell approximately four feet to the ground, still secured in his chair. He landed face-first and suffered a cut to his tongue, broken teeth, a fractured nose, and a cut to the side of his head.

Case Concerns:

- ▶ Staff did not report that equipment was not working correctly.
- ▶ Staff continued to use the vehicle with the faulty lift.
- ▶ Staff turned away from Matt and did not maintain contact with Matt’s wheelchair while he was on the lift.
- ▶ Staff did not engage wheelchair brakes to prevent the chair from rolling off the lift.

Case #6

Leslie was returning from a local community event in her home’s wheelchair accessible van. As the van turned around a sharp curve in the road, Leslie’s wheelchair tipped over with Leslie still strapped in it and she injured her collarbone. Staff stopped the van, set Leslie’s wheelchair upright, tightened the floor restraints, and called the nurse on call, who directed them to bring Leslie to the emergency room of a hospital a few blocks away. Leslie was treated in the emergency room for a broken collarbone and released.

On the way back to the residence, the staff had to brake hard to avoid hitting another car, causing

Leslie’s wheelchair to collapse. She fell to the floor. Staff later realized her wheelchair had been damaged when it tipped over in the earlier accident. During the investigation of the incident, it was discovered that the staff had not been trained on wheelchair securement in more than three years. Moreover, the training staff received was in a different vehicle and used a different type of securement system than the one used to secure Leslie.

Case Concerns:

- ▶ Leslie and her wheelchair were not secured properly.
- ▶ Staff had not attended a refresher training on wheelchair securement and had not been trained on the specific securement system used in Leslie’s van.
- ▶ Staff did not inspect the wheelchair after the accident or replace it until it could be inspected.
- ▶ Staff sat Leslie’s wheelchair upright rather than contacting emergency medical services first to ensure it was safe to move her after the fall.

What You Can Do – Partners in Prevention

AGENCIES	CAREGIVERS AND STAFF	PEOPLE RECEIVING SERVICES
<p>Create a thorough policy regarding safe transportation that includes safety measures for people who use wheelchairs. See policy suggestions below.</p>	<p>Read and review policy, follow guidelines, and ask questions if something does not make sense.</p>	<p>When possible, request and review agency policies regarding transportation.</p>
<p>Provide interactive training for staff on securement of both wheelchairs and people in wheelchairs. Retrain staff when new securement systems or vehicles are used, and on a regular basis. Offer sensitivity training related to the wheelchair securement process. Document training and identify the type of vehicles and securement systems used in training.</p>	<p>Attend all required training on wheelchair securement- and transportation-related topics. Ask questions!</p>	<p>When possible, participate in training and share personal perspective of what it's like to be secured in a wheelchair for transportation.</p>
<p>Provide thorough train-the-trainer instruction to staff who provide training on the wheelchair securement process. Document training, provide re-training on a regular basis, and monitor instruction to ensure quality of training provided to staff.</p>	<p>Request to become a trainer and advance knowledge on this topic. Share feedback regarding any training concerns or recommendations.</p>	<p>When possible, participate in instructor training to share personal perspective of the wheelchair securement process.</p>
<p>Consistently document supports and safeguards required for safe transportation across all service plans. Make sure plans address all requirements for securing both the person and the wheelchair, and address the use of postural supports during transportation.</p>	<p>Participate in planning meetings where individual supports and safeguards are discussed. Share feedback and ask questions!</p>	<p>Participate in staff training to help staff learn about your needs, wishes, and preferences.</p>
<p>Provide staff training on supports and safeguards that is frequent and interactive. Training should document objectives, content, type of training, and length of training.</p>	<p>Familiarize yourself with service plans, safeguards, and supports needed to provide services to people in care. Ask questions!</p>	<p>Participate in staff training to help staff learn about your needs, wishes and preferences.</p>
<p>Provide routine inspections of vehicles, lifts, and wheelchair securement equipment. Maintain equipment according to manufacturer guidelines. Inspect and/or replace equipment after any incidents or accidents.</p>	<p>Document inspection of equipment according to policy. Report any issues immediately.</p>	<p>Inform staff if you are aware of any equipment issues.</p>

Policy Guidance on Safe Transportation of People Using Wheelchairs

This policy guidance was created by the New York State Justice Center for the Protection of People with Special Needs as a resource for provider agencies. It does not address every scenario that could occur and does not constitute legal advice. It is intended to be used as a guide that may be modified as needed. Providers should consult with their agency counsel to resolve any questions on the legal implications of specific provisions. Agencies should ensure their policies comply with all pertinent New York State laws, codes, regulations, or administrative memos from relevant state oversight agencies regarding the safe transportation for people receiving services, including those who use wheelchairs. Agencies should also make sure policies include or address the specific considerations noted below.

Training

- ▶ Include people receiving services in the training and education process.
- ▶ Require sensitivity training so that staff gain a deeper awareness of the experience of a person using a wheelchair, and of the related concerns and vulnerabilities.
- ▶ Require interactive staff training related to wheelchair securement and identify refresher training requirements.
- ▶ Ensure staff are trained on wheelchair securement when new vehicles or securement systems are used.
- ▶ Require staff training that is individualized for people who use specialized equipment, such as tilt-in-space wheelchairs.
- ▶ Detail agency-wide requirements for retaining and storing training documentation.
- ▶ Identify who is responsible for providing staff training on wheelchair securement and outline how monitoring will take place to ensure training requirements are met.

Supports and Safeguards

- ▶ Identify all documents that detail individual transportation-related supports.
- ▶ Address requirements for passenger seat belt use.
- ▶ Use person-centered language in all service planning documents.
- ▶ Require site-specific plans needed to have staff trained in wheelchair securement.
- ▶ Ensure all transportation-related documents for wheelchair securement are consistent and updated as changes occur.

Equipment

- ▶ Use consistent terminology to refer to wheelchair tie-down and occupant restraint systems.
- ▶ Address whether the use of postural supports is safe for transportation.
- ▶ Direct staff to secure equipment not in use and other loose objects.
- ▶ Identify limitations and safety requirements for the use of the platform lift by people who do not require a wheelchair for transportation.

- ▶ Include agency-wide requirements to maintain securement equipment according to manufacturer's guidelines.
- ▶ Outline requirements to keep wheelchairs in working order.
- ▶ Include requirements for conducting regular inspections of equipment in keeping with manufacturer's guidance at minimum.
- ▶ Have a process for reporting equipment malfunctions or issues.
- ▶ Detail a process for inspecting or replacing equipment that has been involved in an accident or incident.
- ▶ Address the need and use of accessible parking tags.

Staffing

- ▶ Address requirements for staff seating and placement in vehicles to maximize support available to people in care.
- ▶ Detail supervision requirements while people in care are in vehicles.

Toolkit Resources

[Q'STRAIT – Training Solutions](#)

[University of Michigan Transportation Research Institute – Wheelchair Transportation Safety](#)

[Massachusetts Department of Developmental Services Learning and Development Website – Wheelchair Safety Tips](#)

[University of Massachusetts Medical School – Eunice Kennedy Shriver Center – Center for Developmental Disabilities Evaluation and Research – DDS Safe Transportation of People in Wheelchairs](#)

[Rehabilitation Engineering and Assistive Technology Society of North America – Position Papers, White Papers, and Provision Guides](#)

[National Highway Traffic Safety Administration](#)