ACSA
Aged & Community Services Australia

ABN 48 609 882 288

7 March 2019

Marde Bevan
Coroner's Registrar
Coroner's Court of Victoria
65 Kavanagh Street
Southbank VIC 3006

Dear Ms Bevan

Re: Court ref: COR 2016 003726 – Doris C Spratling

Aged & Community Services Australia (**ACSA**) acknowledges receipt of your letter dated 14 December 2018 regarding the death of Doris C Spratling (Court ref: COR 2016 003726).

Pursuant to Section 72(3) of the *Coroners Act 2008* (Vic), ACSA responds to the recommendation as follows:

Recommendation

That Aged & Community Services Australia alert their members regarding this finding and encourage members to review their use of ceiling hoists in accordance with the manufacturer's instructions and their compliance with the WorkSafe Safety Alert on patient handling and portable ceiling hoists dated August 2013.

ACSA developed a publication titled "Coroners Court of Victoria calls on aged care providers to review use of ceiling hoists". ACSA provided its members with an email alert on 07 March 2019 at 3.24pm, directing them to the ACSA Weekly publication dated 07 March 2019. A link to this publication can be found at the following URL address https://www.acsa.asn.au/getdoc/ba116945-4a06-42c3-94d3-f7bbf6debd89/Coroners-Court-of-Victoria-calls-on-aged-care-prov.aspx please also refer to Attachment 1 provided on page 2 of this correspondence for the full article.

Should you or the Coroner wish to discuss this further, please contact ACSA on (03) 9108 0750.

Yours faithfully

Pat Sparrow

Pat Sparrow
CEO
Aged & Community Services Australia

ADELAIDE
1st floor, Building 3, 32-56
Sir Donald Bradman Dr
Mile End SA 5031
(08) 8338 7111

BRISBANE
Level 3, 19 Lang Pde
Milton QLD 4064
0414 470 940

CANBERRA
Level 1, 10 Thesiger Ct
Deakin ACT 2600
(02) 6282 7827

HOBART
19 Brisbane St
Hobart TAS 7000
(03) 6105 0246

MELBOURNE
Suite 3, Level 6, 24-28 Collins St
Melbourne VIC 3000
(03) 9108 0750

PERTH
Level 2, 25 Walters Dr
Osborne Park WA 6017
(08) 9244 8233

SYDNEY
Level 6, 5 Rider Blvd
Rhodes NSW 2138
(02) 8754 0400

Attachment 1

Coroners Court of Victoria calls on aged care providers to review use of ceiling hoists

ACSA received a report from a Coroner of the Coroners Court of Victoria in December 2018 in relation to the investigation into the death of a resident in care at a Victorian aged care facility operated by Facility A. The death, which occurred on 11 August 2016, was the direct result of an accident and therefore, in accordance with the Coroners Act 2008, was reportable to the Coroner. The resident died as a consequence of a fall from a ceiling hoist. At the time of the incident two care staff were working together to transfer the resident to assist her with her hygiene activities. The staff were using a hygiene sling attached to a straight bar ceiling track and a Molift Portable Ceiling Hoist to transfer the resident from her bed to a shower chair. There was no evidence available to firmly establish the cause of the incident.

As verified by an eye witness of the incident, the circumstance attributing to the resident's death was that the 'lifting machine used to transfer the resident separated from the overhead track and the resident fell to the ground'.

The aged care facility where the incident occurred conducted extensive internal investigations into the resident's death and external investigations were also conducted by WorkSafe Victoria and the Coroner's investigator. Investigations undertaken into the equipment used and work practices at Facility A - including staff qualifications, training, work policies, work practices and general facility quality controls - uncovered the following findings:

<u>Coroners investigations</u>

- The Molift Portable Ceiling Hoist used during the incident was a remote controlled automatic lifting machine that connected to an overhead tracking system, enabling resident transfer. The hoist had a safe working load of 235kg.
- The hoist machine was attached to the hygiene sling and was used to extend/or retract the hoist webbing to lift or lower the resident.
- A flexi-link carabiner clip (safety hook) connected the hoist webbing to the ceiling track assembly by a trolley strap assembly that acted as an extension strap.
- An extension rod (aluminium rod) was used to operate the safety hook in order to attach it to the lower D-ring of the trolley strap.
- There was evidence to support that the hoist was inspected on an annual basis and was in good working order.
- An investigation of Facility A's Manual Handling Policies and Procedures Resource Book (updated in July 2016) included procedures to ensure the safety hook was correctly locked and in good condition and to check all ceiling hoist connections to ensure they were secure before transferring residents.
- An October 2018 Occupational Health and Safety Risk Assessment and Control Plan for the use of ceiling hoists identified that the ceiling hoist had a manufacturer designed retrofit to hook directly into the ceiling track and staff were trained in pre-transfer and cross checks to ensure safety prior to transferring residents.
- Both staff involved in the incident had received annual manual handling training and competency assessments and were qualified in either Certificate VI or Certificate III Aged Care.

Facility A investigations

- At the time of the incident a blue sling was in use, which was designed for use by large people. However, the resident's care plan directed that a medium sling be used for transferring the resident. This discrepancy did not cause the incident.
- Following the incident - on examination of the equipment used to transfer the resident - all hooks, the blue strap and connections, the Flexi-link and the Molift lifter were intact.
- There was sideways movement from the keeper on the Flexi-link, but the keeper still contacted the hook.

WorkSafe investigations

- The fall occurred because the latch disconnected from the strap linkage.
- There was no obvious failure of any hoist components.
- An observation was made by the investigator that the safety latch of the Flexi-link had considerable play - resulting in an incomplete closure - and was absent of any additional latch features.
- The investigator concluded that the clip was not correctly attached to the strap D-ring on the date of the incident.

Facility A - response to the Incident

- All models of Molift Portable Ceiling Hoist were removed from service pending further investigation and the ceiling hoist provider was informed of the incident.
- Trolley components of the ceiling tracks were replaced with larger fixed-point ceiling track attachments.
- The swivel trolley attachment and hanging strap used at the time of the incident was replaced with a direct non-swivel trolley attachment.

Recommendations resulting from the Coroner's findings included:

1. That ACSA members received notification of the finding into the death of the resident.
2. Encourage ACSA members to review the use of their ceiling hoists in line with the manufacturer's instructions and with compliance with the WorkSafe Victoria safety alerts on patient handling and portable ceiling hoists, published in August 2013.

ACSA recommends members consider the following when reviewing their practices related to the use of ceiling hoists (noting this list is 'illustrative' rather than 'exhaustive'):

Are you able to demonstrate the following?

- Contemporary falls risk assessments for residents who require the use of mechanical lifting devices, including up to date manual handling procedures within resident care plans;
- Correct emergency management procedures being in place, including the commencement of observations (including neurological) and rapid decision to call the ambulance, when traumatic injuries occur;
- Equipment has been serviced and inspected annually and/or in accordance with manufacturer's guidelines;
- Appropriate worker qualifications, training, work practices, facility quality controls etc;
- Details for using a ceiling hoist detailed in manual handling resource information, and routinely updated;
- Training – contemporary records of staff having completed manual handling workbook and competency assessment in relation to the operation of mechanical lifters;

- Contract staff: evidence of contract/agency staff being provided with manual handling training by the contracting service that engages them and that this is incorporated into the services agreements; and
- Completed contract staff induction processes.

You may like to also consider a practice that requires two staff to 'cross check' the security of connections on mechanical lifters prior to undertaking lifting of a resident.

References:

1. WorkSafe Victoria – Safety Alert, August 2013
'Patient handling - Portable ceiling hoist: Information for employees about the safe use of ceiling hoists.'
https://www.disabilitysafe.org.au/sites/all/themes/nexus/files/safety_alert%20ceiling%20hoist.pdf

2. WorkSafe Victoria – Safety Alert, Friday 1 November 2013
'Portable Hoist with Sling Attachments - Information for employers about the safe use of portable hoists with sling attachments.'
https://www.worksafe.vic.gov.au/safety-alerts/portable-hoists-sling-attachments

3. WorkSafe Victoria – Safety Alert, Wednesday 23 January 2019
'Portable Hoist with Sling Attachments - Information for employers about safe use of portable patient handling ceiling hoists.'
https://www.worksafe.vic.gov.au/safety-alerts/portable-patient-handling-ceiling-hoists